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TRAINING PROGRAMMES

The training programmes at FACT are separated according to geography. There are three programmes:

- Community based training programme to service local Manicaland programmes
- School Without Walls assists in training of other Zimbabwean programmes
- Regional Training Programme that involves surrounding African country programmes

Training is participatory and practical, based on field visits and personal experience.

Community Based Organisational Development Programme (CBODP)

86% of the Manicaland population is rural. Many centres have established groups within churches, farms and missions.

Between 1992 and 1996 over 20 000 people were trained from rural centres in HIV/AIDS information and communications skills. As a result of the skills training, several groups have since established home care, training and support programmes for people living with HIV and orphans. These programmes are provided with training, skills, material and technical support by CBODP.

School Without Walls

This programme provides practical training in specific modules during a 3 - 5 day course. Participants are invited from throughout Zimbabwe. Modules facilitated include home care, youth, organisational development, spiritual care and orphans. Exchange visits between programmes are facilitated.

Regional Training Programme

This new programme began in 1996 as a result of requests to assist other groups outside Zimbabwe to provide training. Participants from Southern and Eastern Africa countries apply to attend an intensive two week course consisting of three modules designed to suit the particular group. Modules are available in home care, youth, and organisational development. Training is practical and participatory and course materials are provided. Following training participants are encouraged to form their own informal networks.

MEMBERSHIP

FACT depends on its membership for support and guidance.

Members are encouraged to be involved in fund raising, information giving and raising awareness of both the organisation and the disease.

The membership elects an Advisory Board. An Executive Committee oversees the running of the organisation and report to the membership annually.

ADMINISTRATION

FACT has an administrative department which is responsible for overseeing financial issues, supporting programmes and communicating with members of the public.

Further information about any of the programmes can be obtained from:

Information Officer
Family AIDS Caring Trust (FACT)
P O Box 970
Mutare

Telephone:	61648/67493/66015
FACT Youth Centre:	67638
FASO Centre:	66309
FACT Rusape	025 - 3491
Fax:	65281
E-Mail:	fact@mango.zw

Printed: October 1998

Information about Family AIDS Caring Trust, Mutare

Founded in 1987, in Mutare, as Zimbabwe's first AIDS Service Organisation, FACT is a community-based organisation, and has strong links with many churches and other organisations. Other associations/branches were started in Masvingo, (1989), Chiredzi (1992) and Rusape (1994).

FACT Mutare Mission Statement

FACT is a Christian-based organisation working with various communities to provide HIV prevention programmes, training and care for the whole person.

FACT promotes sexual abstinence outside marriage and faithfulness within marriage.

FACT provides unconditional care and support to people affected by HIV/AIDS.

Worldwide FACT supports and cooperates with others who are responding to AIDS in their communities.

The World Health Organisation believes that the AIDS epidemic will take its greatest toll in countries in Southern Africa. In Zimbabwe:

- About 1.5 million people are infected with HIV; in some towns in Zimbabwe, over one third of pregnant women were found to be HIV positive (1997)
- Increasing numbers of young adults and infants die annually as a result of AIDS

FACT has established a number of prevention, care and training programmes.

PREVENTION PROGRAMMES

Prevention programmes are based on the concept of peer education and operate within Manicaland.

Youth Programme (Family Life AIDS Action Groups - FLAG)

Young people are both a vulnerable as well as impressionable group. FACT developed its educational programme in schools in 1998 using a storytelling technique and visual aids. During 1989, FACT assisted in the establishment of Zimbabwe's first AIDS Action Group in Mutare and the programme was launched in 1992. By 1997 FLAG was operating in six rural areas and supporting 254 clubs. Clubs are in secondary schools, primary schools, out of school and at teachers colleges.

Each FLAG has a committee of young people which organises weekly club activities such as talks, visits, drama or videos. Members of clubs seek to avoid sex before marriage and help to raise awareness of AIDS by others around them. They also seek to encourage caring responses towards people with HIV/AIDS. FACT supports the clubs with materials, training as well as facilitating networking and exchange visits.

Street Youth

Homeless or financially poor youths are particularly vulnerable to sexual abuse and experimentation and drug abuse. In 1994 a programme was initiated to develop relationships with youths living on the streets in Mutare. Youths meet weekly for entertainment, training and skills development.

Nyanga

The Nyanga district is large and has some particularly active HIV/AIDS programmes. An office in Nyanga was opened in 1996 and provides support to youth, home care and training programmes in the area and supports other local programmes.

Rusape

The Rusape programme runs peer education (community and workplace), home care and youth projects. The programme has a local committee overseeing projects and receives technical and administrative assistance from FACT Mutare.

Mutasa Peer Education

This combined research and implementation project began in mid 1998. Peer educators are trained from different sites which include commercial, semi urban, farms and growth points. The implementation of prevention activities is closely monitored in order to analyse the effects and strengths of such programmes. FACT is involved in the implementation of this project. Blair Research is carrying out the research studies.

Moçambique

The Moçambique border is 10kms from Mutare. A natural linkage was made with AIDS programmes in Chimoio. FACT provides training and technical support to various prevention, youth and women's programmes in operation areas.

CARE and SUPPORT PROGRAMMES

Home Care

This programme links with other city wide home care projects through membership with the Mutare Home Care Forum. The present programme started in 1992 by developing links with medical institutions and visiting patients in homes.

A coordinator and four assistants visit patients with HIV/AIDS in Mutare. The frequency of their visits is determined by the clinical and social conditions of their patients. Training of family members in home care and home help services are provided.

Assistance is given to two rural based home care programmes.

Church

Churches are established community groups with a mandate to provide care and support to the sick, widows and orphans.

Local community members refer patients to the programme which trains and supports local churches to run prevention and care programmes within their communities. The programme works closely with the home care programme in providing spiritual support to patients with HIV/AIDS. Prevention programmes have been established within youth groups in many churches.

Families, Orphans, Children under Stress (FOCUS)

In 1991, it was estimated that there were 47 000 children in Manicaland who had lost either a father or mother. Only 170 of these were living in institutions. The rest were being cared for by members of their extended family. Many child and adolescent headed households now exist.

This programme operates in five rural areas and one urban, where support is given to community groups to provide support to children in need in their homes. Training, material and technical support is provided to the programmes run by members of the local community. Social activities and informal skills training is arranged for children.

Family AIDS Support Organisation (FASO)

People with HIV may make the best educators and counsellors in view of their special understanding of AIDS. Since mid 1992, the FASO group has met regularly. Skills training and income generation activities include sewing, knitting, tie and dye, group management and financial administration.

A drop in centre was opened in 1997. This provides:

- spiritual and psychological support
- income generating
- health care
- stigma reduction
- material assistance
- skills development

FASO has its own constitution, however FACT provides technical assistance and administrative support, and administers financial resources.

Achievements of RTP

* 302 Trainees trained and equipped
* Over 15 000 community members trained
* Institutional capacity building
* Material production

Impact on Individuals

* Acquisition of skills
* HIV/AIDS taken more seriously
* Improved community status
* Change in attitudes
* Behaviour changes

People Remember:

20% of what they read

40% of what they learn

80% of what they discover

The Rural Training Programme provides training and materials that are condusive to learning by discovery. Participatory methods are used and materials do not require specialised equipment.

For further information contact:

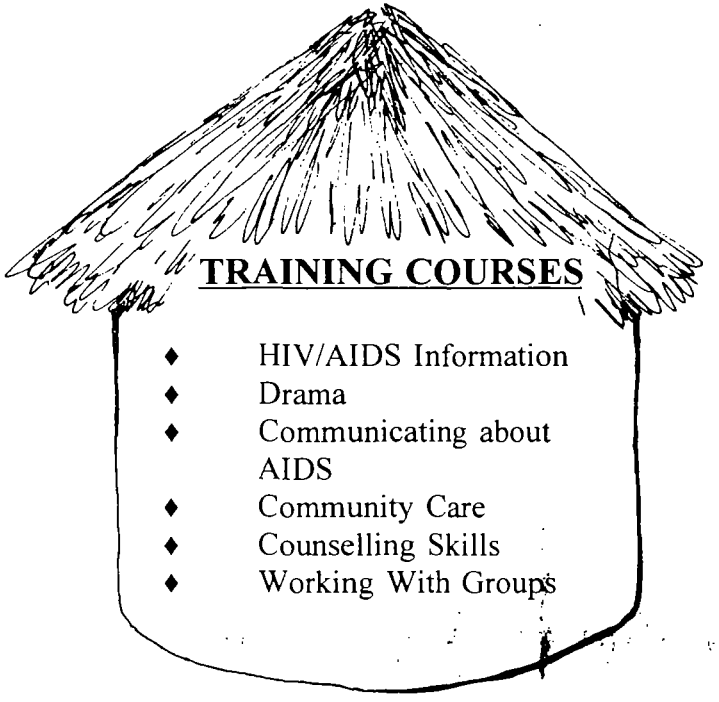
RURAL TRAINING PROGRAMME,
FACT,
P.O. BOX 970,
MUTARE.

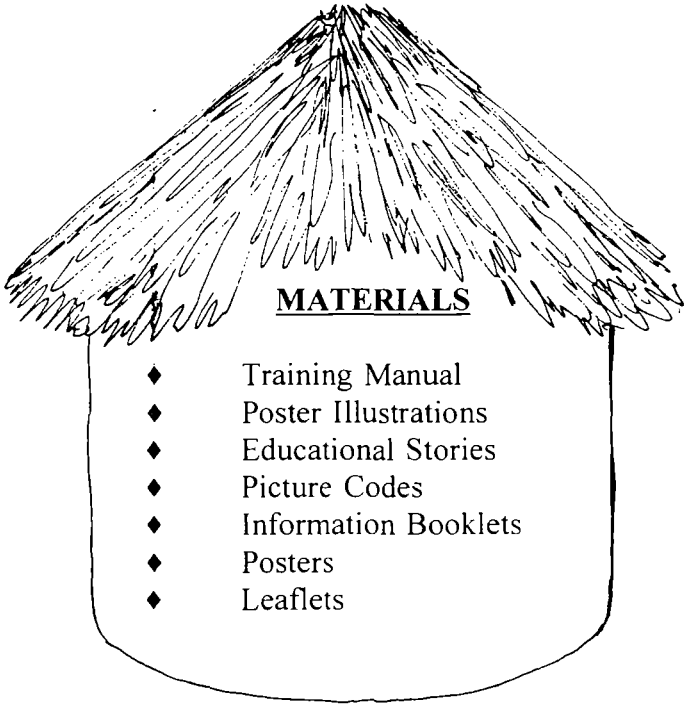
AIDS EDUCATION

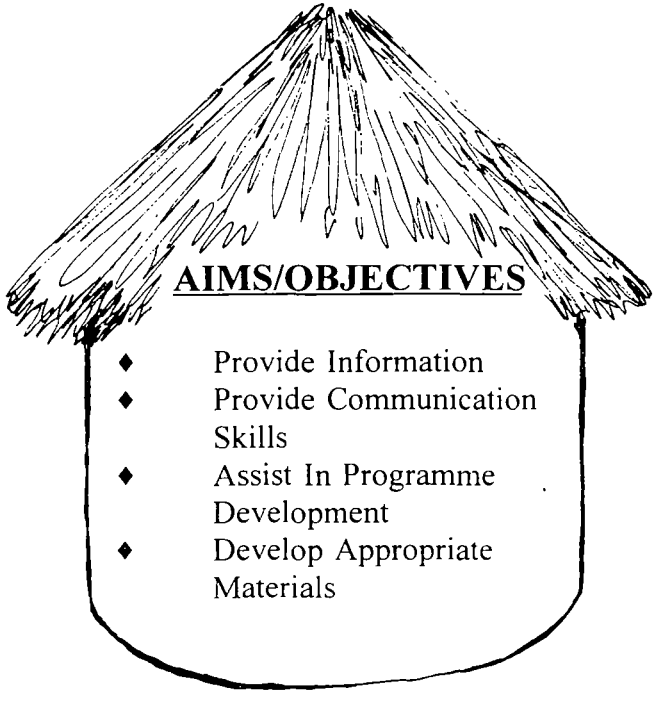
FOR RURAL ZIMBABWE

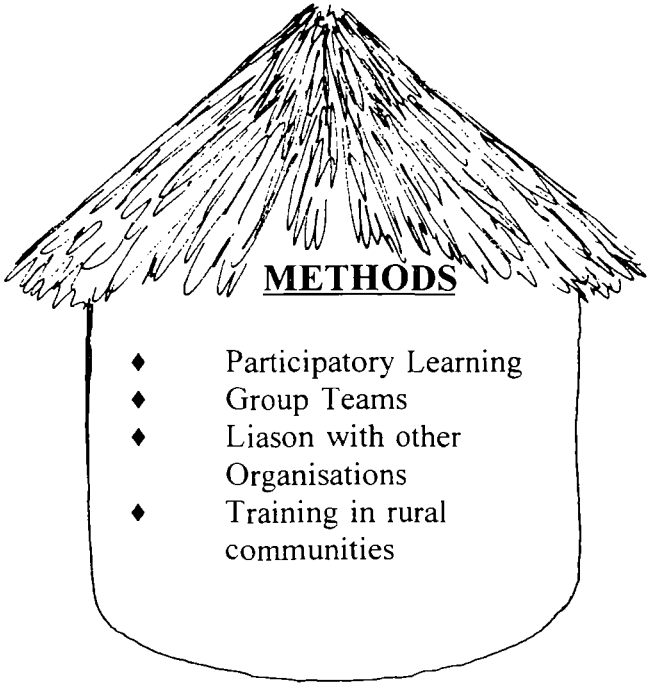
An HIV/AIDS Information and Programme Development activity of Family AIDS Caring Trust (Mutare).

SUPPORT
Newsletters
Correspondence
Site Visits
T Shirts
Identification Badges
Training Materials
Training Workshops


TRAINING COURSES
HIV/AIDS Information
Drama
Communicating about AIDS
Community Care
Counselling Skills
Working With Groups


MATERIALS
Training Manual
Poster Illustrations
Educational Stories
Picture Codes
Information Booklets
Posters
Leaflets


AIMS/OBJECTIVES
Provide Information
Provide Communication Skills
Assist In Programme Development
Develop Appropriate Materials


METHODS
Participatory Learning
Group Teams
Liason with other Organisations
Training in rural communities

established homecare, awareness and orphan support activities.

YOUTH PROGRAM

FACT developed its educational programme in schools in 1988 using a storytelling technique and visual aids. During 1989, FACT assisted in the establishment of Zimbabwe's first anti-AIDS club in Mutare.

The FLAG programme was launched in 1992. Each Family Life Anti-AIDS Group has a committee of young people which organises weekly club activities such as talks, visits, drama or videos. Members of clubs seek to avoid sex before marriage and help to raise awareness of AIDS by others around them. They also seek to encourage caring responses towards people with HIV/AIDS

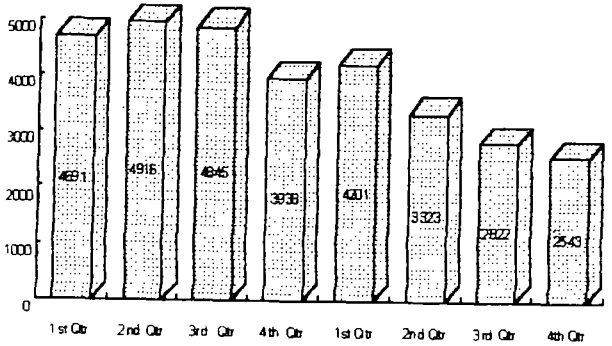
Over 40 schools and 5 out-of-schools groups have been established. Most schools clubs have memberships of between 30-80 students within two or three weeks of their establishment. Income-generation is a focus of the smaller out-of-schools clubs.

HIV PREVENTION PROJECT

The spread of HIV in Zimbabwe has been rapid. One of the most important factors in the spread of HIV is prostitution. Most Zimbabwean men have engaged in prostitution. During a survey carried out on one night in 1993 in Mutare, nearly 2,000 women were actively seeking commercial sex at bars, beerhalls and bottle stores. Programmes which lead to changes in sexual behaviour of prostitutes and their clients may lead to rapid reductions in the spread of HIV and other sexually transmitted diseases (STDs).

The project is run in collaboration with the Mutare City Health Department and the University of Zimbabwe. The coordinator meets each week with a group of 40 peer educators, mainly women previously involved in prostitution. During the week educators organise and conduct over 100 meetings in bars, beerhalls and private homes. AIDS education becomes entertainment as educators sing songs and perform drama about AIDS, family life and the advantages of staying faithful and avoiding sex outside marriage.

In addition, over 100 workers from some 20 companies were trained to conduct regular AIDS awareness in the workplace. Most of the educators are men. The programme has led to changed behaviours and a remarkable fall in STDs; many of the men now avoid getting drunk and practising commercial sex.



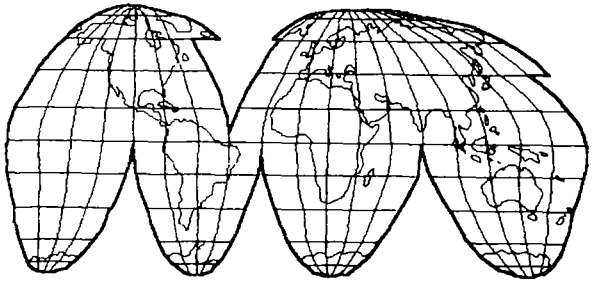
STDs started to fall in Mutare City soon after the programme started in late 1991

For more information, contact FACT, Box 970, Mutare, Zimbabwe. Tel 20-61648; Fax 20-60652. Visits to programmes may be arranged by written request.

Information about Family AIDS Caring Trust

Founded in 1987 as Zimbabwe's first AIDS Service Organisation, FACT is a community-based organisation, and has strong links with many churches and other organisations. FACT was established in Mutare, Zimbabwe's third city (population 140,000). In 1989, a branch was established in Masvingo though this is currently non-operational; in 1992, a branch was opened in Chiredzi and in 1994, another was opened in Rusape.

FACT's approach to the AIDS epidemic is community-based and development-oriented. FACT has assisted communities to establish their own AIDS-related activities through the provision of training, material and technical support. Development issues are addressed through emphases on women's programmes and income generation.



The privilege of being involved in Zimbabwe's AIDS programmes is tempered by the increasing toll of human suffering caused by AIDS. The AIDS epidemic in Zimbabwe continues to advance at a staggering pace. The World Health Organisation in December 1993 stated:

- Of the **15 million** people with HIV infection worldwide, nearly 10 million live in Africa

- In the last 12 months, 1.5 million people in Africa were infected; over half of them were 15-24 year olds.

WHO believes that the epidemic will take its greatest toll in countries in southern Africa; in Zimbabwe:

- About one million people are infected with HIV; in some towns in Zimbabwe, nearly **one half of pregnant women** were found to be HIV-positive

- Increasing numbers of young adults and infants died as a result of AIDS. Many children are being orphaned and are now being cared for by aunts, grandmothers and in some cases older sisters and brothers.

CARE AND SUPPORT

A counselling service was established by FACT in 1988; although this has continued, a greater emphasis is now placed upon material and pastoral support for those affected by HIV/AIDS. FACT currently operates two care programmes and assists FASO, a support organisation run by people with HIV.

HOMECARE PROJECT

The present programme started in 1992. A coordinator supervises four trained assistants who visit patients with HIV/AIDS in Mutare. The frequency of their visits is determined by the clinical and social conditions of their patients. Training of family members in homecare and home help services (cleaning, shopping and cooking) are provided.

Each month, approximately 100 home visits are made, 20 clients are counselled and 20 families are assisted with material support. Prayer and bible study take place in homes as requested.

FAMILIES, ORPHANS AND CHILDREN UNDER STRESS (FOCUS)

In 1991, we estimated there were 47,000 children in Manicaland (popn 1.5 million) who had lost a father or mother; 170 of these children were living in institutions. The rest were being cared for by members of their extended family. We estimated one quarter of households in Zimunya, a rural area adjacent to Mutare, contained orphaned children; some child-headed households were identified and have received material assistance.

FACT's programme now operate in two rural areas; we seek to work closely with community groups to provide support to children in need **in their homes**. Church women have been trained to map out their local area, identify those families most in need and provide support; this may be food, clothes, school fees, help with buildings, regular visits, help in developing an income or spiritual support.

FAMILY AIDS SUPPORT ORGANISATION

People with HIV may make the best educators and counsellors in view of their special understanding of AIDS. Since mid-1992, the FASO group has met weekly. Skills training and income generation activities include sewing school uniforms and knitting jerseys; material assistance has been given when possible; and members have been helped through counselling, advice and spiritual support.

FASO has spearheaded national activities on behalf of people with HIV/AIDS. In 1993, FASO organised a national conference for 80 people with HIV/AIDS and developed a charter of rights; these activities were aimed at reducing the stigma attached to AIDS by lobbying for human and legal rights for people with HIV/AIDS.

PREVENTION

Four prevention programmes are administered: workplace and high risk HIV prevention programmes are limited to Mutare City. Youth and rural training programmes operate throughout Manicaland. The programmes are based around the concept of **peer education** - people are trained so that they can help to influence behaviour change in others around them.

RURAL TRAINING PROJECT

The programme trains people from rural areas (e.g. farmworkers, women's club members, church members) who then educate others about AIDS, STDs and prevention during 20-hour training courses. During an 18 month period, 200 people were trained who have in turn trained 5000 others. As a result of the programme, some groups have now

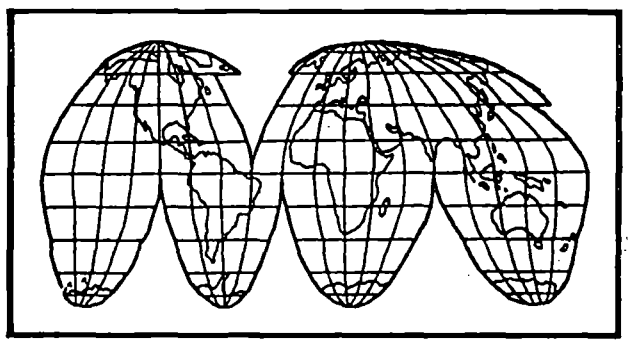
assisted communities to establish their own AIDS-related activities through the provision of training, material and technical support. Under-development is a major underlying cause of the rampant AIDS epidemic and development issues are addressed through emphases on women's programmes and income generation.

Mission Statement

FACT is a Christian-based organisation working with communities to provide HIV prevention programmes, training, and holistic care.

FACT promotes sexual abstinence outside marriage and faithfulness within marriage and provides unconditional care and support to people affected by HIV/AIDS.

Worldwide, FACT supports and cooperates with others who are responding to AIDS in their communities.

