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REVIEW ARTICLE

HIV/AIDS AND ORPHAN AND VULNERABLE CHILDREN (OVC) IN ZIMBABWE

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ABSTRACT

The HIV/AIDS prevalence rate in Zimbabwe is among the highest in Africa, wherefore higher number of orphans and vulnerable children. These children face enormous problems ranging from economic, education, health, nutrition, psychological and emotional effects resulting from the stigma and discrimination which has warranted various projects from the government of Zimbabwe and other organizations to help them meet their needs. Although these interventions are making impacts in the lives of the OVCs, there are still challenges that impede their development. There is therefore the need to measure for efficiency while tailoring implemented projects to suit their local needs. This paper reviews the situation of HIV/AIDS and OVCs in Zimbabwe, risk factors, interventions and challenges.

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INTRODUCTION

HIV/AIDS has become a pandemic especially in sub-Saharan Africa, 22.5 million people have contracted the disease and consequently, almost 12 million children have been orphaned, making it an impediment to the long-term development of the region. Particularly in the southern parts of Africa, HIV/AIDS has reduced life expectancy and fought against several efforts to increase healthy livelihood and poverty reduction (Lule, Seifman and David, 2009). According to Foster and Williamson (2000), an orphan is defined as "a child bereaved by the death of one or both parents" (para 1). UNICEF (2006) argues that since 2001, the number of children who have been orphaned by HIV/AIDS in Africa accounts for about 80% of the world's total. Other vulnerable children who may be at greater health risks include those infected with the disease, those whose parents are infected and those living in poverty and are discriminated against as a result of HIV/AIDS and other factors. Unfortunately, the number of orphans and vulnerable children has a higher tendency of rising since adult HIV/AIDS prevalence and incidence rate in sub-Saharan Africa keeps increasing; there has been more than 50% increase in the number of orphans in the region since 1990. Countries including Lesotho, Swaziland, Zimbabwe and Botswana have the highest percentage of children orphaned by HIV/AIDS. However, Zimbabwe, which had its first recorded HIV/AIDS case in 1985 also has the highest percentage of orphans from all causes as well as those specifically from HIV/AIDS, compared to countries like Zambia, Botswana and Lesotho. Zimbabwe is a landlocked area located in the Southern part of Africa and is bordered by Mozambique to the East and Northeast, by South Africa to the South, by Zambia to the Northwest and Botswana to the West. This paper will therefore focus on orphan and vulnerable children (OVC) in Zimbabwe.

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Problem Statement

Foster and Williamson (2000) indicate that only 2% of families in Zimbabwe write wills before death and this situation leaves the majority of children who had no property arranged for them in difficult situations. In most cases, when the husband dies, the widow will be prevented by the husbands' family to take over the property and in several cases, the brothers-in-law continue to engage in sexual relations with the widows but refuse to provide for them and the children. In the case where both parents die, the children are sometimes denied care by extended relatives and therefore have to take care of themselves. Families that migrate to urban areas and commercial farms tend to have less contacts with extended family and in case of death of the parents, there is a high tendency of child-headed family with less quality care and protection as a result of possible neglect from the extended family, posing a danger of contracting HIV/AIDS. Khumalo-Sakutukwa (2003) also argue that the use and abuse of harmful substances like alcohol and cannabis, the lack of confidence in health workers, the abuse of girls and women, early and/or polygamous marriages and stagnant rate of contraceptive use,

have led to the higher rates of infections. If these factors are not tackled, more and more children will end up becoming orphans and their struggle for survival will make them more vulnerable to the disease. Hence, becoming a vicious cycle, which not only affect the family, but the entire community as well as the country. These effects range from economic, education, health, nutrition, psychological and emotional effects resulting from stigma and discrimination. This paper therefore elaborates on these challenges, focusing on how they affect the health and the entire well-being of orphans and vulnerable children in Zimbabwe. I will also examine in this paper, the various projects and policies the government and other organizations have put in place to reduce the level of infections as well as improve the standard of living of these children who will be the future leaders of the country as well as the various challenges and recommendations.