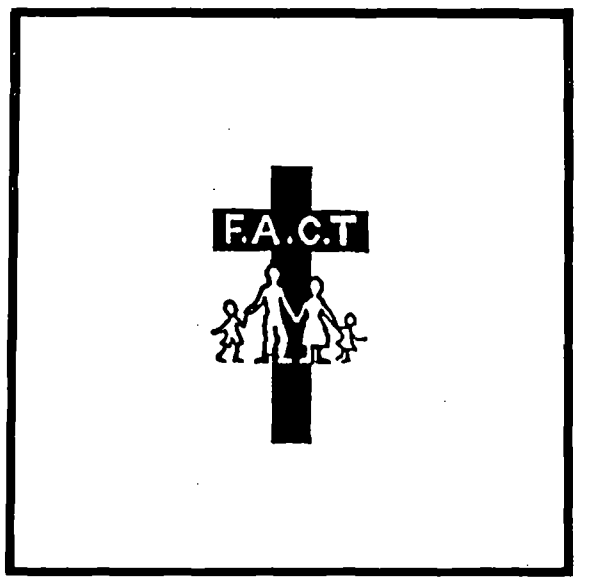


FACT has a staff of sixteen with programmes in the following areas

Prevention
Youth Programme
Workplace Programme
Community HIV Prevention Programme
Rural Training Programme

Care and Support
Home Care Programme
Families, Orphans and Children Under Stress (FOCUS) Community Support Programme
HIV Support Group (Family AIDS Support Organisation)

Family AIDS Caring Trust



YOUTH PROGRAMME

Background

The Youth Programme, commonly known as Family Life AIDS Action Groups (FLAG), was established in April 1992; at that time, there were two clubs in secondary schools in Mutare, Approval was obtained from the Ministry of Education and by early 1995, there were over 150 clubs in schools in Manicaland and else where.

Peer education is in the cornerstone of the programme. Young people learn about AIDS in their clubs and then teach their colleagues what they have learnt. The objectives of the clubs are to:

- help members avoid HIV/AIDS by avoiding sex before marriage
- provide appropriate, sufficient and accurate information on how HIV transmission can be prevented.
- increase members' compassion for those who are HIV - positive or suffering from AIDS
- enable FLAG members to be in a position to educate others about HIV/AIDS

About Family Life AIDS Action Groups

The clubs are groups of people who have decided they will try to stop the spread of AIDS. They have decided to protect themselves from the disease and to help other people to stay safe by telling them about AIDS. They have also decided to help anyone who is already infected with HIV or ill with AIDS. Club members discuss AIDS and other issues which affect them and come up with solutions to these problems.

Why focus attention on youth?

Most young people are not infected with HIV. But with over one half of Zimbabwe's population under 18 years old, each year a large number of teenagers are becoming sexually active; about two-thirds of new HIV infections in Zimbabweans occur in people under 25.

Young women are particularly at risk. Teenagers get HIV and other sexually transmitted infections particularly easily.

The high risks of HIV infection for today's youth are not balanced by high rates of knowledge; young people have restricted access to information about sex.

Support to clubs

FACT provides support to FLAGs in several ways; Each term, FLAG staff produce a programme and a pack of resource materials for clubs to use each week during their meetings;

Membership cards and pocket calendars are provided free of charge for each member. Badges for committee members and club members are also provided. Members may purchase FLAG tee shirts and ball pens.

A termly newsletter is provided for each FLAG member. Competitions and joint inter-schools end-of-term meetings are organised and outstanding members and clubs receive certificates and trophies.

As well as suggesting speakers and facilitators for clubs, the programme coordinator has trained and supervises a network of youth programme assistants who visit clubs in their allotted areas:. The programme provides training for teachers in charge of FLAGs.

Programme Assistants in the FLAG Programme

AREA	NAME
Mutare City & District	Fungai Faida
Nyanga	Perkins Machanganje
Mutasa (Honde Valley)	Timothy Chirewo
Buhera	Action Zion
Mutare (Zimunya)	Mrs. J. Bhudiyo
Mutare (Marange)	Maxwell Mabutu
Rusape	Loveness Machingauta

Type of Clubs

Secondary school clubs are usually run by older students in the school. Primary school clubs involve Grade 6 and 7 pupils.

Out-of-school youth clubs involve school leavers, mostly 15 - 19 years old. Clubs have also been established in places of higher education.

Many church youth groups are now using FLAG materials on a monthly basis in their existing youth programmes; further information about this may be obtained from FACT's church programme leaflet.

Family Life AIDS Action Groups in Manicaland

DIST.	SEC. SCHOOL	PRIMARY SCHOOL	OUT-OF -SCHOOL	TEACHERS' COLLEGES	TL.
Mutare	30	0	1	2	33
Nyanga	13	25	2	0	40
Mutasa-Honde	12	27	1	0	40
Buhera	6	9	0	0	15
Mutare-Zimunya	3	4	0	0	7
Mutare-Marange	8	12	0	0	20
Rusape	5	0	0	0	5
TOTAL	77	77	4	2	160

In addition to clubs directly supervised by Youth Programme staff, FACT also helps other organisations to start and supervise clubs; FACT provides FLAG programme support materials to: FACT Chiredzi (2 secondary schools, 5 primary schools and 2 out-of school clubs), Catholic Diocese of Hwange (Lubchanko House), Anti-AIDS Project (Zambia), Youth Project (Namibia) and OJM (Mozambique Youth Project).

Behaviour Change taking place

School and communities which have a club operating have noticed a difference in sexual behaviour. Giving young people support and information is the best way to stop the spread of HIV/AIDS.

Starting a Club

Permission from the headmaster is required before starting a schools club; this may be obtained more easily after communication with FACT. Anyone interested in forming a club is invited to attend the first meeting. School clubs elect a student committee.

A patron of the club is also chosen, usually a teacher interested in the subject. FACT runs workshops for teachers interested in supporting a FLAG in their school. Clubs weekly in school terms and those registered with FACT receive support materials, badges, membership cards cheap tee shirts.

How can I start a FLAG club?

For more information on starting a youth Family Life AIDS Action group in your area, contact:

Youth Coordinator,
FACT
Box 970
Mutare

Tel. Lovemore Tapfuma Magwere 20 61648

About FACT

Family AIDS Caring Trust is Zimbabwe's oldest AIDS Service Organisation founded in 1987. FACT has strong linkages with most Christian denominations.

FACT was established in Mutare, Zimbabwe's third city with a population of 140.000. Branches were established in Masvingo (1989), Chiredzi (1992) and Rusape (1994).

FACT's approach to the AIDS epidemic is community-based and development-oriented. FACT

providing counselling and spiritual support to families.

How can you help?

There are several ways you can get involved in homecare services: perhaps you might like to invite FACT to speak at your church or community group about the homecare programme. Or you might like to undergo training so that you can start home visiting. You do not need to be a qualified nurse in order to become involved. All you need to start is a basic concern for other people like yourself - people who need friendship, care, practical support and prayer.
If you are interested in knowing more about this programme, please contact:

Mrs. Tebbie Nyaruwa
Home Care Coordinator,
FACT,
Box 970,
Mutare
Tel./Fax 20-61648/67493

ABOUT FACT

Family AIDS caring Trust is Zimbabwe's oldest AIDS Service Organisation founded in 1987. FACT is a Christian-based organisation, with strong linkages with most Christian denominations.

FACT was established in Mutare, Zimbabwe's third city with a population of 140,000. Branches were established in Masvingo (1989), Chiredzi (1992) and Rusape (1994).

FACT's approach to the AIDS epidemic is community-based and development-oriented. FACT has assisted communities to establish their own AIDS-related activities through the provision of training, material and technical support. Under-development is a major underlying cause of the rampant AIDS epidemic and development issues are addressed through emphases on women's programmes and income generation.

FACT works in collaboration with both government organisations and community groups. FACT has a staff of sixteen with programmes in the following areas.

Prevention
Youth Programme
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Home Care Programme
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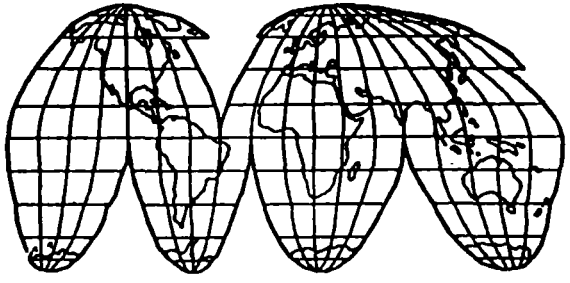
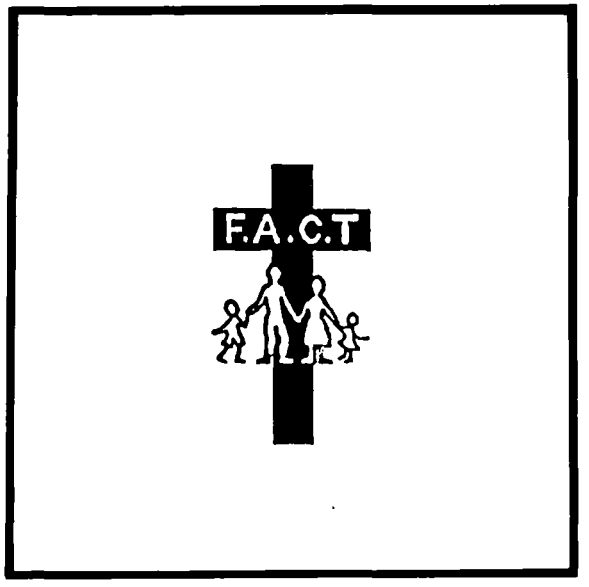
HIV Support Group (Family AIDS Support Organisation)



Family AIDS Caring Trust



Homecare Programme

Background

FACT started counselling services in Mutare in 1988 and helped the Ministry of Health to establish a homecare service based at Mutare Provincial Hospital. In 1990, FACT was invited to provide counselling by a local mission hospital dealing with TB patients. Patients were then visited in their homes by FACT staff and volunteers. Home visits had a strong spiritual focus. With increasing demand for its services, FACT appointed an experienced nursing sister to be its homecare coordinator in August 1992.

Objectives

* To provide medical, spiritual, psychological and physical support to the terminally ill
* To provide teaching and support to family members of patients
* To mobilise members of the community to become active in homecare and pastoral counselling
* To enlist the support of local churches in identifying and visiting patients requiring homecare.

The programme overlaps with FACT's church and orphan programmes and with Family AIDS Support Organisation, a support group for people with AIDS.

Structure of Programme

Mutare is the third city of Zimbabwe with a population of 140,000. Most patients are referred from the government hospital, though there is an increasing number of community referrals, through churches, neighbours and relatives contacting the homecare programme directly. Four Red Cross-trained assistants provide homecare to patients. Each assistant is allocated a zone in the city centre, suburbs or three high density townships. The programme also provides training and supervision to rural homecare programmes administered by a local church and a mission clinic. A pastoral worker, Mrs. Lorraine Muchaneta, is attached to the homecare programme.

Types of Services

Home Visiting: Frequency of visits is based on the status of the patient; the programme focuses on seriously ill patients. Housebound and bedbound patients are visited once or twice weekly. Critically ill patients are visited once or twice per day. Mobile patients are visited every one to three months.

Training of Family: The emphasis is upon the needs of the patient, nutrition and infection control. Education on hygiene and other health issues is also given to clients.

Counselling: This is provided by the coordinator, pastoral worker, and to a lesser extent by assistants.

Pastoral Support: Prayer, bible studies and counselling are provided when appropriate.

Material Assistance: Food, soap, disinfectant, gloves and other supplies are provided to clients and their relatives.

Home Help: Practical activities around the house such as cleaning, washing up, laundry and shopping are carried out when necessary.

Nursing Care: Basic nursing care such as bathing the patient and dressing wounds are carried out.

Funerals: Assistance is given in terms of food. Follow up activities are carried out and orphans are connected to FACT's orphan support programme. Referrals to Social Welfare are made. This department can assist with school fees, rent and sometimes through Public Assistance with a modest living allowance.

Future Developments

The number of people needing homecare is set to rise each year for at least the next decade. Only a minority of people requiring homecare services are currently being visited. The way forward must see an expansion of homecare services to involve greater numbers of volunteers and better methods of finding people needing homecare services. An evaluation of the programme in 1994 led to new directions for the homecare programme:

Coverage: Success in the homecare programme must not be seen in terms of providing good services for the few but in providing a service to all those in need. To do this, monitoring of coverage is vital.

Community-referrals: Many people requiring homecare are known to community-based organisations. Efforts need be made to encourage referrals to the homecare programme from churches and women's groups.

Training Volunteers: These organisations have a vital role to play in identifying members interested in giving a few hours a month to visit people needing homecare. FACT is able to offer training in homecare and short-term attachments to its homecare programme and assist in the supervision of volunteers.

Church involvement: Churches have a great advantage when it comes to getting involved in homecare. Some are already giving support to people in their homes through Christians experienced in

Return Form

I am interested in the FACT Training kit.
(Please tick appropriate box)

Θ I would like to order a kit/kits.

Quantity

Payment made by: Cheque/Money Order/Cash

Θ I would like to view the training kit. Please contact me to arrange an appointment.

Θ I would need additional information on beginning a training programme.

Θ I would require personal consultancy in beginning a training programme.

NAME OF APPLICANT:

.....

COMPANY/ORGANISATION:

.....

ADDRESS:

.....

.....

.....

TELEPHONE:.....

WHAT ELSE IS NEEDED?

Very little - besides a motivated and enthusiastic person to run training courses. Flipchart paper and makers will be used.

Training courses are enhanced by providing information booklets, certificates, paper and pens - but these are not compulsory.

HOW ELSE COULD FACT ASSIST?

FACT can provide written step by step guidelines on beginning a training programme which can be adapted to suit local situations. FACT can also provide personal consultancy to programmes in and around Mutare.

FACT can also assist in training small numbers of trainers who will use material in programmes. This would be done in conjunction with FACT's existing training programme on a consultancy basis.

HOW MUCH DOES IT COST?

The total training kit will cost Zimbabwe $250,00. A 10% discount is given for orders over 10.

WHERE DO WE PURCHASE IT?

Orders are made through FACT.
Contact person: Mrs. Fiona Robinson.

A TRAINING KIT FOR HIV/AIDS INFORMATION AND COMMUNICATION

A comprehensive training kit designed in Zimbabwe to equip trainers in participatory methods of peer education.

Produced by:
Family AIDS Caring Trust (FACT)
P.O. Box 970,
MUTARE

Telephone 120-61648

WHO IS IT FOR?

This training kit will suit organisations that have existing prevention, or propose to begin such programmes.

WHAT IS IT USED FOR?

Materials provided in the kit will equip trainers to run courses covering HIV/AIDS information and communication skills. The peer educators so trained will have increased knowledge and the necessary skills to begin activities aimed at preventing the spread of HIV.

HOW DO WE KNOW IT WORKS?

FACT has used these materials in a Rural Training Programme. During a two-year programme 185 Trainers have been trained. These trainers have then held courses in their communities and trained over 6000 peer educators. As a result existing programmes have been enhanced and five new programmes have started.

The materials are easy to use. Clear instructions for use are given and no specialised equipment is required.

The materials have been extensively modified based on the experiences during use. In particular, suggestions made by trainers have been included.

F.A.C.T.

A TRAINING MANUAL FOR HIV/AIDS INFORMATION & COMMUNICATION

Fiona Robinson

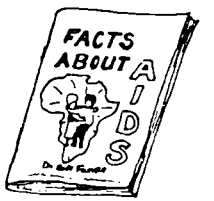
WHAT DOES IT CONSIST OF?

The training kit consists of:

A 230-page manual

31 poster illustrations - giving basic information about HIV/AIDS.

5 illustrated educational stories:
- Clever (mixed groups)
- Heavy (school children)
- Felix (workplaces - men)
- Anna (women)
- Amos (churches)



(Posters, illustrations and educational stories are on A3 size card)

"Facts about AIDS" information booklet.

Picture Code (prostitution) - designed to stimulate relevant discussion.

All in a convenient case.

WHO CAN USE THE MATERIALS?

The materials can be used by both professional and non-professional educators.

Written material is in English with some participatory sessions provided in Shona.

Because the training is participatory it is not necessary for trainers to have medical or educational backgrounds.

HOW IT IS USED?

The training uses five main educational forms:

- illustrated stories
- group discussions
- community surveys
- role plays
- illustrated information

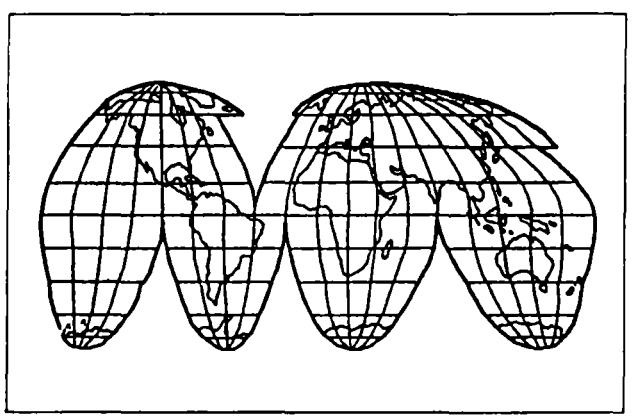
All training is participatory and instructions on how to hold sessions are given with each session in the manual.

A programme for a five-day training course is provided with instructions on how to run such a course. The programme can be easily be adapted to suit particular needs.

Is behaviour changing as a result of the programme?
The change of behaviour of many peer educators after completion of training is most evident. Often, men who used to get drunk and visit prostitutes change their behaviour following completion of training. They are sober when they leave the beer hall and have the strength to refuse women soliciting for commercial sex. The number of workers getting sexually transmitted diseases has fallen. Some companies which run their own health clinics have noted reductions of STDs after the start of the programme.

How can my company start the programme?
If your company is in Mutare, you may be interested in starting the programme. If you would like the co-ordinator to pay you a visit to explain the programme, contact:

Workplace Co-ordinator, FACT, Box 970, Mutare
Telephone: Thandiwe Gara, 61648



ABOUT FACT
Family AIDS Caring Trust is Zimbabwe's oldest AIDS Service Organisation founded in 1987. FACT is a Christian-based organisation, with strong linkages with most Christian denominations.

FACT was established in Mutare, Zimbabwe's third city with a population of 140 000. Branches were established in Masvingo (1989), Chiredzi (1992) and Rusape (1994).

FACT's approach to the AIDS epidemic is community-based and development-oriented. FACT has assisted communities to establish their own AIDS-related activities through the provision of training, material and technical support. Under-development is a major underlying cause of the rampant AIDS epidemic and development issues are addressed through emphases on women's programmes and income generation.

FACT works in collaboration with both government organisations and community groups. FACT has a staff of sixteen with programmes in the following areas:

Prevention
Youth Programme
Workplace Programme
Community HIV Prevention Programme
Rural Training Programme

Care and Support
Home Care Programme
Families, Orphans and Children Under Stress (FOCUS) Community Support Programme
HIV Support Group (Family AIDS Support Organisation)
Church-Based Programme

Family AIDS Caring Trust

F.A.C.T

Workplace Programme

Background

The programme was established in February 1992 by the Mutare City Health Department in collaboration with FACT. Peer educators were recruited from ten companies and trained to organise and conduct AIDS awareness meetings in their own workplace. Most of those employed are aged 25-45 years which is also the age group chiefly affected by HIV. Peer educators were recruited from ten companies and trained to organise and conduct AIDS awareness meetings in their own workplace. The programme aims to:

- increase AIDS awareness among workers
- develop positive attitudes towards HIV-infected workers by their colleagues
- prevent the spread of sexually transmitted diseases and HIV

Coverage

There are about 200 companies in Mutare with about 20 000 workers. The larger companies were chosen initially and by early 1995, 31 companies employing over 10 000 workers were taking part in the programme, about one half of the total workforce.

There were 140 trained peer educators, about one for every 75 workers. Each peer educator organises an average of four meetings each week with 50 people attending the meetings. Most meetings consist of discussions with co-workers during lunch and tea breaks. Regular meetings are also organised for groups of workers during lunch breaks, after work or during working hours, subject to the approval of management.

Methods of Teaching

Workforce peer educators need a constant flow of ideas and methods if they are going to sustain the interest of their colleagues at work. Methods include picture codes, slide shows and video films. Topics include avoiding HIV infection, living positively with HIV infection, recognition of sexually transmitted diseases, signs and symptoms of HIV/AIDS and the use and disposal of condoms.

Company	Workforce Size	No. of peer Educators
Nat Railways Zimbabwe I	1 200	20
Nat Railways Zimbabwe II	300	12
Zimbabwe National Army	2 000	13
Forestry Commission	1 200	10
Guard Alert Security Company	800	9
Posts and Telecommunications Corpn	400	6
Karina Textiles	380	6
Manpac Packaging Co.	300	5
Securitas Security Company	200	5
Safeguard Security Company	800	4
ZUPCO Bus Company	230	4
Cairns Foods	140	4
B & C Bus Company	130	4
Mitchells Bakery	120	4
Fawcetts Security Company	400	3
Tanganda (Tea) Company	240	3
Bratex (rubber products manufacture)	200	3
Grain Marketing Board	180	3
Zimbabwe College of Forestry	150	3
PG Timbers	100	3
Mutare Prison	30	3
Forestry Industries Training Centre	170	2
Swift (Transport) Company	120	2
Carlisle Enterprises (Transport)	120	2
Cotton Marketing Board	120	2
Johnson & Fletcher (hardware store)	20	2
Meikles Store	120	1
Buffalo Soap Company	80	1
TM Supermarket	80	1
Nyabara (wood manufacture)	50	1
Total:	10 380	141

Establishment of the Programme in a Workplace

Thandiwe Gara, a qualified nurse employed by Mutare City Council, supervises the workplace programme. She is assisted by Jealous Samupindi, a workplace programme assistant. Meetings with the general manager or personnel manager of a company are necessary before a programme can be initiated. Peer educators are then selected following discussions with workers committees. Peer educators are chosen on the basis of their ability to communicate well with their peers.

Peer educators receive training in their own or in a nearby workplace. Training sessions last 20 hours following which the educator is supplied with educational materials and condoms. Records are kept by the educators. The workplace assistant and co-ordinator make approximately 100 visits per month to different workplaces to supervise meetings, meet with management, distribute materials and receive reports.

On average each month in 1994, 916 meetings took place, attended by 4 160 women and 12 700 men. A total of 310 000 condoms were distributed through the programme (26 000 per month).

Workplace Programme Co-ordinating Committee

Monthly support and supervision meetings are held at two venues so that peer educators can attend close to their place of work. The meetings are organised and conducted by an elected workplace programme committee made up of capable peer educators. At these meetings, educators learn more about AIDS and different methods of information to their peers.

The meetings provide the programme with an element of competition - during 1994, Zimbabwe National Army, National Railways of Zimbabwe and Forestry Commission had all received trophies in recognition of the effectiveness of their workplace programmes.

POPULAR SOCIAL ACTIVITIES WITH CHILDREN DURING WEEKENDS

* SOCCER, NETBALL
* POEM WRITING
* TRADITIONAL DANCING
* BIBLE VERSE RECITATION
* ROLE PLAYS ON SCRIPTURE
* DRAMA

INFORMAL SKILLS TRAINING IN:

* POULTRY
* GARDENING
* POTTERY
* WELDING
* CARPENTRY
* SEWING, KNITTING
* COOKING
* HOUSE KEEPING

MATERIAL ASSISTANCE IN THE FORM OF:

* CLOTHES, JERSEYS
* BLANKETS
* SCHOOL FEES
* MEALIMEAL
* COOKING OIL
* SALT, SUGAR
* BEANS, KAPENTA
* PEANUT BUTTER
* DRIED MILK

Families, Orphans and Children Under Stress

(FOCUS)

FACT
PO Box 970
Mutare

Families, Orphans and Children Under Stress (FOCUS) Project

THIS IS WHAT GOD THE FATHER CONSIDERS TO BE PURE AND GENUINE RELIGION: TO TAKE CARE OF ORPHANS AND WIDOWS IN THEIR SUFFERING.....JAMES 1:27

BACKGROUN)

The FOCUS project supports relatives from the extended family who are looking after orphans in their homes. The programme was established in 1993 following a survey which found:

1. Most orphans are being cared for by members of their extended family, often in conditions of extreme poverty.

2. Children who grow up in extended families have a sense of belonging to their family and community.

3. Many children are being cared for by elderly grandparents who need encouragement and material support.

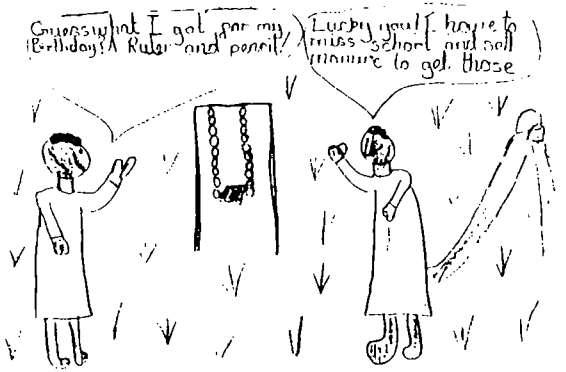
4. The number of households headed by older brothers and sisters is increasing. Teenage children who take the place of a deceased mother or father need a high degree of support.

Children who have lost one or both parents have particular problems to face:

* Coping with bereavement of their mother or father
* Adapting to lower standards of living, poorer food etc.
* facing interruptions in their schooling due to difficulties in paying school fees or obtaining school uniforms.
* Coping with victimisation from others or a result of being an orphan
* Being moved to live in a strange area with different family members.
* Being separated from other brothers and sist s.

.E' 'THE CH L)REN SPEAK

Orphaned children feel the loss of their mother or father, especially when they compare themselves to non-orphaned children. FOCUS aims to close that gap by showing extra love and support to the children. Women volunteers make regular visits to orphan families and assess individual children's needs. The children establish close relationships with the women. Some have become like surrogate mothers.



Children are children. Even when they have assumed responsibilities of being fathers or mothers, they will still be children at heart. One way the women help is by organising weekend sporting activities for orphaned and non-orphaned children.

HOW DOES FOCUS HELP?

FOCUS aims to work with local churches. The churches identify women volunteers, living in different zones in the programme area. Each woman then becomes responsible for identifying all orphans living in a 2 - 3km radius of her home.

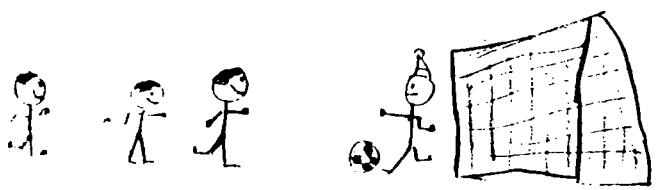
She is committed to visiting the most needy families at least twice each month. Once a month she meets with other visitors and the local FOCUS programme supervisory committee.

During these meetings reports are given on the number of visits carried out in the previous month. Training is given in how to assess needs, child care, recognising abuse, how to refer children to social welfare/health/education agencies etc.

HOW DO THE WOMEN IDENTIFY FAMILIES WITH THE GREATEST NEEDS?

Families in the following groups are more likely to be the poorest of the poor, struggling to provide satisfactory care and supervision of children:

* those where both parents have died
* those looked after by older sisters and brothers
* those looked after by elderly grandmothers
* those with caregivers who are sick
* families with large numbers of children, often grandmothers looking after several families of orphans.



Soccer is one of the most popular social activities that children enjoy. Both orphans and non-orphans join in to be members of the team.

FACT NEWSLETTER

News about Family AIDS Caring Trust's activities in Zimbabwe

Volume 8 Number 3 *October 1995*

FASO Health Service Starts

Another benefit was recently introduced for people joining FASO, Mutare's support group for people living with HIV/AIDS

Mrs Nyaruwa, FACT's homecare nurse is available on Monday mornings for medical consultations. Simple treatments are available and complicated cases are referred to a City Health clinic. The service has been established in collaboration with the City Health Department on a trial basis.

Training Project reaches out

Can an AIDS programme be too successful? Over 13,000 people from rural areas have attended a 20-hour course in AIDS information as part of FACT's Rural Training Programme (RTP). It is a common to see some of the 250-plus trainers carry out many more activities than those that are expected.

Five groups have now started regular AIDS activities in their areas as a result of the RTP. Murambinda Mission Hospital in Buhera has started training its own trainers rather than relying on FACT. Another group in Nyanga opened a FACT Training Programme office and employ a coordinator to train their own trainers. No wonder that an evaluation of the programme by consultants earlier this year found the programme an outstanding success.

FACT helps others

Many groups are trying to start AIDS-related activities. They can avoid making the same mistakes by learning from others.

Since 1994, FACT has run seven "Clinics" designed to help organisations learn from one another. The clinics, part of SAT's "School Without Walls" programme have been held in Homecare, Youth Activities, Orphan Programmes and Pastoral / Spiritual Care.

Reports of the clinics are available from FACTas resource materials:
"Setting up orphan programmes"
"Spiritual support in homecare programmes."
"Using church volunteers"
"AIDS education in church youth groups."

SCHOOL YOUTH GROUPS SUCCESSFUL

Some 150 schools in Manicaland have established Family Life AIDS Action Groups (FLAGs) which meet each week in term time. The programme, led by Lovemore Magwere, involves a network of seven locally-based programme assistants. How successful is the programme in influencing the sexual behaviour of young people?

During 1994, an evaluation was carried out in three schools. One had a well-established club, another had a recently-established club while one school had no club; 200 students were interviewed regarding their knowledge, attitudes and intentions concerning future sexual behaviour.

The presence of a club leads to positive changes in students' sexual knowledge, attitudes and future intentions. Clubs help to raise the knowledge and change the attitudes of students even if they are not club members since FLAGs help generate discussions in the school.

"People's sexual behaviour is notoriously difficult to assess" said Dr Geoff Foster, FACT's director. "This study suggests FLAG clubs are helping young people to postpone sex before marriage and avoid HIV-infection." Keep up the good work, FLAGs.

New Orphan Programmes

FACT is not involved in giving support directly to widows and orphans. Instead, Choice Makufa, the FOCUS programme coordinator provides training and advice to other organisations. This strategy increases FACT's ability to provide support to a large number of orphans.

In 1993, Chirovakamwe Christian Life Centre 25km from Mutare set up an orphan visiting programme; this model involved women from different churches visiting orphan families.

Visiting has started in urban Dangamvura and some rural areas, Rusitu United Baptist Church in Chimanimani and Mt Makomwe United Methodist Church in Marange have identified volunteers who visit needy orphan families, with support from FOCUS.

Church challenges

Keeping up with requests to speak about AIDS is a full-time job, according to Lorraine Muchaneta, FACT's Church Liaison Officer.

Initial reluctance of church leaders to become involved with AIDS-related issues has changed to outright enthusiasm. Twenty churches in Mutare are now supported by FACT and run AIDS education activities each month for their youth groups.

Some church volunteers have started visiting sick people in their areas following FACT-organised training workshops.

Information materials for churches interested in becoming involved in AIDS-related activities are available from FACT (see above).

Mrs Muchaneta and Mrs Nyaruwa (Homecare) recently returned from a Tear Fund-sponsored AIDS consultation held in Uganda.

MEDICAL NEWS
Herbal tests - Results disappoint

Trials in Zimbabwe suggest that herbal medicines could help ease the symptoms of AIDS. However subsequent laboratory tests in Britain have been disappointing.

The trials show increases in the CD4 count of 22 HIV-positive patients over a 10-month period. (The CD4 count is an indication of how far an AIDS patient's immune system has deteriorated). In some cases, CD4 counts rose dramatically.

"The most important thing is that those involved all told us they were feeling much better" said Stephen Chandiwana of the Blair Research Institute in Harare. The trial cannot be taken as conclusive proof of the medicine's effectiveness because there was no control group. The patients' improvements could be due to the 'placebo effect' - patients feeling better because they expect to. Most tests of drugs begin in this way. Chandiwana expects to begin a 'double-blind trial' - with a control group - at a later date.

Test-tube trials in England have not produced encouraging results - the herbs had no effect on HIV-infected T-cells. An MRC spokesman said that his unit had identified some herbal medicines effective in attacking the virus but none powerful enough to encourage them to proceed further. (AIDS Analysis Africa, 5:3; June 1995)

Membership News

Leaflets have been produced describing the Youth, Homecare and Workplace and FACT Rusape programmes as well as overall on the work of FACT. Work is in progress on information materials to describe FASO and the Orphan programme.

These materials form part of the membership pack being developed for all members. In addition, the pack contains a membership card, video library catalogue and newsletter giving up-to-date information on the progress of various FACT activities.

Membership packs will be available for all new subscriptions received. This month, three FACT members will be attending a two-day conference in Harare. This will cover various methods of fundraising; some of these will be implemented in Manicaland.

Personnel News

APPOINTMENTS

Rusape Coordinator: Mrs Temberere, previously on secondment from Save the Children Fund

Bookeeper: Mrs Ophelia Munowenyu, from Wallers Engineering

Driver: Mr T Disa

Security Guard: Mr Clemence Makoni

OTHER CHANGES

Resigned: Guide Mufandauya, previously FACT Rusape coordinator.

Changed Role: Jeff Limebeer, standing down as part-time accountant, now providing financial consultancy services to FACT and Treasurer.

Welcome Back: Rosemary Gomo, HIV Prevention Programme coordinator, after the safe arrival of Ruva-Rashe on June 22, birthweight 3.1kg.

FACT is a Christian-based organisation working with communities to provide HIV prevention programmes, training, and holistic care. FACT promotes sexual abstinence outside marriage and faithfulness within marriage and provides unconditional care and support to people affected by HIV/AIDS. Worldwide, FACT supports and cooperates with others who are responding to AIDS in their communities.

Produced by Family AIDS Caring Trust, Mutare, Box 970, Mutare Tel (1)20-61648/67493 Fax (1)20-65281

FACT Rusape, P/Bag 8129, Rusape, Tel/Fax (1)25-3491; FACT Chiredzi, Box 381, Chiredzi, Tel (1)31-3002; .

NEEDS

- FINANCE
- SPONSORSHIP FOR:

  → ALLOWANCES
  → SCHOOL FEES

- PRAYER
- SKILLS TRAINING

  → DRESSMAKING
  → COUNSELLING
  → BUILDING
  → COOKING

- MATERIAL ASSISTANCE

  → CLOTHING
  → FOOD

FOR MORE INFORMATION CONTACT:-

F.A.S.O.
107 HERBERT CHITEPO ST.
(Opp. ZIMNAT HOUSE)
MUTARE
Phone: 120-66309

POSITIVE LIVING

FAMILY AIDS SUPPORT ORGANISATION

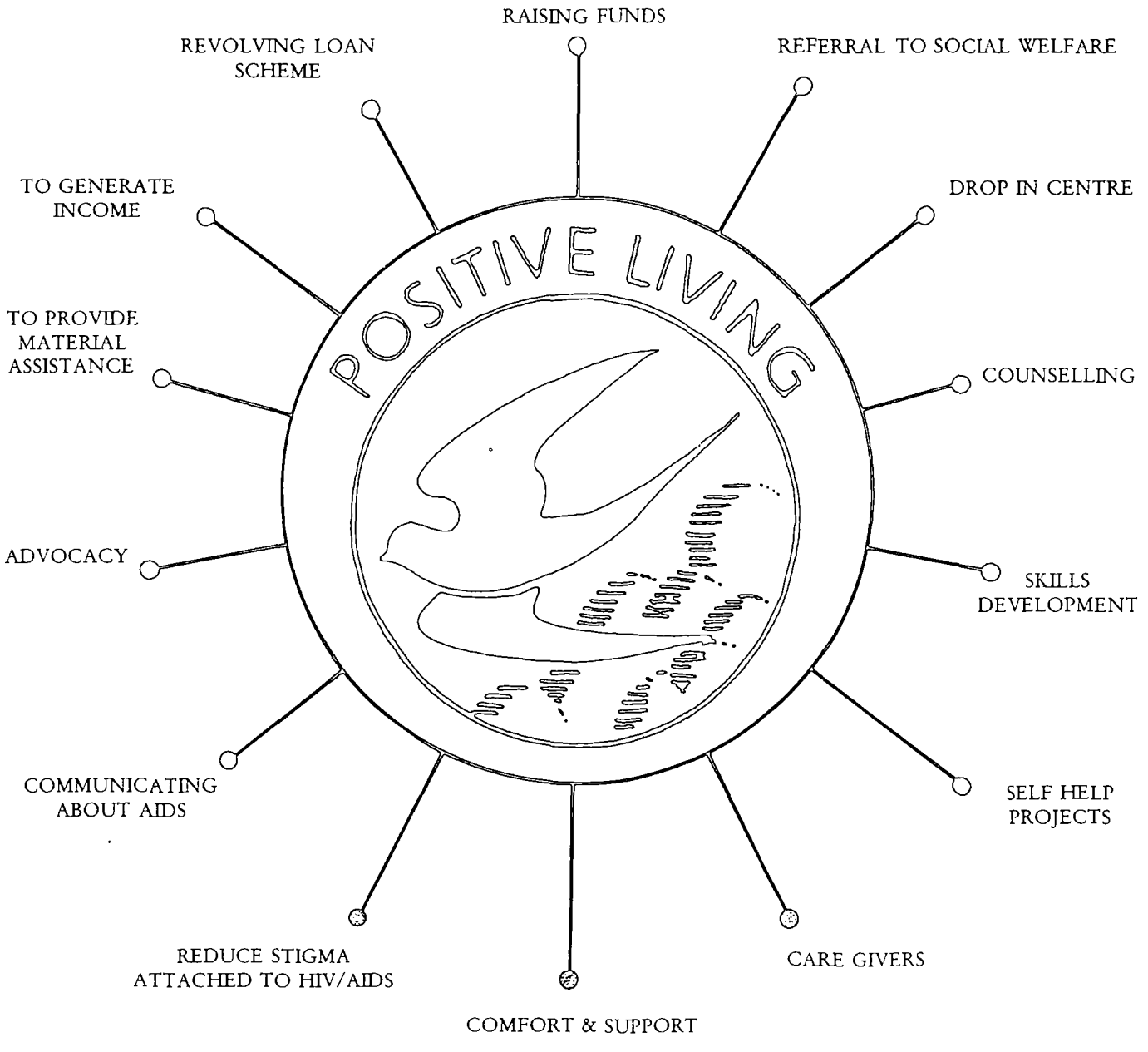
BACKGROUND

Family Aids Support Organisation (F.A.S.O.) was founded in 1992. It is a self-help group for people living with HIV/AIDS. F.A.S.O. is affiliated to the Family Aids Caring Trust (F.A.C.T.). F.A.S.O. has its own constitution, however F.A.C.T. provides technical assistance and administrative support. At present all financial resources are administered by F.A.C.T. on behalf of F.A.S.O. All people who have HIV/AIDS can be members.

Benefits Include:

- Material assistance
- Psychological support
- Social support

OBJECTIVES



OUR OBJECTIVES

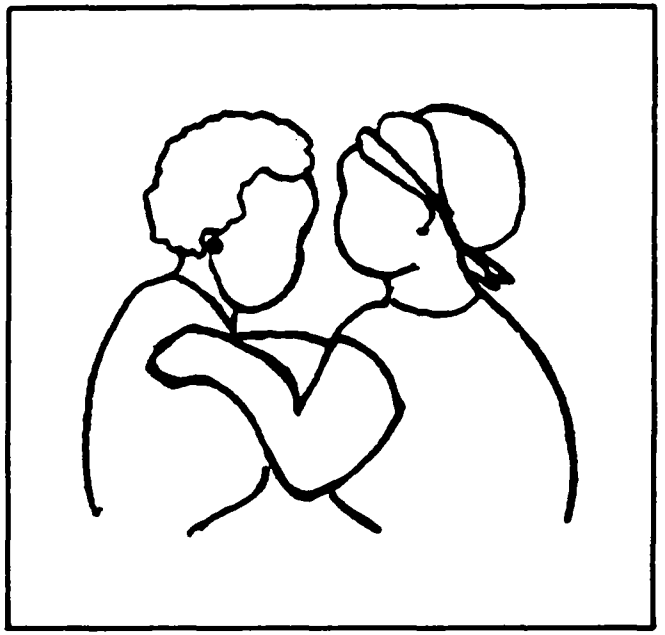
* To increase the levels of knowledge about AIDS amongst members.
* To promote caring responses towards people living with AIDS.
* To enable the Church Youth to become peer educators within their youth groups and within their communities.
* To enable church members to become peer educators within their churches.
* To support and strenghthen inter-church responses in the area of AIDS prevention, care and support.

FOR MORE DETAILS CONTACT:-

Church Programme Co-ordinator
P.O. Box 970
MUTARE

Telephone: 120-61648

FAMILY AIDS CARING TRUST

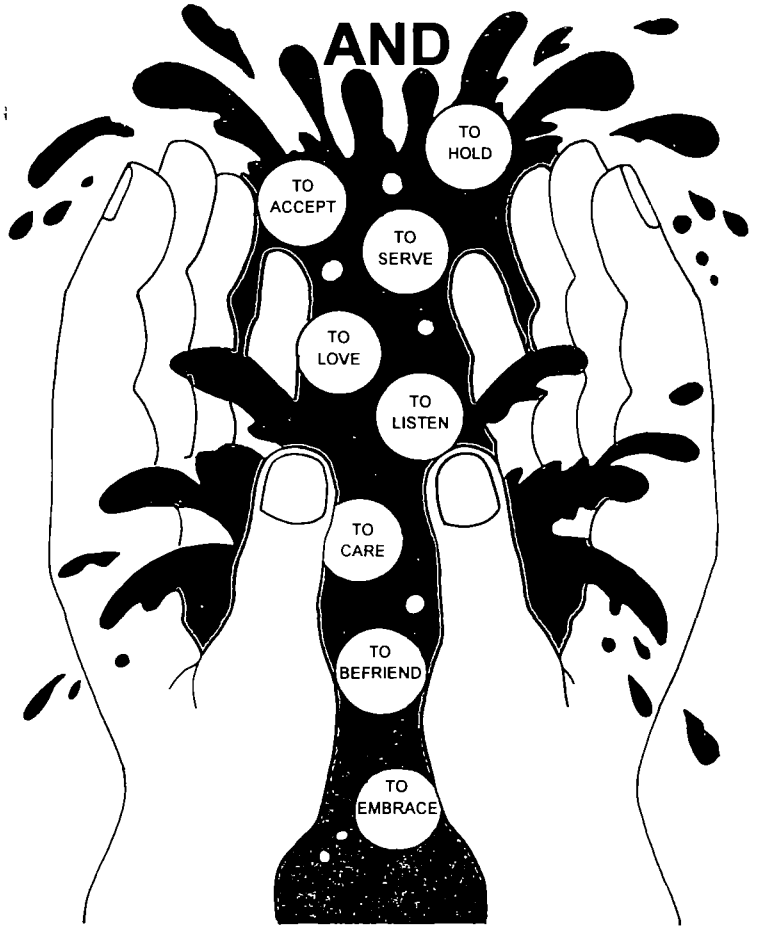


(C.A.I.P.)
CHURCH AIDS INITIATIVE PROGRAMME

ADULT

This Promotes Church Members To Be:-

- **AIDS PEER EDUCATORS IN**
  - → The Church
  - → The Community
- **CAREGIVERS**
  - → Supporting the sick
  - → Supporting bereaved families
- **RESPONSIBLE FOR CARE OF ORPHANS**



OFFERS:-

▲ TO ANYONE WHO IS LIVING WITH H.I.V. OR AIDS
▲ TO THE FAMILIES, PARENTS, LOVED ONES, FRIENDS AND CARERS:-

- a non-judgemental approach, a warm welcome and support.
- professional conselling in a comfortable, safe environment.
- spiritual direction - wherever you are on your journey we will walk with you.
- pastoral care - every person is unique and of finite worth.

YOUTH

The Young Are Given:-

- **GROUP SUPPORT**
- **POSITIVE PEER INFLUENCE**
- **ENCOURAGEMENT TO HAVE WHOLESOME RELATIONSHIPS**
- **AIDS RELATED ACTIVITIES TO LEARN FROM**

WHO CAN JOIN FACT?

Membership of Family AIDS Caring Trust (FACT) is open to any person who abides by the Constitution. In particular members should be in agreement with FACT's Aims and Objectives which are :

* **to be a support to people affected by the AIDS virus**
* **to educate about the causes, effects and prevention of HIV infection**
* **to offer a counselling service to people infected with HIV and their families**
* **to increase public awareness of the AIDS epidemic**
* **to provide a forum for the exchange of information on problems of AIDS in Zimbabwe**
* **to organise and manage fundraising activities for the financing of activities relating to the prevention of the spread of AIDS**
* **to present the biblical view, that we as humans were created for faithful, permanent marriage relationships and that sex outside God's laws accelerates the spread of AIDS**
* **to present the message of eternal life, forgiveness of sins and power to live by the Holy Spirit when appropriate to situations or when requested**
* **to minister to emotional, physical and spiritual needs of HIV-infected persons and their families**
* **to pursue other objectives in keeping with the work of FACT**

If you are in agreement with these and would like more information about becoming a member of FACT please contact FACT's membership secretary, Mel Paterson.

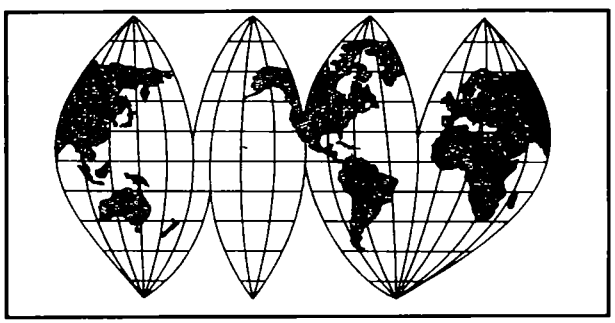
P.O. BOX 970 MUTARE, ZIMBABWE. TELEPHONE 61648

How do I start a FLAG club?