Risk Factors

Over the years, HIV/AIDS has become an epidemic in many countries, especially is sub-Saharan Africa, costing people their lives and destroying homes and the future of many children. As indicated earlier, the number of orphans and vulnerable children are at an increasing rate in Zimbabwe. Garbusand Khumalo-Sakutukwa (2002) show that the percentage of children orphaned by HIV/AIDS in 2001 stood at 76.8% as against 16% in 1990. According to the statistics on HIV and AIDS in Zimbabwe (2016), as of 2015, 1.4 million people had HIV/AIDS in Zimbabwe, adult prevalence rate stood at 14.7% and the number of AIDS-related deaths were 29,000. Although this was an improvement in the rate as compared to the previous years, we cannot overlook the effects on the children who are affected. The actual fact that there is high HIV/AIDS prevalence and related death rates means there will be more orphans and vulnerable children. Even in cases where the HIV adult prevalence rate falls, the number of orphans will remain high over a long period due to the gap between infection and death (UNICEF, 2006). One important factor that cannot be overlooked is the immense rate of gender inequalities both in marriages and other sexual relationships, resulting in the inability of these women or girls to express their opinions or opt for protection during sexual activities. The rates of sexual initiation among girls who lose their mothers at any age and those who lose their fathers while below age 12 tend to be high. Young girls who have lost their mothers or both parents tend to have multiple sexual partners and are less likely to use condoms at first sex. Moreover, many Zimbabweans have the belief that promoting condom use for the youth is a way of encouraging early sex. This exacerbates the rate of infection and deaths (HIV and AIDS in Zimbabwe, 2016 and Birdthistle *et al*., 2008). Migration is another factor that worsens the situation of OVCs. When parents migrate to places which are far away from the extended family, the children move out of the safety net of the extended family when death occurs. If no extended family is willing to cater for them, they have to fend for themselves and survive. Out of every thousand heads of households in Zimbabwe, four of them are headed by children (UNICEF, 2006). If there is an extended family member who will be willing to take these children in their care, they are in most cases the grandmothers who are often less strong, poor, and do not have the capability to provide adequate care for them or control any rebellious behaviors. These children therefore tend to live risky lives resulting in HIV/AIDS infection (Foster and Williams, 2000).

Certain inheritance practices that leave the children with nothing also put them at greater risks. For instance, force grabbing of properties, especially by the father's family leaves the surviving widow and the children with little or no economic resource to depend on for survival. This means that apart from insufficient nutrition, clothing and shelter, these children are also faced with no or less education and training to sustain them in the future and this gives them fewer or no other alternative than to engage in sex trade or other dangerous activities for money. One horrifying reality is that Zimbabwe is one of the sources where men, women and children are trafficked for commercial sexual exploitation and farm labor in South Africa and it also serves as a transit of trafficked people from countries like Zambia, South Africa, Mozambique and even Asia. Particularly in Beitbridge, a border town in Zimbabwe, an ANC survey in the year 2000 revealed an HIV/AIDS prevalence of41.4%, which is far higher than the 1990 adult prevalence peak rate of 29%. This is more disturbing because about 5,000 to 10,000 truck drivers pass through the town each month. Most of these women come to Beitbridge with the view of getting jobs but often fail to secure any decent jobs and therefore end up engaging in sex trade. Girls as young as 14 years work as vendors during the day and as sex workers at night for more funds for upkeep and due to their determination to improve their economic wellbeing which ends up increasing their vulnerability, they are not able to insist on condom use or any other forms of protection and this further results in high rates of infection (Halperin *et al*., 2011 and Garbusand Khumalo-Sakutukwa, 2002).

Major Interventions, Programs, and Policies

After the discovery of HIV/AIDS in 1985, the government of Zimbabwe initiated surveillance in 1991 and implemented antenatal care (ANC) survey in the year 2000. The United States Agency for International Development (USAID) collaborated with the government and Population Services International (PSI) in 2001 which launched 10 New Start VCT centers, tested and counseled over 50,000 people. According to Halperin *et al*. (2011), there has been evidence of a decline in the estimated HIV/AIDS prevalence rate in Zimbabwe after the year 2000, and this can be attributed to the change in behavior of the population, especially risky sexual behavior. Using the 2005/2006 DHS, they revealed that not only has there been a decline in multiple sexual relationships, but men have also developed a different view on sexually transmitted diseases (STI). In comparison to the 1990s, when a man got infected with STIs, he was regarded "man-enough", but in these recent years, it is a shame for a man to contract any form of STI in Zimbabwe. Gregson (2005), indicated that sexual behavior changes lead to increase in condom use and reduction in multiple sex partners and this resulted in the decline of HIV/AIDS between 1994 and 2004. Other reasons for this drastic decline include the improvement in the consistency of the use of condoms by women in casual relationships, high secondary school education level among urban men and the increase in access to HIV/AIDS information. Many of these individuals have also witnessed HIV/AIDS related deaths, and this fear has contributed to the reduction of risky sexual behavior and multiple sex relations (Halperin *et al*., 2011). Behavioral change is very difficult to achieve, especially in areas where individuals have pre-existing knowledge and heavily embedded misconceptions, shaped by traditions and culture. However, when behavioral change is achieved, it does not only reduce the rate of infection among the sexually active