For more information on starting a youth Family Life AIDS Action group in your area, contact:

Youth Project Co-ordinator,
FACT
P.O. Box 970
Mutare

Tel: David J.N. Musendo on 263-020-67638
Fax: 263-020-65281



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Mission Statement

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Worldwide, FACT supports and co-operates with others who are responding to AIDS in their communities.

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Prevention
Youth Programme

Training Programme
Regional Training
Community Development Organisation Programme

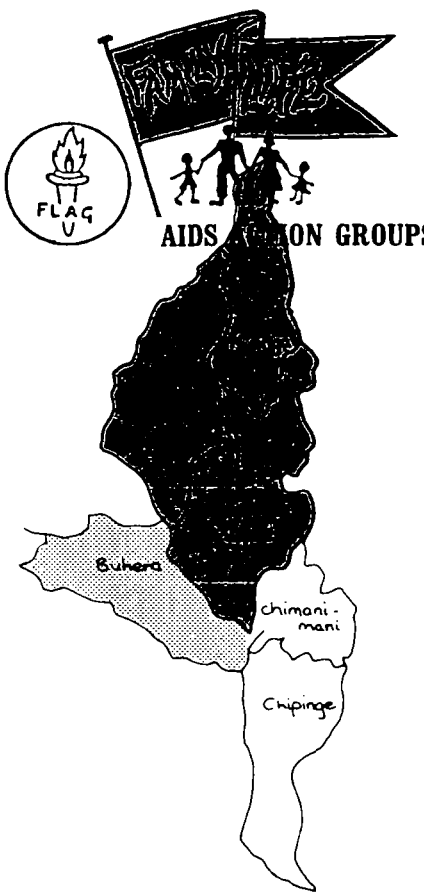
Care and Support

- Home Care Programme
- Families. Orphans and Children Under Stress (FOCUS) Church Programme
- HIV Support Group (Family AIDS Support Oganisation) FASO.
- Church Programme

BRILPRINT

F.A.C.T.

YOUTH PROGRAMME



"We can soar above the situation"

Background

The Youth Programme, commonly known as **Family Life AIDS Action Groups (FLAG)**, was established in April 1992; at that time, there were two clubs in secondary schools in Mutare. Approval was obtained from the Ministry of Education and by early 1995, there were over 150 clubs in schools in Manicaland.

Peer education is the cornerstone of the programme. Young people learn about AIDS in their clubs and then teach their colleagues what they have learnt. The objectives of the clubs are to:

- help members avoid HIV/AIDS by avoiding sex before marriage
- provide appropriate sufficient and accurate information on how HIV transmission can be prevented.
- increase member's compassion for those living with HIV/AIDS
- enable FLAG members to be in a position to educate others about HIV/AIDS.

About Family Life AIDS Action Groups

The clubs are groups of people who have decided they will try to stop the spread of AIDS. They have decided to protect themselves from the disease and to help other people to stay safe by telling them about AIDS. They have also decided to help anyone who is already infected with HIV or ill with AIDS. Club members discuss AIDS and other issues which affect them and come up with solutions to these problems.

Why focus attention on youth?

- Most young people are not affected with HIV, but with over one half of Zimbabwe's population under 18 years old, each year a large number of teenagers are becoming sexually active; about two-thirds of new HIV infections in Zimbabweans occur in people under 25.
- Young women are particularly at risk. Teenagers get HIV and other sexually transmitted infections particularly easily.
- The high risks of HIV infection for today's youth are not balanced by high rates of knowledge; young people have restricted access to information about sex.

Support to clubs

FACT provides support to FLAGs in several ways; Each term, FLAG staff produce a programme and pack of resource materials for clubs to use each week during their meetings;

Membership cards and pocket calendars are provided free of charge for members. Badges for committee members and club members are also provided. Members may purchase FLAG tee-shirts and ball point pens.

A termly newsletter is provided for each FLAG member. Competitions and joint inter-schools end-of-term meetings are organised and outstanding members and clubs receive certificates and trophies.

As well as suggesting speakers and facilitators for clubs, the programme co-ordinator has trained and supervises a network of youth programme supervisors who visit clubs in their allotted areas. The programme provides training for teachers in charge of FLAGs.

Programme Assistants in the FLAG programme

AREA	NAME
Mutare (Urban)	Ruramai Jere (in school FLAGs)
Nyanga	David Tembo
Honde Valley	Timothy Chirewo
Mutasa	Patience Saungweme
Marange	Maxwell Mabutu
Rusape	Fungai Mugoti
Zimunya	

Key Areas of Focus

- In School
- Out of school
- Street youths

Activities

- weekly meeting on HIV/AIDS ACTIVITIES , debates and discussions
- talks in assembly. Games, drama, role play, songs, videos, fundraisings, visiting the sick and general cleaning.

* Close working relationships with the FACT Church Programme Youth and Scripture Union concerning activity and material exchange, helps strengthen the project.

Club Statistics

Family Life AIDS Action Groups in Manicaland

DIST.	SEC.. SCHOOL	PRIMARY SCHOOL	OUT-OF SCHOOL	TEACHERS COLLEGES	TLL.
Mutare	16	5	3	2	**26**
Nyanga	17	53	4	0	**74**
Honde	12	27	2	0	**41**
Mutasa	10	9	2	0	**21**
Mutare-Zimunya	4	1	3	0	**8**
Mutare-Marange	22	28	11	0	**61**
Rusape	12	9	2	0	**23**
TOTAL	**93**	**132**	**27**	**2**	**254***

* *One group of street youths in Mutare urban*

Training

Workshops are run for teachers. (patrons),club members, out of school and street youths.
Trainings focus on HIV/AIDS communication, activity facilitation, and general health related issues.

Networking

In addition to clubs directly supervised by Youth Programme staff, FACT also networks with other organisations; FACT provides FLAG programme support materials to: FACT Chiredzi, Catholic Diocese of Hwange (Lubchanko House), Anti-AIDS project (Zambia), Youth Project (Namibia) , OJM (Mozambique Youth Project),and Kunzwana Women's Association (AIDS Action Groups), (Buhera FLAGs). It also networks with Kwekwe (health clubs).

Behaviour Change taking place

School and communities which have a club operating have noticed a difference in sexual behaviour. Giving young people support and information is the best way to stop the spread of HIV/AIDS.

Starting a Club

Permission from the headmaster is required before starting a schools club; this may be obtained more easily after communication with FACT. Anyone interested in forming a club is invited to attend the first meeting. School clubs elect a student committee.

A patron of the club is also chosen, usually a teacher interested in the subject Clubs meet weekly during the school terms and those registered with FACT receive support materials, badges, membership cards and tee shirts, at less than cost price.

Community Mobilisation Best Practices

The Families, Orphans and Children Under Stress (FOCUS) Programme

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Report produced for "Community Mobilisation in eastern and southern Africa" meeting held in Pretoria, South Africa, 9-11 November 1998 organised by UNAIDS.

Executive Summary

This document describes the Families, Orphans and Children Under Stress (FOCUS) programme established by Family AIDS Caring Trust, Zimbabwe in 1993. It illustrates the importance of formative research in programme establishment, techniques of community mobilisation and the operation of reporting systems. The programme is an example of "Best Practice" as shown by it relevance, efficiency, impact, sustainability and ethical soundness. The programme has been replicated by other organisations in eastern and southern Africa.

In 1991, orphan enumeration was carried out in the Manicaland province in Zimbabwe; it was estimated that 6.8% of children under 15 years were orphaned by loss of their father or mother and that there were some 47,000 orphans in the province, with over 99.5% being cared for by their extended family. In 1992, a further random household orphan enumeration was carried out in one urban and one rural site and efforts were made to understand extended family and community coping mechanisms prior to programme design. The Families, Orphans and Children Under Stress Programme was established in 1993 in a rural area close to Mutare by a local independent church with technical support from Family AIDS Caring Trust.

One year after its establishment, an evaluation was conducted. This demonstrated that the programme had identified a large proportion of orphans in the catchment area of the programme, had prioritised the most needy orphan households and had succeeded in identifying, training and mobilising village-based volunteers to regularly visit orphan households. The programme was owned by members of the rural community and as new needs were identified, new activities were initiated by community members. Small amounts of material support provided through the programme were targeted to the most needy households. Further studies documented the cost-effectiveness of the FOCUS programme.

Volunteers connected with the programmes receive minimal financial incentives; there have been few volunteers dropping out of programmes, even in those established several years. New forms of support to volunteers were developed such as the provision of uniforms, annual Christmas monetary gifts and the provision of training through exchange visits to other FOCUS programmes.

The initial focus of the programme on orphan enumeration, needs assessment, prioritisation, regular visiting, provision of material support and record keeping has expanded to include income generation, micro credit, advocacy, psychological needs assessment and support, awareness raising in sexual abuse and child rights. Carefully established record systems enabled communities and programme directors to identify and study emerging issues such as stigmatisation against orphans, child-headed households and the increasing vulnerability to HIV of orphaned children.

The programme led to the establishment of partnerships between government and non-governmental organisations, and between international, local and community-based NGOs. The FOCUS programme was replicated and operates in five rural and one urban community in Manicaland, supervised by FACT. In 1995, the Bethany Project in Zvishavane, Masvingo Province was established by a volunteer working with the British Volunteer Programme following visits to the FOCUS programme; this orphan visiting programme now involves some 300 volunteers throughout the whole administrative district. Orphan programmes were

established in Zambia, Kenya and Malawi following visits to FOCUS sites as part of FACT's Regional Training Programme.

1. BACKGROUND

In 1991, orphan enumeration was carried out in the Manicaland province in Zimbabwe as part of a national Maternal and Child Health survey; it was estimated that 6.8% of children under 15 years were orphaned by loss of their father or mother and that there were some 47,000 orphans in the province; over 99.5% were being cared for by their extended family with only 170 orphans (0.4%) being cared for in children's homes[1].

In 1992, a further random household orphan enumeration was carried out by Family AIDS Caring Trust in one urban and one rural site; further research was undertaken to understand extended family and community coping mechanisms[2]

2. DESCRIPTION OF PROGRAMME

The Families, Orphans and Children Under Stress (FOCUS) programme was established in 1993 by Family AIDS Caring Trust in Mutare, Zimbabwe. An independent Pentecostal church situated in a peri-urban rural area 20km from Mutare established AIDS awareness and homecare activities in 1991 in collaboration with FACT's Rural Training Programme. In 1993, the church established the FOCUS programme by recruiting 25 women from 18 villages throughout the programme area. The programme operated in a communal farming area of approximately 200 square kilometres with a population of 10,611 people in 2,089 households.

The women were recruited on the basis of concern for orphans; most were already caring for orphaned relatives. As community visitors, they became responsible for identifying and visiting orphan households within a 2-kilometre radius of their homes. The parental status of families living nearby could be easily ascertained by the women. The names of orphan households were placed on a register. As the FOCUS programme became known, unregistered orphan households were referred to the community visitors by concerned neighbours or school authorities. Volunteers were provided with basic training so that they are able to identify and register all orphans in the community. The most needy families (approximately one half of those identified) were placed on a priority register. The programme aims to visit each household twice per month with those in greatest need such as child-headed households being visited weekly [3].

By 1998, the programme supervised by FACT had extended with activities being carried out by 137 volunteer visitors. The programme was based at 5 discrete rural sites with an estimated total catchment area population of 50,000 and a low income high density area in the city of Mutare where a large number of dwellings were wooden shacks. Each programme was supervised by a volunteer supervisor who had specific responsibilities in terms of reporting to FACT and liaising with those involved at local level. Each two months, the FACT FOCUS Coordinator met with the supervisor and volunteers at their monthly report and training meeting. Every other month, the supervisor met together with the Coordinator at FACT's office in Mutare.

During the first nine months of 1998, some 2,100 support visits were made each month to some 1,200 orphan households in these six sites. The total cost per month of the FOCUS programme was Z$42,517 (approximately US$1,150), excluding FACT administrative costs of an additional estimated 20% of programme expenditure. Of the direct FOCUS expenditure, 56% was spent to directly benefit the community in the form of material assistance (78%), volunteer allowances and uniforms (13%) and training and meeting expenses (9%). Material assistance was mostly in the form of maize seed and fertiliser, primary school fees for some 500 children, blankets and food. The remaining 44% of FOCUS programme expenditure was utilised by FACT to employ a Coordinator and Assistant Coordinator, to pay for FOCUS programme travel costs and for FOCUS administrative expenses such as office and computer rental, telephone, stationery and photocopying .

Volunteers connected with the programmes receive minimal financial incentives; there have been few volunteers dropping out of programmes, even in those established several years New forms

of support to volunteers were developed such as the provision of uniforms, annual Christmas monetary gifts and the provision of training through exchange visits to other FOCUS programmes.

2.1 Aims and Objectives

Each programme has the following objectives:

- to identify all orphaned children in each programme's catchment area and prioritise those households with the greatest needs
- to visit all prioritised households at least twice per month
- to identify households where children's basic needs are unmet and to provide these households with limited development-oriented material support
- to liaise with other community groups, leaders and organisations concerning the operation of the programme
- to enable community members to own each FOCUS programme and over time reduce their dependence on FACT
- to identify new or emerging problems affecting children who have been orphaned

2.2 Establishment of Programmes

Initially, great attention is paid to the methods by which each FOCUS programme becomes established. Programmes have been established as a response by FACT to felt needs of communities. The provision of material support from FACT through the community group to beneficiaries has been avoided wherever possible until programmes have demonstrated their to prioritise those in greatest need of such support and monitor their activities. The following steps have been identified in establishing community-based orphan support programmes[4].

- *Organisational Analysis*: Though NGOs have a supportive role, programmes can only be implemented by community-based organisations. The community where
- *Community Identification*: The community where the programme is to operate should be identified. There should be a defined catchment area. The programme is more likely to succeed if it is based on and develops existing activities.
- *Volunteers:* The volunteers are the key human resources within the programme. Great care should be taken over their selection, training, support and motivation. Paid staff are not primarily implementors but should take on a coordinating role.
- *Client Identification*: Steps in client identification include defining the target group, enumeration, registration, needs assessment and prioritisation
- *Monitoring and Evaluation:* A record system should be established and volunteers trained in its use. Community mapping of the catchment area is a crucial activity in the development of the programme. Objective process and outcome indicators need to be identified and measured.

More detailed information regarding methods of Community Mobilisation are described in FACT's training manual used in its Regional and National NGO training programmes[5].

2.3 Development of Programmes

Programmes have developed new features since their initial establishment. Some of these activities have been initiated by community members themselves[6]. Some developments have generally been established in response to felt needs of community members, or following research conducted as a result of recognition of new or emerging problems affecting children who have been orphaned:

- *Voluntarism from within community*: community members who are not volunteers within the programme have given their time and materials to help orphaned families. Activities include ploughing fields, repairing broken-down housing, advice in agriculture, health care, child care and income supplementation.

- *Income generating activities*: Material inputs to community groups have been provided for community-based projects such as poultry, vegetable gardens etc. Income from such projects are used to support destitute families and raise money for use by the community group

- *Micro credit schemes:* These operate to benefit individual volunteers who may learn family-based income generating skills and simple money management.

- *Psycho-social Support:* The establishment of weekly crafts, agricultural, cultural or sporting activities operated by members of the community for the benefit of older orphaned children.

- *Awareness raising and Advocacy*: Volunteers connected with the programmes have advocated on behalf of children with political and traditional leaders, headmasters and health workers in order to improve the situations of orphans and children in especially difficult circumstances

- *Abuse monitoring*: The presence of a body of community members concerned about the situation of children acts as a reference body. Incidents of sexual and physical abuse have been reported by volunteers and as a result of such supervision, it is likely that instances of abuse have lessened. Training of volunteers and teachers in identification and management of cases of abuse was conducted in 1998 within communities with FOCUS programmes by a child psychologist working as a volunteer with FACT.

2.4 Research and Evaluation of Programme

Appropriate community-based process monitoring systems are maintained by each FOCUS programme. Orphan register and orphan visiting records are forwarded each month to FACT for collation of statistics. Newly emerging problems have been identified through this mechanism and specific research has been conducted or is planned. These include:

- *Psycho-social needs of orphans:* focus group discussions were held with groups of orphaned children to identify their perceptions concerning effects of loss of parenting, discrimination, exploitation and abuse [6].

- *Child-headed households:* the reasons why such households were occurring was studied through identification of index households by community-based volunteers. Households were interviewed. Feedback of the findings of this research led to greater awareness of the needs of children in especially difficult circumstances[7].

- *HIV prevention needs in orphaned girls and needs of HIV-infected orphaned children and mothers*. These newly emerging problems which have been identified by community members are the current focus of attention of FACT programme researchers.

The first FOCUS programme was evaluated in 1995, one year after its establishment. This demonstrated that the programme had identified a large proportion of orphans in the catchment area of the programme, had prioritised the most needy orphan households and had succeeded in identifying, training and mobilising village-based volunteers to regularly visit orphan households. The programme was owned by members of the rural community and as new needs were identified, new activities were initiated by community members. Small amounts of material support provided through the programme were targeted to the most needy households[3].

A further review of programme records and costs during 1996 when the programme had expanded to three further sites documented the cost-effectiveness of the FOCUS programme[4]. A further evaluation of the FOCUS programmes is being conducted during 1998-99.

2.5 Replicability of Programmes

Following the successful evaluation of the first FOCUS programme in 1995, the programme was replicated to four further rural and one urban sites during 1995-97. Process monitoring of the four replicated rural programmes indicate successful levels of programme activities (see Section 2 above). The model was not established as effectively at urban level. An operational evaluation of the FOCUS programmes which will include a special study of the functioning of the urban programme is being conducted in 1998-99.

In 1995, the Bethany Project in Zvishavane, Masvingo Province was established by a volunteer working with the British Volunteer Programme following visits to the FOCUS programme; this orphan visiting programme now involves some 300 volunteers throughout the whole administrative district.

FACT's Regional Training Programme was established in 1994. Up till August 1998, 63 participants attended two-week field-based training courses with exposure to FACT's Prevention (Youth, Workplace and Community HIV Prevention) and Care (Homecare, PWA Support, Orphan Support and Church) programmes. An evaluation of FACT's Regional Training Programme was completed in October 1998 through questionnaire study supplemented by visits to 16 participants in three countries (Kenya, Zambia and Uganda) from where 55% of participants attended. This study identified that orphan programmes had been established by three NGOs in Zambia, Kenya and Malawi as a result of visits to FOCUS sites during two-week course attachments to FACT; two other NGOs had initiated orphan care programmes through training community volunteers [1].

3. CORE CRITERIA OF "BEST PRACTICE" IN COMMUNITY MOBILISATION

According to UNAIDS, the initial criteria for addressing best practice is that it addresses HIV/AIDS prevention and care, works towards reducing people's vulnerability and tries to alleviate the epidemic's social and economic impact. Once an initiative is identified as doing any or all of the above well, the following more detailed criteria are proposed for assessing the effectiveness of the approach or practice in the area of community mobilisation:

3.1 Relevance

The programme was initiated in response to HIV/AIDS. However orphan visiting was carried out by community members on an informal basis prior to programme establishment. Prior to the initiative,

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[1] A mission hospital in Zambia has started an orphan support programme with 300 orphans on the register and 60 volunteers out of 100 trained;

An NGO in Malawi has started a community-based orphan care project bringing together women volunteers from four different churches.

An NGO in Kenya has started an orphan project.

In addition, an orphan care workshop was held in Zambia and women volunteered to become orphan carers. Another organisation used FACT's Community Care manual in the selection of community volunteers for orphan care.

an assessment of the needs, resources and skills of the community was carried out. The objectives are relevant to the assessed needs and resources of the community.

New needs have been identified since the programme started and the initiative has changed to respond to these new needs (see 2.3 & 2.4 above). The goals of the initiative are relevant and realizable given the resources and capacity of the community.

The strategies are relevant to existing socio-cultural and political contexts. In addition, the programme has challenged existing structures. Advocacy for children is a new concept amongst many of the community members. Involvement in AIDS-related activities through involvement with orphans has been a challenge for several churches as a result of their involvement with the initiative. The strategy has been found to be useful and adaptable for other countries in southern and eastern Africa (see 2.5 above).

3.2 Efficiency

The available resources are used to the maximal extent. The programme could be made more efficient by redesigning the strategy so that support is offered to families affected by HIV/AIDS during parental illness through a combination homecare/children affected by HIV/AIDS programme rather than the entry point being to children following parental death; also by combining prevention activities with care provision.

Human resources could be utilised more efficiently by encouraging greater involvement of other agencies (e.g. Health workers, teachers, police, political and traditional leaders) from programme establishment. The particular skills and commitment of volunteers have been critical to the efficient management of the initiative. The particular experience gained by FACT in the management of volunteers could be valuable to other organisations.

Resources are mobilised, provided and used in a timely manner. One obstacle in this respect has been delayed disbursements or limitations in types of expenditure conditions placed by donor organisations. Expectations raised by the community in relation to financial commitments are often not provided through this programme. This decision is made only partly on the basis of limited funding availability. The main reason for limiting provision of material support has been because of concerns about programme sustainability. Training provision is provided wherever possible. FACT has been able to help community organisations to develop their own project proposals.

The use of resources is monitored regularly. However with a large number of small amounts of material support to programme beneficiaries, it is difficult for FACT to monitor whether these are targeted correctly. FACT closely monitors its own use of resources and relies on self-righting mechanisms of community groups to monitor use of resources provided by FACT through community groups to programme beneficiaries. There is fair coordination with other partners.

The process of recruitment and training of volunteers matches the skills of the volunteers to the needs of the initiative. Incentives are provided to keep volunteers motivated (see 2 above).

3.3 Effectiveness / Impact

The initiative is achieving its intended goals and objectives and impacts (see 2.4 above). The programme has reached its intended community and has extended beyond the expected scope of the initiative. There have been unexpected positive impacts (see 2.3 above). Unintended negative impacts include claims of duplication of activities by other government and non-governmental organisations (baseline survey suggested that there was limited formal service provision by other welfare agencies in target areas). Impacts are being monitored through a well-established reporting system.

3.4 Sustainability

Funding was received from Plan International (Mutare) who have continued to be the principal donor to the programme. Donations have been received from NORAD and UNICEF as well as a large number of smaller donations in cash and kind through FACT. In addition, donations have been given directly to community groups, often following visits by outsiders to the projects.

There has been remarkably little turnover of volunteer staff with only one volunteer actually leaving the programmes, some of which have been established for nearly five years. There are reports of community members requesting programme supervisors that they be allowed to become FOCUS visitors. Tangible incentives to volunteers include monthly bus fares to support meetings, tee-shirt, skirt, training shoes and scarf once per year and an annual Christmas bonus of US$10. Volunteers receive initial and monthly training. Some visit other programmes through an exchange visit scheme. Volunteers who look after orphans in their own homes may receive small amounts of material support (average US$11 per annum).

The initiative has maintained its funding resources through maintaining a low-cost programme. Future funding plan include diversifying donor base and including research as part of ongoing programme activities. The initiative has led to policy changes by the Dept of Social Welfare which, partly as a result of FOCUS, is now a strong advocate of community-based orphan support.

The community owns each FOCUS programme. Although the initiative was started as a response to the HIV/AIDS epidemic, at community level, it has little emphasis on HIV/AIDS. It has expanded to include other concerns such as income generation and child welfare in general, not just specifically children orphaned by AIDS or only orphans but also other categories of children in especially difficult circumstances.

The key change in the project over time has been concerning ownership of the project. Initially, this rested largely with FACT. Over time, the projects have been increasingly owned by community organisations.

3.5 Ethical Soundness

Confidentiality concerning people affected by HIV/AIDS has been maintained. The programme does not directly address HIV/AIDS issues. The project has conveyed a positive, non-discriminating approach to awareness raising and care through its emphases on coverage, prioritisation of those in greatest need and the provision of regular visits and material support to the most needy households. Children's rights to protection, health, education, non-discrimination, lack of work are some rights which this strategy has supported.

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CARFAX

Today's children—challenges to child health promotion in countries with severe AIDS epidemics

G. FOSTER

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Abstract *Recent declines in infant and child mortality rates (IMR and CMR) are being reversed due to AIDS. Greatest impacts are in southern African countries with severe HIV epidemics and lower non-AIDS IMR/CMR. Zimbabwe and Zambia's IMR were estimated to be 40% and 30% higher in 1996; CMR by 2010 was projected to increase fourfold in Zimbabwe, threefold in Botswana and to double in Kenya and Zambia due to AIDS. HIV indirectly impacts children through orphanhood, TB and poverty. By 1996, life expectancy fell to 36 in Zambia, 42 in Zimbabwe and 40 in Uganda. One-third of children may become vulnerable after maternal orphanhood since elderly and juvenile caregivers are frequently uninformed about nutrition, oral rehydration, immunization and diagnosing serious illness. Resurgence of adult and paediatric TB affects children through increasing orphanhood and increased child mortality. AIDS-induced poverty among survivors leads to deterioration in children's health and increased vulnerability of adolescent survivors to HIV infection. The situation is set to worsen, especially in communities experiencing the cumulative impact of repeated parental deaths. Reducing the number and vulnerability of children and adolescents becoming HIV infected and increasing support to affected children are important strategies to improve child health in countries with severe epidemics.*

> We are guilty of many errors and many faults, but our worst is abandoning the children, neglecting the fountain of life. Many of the things we need can wait. The Child cannot. Right now is the time his bones are being formed, his blood is being made and his senses are being developed. To him we cannot answer 'Tomorrow'. His name is 'Today'. Gabriella Mistral, Nobel Prize-winning poet from Chile.

AIDS is having a profound impact on children's health. By mid-1996, UNAIDS estimated that worldwide, there were 3 million HIV infections in children and 9 million maternal orphans due to AIDS (UNAIDS, 1996). At least 30 million additional children are likely to become orphaned in the next few years since they are currently living with HIV-positive parents.

How is AIDS affecting children's health? This paper will consider the impact of HIV infection on children and its indirect effects on children who are affected by but not infected with HIV. In the light of these implications of the AIDS epidemic, possible directions for

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The Project: **TRAINING OF TRAINERS IN HOME-BASED CARE INITIATIVES** Oak Foundation 1998 Scheme

Target areas: M'hondoro Communal Lands, M'sengezi Re-settlement Area and (a continuation of the previous project funded by OAK) Norton's High Density Townships: Katanga & Ngoni

Goal and Objectives

The overall goal is to train "Networkers" of women in the rural areas to target Care-Givers in their villages to look after their relatives who are suffering from "Life - Threatening" illnesses and to continue to sustain the palliative care initiated in the OAK (Zimb.) Foundation "Family Care" programme in 1997

* **Background of previous programmes done in the target areas**

In the OAK (Zimb.) Foundation pilot scheme, six women were trained to become Trainers of Trainers in Home-Based Care. Each member has completed the training by attending and passing a three-week Red Cross Course. This team is now ready to go further afield and assist in H-B.C. training in the rural areas as well as supervising the training of care-givers in Norton.

In the behavioural changes AIDS Intervention Programme in M'hondoro and M'sengezi, work completed during the year was:

> Base-line Survey: Focus Group Discussions with four target groups of Key Leaders, Sexually Active Men, Women of Child-bearing Age and Youth
> Dissemination of findings: Planning the way forward
> Training of Trainers in the LADA method of approach
> Six Dialogue Courses for Key Leaders in the target areas
> Setting up of AIDS Action Groups in community villages
> The registration of Orphans (756 orphans are currently on Tsungirirai's books)
> Report-back Meetings for monitoring and evaluation purposes.

* **Justification**

Lessons learnt in 1997

> The projects (being pilot schemes) are incomplete. The work done in 1997 requires sustainment and the consolidation and augmenting of the activities already put in place AusAID has been approached for funding to target women and youth in the AIDS Prevention Programme for 1998
> To have real impact, Counselling and Home-Based Care services need to be set up in both rural communities.

According to the Chiefs, Head Kraalmen and Local authorities, Tsungirirai is the only NGO operating in their areas with regards to the AIDS endemic. A good relationship with the people has been established during the past year and an appeal has been made by them for Tsungirirai to remain and continue the work done in empowering the people to take responsibility for themselves and their families in this current crisis.

Key Leaders are most concerned about the rising number of deaths occurring, and the plight of their orphans and elderly who have no "middle" family to look after them and no expected income.

Justification contd
District Hospitals report an increase of Sexually Transmitted Infections:
December 1997: 1314 cases.- Holiday period - January 1998: 1619 cases.

The socio-economic rural background is agricultural - either small-holder or communal farmer, with much of the burden of work and responsibility falling on women. Their work is seasonal, depending on reasonable rainfall, their income paid out once a year at harvest time. In Norton, in the high-density townships being targeted, many of the people are living below the bread-line. Some are accommodated in tin shacks or lean-to extensions.

Implementation Aims

Phase 1 (Three months)

* To establish a good relationship with the Sister-In-Charge of the area clinics for networking purposes and monthly report-back meetings.
* To convene eight initial workshops for ten women trainees in the skills of palliative care, First Aid and Home Nursing in each of the following areas:

M'hondoro North:	Chief Chivero and Chief Nyaweda villages.
M'hondoro South:	Chief Mashayamombe and Chief Ruizi villages
M'sengezi:	M'sengezi Villages and Kutama
Norton contd.	Katanga and Ngoni Townships

* To include the following dialogues and demonstrations in the Workshop:
> AIDS Information
> AIDS related infections: Tuberculosis, candida, diarrhoea etc.
> Training care-givers on patient care: allaying fears, patient comfort / home atmosphere
> Hygiene: Cleanliness, infection control, diets and nutrition
> Ist Aid: Treating wounds, injuries, bed sores etc. Demo: Bandaging, slings, splints
> Home Nursing: Lifting patients, bed baths, bleeding, care of the dying.
> Report-writing, record keeping and case-histories

* To give the trainees tasks:
Dialogues with care-givers, visits to patients for assessments and the offering of resource advice
Networking with the Ministry of Health at the area clinics
Monthly Report-Back Meetings. Planning activities for World Health Week.

Phase 2 (Three months)

Tsungirirai facilitators to hold Meetings at the rural venues with each of the village groups to monitor and evaluate the progress being made.

Agenda:	Learning to fill in Process Data forms (End of month monitoring) Case Histories, Reports & Records. First Aid/Health lecture
Tasks:	The setting up of Self-Help projects for HIVs, orphans, elderly. In 1997, chicken projects were set up in aid of Drama Group transportation. When the chickens had been reared and sold, the profits were given to the Drama Club for bus fares after buying more chicks and chick mash for sustaining the project.

Phase 3 **(Three months)**

Second one-day workshop with each of the groups at their rural venues:
Tsungirirai facilitators will involve the participants in the following topics:

> First Aid demonstrations
> The basic skills of counselling
> The way forward for Care-Givers and their patients
> Sensitive issues dialogue
> Resources for the care of orphans and elderly
> Women's rights: Resistance to change by men

Tasks

Continued Record and Report Meetings and the filling in of Process Data Forms
Training of care-givers: Networking in the Village
Dialogue with young girls on AIDS/Sexual matters
Planning a Field Day for donors, facilitators and the community

Phase Four **(Three months)**

A Field Day visit to evaluate impact in the communities. Cokes and biscuits to be served and incentives for the groups. This will be shared with the AIDS prevention Intervention programme currently running in the areas

Expected Project Outputs / Performance Indicators

By the end of one year, the following targets will have been reached:

*	Tsungirirai will have trained eight groups as Trainers of Trainers in Home-Based/Palliative Care skills to assist people suffering from a Life-threatening illness:	80 Trainers
*	The 80 Trainers will have trained at least 5 care-givers each:	400 care-givers
	At least 400 patients will have received medical care at home	400 patients
*	The 80 Trainers will have guided at least 10 young village girls each in Hygiene, their sexuality and rights, and the perils of HIV spread:	800 young girls
*	The 8 groups will have formed at least two Activity Action Clubs and one Self-Help project in their village	24 Clubs

Possible Constraints

> Seasonal patterns of farming activities: Less community participation at the onset of the rains and during planting times
> Transportation: Buses break down and schedules are erratic, resulting in some of the participants arriving late for workshops
During the rains some of the rural rivers come down in flood, cutting off Tsungirirai's facilitators from reaching the meeting venues.
> Communications: Telephones are not always functional or there is not a service operating in the area. The Japanese Government has offered Tsungirirai motor-bikes, but they haven't arrived as yet.
> Community response: Without remuneration this is always an unknown factor. Tsungirirai's voluntary Field Officers, resident in both areas are visiting clinics/schools and giving guidance to groups who have already started AIDS Action Groups, so expectations are high for a good response.

TSUNGIRIRAI "TRAINING OF TRAINERS" IN HOME-BASED CARE SKILLS IN M'HONDORO NORTH & SOUTH, M'SENGEZI AND NORTON

OAK ZIMBABWE FOUNDATION FUNDING
ESTIMATED BUDGET

Personnel			
Tsungirirai Book-keeping	(1000 x 12)	12000.00	
& secretarial fees:	(500 x 12)	6000.00	
Allowance for Norton initiative	(100 x 7 x 12)	8400.00	26 400.00
Project Expenses			
Licensing, Insurance and repair to bicycles:	(7 x 200)		1 400.00
Material Assistance			
Medicines/destitute care World AIDS Week incentives and Self-Help projects	(500 x 8 x 12)		48 000.00
Training Expenses			
Training Sessions and Meetings			
Four courses for each area:	(8 x 4)	32 courses	
Ten trainees from each village:	(10 x 8)	80 people	
Two facilitators: Training Officers	2		
Two observers: Clinics	2		
Catering			
10 Meetings and 32 courses	(42 x $90)	3780.00	
Stationery	(80 x $32)	2560.00	
Travel			
Mileage and bus fares	(32 x $300)	9600.00	
Subsistence			
Facilitator allowance	(32 x $100)	3200.00	
Materials development			
Brochures on Home Nursing Hygiene and Healthy Lifestyles		5000.00	24 140.00

TOTAL EXPENDITURE **ZW $ 99 940.00**

P. B. Henderson
Director/Treasurer

Dated: .....

Multifaceted approach
20 years ownership

Counseling Committee
Abuse
Marital affairs
Grief counseling

Poetry
Knitting
Bridemaking
Shelter

BWAFWANO OVC

HOME BASED CARE

DATE:

7th January, 1999.

REPORT ON ST. ANTONY - (BWAFANO OVC HOME BASED CARE.)

1. FORMATION

1.0 Bwafwano OVC home based care was formed just after the PLA. Exercise conducted by PCIZ in March 1998.

1.2 The name Bwafwano means "Helping One Another" was chosen with the symbol of shaking hands as a sign of helping one another to solve the problems of the Orphans and Vulnerable children.

1.3 During the Transact walk Reserch it was discovered that ST. Antony compound has a population of about 4,500 people and the following statistics were revealed :-

*55 Vulnerable children not attending school.
*40 Women widowed facing hardship.
*15 Aged.
*04 Handicapped.

1.4 This analysis brought to the attention of the community to realise the services of the problem at hand committed themselves to render some kind of help as to reduce certain problems.

2. FORMATION OF THE COMMUNITY ORGANISATION

2.1 To address the problems effectively. The formation of the community committee was agreed upon and it's structure is as follows:-

(a) **The Executive committee:-** services as the Adminstrative Body composed of the Chairman and the Vice, the Treasurer and the Vice, the Secretary and the Vice.

(b) Planning committee:- It is responsible for Policy making and Planning. It comprises six members, the Technical Advisor, Departmental Secretaries and 3 Trusties.

© **The Community Council:-** This is the main Committee involving all community members whose function is to make approval or adjust the recomendation of the Planning committee.

(d) **The Sub - Committee**:-Headed by their departmental secretaries;-

- Health
- Nutrition
- Counselling
- Fundraising and
- Community School

3.0 AIMS AND OBJECTIVES OF THE ORGANISATION.

(a) To address the problems affecting the OVC between the ages of 6[illegible] - 20 years in areas of Education, Health, and fighting agianst all forms of abuse done agianst children.

(b) To attend to problems of the windowed, the aged and the handicapped.

© To render education to community members in the areas of Health, Sanitation, Nutrition, Breastfeeding councelling and general Education.

(d) To encourage Community participation in solving problems affecting the OVC, the widows, Handicapped and the aged even doing projects to develop the community.

4.0 ACTIVITY IN EACH SUB - COMMITTEE.

4.1 Councelling:- More than 40 cases have been recorded.

Marital:- Under marital 18 cases have been recorded out of which 14 of them are direct dealing with husband who left their wives for other women, one man was recently taken to police and the man was discipline for leaving both the wife and children starving and went for another woman elsewhere the man has since changed, other were simply irresponsible, more than as other cases have just been misunderstandind in the homes.

4.2 CHILD ABUSE:- Seven cases so far recorded.

(a) Three cases were dealt with in conjunction with the Police already one woman is serving a 3 year sentence in prison after she was found guilty of burning her 10 year old daughter just over missing K1,000, which was later found. She used parrafin and set the child on fire causing grivious body harm.

(B) One Parent forced his eleven year old son to sleep in the chicken run.

© Another woman was leaving her two daughters between ages of five and seven with the neighbour early in the morning when ever she goes out to drink beer out with other women's husbands and even young men. She's been to police twice we've noticed Some change.

(D) The other four were dealt with by the community councelling group alone, currently investigating on another case involving a 35 year old son said to have been sleeping with her real mother demanding sex especially after a drink (beer). The same woman is a leprosy victim without fingers and no husband.

4.3 GENERAL COUNCELLING

More than eight cases have been recorded so far, individuals make appointments when ever they have personal, domestic or even social problems. A number of residents have been helped out.

4.4 FUNERALS:- Ten have been recorded. At two funerals, coffins and food were supplied by the community.

- The community also provided transport to and from the grave yards as well as money for other expenses.
- A 77 year old man and poor without relatives died on 24th December 1998. It Became the community's responsibility until late Mumba Supuni was buried on the 26th December 1998.
- Food Transport money and many more have been provided at other eight funera[illegible]

Houses.

4.5 HEALTH COMMITTEE:- The health group looks at the health of the community providing at least basic health care and education.

- More than 92 (Ninety Two) pit laterines and 127 rubbish pits have been dug since it's formation in march 1998
- Went round encouraging parents to take children for polio vaccination on both rounds. 482 children were vaccinated on 8th, and 9th, July, 462 during round 2 in August Total 944 children
- Some members of this group attended vitamin A and and HIV/AIDS workshop at Buchi main clinic so that they can educate the community.
- Health campaign have also been conducted, e.g. burring of rubbish, cutting of long grass around to avoid mosquitoes, hence no malaria.
- Introduced stands at the local market to aviod selling food stuffs on ground especially this rainy season. Marketeers were told to cover and wash food before selling and eating to avoid cholera.

4.6 NUTRITION:-

(a) On 2nd July it was a mother's day and mothers were taught how best they can breast feed their babies, their babies, the importance of under five check ups and family Planning services. The event was conducted in conjunction with the medical staff from Buchi main Clinic.

(B) 42 homes have been identified to have the malnourished children so far, they are being helped with soya bean flour only supplied by Buchi main Clinic.

FUNDRAISING:

(a) The fundraising committee has been raising funds through community collection of K5,000 per house hold towards the intended purchase of hammer mill to generate more funds to assist the OVC.

(B) They also raised funds through the market daily levy collection of K200 (Two hundrend kwach only) per person selling.

© The funds collected from the market is assisting in supporting the community during funerals (The Vulnarable people), buying coffins, food, trnsport, and those failing to trace their relatives. The OVC in terms of health buying drugs and buying stationary for the community school.

NB. Recently January 1999, Four pairs of trousers, four shirts and a tablet ach of bathing soap were given to four men two women also received a dress and bath soap each, all these items were bought from the same money.

FUTURE PLANS ON FUND RAISING.

- Plans are under way to come up with the keeping and selling chickens project.
- Putting up a structure for vedio show.
- Hammer mills.
- Building at the market a storage facility for all those coming from distant places and demand a certain fee (storage).

4.7 COMMUNITY SCHOOL ACTIVITIES

(A) The community school has also been put in place to help children who have failed to pay user fees in the government scools. There was no plan to help the OVC to have basic education. A total of 120 children out of which majoriy are ophans have now started attending the community school. Some are coming from nearby Kandabwe compound.

- The scool has three (03) level according to the Zambia Community school

programme. Level I is grade 1 and II level 2 is grade III and IV and Level 3 is grade V and VI

- The school is also running a nursery with the total number of 80 children.There are four (04) teachers, two men and one woman on full time and another man on part time basis.
- During and at the end of term. Tests are being conducted to access the progress of the child. Parents are invited on open day to come and meet as well as discuss with the teacher on child progress.

4.8 COMMUNITY DEVELOPMENT PLANS (PROJECTS)

The commnity has also been involved in making roads and better drainage system. Bigger roads have been by the community where vehicles can pass through. Scaw limited is the only company which helped us with the supply of solid slag on our roads.

Community vice chairman

Contents: Publications by FACT and other organisations

Projected orphans as a result of AIDS in Zimbabwe *(HIV AIDS in Zimbabwe, NACP 1998)*

Community Mobilisation Practices *(Report produced for UNAIDS, 1998)*

Proportion of orphans in southern Africa, 1990-2010 *(USAID, Children on the Brink, 1998)*

Child-headed households in the era of parental deaths from AIDS *(Abstract submitted to International AIDS Conference, 1998)*

Factors leading to the establishment of child-headed households: the case of Zimbabwe *(Paper published by Health Transitions Review, 1997)*

Perceptions of children and community members concerning the circumstances of orphans in rural Zimbabwe *(Paper published in AIDS Care, 1997)*

Today's children - challenges to child health promotion in countries with severe AIDS epidemics *(Paper published in AIDS Care, 1998)*

Practical stepos towards community-based care *(A School without Walls publication, 1996)* (extra Booklet)

Mutasa HIV/STD Prevention Project *(Project update of BRTI/FACT/Ministry of Health collaborative project with rural HIV, STI and behavioural data, December 1998)*

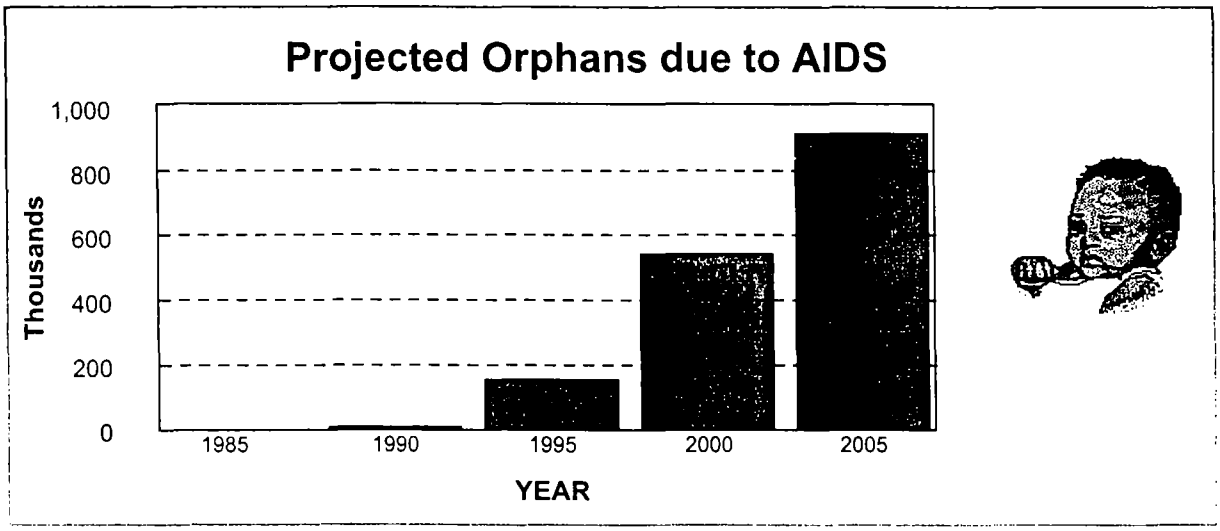
Information about Family AIDS Caring Trust

THE SOCIAL AND ECONOMIC IMPACT OF AIDS

Orphans as a Result of AIDS

One serious consequence of AIDS deaths to men and women in their prime child bearing ages is an increase in the number of orphans. An orphan is defined here as a child under the age of 15 who has lost his or her mother to AIDS. This has become a common definition in addressing the HIV/AIDS epidemic and reflects the central role of the mother in child bearing in many African societies. In reality, given that HIV is spread through heterosexual contact, many children will lose both parents. The number of orphans would rise quickly from a small number in 1990 to 150,000 in 1995, 543,000 in the year 2000 and 910,000 in 2005.

Orphans as a Result of AIDS



There will be a tremendous strain on social systems to cope with such a large number of orphans and provide them with needed care and support. At the family level, there will be increased burden and stress for the extended family, which has the traditional responsibility to care for orphans. Many grandparents will be left to care for young children. Other families will be headed by children and adolescents. At the community and national level, there will be an increased burden on society to provide services for these children, including orphanages, health care and school fees. Many orphans will never receive adequate health care and schooling, increasing the burden on society in future years. There will be a likely increase in the number of street children in urban areas.

Community Mobilisation Best Practices

The Families, Orphans and Children Under Stress (FOCUS) Programme

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Report produced for "Community Mobilisation in eastern and southern Africa" meeting held in Pretoria, South Africa, 9-11 November 1998 organised by UNAIDS.

Executive Summary
This document describes the Families, Orphans and Children Under Stress (FOCUS) programme established by Family AIDS Caring Trust, Zimbabwe in 1993. It illustrates the importance of formative research in programme establishment, techniques of community mobilisation and the operation of reporting systems. The programme is an example of "Best Practice" as shown by it relevance, efficiency, impact, sustainability and ethical soundness. The programme has been replicated by other organisations in eastern and southern Africa.

In 1991, orphan enumeration was carried out in the Manicaland province in Zimbabwe; it was estimated that 6.8% of children under 15 years were orphaned by loss of their father or mother and that there were some 47,000 orphans in the province, with over 99.5% being cared for by their extended family. In 1992, a further random household orphan enumeration was carried out in one urban and one rural site and efforts were made to understand extended family and community coping mechanisms prior to programme design. The Families, Orphans and Children Under Stress Programme was established in 1993 in a rural area close to Mutare by a local independent church with technical support from Family AIDS Caring Trust.

One year after its establishment, an evaluation was conducted. This demonstrated that the programme had identified a large proportion of orphans in the catchment area of the programme, had prioritised the most needy orphan households and had succeeded in identifying, training and mobilising village-based volunteers to regularly visit orphan households. The programme was owned by members of the rural community and as new needs were identified, new activities were initiated by community members. Small amounts of material support provided through the programme were targeted to the most needy households. Further studies documented the cost-effectiveness of the FOCUS programme.

Volunteers connected with the programmes receive minimal financial incentives; there have been few volunteers dropping out of programmes, even in those established several years. New forms of support to volunteers were developed such as the provision of uniforms, annual Christmas monetary gifts and the provision of training through exchange visits to other FOCUS programmes.
The initial focus on orphan enumeration, needs assessment, prioritisation, regular visiting, provision of material support and record keeping has expanded to include income generation, micro credit, advocacy, psychological assessment and support, awareness raising in sexual abuse and child rights. Carefully established record systems enabled communities and programme directors to identify and study emerging issues such as stigmatisation against orphans, child-headed households and increasing vulnerability to HIV of orphaned children.

The programme led to the establishment of partnerships between government and non-governmental organisations, and between international, local and community-based NGOs. The FOCUS programme was replicated and operates in five rural and one urban community in Manicaland, supervised by FACT. **The programme supports some 4,000 orphans. The total cost per month of the FOCUS programme was Z$42,517 (approximately US$1,150) , per visit was Z$20 (US$0.5), per child helped US3 per year.**In 1995, the Bethany Project in Zvishavane, Masvingo Province was established by a volunteer working with the British Volunteer Programme following visits to the FOCUS programme; this orphan visiting programme now involves some 300 volunteers throughout the whole administrative district. Orphan programmes were established in Zambia, Kenya and Malawi following visits to FOCUS sites as part of FACT's Regional Training Programme.

1. BACKGROUND

In 1991, orphan enumeration was carried out in the Manicaland province in Zimbabwe as part of a national Maternal and Child Health survey; it was estimated that 6.8% of children under 15 years were orphaned by loss of their father or mother and that there were some 47,000 orphans in the province; over 99.5% were being cared for by their extended family with only 170 orphans (0.4%) being cared for in children's homes[1].

In 1992, a further random household orphan enumeration was carried out by Family AIDS Caring Trust in one urban and one rural site; further research was undertaken to understand extended family and community coping mechanisms[2]

2. DESCRIPTION OF PROGRAMME

The Families, Orphans and Children Under Stress (FOCUS) programme was established in 1993 by Family AIDS Caring Trust in Mutare, Zimbabwe. An independent Pentecostal church situated in a peri-urban rural area 20km from Mutare established AIDS awareness and homecare activities in 1991 in collaboration with FACT's Rural Training Programme. In 1993, the church established the FOCUS programme by recruiting 25 women from 18 villages throughout the programme area. The programme operated in a communal farming area of approximately 200 square kilometres with a population of 10,611 people in 2,089 households.

The women were recruited on the basis of concern for orphans; most were already caring for orphaned relatives. As community visitors, they became responsible for identifying and visiting orphan households within a 2-kilometre radius of their homes. The parental status of families living nearby could be easily ascertained by the women. The names of orphan households were placed on a register. As the FOCUS programme became known, unregistered orphan households were referred to the community visitors by concerned neighbours or school authorities. Volunteers were provided with basic training so that they are able to identify and register all orphans in the community. The most needy families (approximately one half of those identified) were placed on a priority register. The programme aims to visit each household twice per month with those in greatest need such as child-headed households being visited weekly [3].

By 1998, the programme supervised by FACT had extended with activities being carried out by 137 volunteer visitors. The programme was based at 5 discrete rural sites with an estimated total catchment area population of 50,000 and a low income high density area in the city of Mutare where a large number of dwellings were wooden shacks. Each programme was supervised by a volunteer supervisor who had specific responsibilities in terms of reporting to FACT and liaising with those involved at local level. Each two months, the FACT FOCUS Coordinator met with the supervisor and volunteers at their monthly report and training meeting. Every other month, the supervisor met together with the Coordinator at FACT's office in Mutare.

During the first nine months of 1998, some 2,100 support visits were made each month to some 1,200 orphan households in these six sites. The total cost per month of the FOCUS programme was Z$42,517 (approximately US$1,150), excluding FACT administrative costs of an additional estimated 20% of programme expenditure. Of the direct FOCUS expenditure, 56% was spent to directly benefit the community in the form of material assistance (78%), volunteer allowances and uniforms (13%) and training and meeting expenses (9%). Material assistance was mostly in the form of maize seed and fertiliser, primary school fees for some 500 children, blankets and food. The remaining 44% of FOCUS programme expenditure was utilised by FACT to employ a Coordinator and Assistant Coordinator, to pay for FOCUS programme travel costs and for FOCUS administrative expenses such as office and computer rental, telephone, stationery and photocopying .

Volunteers connected with the programmes receive minimal financial incentives; there have been few volunteers dropping out of programmes, even in those established several years New forms of support to volunteers were developed such as the provision of uniforms, annual Christmas monetary gifts and the provision of training through exchange visits to other FOCUS programmes.

2.1 Aims and Objectives

Each programme has the following objectives:

- to identify all orphaned children in each programme's catchment area and prioritise those households with the greatest needs
- to visit all prioritised households at least twice per month
- to identify households where children's basic needs are unmet and to provide these households with limited development-oriented material support
- to liaise with other community groups, leaders and organisations concerning the operation of the programme
- to enable community members to own each FOCUS programme and over time reduce their dependence on FACT
- to identify new or emerging problems affecting children who have been orphaned

2.2 Establishment of Programmes

Initially, great attention is paid to the methods by which each FOCUS programme becomes established. Programmes have been established as a response by FACT to felt needs of communities. The provision of material support from FACT through the community group to beneficiaries has been avoided wherever possible until programmes have demonstrated their to prioritise those in greatest need of such support and monitor their activities. The following steps have been identified in establishing community-based orphan support programmes[4].

- *Organisational Analysis*: Though NGOs have a supportive role, programmes can only be implemented by community-based organisations. The community where
- *Community Identification*: The community where the programme is to operate should be identified. There should be a defined catchment area. The programme is more likely to succeed if it is based on and develops existing activities.
- *Volunteers:* The volunteers are the key human resources within the programme. Great care should be taken over their selection, training, support and motivation. Paid staff are not primarily implementors but should take on a coordinating role.
- *Client Identification*: Steps in client identification include defining the target group, enumeration, registration, needs assessment and prioritisation
- *Monitoring and Evaluation:* A record system should be established and volunteers trained in its use. Community mapping of the catchment area is a crucial activity in the development of the programme. Objective process and outcome indicators need to be identified and measured.

More detailed information regarding methods of Community Mobilisation are described in FACT's training manual used in its Regional and National NGO training programmes[5].

2.3 Development of Programmes

Programmes have developed new features since their initial establishment. Some of these activities have been initiated by community members themselves[6]. Some developments have generally been established in response to felt needs of community members, or following research conducted as a result of

recognition of new or emerging problems affecting children who have been orphaned:

- *Voluntarism from within community*: community members who are not volunteers within the programme have given their time and materials to help orphaned families. Activities include ploughing fields, repairing broken-down housing, advice in agriculture, health care, child care and income supplementation.

- *Income generating activities*: Material inputs to community groups have been provided for community-based projects such as poultry, vegetable gardens etc. Income from such projects are used to support destitute families and raise money for use by the community group

- *Micro credit schemes:* These operate to benefit individual volunteers who may learn family-based income generating skills and simple money management.

- *Psycho-social Support:* The establishment of weekly crafts, agricultural, cultural or sporting activities operated by members of the community for the benefit of older orphaned children.

- *Awareness raising and Advocacy*: Volunteers connected with the programmes have advocated on behalf of children with political and traditional leaders, headmasters and health workers in order to improve the situations of orphans and children in especially difficult circumstances

- *Abuse monitoring*: The presence of a body of community members concerned about the situation of children acts as a reference body. Incidents of sexual and physical abuse have been reported by volunteers and as a result of such supervision, it is likely that instances of abuse have lessened. Training of volunteers and teachers in identification and management of cases of abuse was conducted in 1998 within communities with FOCUS programmes by a child psychologist working as a volunteer with FACT.

2.4 Research and Evaluation of Programme

Appropriate community-based process monitoring systems are maintained by each FOCUS programme. Orphan register and orphan visiting records are forwarded each month to FACT for collation of statistics. Newly emerging problems have been identified through this mechanism and specific research has been conducted or is planned. These include:

- *Psycho-social needs of orphans:* focus group discussions were held with groups of orphaned children to identify their perceptions concerning effects of loss of parenting, discrimination, exploitation and abuse [6].

- *Child-headed households:* the reasons why such households were occurring was studied through identification of index households by community-based volunteers. Households were interviewed. Feedback of the findings of this research led to greater awareness of the needs of children in especially difficult circumstances[7].

- *HIV prevention needs in orphaned girls and needs of HIV-infected orphaned children and mothers.* These newly emerging problems which have been identified by community members are the current focus of attention of FACT programme researchers.

The first FOCUS programme was evaluated in 1995, one year after its establishment. This demonstrated that the programme had identified a large proportion of orphans in the catchment area of the programme, had prioritised the most needy orphan households and had succeeded in identifying, training and mobilising village-based volunteers to regularly visit orphan households. The programme was owned by members of the rural community and as new needs were identified, new activities were

initiated by community members. Small amounts of material support provided through the programme were targeted to the most needy households[8].

A further review of programme records and costs during 1996 when the programme had expanded to three further sites documented the cost-effectiveness of the FOCUS programme[4]. A further evaluation of the FOCUS programmes is being conducted during 1998-99.

2.5 Replicability of Programmes

Following the successful evaluation of the first FOCUS programme in 1995, the programme was replicated to four further rural and one urban sites during 1995-97. Process monitoring of the four replicated rural programmes indicate successful levels of programme activities (see Section 2 above). The model was not established as effectively at urban level. An operational evaluation of the FOCUS programmes which will include a special study of the functioning of the urban programme is being conducted in 1999.

In 1995, the Bethany Project in Zvishavane, Masvingo Province was established by a volunteer working with the British Volunteer Programme following visits to the FOCUS programme; this orphan visiting programme now involves some 300 volunteers throughout the whole administrative district.

FACT's Regional Training Programme was established in 1994. Up till August 1998, 63 participants attended two-week field-based training courses with exposure to FACT's Prevention (Youth, Workplace and Community HIV Prevention) and Care (Homecare, PWA Support, Orphan Support and Church) programmes. An evaluation of FACT's Regional Training Programme was completed in October 1998 through questionnaire study supplemented by visits to 16 participants in three countries (Kenya, Zambia and Uganda) from where 55% of participants attended. This study identified that orphan programmes had been established by three NGOs in Zambia, Kenya and Malawi as a result of visits to FOCUS sites during two-week course attachments to FACT; two other NGOs had initiated orphan care programmes through training community volunteers [1].

3. CORE CRITERIA OF "BEST PRACTICE" IN COMMUNITY MOBILISATION

According to UNAIDS, the initial criteria for addressing best practice is that it addresses HIV/AIDS prevention and care, works towards reducing people's vulnerability and tries to alleviate the epidemic's social and economic impact. Once an initiative is identified as doing any or all of the above well, the following more detailed criteria are proposed for assessing the effectiveness of the approach or practice in the area of community mobilisation:

3.1 Relevance

The programme was initiated in response to HIV/AIDS. However orphan visiting was carried out by community members on an informal basis prior to programme establishment. Prior to the initiative, an assessment of the needs, resources and skills of the community was carried out. The objectives are relevant to the assessed needs and resources of the community.

New needs have been identified since the programme started and the initiative has changed to respond to these new needs (see 2.3 & 2.4 above). The goals of the initiative are relevant and realizable given the resources and capacity of the community.

The strategies are relevant to existing socio-cultural and political contexts. In addition, the

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[1] A mission hospital in Zambia has started an orphan support programme with 300 orphans on the register and 60 volunteers out of 100 trained;

An NGO in Malawi has started a community-based orphan care project bringing together women volunteers from four different churches.

An NGO in Kenya has started an orphan project.

In addition, an orphan care workshop was held in Zambia and women volunteered to become orphan carers. Another organisation used FACT's Community Care manual in the selection of community volunteers for orphan care.

programme has challenged existing structures. Advocacy for children is a new concept amongst many of the community members. Involvement in AIDS-related activities through involvement with orphans has been a challenge for several churches as a result of their involvement with the initiative. The strategy has been found to be useful and adaptable for other countries in southern and eastern Africa (see 2.5 above).

3.2 Efficiency

The available resources are used to the maximal extent. The programme could be made more efficient by redesigning the strategy so that support is offered to families affected by HIV/AIDS during parental illness through a combination homecare/children affected by HIV/AIDS programme rather than the entry point being to children following parental death; also by combining prevention activities with care provision.

Human resources could be utilised more efficiently by encouraging greater involvement of other agencies (e.g. Health workers, teachers, police, political and traditional leaders) from programme establishment. The particular skills and commitment of volunteers have been critical to the efficient management of the initiative. The particular experience gained by FACT in the management of volunteers could be valuable to other organisations.

Resources are mobilised, provided and used in a timely manner. One obstacle in this respect has been delayed disbursements or limitations in types of expenditure conditions placed by donor organisations. Expectations raised by the community in relation to financial commitments are often **not** provided through this programme. This decision is made only partly on the basis of limited funding availability. The main reason for limiting provision of material support has been because of concerns about programme sustainability. Training provision is provided wherever possible. FACT has been able to help community organisations to develop their own project proposals.

The use of resources is monitored regularly. However with a large number of small amounts of material support to programme beneficiaries, it is difficult for FACT to monitor whether these are targeted correctly. FACT closely monitors its own use of resources and relies on self-righting mechanisms of community groups to monitor use of resources provided by FACT through community groups to programme beneficiaries. There is fair coordination with other partners.

The process of recruitment and training of volunteers matches the skills of the volunteers to the needs of the initiative. Incentives are provided to keep volunteers motivated (see 2 above).

3.3 Effectiveness / Impact

The initiative is achieving its intended goals and objectives and impacts (see 2.4 above). The programme has reached its intended community and has extended beyond the expected scope of the initiative. There have been unexpected positive impacts (see 2.3 above). Unintended negative impacts include claims of duplication of activities by other government and non-governmental organisations (baseline survey suggested that there was limited formal service provision by other welfare agencies in target areas). Impacts are being monitored through a well-established reporting system.

3.4 Sustainability

Funding was received from Plan International (Mutare) who have continued to be the principal donor to the programme. Donations have been received from NORAD and UNICEF as well as a large number of smaller donations in cash and kind through FACT. In addition, donations have been given directly to community groups, often following visits by outsiders to the projects.

There has been remarkably little turnover of volunteer staff with only one volunteer actually leaving the programmes, some of which have been established for nearly five years. There are reports of community members requesting programme supervisors that they be allowed to become FOCUS visitors. Tangible incentives to volunteers include monthly bus fares to support meetings, tee-shirt, skirt, training shoes and scarf once per year and an annual Christmas bonus of US$10. Volunteers receive initial and monthly training. Some visit other programmes through an exchange visit scheme. Volunteers who look after orphans in their own homes may receive small amounts of material support

(average US$11 per annum).

The initiative has maintained its funding resources through maintaining a low-cost programme. Future funding plan include diversifying donor base and including research as part of ongoing programme activities. The initiative has led to policy changes by the Dept of Social Welfare which, partly as a result of FOCUS, is now a strong advocate of community-based orphan support.

The community owns each FOCUS programme. Although the initiative was started as a response to the HIV/AIDS epidemic, at community level, it has little emphasis on HIV/AIDS. It has expanded to include other concerns such as income generation and child welfare in general, not just specifically children orphaned by AIDS or only orphans but also other categories of children in especially difficult circumstances.

The key change in the project over time has been concerning ownership of the project. Initially, this rested largely with FACT. Over time, the projects have been increasingly owned by community organisations.

3.5 Ethical Soundness

Confidentiality concerning people affected by HIV/AIDS has been maintained. The programme does not directly address HIV/AIDS issues. The project has conveyed a positive, non-discriminating approach to awareness raising and care through its emphases on coverage, prioritisation of those in greatest need and the provision of regular visits and material support to the most needy households. Children's rights to protection, health, education, non-discrimination, lack of work are some rights which this strategy has supported.

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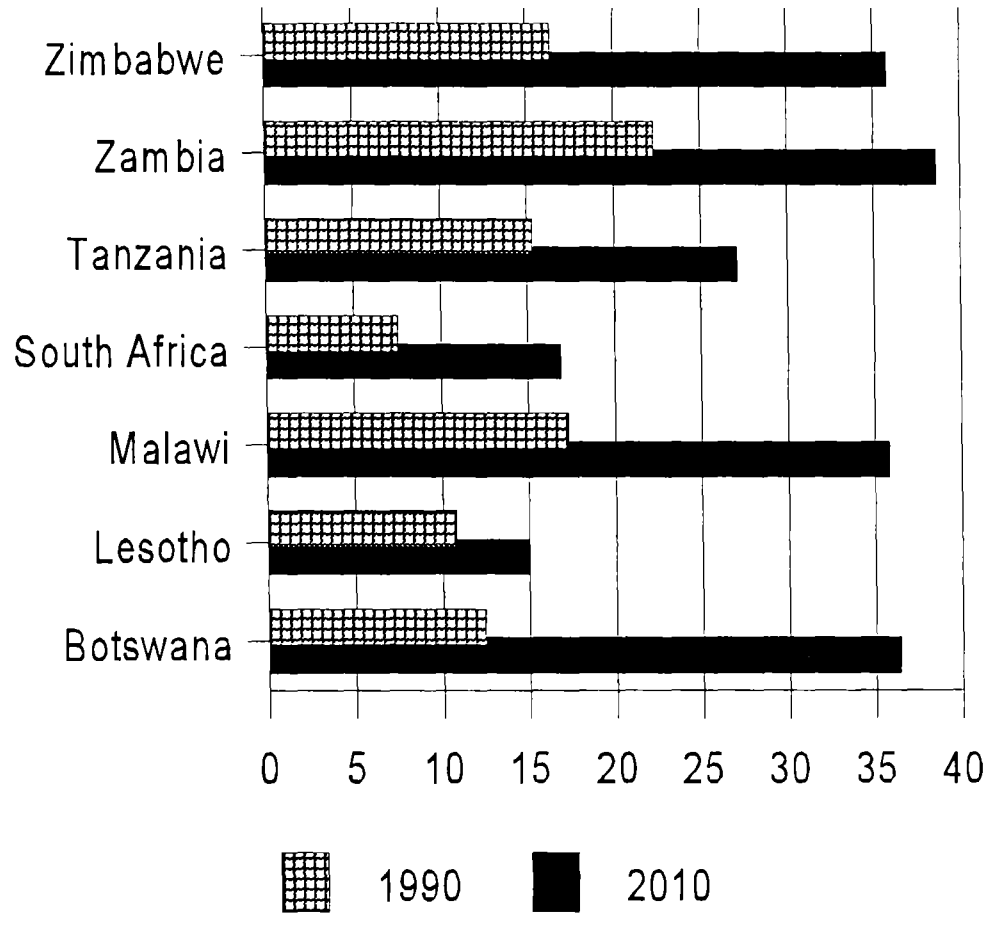

Proportion of orphans, 1990-2010
Zimbabwe
Zambia
Tanzania
South Africa
Malawi
Lesotho
Botswana
0
5
10
15
20
25
30
35
40
1990
2010

CHILD-HEADED HOUSEHOLDS IN THE ERA OF PARENTAL DEATHS FROM AIDS

Geoff Foster, Choice Makufa & Etta Kralovec.

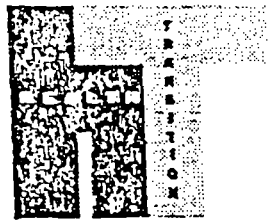
Objective:The appearance of child-headed households (CHH) in communities affected by AIDS is a recent phenomenon with cases noted in the late 1980's in Uganda and Tanzania. This research studied coping mechanisms of child- (<18 yrs) and adolescent-headed (18-24 yrs) households in Zimbabwe: factors surrounding the establishment of CHH, the degree to which CHH are supported by relatives and reasons why relatives do not absorb orphans into their own families were studied.

Methods: Child- and adolescent-headed households (CHH/AHH) were identified by 88 volunteers working in five orphan support programmes administered by Family AIDS Caring Trust; 26 CHH and 17 AHH were interviewed in 1997.

Results: The household head was female in 25 cases and male in 18 cases. Children as young as 9 and 11 years old were responsible for looking after younger children and heading accompanied (containing adults) and unaccompanied households respectively; 75% of CHH/AHH were established in 1995/1996. Both parents had died in 86% of orphan families with 80% of deaths occurring in 1993-96. CHH/AHH were established immediately following the death of a parent in 49% of households, especially the mother, and after illness or death of grandparents, aunts or an unrelated household head in 33%. In 13 households, there was no known relative in the family able to care for the children. CHH/AHH had significantly fewer possessions (0.9 vs 2.0) and less monthly income ($7.3 vs $19.6) than adjacent control households. The minimum rural prevalence of CHH was 4 per 1000 households. Few urban CHH/AHH were identified.

Conclusions: CHH/AHH result from rapid increase in numbers of parental deaths due to AIDS leading to over-burdening of the capacity of relatives to fulfil their traditional role of caring for orphans. At first, CHH may be transient; CHH may disintegrate following crises or as relatives organise fostering arrangements. In communities with high parental death rates, increasing numbers of CHH are likely to occur, headed by younger children with more long-term households. Many CHH/AHH receive regular visits and support from relatives who are often struggling to bring up their own families. Community groups can help extended families to cope with the burden of orphans and prevent the breakdown of the extended family safety net by encouraging the establishment of volunteer-based visiting programmes to at-risk families and by channelling essential material support to destitute families.

Factors leading to the establishment of child-headed households: the case of Zimbabwe



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Abstract

This paper analyses factors associated with the establishment of 43 child- and adolescent-headed households in Manicaland, Zimbabwe. Such households result from the rapid increase in numbers of parental deaths leading to overburdening of the capacity of relatives to fulfil their traditional role of caring for orphans. Most children living in child and adolescent headed households have had both parents die in the preceding five years; many of them receive regular visits and support from relatives. Child-headed households represent a new coping mechanism in response to the impact of AIDS on communities. Community groups can help extended families to cope with the burden of orphans by encouraging the establishment of volunteer-based visiting programs to at-risk households and by channelling essential material support to destitute families.

The number of children being orphaned is rapidly increasing in communities with high rates of HIV infection; by mid-1996, it was estimated that nine million children had lost their mother to AIDS, with over 90 per cent of affected children living in sub-Saharan African countries (UNAIDS 1996). The epidemic is leading to a decreasing proportion of adults in the population and reduced incomes of affected households (Gregson et al. 1994; Leighton 1996:76). As a result of the impact of AIDS on communities, changes are taking place in care-giving arrangements for affected children (Foster et al. 1995); an increasing proportion of orphans are now in the care of the elderly and the very young (Foster et al. 1996; Saoke, Mutemi and Blair 1996:55). The emergence of households headed by children sometimes as young as 10-12 years old is one of the most distressing consequences of the epidemic.

The appearance of child-headed households in communities affected by AIDS is a recent phenomenon with cases noted in the late 1980s in the Rakai district of Uganda (WHO 1990; Alden, Salole and Williamson 1991) and Kagera region of Tanzania (Mukoyogo and Williams 1991). In 1991, such households were observed in Lusaka, Zambia (Ham 1992), Manicaland, Zimbabwe (Foster et al. 1995) and, for the first time, in six villages in the Masaka district of Uganda, where previously no such households had been noted (Naerland 1993). In the United States, cases of teenagers caring for younger siblings after deaths of parents from AIDS were reported in 1993/94 (Levine 1995:194).

In the Rakai district of Uganda, two per cent of orphans were living in households with a carer who was 18 years old or less and 97 per cent of orphan households had an adult of 17 years or more living in the household (UNICEF 1994; Nalugoda et al. 1997). Zambia and Uganda were estimated to have 3.8 and 2.4 per cent respectively of children under 15 years maternally orphaned by AIDS in 1995, increasing to 5.5 per cent and 3.5 per cent by the year 2000 (Michaels 1994). By 1996 in Zimbabwe, it was estimated that eight per cent of children under 15 years were motherless because of AIDS and this was projected to rise to 16-22 per cent by 2001 and 24-40 per cent by 2011 (Gregson et al. 1996).

It seems likely that once households headed by children start to appear in communities affected by AIDS, their numbers and relative proportion will both rise as the cumulative total of orphans continues to increase. Though it is often assumed that the presence of these

CHH in communities implies that extended family methods of support have broken down, this assumption has not been validated since there have been no previous studies of child-headed households. This study seeks to determine factors surrounding the establishment of CHH, the degree to which CHH are supported by relatives and to explore reasons why relatives do not absorb orphans into their own families. Through better understanding of existing coping mechanisms, appropriate methods of support to children living in especially difficult circumstances may be developed.

The extended family and children Traditional Zimbabwean Shona and Ndebele communities are built around a patrilineal kinship system. Members of the same patrilineage are grouped together, and the residential group is, or used to be, three to four generations. Traditional life is characterized by brotherhood, a sense of belonging to a large family and by groups rather than individuals. The extended family gives security and support and the members share many assets. Bourdillon (1991:26)writes "It used to be, and still is, the ambition of a man to gather around him a growing lineage of descendants and dependents who would act as a corporate body for economic purposes and also a united body in times of crisis or tension within the community".

Traditionally, marriage used to be not so much the linking together of two individuals but of two families. When marriage was decided upon, a brideprice in the form of a number of cattle was paid to the bride's family; the payment of brideprice led to the children becoming the responsibility of the father and his family. Brideprice also created a special bond between brothers and sisters. The receipt of brideprice by a family for their daughter's marriage enabled them to pay the brideprice for their son. The son's children thus had a special link with their paternal aunt, who had a unique role in their upbringing. Traditionally, the concept of a "social" orphan did not exist in Zimbabwean societies. Biologically orphaned children were cared by members of their extended family, especially by aunts and uncles who took on the caregiving functions of parents. Under certain circumstances, other adults within the extended family besides the biological parents were called "mother" and "father" (Arvidson, 1996).

The extended family was the traditional social security system and its members were responsible for the protection of the vulnerable, care for the poor and sick and the transmission of traditional social values and education. In recent years, changes such as labour migration, the cash economy, demographic change, formal education and westernisation have occurred which have weakened extended families. Labour migration and urbanisation have led to a reduction in the frequency of contact with relatives and encouraged social and economic dependence; possessions are perceived as personal property and no longer belong to the extended family. Increased life expectancy and family size mean it is now impossible for an extended family of three or four generations to reside together; the diminishing availability of land makes it difficult for large families to be economically independent through subsistence agriculture. Education about social values is likely to result from schools and interactions of children with their peers rather than through traditional mechanisms which has lessened the ability of older people to exert social control over the younger generation. Brideprice is nowadays often a cash payment earned by the husband-to-be, rather than cattle and other possessions raised by members of his extended family; thus marriage itself has become more a contract between two individuals leading to weaker linkages between and within extended families.

Some traditional roles of the extended family have been modified whilst others have almost disappeared. In Zimbabwe, brideprice is still commonly practised, though its nature has changed. The imposition of brideprice with high monetary value has led to unions being established without the payment of brideprice, unrecognized by relatives from either family; such unions are inherently less stable and the children from them may be deemed not to belong to either extended family. Widow inheritance by a brother of the deceased husband is nowadays rare, though the traditional practice may have been replaced by brothers retaining sexual access to widows whilst not customarily inheriting and supporting them as second wives (Drew, Foster and Chitima 1996). The fact that orphans are now being fostered by maternal rather than paternal relatives, especially in peri-urban areas, is symptomatic of the decline of traditional extended family practices (Foster, Makufa and Drew 1995).

In spite of this, it should be emphasized that the extended family remains the predominant caring unit for sick relatives and orphans throughout Africa (Ankrah 1993). In the past, the sense of duty and responsibility of extended families towards other members was almost without limits. Even though a family did not have sufficient resources to care for existing members, orphaned children were taken in. This was the basis of the assertion that traditionally, 'there is no such thing as an orphan in Africa'. Even during the current crisis, and despite the appearance of child-headed households, most orphans are cared for by a member of the extended family. Extended family systems of caring for orphans are adapting to changes taking place within society (Foster, Makufa and Drew 1995). These changes illustrate the strength, resilience and adaptability of extended family coping mechanisms.

Methods

Background

The progression of the HIV epidemic in Zimbabwe has been rapid. Anonymous unlinked surveillance of pregnant women in five urban and 17 rural antenatal clinics during 1992/93 found 21.2 per cent (1205/5679) to be HIV-positive (Ministry of Health 1994). A 1992 enumeration study of orphans in Mutare district found 12.8 per cent of the children in the area studied were orphaned; 50 per cent of recent parental deaths were ascribed to AIDS (Foster et al. 1995). A 1995 enumeration in the area of the current study found 14.7 per cent of children orphaned with one quarter of parental deaths having occurred in the preceding year (Foster et al. 1996).

The Families, Orphans and Children Under Stress (FOCUS) program was established in 1993 by Family AIDS Caring Trust (FACT) in Mutare, Zimbabwe. The program is implemented by local churches in four rural areas of Manicaland province with a population of some 35,000 people; orphan households were identified by 88 volunteer women living in villages in program areas and those families most in need were given priority for regular visiting; during 1996, an average of 1398 supportive visits per month were made to 798 needy orphan households. In the city of Mutare, with a population of about 160,000, FACT supervises a church home care program using 30 volunteers with approximately 500 visits a month to some 200 clients and a FOCUS program with 10 volunteer visitors. FOCUS program records were reviewed and households headed by adolescents and children were noted; volunteer visitors identified additional child- and adolescent-headed households for inclusion in the study. A majority of orphan households were identified by one rural program assessed in 1995 and it is likely that a high proportion of households headed by children and adolescents were identified using local knowledge of rural community visitors (Foster et al. 1996). Much underreporting of such households in urban areas was likely since

Results

A total of 60 households were interviewed; 17 households were excluded because they were found to be headed by a grandparent, mother or aunt. In 43 child- and adolescent-headed households (including 27 child heads and 16 adolescent heads), there were 15 adults over 24 years, 23 adolescents aged 18-24 years and 146 children under 18 years, an average of 0.3 adults, 0.5 adolescents and 3.4 children per household; there were nine children under five years old of whom three were children of adolescent household heads. The median age of respondents was 16 years (range 10-80 years). In six households, information was obtained from grandparents or aunts. The minimum prevalence of child-headed households in the four rural areas was four per thousand households.

Household classification

Of 43 households, 27 were unaccompanied households consisting of children or adolescents caring for younger children; three were unaccompanied single child or adolescent households; 13 were accompanied child-headed households or adolescent-headed households which contained 15 adults. Seven accompanied households contained grandparents who were too ill or debilitated (4) or blind and old (3) to supervise the households; one household also contained a mentally retarded mother; two households contained aunts, one who was too ill to care for children and one who was living in the same household but was not responsible for the daily supervision of orphaned children; five contained adults 25-29 years old, the spouses of two adolescent household heads, two step-brothers lodging with relatives and a 26-year-old female who had previously been the household's adolescent head.

Four adolescent-headed households were established previously when the household head was under 18 years. One child-headed household was previously headed by an adolescent who later left the household. In the month before the study, one household became adult-headed when children moved temporarily to their grandmother's home after their roof collapsed during a storm; and one became adult-headed after the child head ran away, followed by another sibling, leaving two younger children who moved in with an aunt.

Five households headed by adolescents and none by children were identified in the urban area. One urban household consisted of an adolescent who was left living alone after three younger siblings moved to a relative's rural home. The fact that no child-headed and few adolescent-headed households were identified in the urban area may indicate a low urban prevalence of these households. Living costs are higher in urban areas which leads some to relocate to rural areas where food, accommodation and education costs are lower. Children and adolescents living by themselves in urban areas may be evicted from their property for non-payment of rent or because they are exploited and have difficulty retaining their residence when accommodation is in great demand. There were anecdotal reports of urban child or adolescent-headed households breaking up, with boys becoming 'street kids' or leaving to work on rural farms and girls taking up low-paid domestic employment.

Orphanhood

Using a definition of orphans as children under 18 years who have lost either parent, 41 out of 43 (95%) households contained orphans. There were two non- orphan child-headed households: a single mother left home leaving a 16-year-old daughter looking after her younger sister; and a 14-year-old son looked after his mentally retarded mother, three younger children of different, unknown fathers and a blind, old grandmother. There were 44

the orphan support program functioning in the city of Mutare was at an early stage in its development.

Definitions

A household is one or more people who share cooking and eating arrangements. The household head is the person primarily responsible for the day-to-day running of the household, including child care, breadwinning and household supervision; if tasks were shared, an attempt was made to determine the person primarily responsible for these tasks. A child is a person under 18 years old. An adolescent is normally defined as a person 13-24 years old; the definition used in this paper for adolescent-headed households is a household headed by a person 18-24 years old who is not the biological parent of children in the household.

The prevalence of child-headed households is still fairly low and some exist only temporarily. Adolescents may leave adolescent-headed households and such households as a result become child-headed. As child household heads reach 18 years old, their households by definition become adolescent-headed. Although this study focused on child-headed households, those headed by adolescents were also studied in view of the associations and similar situations of these two household types. Households headed by adults over 24 years were also studied if they had previously been child- or adolescent-headed. Where households contained adults with little or no responsibility for the day-to-day running of the household, including those with adult dependants who were sick, disabled or elderly, they were termed 'accompanied' child- and adolescent-headed households to distinguish them from households consisting of unaccompanied children and adolescents.

Although difficulties exist in household definition and classification, it was thought important to draw attention to the growing number of vulnerable, unaccompanied children living in especially difficult circumstances by using the terms 'child-' and 'adolescent-headed households'.

Survey instruments

A questionnaire was developed covering basic demographic and socio-economic information. Interviews were conducted in Shona and answers were written in English. Surveys were carried out during a four-week period from February 1997. The oldest available child or adolescent living in the household was interviewed by trained research assistants; occasionally, information was obtained from adults present in the households. Questionnaires were piloted with households outside the program areas and then modified. All households interviewed received material support in the form of food and some received payment of primary school fees for out-of-school children. Further focus-group discussions with household heads and in-depth family studies with other relatives were planned for a later phase of this research project.

Consent

Consent was obtained from respondents who were informed about the nature of the research, assured of confidentiality and given the option to decline to answer any or all of the survey questions. An attempt was made to identify a legal guardian and obtain informed consent for all households where minors were respondents.

orphan families since three orphan households contained children from two orphan families. In nine cases the whereabouts of at least one of the parents was not known. Both parents had died among 30 of 35 orphan families; in 18 double-orphan families, the father's death preceded the mother's; in three families, both parents died in the same year; and in eight families, the mother's death preceded the father's death.One case had no information on date of death. Most deaths were recent: 84 per cent of maternal and 74 per cent of paternal deaths occurred in 1993-1996.

Household formation

The household head was female in 25 cases and male in 18 cases. In 40 households containing younger children, the household head was an older sister in 25 cases; an older brother in 14 cases; and in one case an uncle. Children as young as 9 and 11 years old were responsible for looking after younger children and heading accompanied and unaccompanied households (Table 1). Seventy-five per cent of child and adolescent-headed households were established in 1995/1996, possibly reflecting an increasing incidence or the fact that many such households do not last long. Four households were established in the year before the mother's death when children or adolescents assumed headship during the mother's terminal illness. Most households were established in the same year as the last parental death, this being the mother's death in 80 per cent of households.

Table 1
Age of household heads, duration and timing of assumption of headship in 43 households

	Type of household (head)			
	Child, unaccompanied	Child, accompanied	Adolescent	All
N	17	10	16	43
Mean age at assumption of headship (years)	14.1	10.5	19.1	15.5
Mean duration of headship (years)	15.5	3.2	1.8	1.5
Assumed headship same year as parental death (N)	13	7	12	32
Assumed headship at least one year after parental death (N)	1	1	3	5
No data on timing, assumption of headship, or no orphans (N)	3	2	1	6

Reasons why current child or adolescent became the household head

In 21 orphan households, children or adolescents became household heads during the terminal illness or immediately following the death of a parent, this being the death of the mother in 15 cases and of the father in six cases (Table 2). One child assumed headship after the mother deserted. Twenty-one households had a total of 24 household heads other than the parent. Most of these caregivers lived with the children for less than a year before they

left, became sick or died. Child or adolescent-headed households were established after illness or death of grandparents, aunts or an unrelated household head in 14 out of 43 households leading to nine unaccompanied and five accompanied households with, in the latter case, grandparents or aunts remaining and children or adolescents taking over household supervision.

Table 2
Reasons for change in headship by characteristics of the previous household head among 43 child and adolescent-headed households (CHH/AHH).

	Mother	Father	Grand-parent	Sibling	Aunt	Other	Total
Death or terminal illness	15	6	3	1	2	1	28
Illness or incapacitation	0	0	4	0	1	0	5
Left because of illness	0	0	3	0	0	0	3
Left for other reasons[a]	1	0	0	8	1	0	10
Total	16	6	10	9	4	1	46[b]

[a] Other reasons include employment, education, marriage; deserted; moved in temporarily; replaced by older household head.

[b] Three CHH/AHH had two previous household heads.

Respondents were asked why relatives left children or adolescents living by themselves (Table 3). In 13 households, there was no known relative in the family able to care for the children. In one household, relatives left children alone because this was the mother's dying wish. In the remaining 29 households, a relative was available who might have been able to provide direct care for the children; but in 88 per cent of these households, the relative did not want to care for the children while in 32 per cent of households, the children did not want to move to the relative's household or the relative to move in with them. Relatives did not want to have the children living with them because the relatives had their own life to live, they had no space, they were in need of care themselves or they had no love for the children. In three cases, children did not move in with relatives because the children lived close to a relative who arranged to regularly visit them.

Table 3
Reasons why relatives left children or adolescents living by themselves (n=43, more than one response possible).

Reason	Number of responses
Relatives did not want children to move in with them	13
Relatives did not want to move in with children	11
Children did not want to move away from their home	8
Children wanted to stay together	3
Children did not want relative to move in with them	2
Mother's dying wish for children to stay by themselves together	1
No known relative	13
Not known or not answered	4

Extended family support

During the two years before the study, eight children under five years old, five children 5-9 years and four children 10-14 years left 13 households to stay with nine aunts, four grandparents, two sisters and one unspecified relative. One 14-year-old household head and his 13-year-old sister ran away from their household.

Sixteen households headed by children or adolescents received regular visits (more than once a month) by aunts (8), grandparents (2), sisters (1) or unspecified relatives (5); 11 received irregular visits (less than once a month) by relatives; three were known to have living relatives but received no visits from them. In those receiving irregular or no visits, relatives lived far away in 27 per cent of households. Relatives were unable to visit because they were too old in two cases. In the year before the study, 14 households received material support from relatives in the form of money (9), clothing (7), food (6) and school fees (5). Ten households known to have living relatives received no material support whilst there was no information on six households with living relatives.

Discussion

Although AIDS is only one of several factors leading to the changes being observed in traditional patterns of child care (Foster, Makufa and Drew 1995), it is undoubtedly the main factor predisposing to the establishment of child-or adolescent-headed households in this study. The AIDS epidemic is leading to a rapid increase in the number of double and maternal orphans. Previous studies have shown AIDS to be the underlying cause of most recent parental deaths in one area where this study was carried out (Foster et al. 1995). In a majority of these households, their establishment was associated with the second parental death which was usually that of the mother; 82 per cent of households contained children who had lost both mother and father and 89 per cent of parental deaths occurred in the preceding five years. In view of this characteristic pattern of parental deaths, it is likely that AIDS was the cause of death in a majority of study households. A number of other factors also predispose to the establishment of child-headed households: rapid increase in the number of parental deaths; death of one or both parents; reluctance of relatives to foster

orphans; lack of contact of relatives with children; death or sickness of a relative; presence of adolescents or older children able to care for younger children; preference of children to live in child-headed households; last wish of dying parent; death of single mother; and inheritance of residence by surviving children .

Uncles' and aunts' reluctance

There were 30 study households where a relative was known to be alive and in most (88%) of these households, it was stated that the relative did not want to care for the children. The preference of many parents should they be incapacitated is that their children be looked after by a same-generation relative such as an aunt or uncle (Foster et al. 1996). But many uncles and aunts are reluctant to foster relatives' children, possibly because of their concern that fostering relatives' orphans would result in a reduction of their own children's standard of living. If forced by economic circumstances to choose between their own and fostered children, they would tend to show preference towards the former. This course of action might lead to accusations against them of neglecting fostered children in their care by community members. Rather than risk such censure and in order to protect their own children, relatives may refuse to accept orphaned children into their family.

However, in 30 per cent of the households studied, relatives, mostly aunts, had taken at least one child from families in the study into their own households; most children under five years were fostered by relatives though older children were often not taken in. The main reason for refusal to take in relatives' children was probably economic. In many cases, aunts and uncles provided material support or regularly visited child-headed households; in some cases it was stated that relatives did not foster children in their own families because they lived nearby and instead had chosen to regularly visit. These are indications that in many cases, households headed by children or adolescents are a new expression of the extended family's coping mechanism rather than the result of children slipping through the extended-family safety net.

In some cases, relatives may consider themselves free of responsibilities towards orphans, even though they are closely related to the children. Relatives may not recognize the legitimacy of orphaned children, if, for example, a sister had children but was never married or if brideprice was never paid to her brothers; in such circumstances, they may feel justified in not providing support to her orphaned children after her death. Some relations have had little contact with a relative's family before the parent's death. A Kenyan study found that whereas families living below the poverty line tended to foster children, wealthier relatives, whom one might expect to be more able to foster relatives' children, maintained minimal links with orphans (Saoke et al. 1996:51). Some relatives may be concerned about fostering orphans when they suspect that the parent died from AIDS. They may fear contracting HIV infection from the children, or are afraid that bringing such children into their home may lead to stigmatization.

Distance and lack of knowledge of relatives about situation of children

There were 13 households in this study where respondents reported that they did not know any living relative. However the actual number of such households without living relatives is probably smaller, given the youth of the respondents in this survey. With families sometimes being separated by large distances, regular communication between family members may be difficult; as a result, close ties that formerly existed between family members have become weaker. Lack of assistance by relatives to child-headed households may be due to poor communication, with relatives simply not knowing about the desperate situations being faced by orphaned children living in difficult circumstances. Households

which are separated by large distances from their relatives such as migrant families and foreigners who have infrequent contact with their extended families are especially vulnerable in this regard (SafAIDS 1996). Barriers such as national borders make it especially difficult for extended families to fill their traditional roles of providing social support in times of difficulty.

Death or sickness of a relative

In this study, ten households were established following the death or illness of a grandparent and five followed death or illness of an aunt or unrelated household head. Three household heads who became ill moved out to be cared for by another relative while five continued living in the households.

When a parent, especially a mother, dies of AIDS, orphaned children often go to live with a grandmother, a practice referred to as 'skip-generation parenting' (Levine 1995:193). Orphans are often cared for by grandparents because there is no other relative willing or able to look after the children. Grandparent-headed orphan households are becoming increasingly common as a result of AIDS. In Zimbabwe, 125/292 orphan households (43%) were headed by grandparents; in Kenya, 41/152 (27%) were grandparent-headed whilst in New York, 25 out of 43 maternal orphans (58%) lived with a grandmother or an aunt (Foster et al. 1996; Saoke et al. 1996:55; Working Committee 1996:23). Grandparents are likely to be older and be more incapacitated than aunts and uncles. In Zimbabwe, 82/256 orphan caregivers (32%) were 60 years or older. During one year, in a population in Zimbabwe of some 11,000 people, three sibling-headed households became established following the death of a grandparent (Foster et al. 1996). Increasing numbers of child-headed households are likely to occur in the future through the death or sickness of relatives.

Adolescents learn child care during caregiver's illness

In four cases the households were established in the year before the last parental death. In such cases, households may be left by relatives to continue after the death of the parent because of the demonstrated ability of the adolescent to care for children appropriately during the parent's terminal illness. It is common for older children to take over parenting roles during prolonged parental illness due to AIDS. Adolescents learn responsibility, effective coping mechanisms and nurturing skills in this situation (Grodney 1994:140; Levine 1995:194). Were parents to die suddenly and unexpectedly, adolescents would have had no opportunity to take over care-giving responsibilities for younger children, forcing relatives to foster children. Similarly, if there were no adolescent caregivers in the household, relatives might feel forced to foster a relation's orphans.

Children's preferences and parent's dying wish

In this study, eight orphan families stated that they wanted to stay together and either declined to move to a relative's home or refused to have an unwelcome relative move in with them. In some cases, siblings in a family may choose to form child or adolescent-headed households. The children may desire to stay together as a family group rather than be split up between various relatives, or wish to stay living at their own residence in familiar surroundings, rather than change school, friends, home and neighbourhood. They may resist attempts of relatives to foster them in the relative's household, fearing maltreatment or because the relative only agrees to foster younger siblings. Orphaned children may be concerned about losing their inheritance rights to property and land if they are fostered. They may also be concerned about the possibility of neglect, abuse and exploitation by

certain relatives. Urban children in particular may be concerned about their schooling being discontinued or a deterioration in their standard of living should they be fostered by a poor rural relative. So instead, children may actively choose to stay living together in their own household rather than relocate to a poor, reluctant or abusive relative's home.

In one case, a child-headed household became established to fulfil promises made to a dying mother. Sometimes, adolescents have to make a deathbed promise to take care of young children and keep them together (Levine 1995:194; Foster et al. 1996). As a result of such promises, adolescents who might otherwise prefer to see the family fostered resist reasonable strategies for fostering suggested by relatives or child welfare authorities.

Death of a single mother

Child-headed households may be particularly likely to result from single-mother households. In this study, four such households resulted from the death of a single mother whose partner had left or deserted, and one resulted from a single mother leaving her teenage daughters to care for themselves. Increasing numbers of children in developing countries are being cared for in single-parent-headed households. In Zimbabwe, nearly one million children were born to divorced, widowed and never-married women (Central Statistical Office 1994). Some of the most vulnerable orphans are children of single mothers, especially if the mother was a prostitute. When a single mother becomes sick or dies, her children may be left in the care of grandparents. Because such orphans are from single-parent households, they may be neglected by other relatives who refuse to provide any support to the children because they consider them illegitimate.

Inheritance of residence by surviving children

The right of children to remain in their home after the death of their parents influences whether or not the family will continue to stay living together in their residence. In rural areas in Zimbabwe, the issue of land alienation by relatives seems not to be pronounced. However in a study of single-mother households in a rural area of Zimbabwe, whereas a majority of married and widowed women lived in their own accommodation, most divorced and never-married women rented accommodation or shared their house with relatives (Juliusdottir 1995); children of single mothers may be forced out of their accommodation after maternal death. In other African countries, the right of surviving children to continue living in their rural residence appears to be an important factor in determining whether child or adolescent-headed households become established. In urban areas in Zimbabwe where there is shortage of accommodation, it is difficult for children to hold on to their accommodation after parental death. Most people lived in rented accommodation in urban areas where this study was carried out. However, three out of five urban child-headed households lived in their own accommodation, suggesting that if children were living in rented accommodation before the parental death, it may be less likely for child-headed households to become established.

Conclusion

The new phenomenon of child-headed households appearing in communities affected by AIDS is an indication of saturation of traditional extended-family orphan coping mechanisms. Some communities may have better preservation of traditional coping mechanisms, such as those in remote rural areas with little urban migration and with lower life expectancy; the more traditional the community, the more capable it may be to cope with increasing numbers of orphans. Thus in an area of rural Mwanza, Tanzania, with an

HIV prevalence of six per cent, eight per cent of children were orphaned but 32 per cent of non-orphaned children were fostered, not living with their biological parents, an indication that extended family coping mechanisms were relatively intact; of 3353 households surveyed, only one child-headed household was identified (Urassa et al. 1997). High numbers of such households may indicate weakened traditional coping mechanisms or overwhelming of coping mechanisms by large numbers of orphaned children.

HIV prevalence rates in urban areas are higher than in rural areas in Zimbabwe. It is somewhat surprising that child-headed households in this study appeared to be less prevalent than in rural areas, notwithstanding differences in sampling methodology. In urban areas, a combination of social and economic factors hinders the establishment of such households. Prospective studies of households with risk factors predisposing to their being headed by children or adolescents might clarify whether child-headed households are being established in urban areas following parental death and the ways in which such households terminate.

When these households first occur in communities, they may be transient. Families take time to organize coping strategies in response to unaccompanied children. Child-headed households may disintegrate when children integrate into a relation's household, sometimes after a crisis when relatives who were previously equivocal agree to take in the children. Projections for Zimbabwe suggest that the current high orphan incidence rate of 2-3 per cent per annum has occurred since the early 1990s and is likely to continue until at least 2010 (Gregson et al. 1997). As the numbers of orphaned children multiply, it is likely that there will be increasing numbers of child-headed households; they will become less transient, existing for longer periods; and household heads will be younger.

The appearance of child-headed households does not necessarily mean that extended families are abandoning their responsibility to care for relations' children. This study demonstrates that among households with known relatives, most were receiving regular supportive visits and small amounts of material support from their extended family. In some cases, members of the extended family refused to take unaccompanied children into their households because they knew that a relative was living nearby who could provide support and supervision. A number of orphans were taken into a relative's household where they were being cared for, especially when the children were under five. In a minority of child-headed households it seemed that extended-family methods of support had broken down since such children received little or no support from relatives and appeared to be particularly vulnerable to exploitation as a result of destitution and lack of adult supervision. The numbers of such unsupported households are likely to increase dramatically in the future in the face of poverty as the number of new orphans increases and as grandparent-caregivers or aunts and uncles become sick and die.

Households headed by children or adolescents thus represent a new coping mechanism in response to the impact of AIDS on communities. Where these households exist, there are often relatives living nearby who are providing material support, supervision and regular visits; such relatives are often also struggling to bring up their own families. Community groups can help extended families to cope with the burden of orphans and prevent the breakdown of the extended-family safety net by encouraging the establishment of volunteer-based visiting programs to at-risk families, and by channelling essential material support to destitute families (Foster et al. 1997).

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CARFAX

Perceptions of children and community members concerning the circumstances of orphans in rural Zimbabwe

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Abstract *Focus group discussions and interviews were held with 40 orphans, 25 caretakers and 33 other community workers from a rural area near Mutare, Zimbabwe. Orphan concerns included feeling different from other children, stress, stigmatization, exploitation, schooling, lack of visits and neglect of support responsibilities by relatives. Many community members, while recognizing their limitations due to poverty, were already actively helping orphans and caretakers. Extended family networks are the primary resource for orphans, though some relatives exploit orphans or fail to fulfil their responsibilities. Interventions are suggested which support community coping mechanisms by strengthening the capacities of families to care for orphans. Outside organizations can develop partnerships with community groups, helping them to respond to the impact of AIDS, by building upon existing concern for orphan families. They can help affected communities to develop orphan support activities which encourage caring responses by community leaders and relatives and which discourage property-grabbing and orphan neglect. Material support channelled through community groups to destitute families at critical times can strengthen family coping mechanisms. Income-generating activities should build upon communities' existing capabilities and benefit the most vulnerable orphan households. Some communities are responding to the AIDS disaster by adaptations to cope with devastating changes taking place in their communities.*

> This disease has spread. There are graves everywhere. Sometimes we bury three people a day within the same area, mostly men who died while working in Harare; there is a high death rate among the young. (Home visitor with an orphan support programme.)

Introduction

One of the most distressing consequences of HIV/AIDS is its impact on children. The number of orphans has increased recently because of deaths from AIDS. WHO estimates that

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by late 1993 about 2.5 million children had lost one or both parents to AIDS. By the year 2000 the number is projected to reach 10 to 15 million with roughly 90% of these children living in Africa (Merson, 1991). Protection and care for growing numbers of orphans are becoming global concerns.

The progression of the HIV epidemic in Zimbabwe has been rapid. Anonymous unlinked surveillance of pregnant women in 5 urban and 17 rural antenatal clinics during 1992/93 found 21.2% (1,205/5,679) to be HIV-positive (MOHCW, 1993). Families are caring for numerous orphans in Zimbabwe and other developing countries. A 1992 enumeration study of orphans in Mutare district found 12.8% of the children in the area studied were orphaned; 50% of recent parental deaths were ascribed to AIDS (Foster *et al.*, 1995a). A 1995 enumeration in the area of the current study found 14.7% of children orphaned with one quarter of parental deaths occurring in the preceding year (Foster *et al.*, 1996).

AIDS is unlike other disasters in that its impact is diffused over large geographical areas; multiple illnesses and deaths have a cumulative effect with an increasing attrition rate year after year; and unlike most other disasters, it is difficult to envisage an end to the cataclysm after which life can return to normal. It has been suggested that because of AIDS, households and communities could quickly cease to be viable social or economic units. The trauma of grieving death after death can induce a feeling of powerlessness and an inability to act. Support systems could falter with the seemingly endless demands made upon them; relatives, already overburdened caring for their own children, must also bear the economic burden of caring for orphans (UNDP, 1993).

In view of the unique features of this long-term, slowly-evolving disaster, it is imperative to understand the ways in which those affected are responding. Are communities characterized by powerlessness, inability to act and breakdown in the face of AIDS? Or are some communities responding to the disaster by trying to muster their available resources to cope with the devastating changes taking place in their localities? Previous studies have demonstrated the importance of the extended family as the predominant orphan caring unit, while noting that some relatives neglect or sometimes exploit orphan relatives; extended families and communities are adopting strategies to cope with increasing numbers of deaths of adults (Foster *et al.*, 1995a; Lwihula *et al.*, 1995; Over *et al.*, 1995; Semali *et al.*, 1995). It is important that outside organizations seeking to help devastated communities avoid making matters worse by adopting strategies which do not undermine existing community coping mechanisms. This paper describes the responses of a community coming to terms with the pandemic by examining the views of orphaned children and the perceptions of community members. In the light of these findings, interventions are suggested which can help policy-makers and programme planners seeking to strengthen the capacities of communities and families to care for growing numbers of orphaned children.

Methodology

Site of study

Focus group discussions and interviews were conducted in a rural area 20 km from the city of Mutare, Zimbabwe, at an independent church which also served as the administrative centre for the families, orphans and children under stress (FOCUS) orphan support programme. The church established AIDS awareness and homecare activities in 1991 in collaboration with Family AIDS Caring Trust (FACT), an AIDS service organization founded in 1987 based in Mutare. In 1993, the church helped to establish the FOCUS

/burl:/usr/burg/carfax/aic/aic9.4/Paicp0395 Thu May 29 00:06:05 1997 Page 1

programme in its community with assistance from FACT; 25 women from different community groups were recruited from the 18 villages throughout the programme area. The programme operates in a communal farming area of approximately 200 square kilometres with a population of 10,611 people in 2,089 households. Nearly half of the orphan homesteads in the area consist of huts made with mud bricks and grass roofs; most households are poor, with the main source of income being from the sale of maize and other agricultural produce.

The principle throughout the programme was to target limited material support and regular home visits to families with the greatest needs. Women were recruited based on their existing concern for orphans; some were already visiting orphan households on a sporadic basis and most were caring for orphaned relatives in their own homes. As community visitors, they became responsible for regularly visiting nearby orphan households and assessing physical, educational, psychological and spiritual needs (Makufa, 1995). They met monthly with FACT's FOCUS programme co-ordinator to report on their activities and decide whether orphan households should receive regular material assistance. A committee of three caretaker-visitors, a volunteer administrator and the pastor of the church supervised the programme; the pastor was responsible for liaison with community leaders and government departments.

One year after its establishment, the programme was evaluated (Foster *et al.*, 1996). The visitors identified 300 households containing 702 orphans and in one year made 1725 home visits. They also initiated assistance activities with local resources, including a communal garden, agricultural training for children, and small income-generating projects run by older children. The programme provided an average of $9.60 of material assistance (food, blankets, maize seed and clothing) to 123 needy households. Primary school fees ($3.50) were paid for 42 orphans. By the time of the current research project in mid-1995, community visitors were carrying out some 300–400 home visits per month.

Subjects and method

Seven focus group discussions were held with orphans and caretakers representing a geographical cross-section of households in the programme area. The discussions took place during regular weekly meetings for caretakers and orphans. Prior consent was obtained from orphans involved in the discussions, from their caretakers and from other caretakers taking part in the discussions. No attempt was made to distinguish households where children were orphaned as a result of AIDS or to determine whether children or caretaker were HIV-infected. Care was taken to ensure that confidentiality of sensitive personal details was maintained. Counselling was provided by community visitors for children who became upset during focus group discussions.

Orphans were defined as children below 18 years old who had lost one or both parents; two focus groups consisted of girls only, one of boys and one was mixed. The groups totalled 40 children aged 9–16 years old, 21 girls and 19 boys; there were 30 paternal orphans, 7 maternal orphans and 3 double orphans; their caretakers were grandparents (24), mothers (13), and a stepmother, older brother and uncle. The higher number of paternal compared to maternal orphans in the sample and the proportions of each type of caretaker reflect the general situation of orphan households in the programme area.

Caretakers, defined as relatives looking after orphans, totalled 24 women who between them cared for 96 orphans; one focus group was predominantly widowed mothers; grandmothers predominated in the other two groups which included 7 women ('caretaker-visitors') who were also community visitors in the FOCUS programme.

/burl:/usr/burg/carfax/aic/aic9.4/Paicp0396 Thu May 29 00:06:05 1997 Page 1

Two focus groups were held with 28 community workers responsible for home visiting, mainly community workers employed by the ministry of community development or an international non-governmental organization, or volunteers in a church-led homecare programme.

Interviews were held with six key informants: a 23-year-old male ('brother-caretaker') caring for five younger orphaned brothers and sisters; the headmaster of the local primary school; an elected councillor involved in local government decision-making; a kraalhead (village leader) involved in the traditional structure of community administration; the pastor in charge of the local FOCUS programme; and the wife of the pastor, a schoolteacher and volunteer worker with the FOCUS programme.

Focus group discussions were held in the Shona language and were led by an experienced facilitator with an observer; two stenographers recorded literal transcripts of respondents' comments. Discussion group checklists were drawn up during training of researchers before gathering data; a pilot study was carried out with groups outside the programme area; afterwards, checklists were modified and were subsequently used to guide discussion groups. One facilitator and one stenographer attended interviews with key informants. Following each session, the researchers reviewed their transcripts and translated the reports into English. The results below present respondents' verbatim quotations which have been edited with minor grammatical changes for clarity.

Results

Situation

Many orphans are satisfactorily cared for and have their basic needs met by their extended family, sometimes in circumstances of extreme deprivation. The study provided valuable insights into the situation of orphans, with the children themselves identifying several key issues. One aim of the research was to identify issues of concern to affected children, families and community members. Consequently, the problems experienced by orphans and difficulties faced by caretakers and community members receive prominence in this situation analysis.

Extended family support to orphan households. Most responses concerning the function of the extended family concerned the important role of relatives in providing support to orphans. Relatives are providing support to orphans in their extended family in different ways (Foster *et al.*, 1995b). They may take responsibility for orphan care by moving in with the children or by taking the children into their own homes; they may contribute financial assistance to impoverished orphan families, provide school fees, clothing or food. Orphaned children may be divided between different family members, or may move between urban and rural areas; loss of a father led to urban-rural relocation for three families:

> When father was alive, we used to go to school without any problem of school fees; my uncle helped with school fees and now my brother helps. (Girl, 13.)

> We moved from our original home and built on another spot after my aunts and grandmother refused to take care of us. (Brother-caretaker.)

Seven children noted that relatives had stopped visiting their household following the death

url:/usr/burg/carfax/aic/aic9.4/Paicp0397 Thu May 29 00:06:06 1997 Page 1

of a parent. Relatives may cease visiting to avoid feelings of guilt induced by observing the destitution of family members without providing any assistance:

> Relatives were once helping but do so no longer. (Girl, 14.)
>
> Fathers often desert to town and remarry. (Wife of pastor.)
>
> There is not much help rendered by relatives unless a girl is to be married; then the uncles grab most of the bride price; but they never help boys who need to pay bride price. (Caretaker-visitor.)

In traditional Shona culture, the death of a husband led to the inheritance of the wife, children and property by a brother of the deceased. Inheritance patterns in Zimbabwe are changing; many women now refuse traditional remarriage and paternal relatives less frequently take on responsibility for orphan care (Drew *et al.*, 1996; School of Social Work, 1994). The inheritance of property continues, though the extent and severity of 'property-rabbing' is unclear. Although two children said that property was left behind, seven stated that relatives had taken property; in one case, everything was taken. Children seemed resigned to the fact that relatives removed household property:

> My uncle used to come when he wanted mother to be his wife but when mother refused, he stopped coming. (Girl, 15.)
>
> Auntie only came when she wanted to take the property. (Girl, 14.)
>
> Some relatives, especially the husband's, take the property and leave the children with nothing and no one looking after them. (Caretaker-visitor.)
>
> These days all property—is left to the deceased's family. I disagree; even today, the husband's relatives take the property they take the cattle and leave the chickens. (Two community workers.)

In seven cases, families sold livestock to get money for food or school fees. Livestock are a form of savings for many rural families with their sale being a measure of last resort when there are no other sources of income. Selling assets such as oxen which provide draught power meets immediate needs by undermining long-term development.

Extended family networks remain the primary source from which most orphaned children obtain support and assistance. The extended family, though weakened, continues to be the predominant orphan-caring unit and the principal social structure on which the livelihood of the community depends (Williamson, 1995). Criticism was frequently levelled against relatives, especially uncles and aunts, who failed to fulfil their responsibilities within the extended family. Such strongly-held convictions among community members suggests it may be possible to work with communities to strengthen mechanisms which encourage erring relatives to fulfil traditional family responsibilities.

Differences from other children. Five orphans considered there were no differences between themselves and non-orphans. Twenty children stated that significant differences existed in the lifestyles of orphans compared to non-orphans. Several children complained that they were treated differently from others. Two children said their workload of domestic chores was excessive compared to non-orphans while others felt they were discriminated against and were not allowed to complain about unfair treatment:

> We steal and sell to earn a living which is different from them (non-orphans). (Girl, 15.)

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> Even if there are other children in the family, the orphans are forced to do the work and are found doing the job alone. (Caretaker-visitor.)
>
> Other children can refuse to do some work but orphans cannot. (Caretaker-visitor.)

Some families treat a children equally, but others discriminate against orphans; this may be due to poverty since caretakers struggling to provide for their family sometimes ration scarce resources to benefit biological rather than inherited children:

> We want to go to school but I must help uncle in the fields. He said 'you are not my child so I cannot send you to school'. (Girl, 16.)
>
> When a woman dies the husband takes another wife who does not look after the children well. At times, they are not bathed. It is better to move the children to another home. (Kraalhead.)
>
> The caretaker's own children ill treat the orphans. (Community worker.)

Many orphan households contain a large number of dependants with a shortage of productive adults. As a result, orphans may be required to work to produce an income for their households. The mother or another caretaker may seek employment away from the home leaving children in the care of a grandmother or older orphan. Although these strategies illustrate the flexibility of households to cope with the loss of family members (Over *et al.*, 1995), child labour and the absence of the caretaker may adversely affect children's education and expose them to injury, exploitation or abuse:

> When my ballpoint finishes, I sometimes absent myself from school and sell manure to get money to buy the pen. I am not pleased being absent from school. (Boy, 13.)
>
> Orphans are always busy and work at odd hours. (Community worker.)
>
> The orphans do a lot of hired labour leaving themselves with very little time to attend to their own fields or gardens. (Caretaker-visitor.)
>
> Frequently, these orphans do work which is not in accordance with their age. (Caretaker-visitor.)
>
> These (caretakers) even leave their children in search of employment, thus creating more problems. (Community worker.)

Some relatives and community members exploited orphans directly or indirectly by taking advantage of their extreme poverty:

> People take these orphans as their labourers with little reward. (Community worker.)
>
> Some families looking after orphans use them as cheap labour, fetching water, firewood and for cooking and deny them access to education; however some treat them very well. (Councillor.)
>
> Some people take advantage of the deceased's property and ask the orphans to sell these to them. The orphans sell at low prices due to poverty. (Neighbourhood watch committee chairman.)

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Girl orphans are particularly vulnerable to exploitation, resulting in their being married off while still young, their involvement in commercial sex, or sexual abuse:

> Father remarried another woman who mistreats me. (Boy, 11.)
>
> Under age girls are married to get the bride price; or they are made pregnant by older men out of desperation. (Community worker.)
>
> Girls are being married early and child abuse is rife. (Wife of pastor.)

No respondent commented upon stigmatization of children occurring because of AIDS. Although most Zimbabweans recognize that the recent increase of parental deaths is the result of AIDS, there is reluctance to state publicly that an individual died of AIDS; the same observation was made in Uganda (Naerland, 1993). Stigmatization was based upon orphan status or poverty rather than the possible death of a parent from AIDS:

> A certain girl assaulted me saying she did not want to play with those who don't have fathers. (Girl, 13, who then started crying.)
>
> My friends changed after the death of my mother. (Two 10-year-old boys.)
>
> I am sometimes scolded because my father is dead. (Girl, 12.)
>
> We are segregated because we don't have shoes. (Girl, 12.)
>
> The grade six child often repeats bad things which people say about my family. (Brother-caretaker.)
>
> Most of the people in the community laugh at us or give us nicknames, saying we don't have anything to do and anyway, we are not being paid (for voluntarily visiting orphan households). Frequently, the relatives of the orphans are leading in the mocking. (Caretaker-visitor.)

Psychological problems. Children suffer anxiety and fear during the years of parental illness, then grief and trauma following the death of a parent. Stigmatization, dropping out of school, changed friends, increased work-load, discrimination and social isolation all increase stress for orphans; this makes coping with their situation more difficult and painful. Difficult relationships with new caretakers also contribute to stress; two children said they were 'being given a hard time' by a grandparent and a stepmother.

As a result, children may become depressed, reducing their ability to cope with growing pressures. During one focus group discussion, the facilitator asked about changes experienced following parental death. one boy stated his stepmother mistreated him whereon a 12-year-old boy started crying and continued sobbing throughout the rest of the discussion. Psychological problems are often less obvious than material ones and may remain unnoticed by the children themselves. However, they were a major concern to relatives, neighbours and community workers:

> The orphans are suffering with no one to look after them; they suffer from stress. (Homecare volunteer.)
>
> They feel inferior to other children. The privileged can get help from other people but the orphans cannot. Therefore they suffer stress. (Community worker.)
>
> Many orphans are withdrawn and lonely. (Wife of pastor.)
>
> A child who has lost a parent is under a lot of stress, especially when he knows what