population, but it also reduces the number of mother-to-child infections. This means that the rate of children who will be infected by HIV/AIDS or orphaned by HIV/AIDS will eventually minimize. In the wake of behavioral change and consequent decline in the prevalence rate, what interventions are in store for the many orphans and vulnerable children to improve their health and overall wellbeing? Answering this question, scholars including Nyawashaand Chipunza (2012), Mushunje and Mafico (2010) and Changaraand Chitiyo (2008) have indicated that there have been projects by the government, communities and non-governmental agencies to reduce the economic and psychological and emotional trauma as well as keep these vulnerable children in school. These services center on the provision of food, health care, socio-economic and education needs. I strongly believe that the existence and sustenance of these projects will help in reducing the cycle that HIV/AIDS and poverty creates in the lives of affected and infected families.

Economic

Nyawashaand Chipunza (2012) in their study, used focus group discussions and conducted personal interviews with 30 children from Tafara and Mabvuku in Harare, Zimbabwe. The two towns are noted to be the home for many poor people who have no access to social amenities like good roads, proper sanitation and potable water. The study revealed that a cash transfer scheme, which was instituted by the government of Zimbabwe in partnership with the United Nations Children's Fund (UNICEF), provides US$20 per month to OVCs. 69% of the participants who receive the cash transfer indicated that the money helps them to buy food, stationery, clothes and other basic needs. Mushunje and Mafico (2010) argue that although the cash transfer cannot totally eradicate the levels of poverty, it however helps in achieving development objectives and improve the daily lives of vulnerable children and their families. According to the National Action Plan for Orphans and Vulnerable Children Phase II (2011-2015), the government of Zimbabwe has set up the Street Children Fund, to provide support for children living on the street. This fund currently provides for more than 12,000 children and supports the re-integration of these children with their families. Skovdal *et al*. (2013) in a study on cash transfer in Eastern Zimbabwe showed that in July 2009, a community cash transfer trial was initiated in 30 communities in Manicaland. In order to make these projects effective and beneficial to the lives of the OVCs, a community-based Cash Transfer committee (CTC) was set up to ensure that the families receiving the money use it appropriately by sending the children to school and also providing them with adequate health care.

Emotional and psychological

On the aspects of psychological and emotional help, the Southern Africa HIV and AIDS Information Dissemination Service (SAFAIDS) (2011) published My Dreams, a booklet which contains stories of children coping with the impacts of HIV and AIDS in Zimbabwe and shows that talking about difficult issues and trauma is the best way to deal with it. This provides an opportunity for children who are affected or infected with HIV/AIDS to share their stories as well as look at how they can overcome the challenges they face to succeed in life. This has not only given the children courage and hope to face their challenges but has also increased community awareness of HIV/AIDS, reduced the stigma and has improved community support for children with HIV/AIDS. Nyawashaand Chipunza (2012) also found that the use of narrative theater programs, which involves drama, storytelling and poetry and children camps have helped OVCs to be more open to deal with their circumstances. This approach has also helped in building the self-confidence of these OVCs, over 70% of the participants attested to the fact that through drama, writing and poetry, they have gained more confidence in themselves. Again, the children's camp helps in addressing different psychological issues affecting OVCs that are normally neglected. They have the opportunity to interact with other children and participate in activities that educate and empower them to cope. 68% of the participants found the camps to be very beneficial, in that they learn new things and share ideas in a welcoming environment. Nyawasha and Chipunza (2012) adds that counselling is also a very important way of supporting OVCs with psychological issues. It has helped most of the participants to deal with individual losses.

Education and school feeding

In 2001, the government of Zimbabwe established the Basic Education Assistance Module (BEAM) with the aim of reducing school dropouts, which may be due to financial difficulties, therefore, students who were identified by their teachers and principals to be in need of educational support, received school fees and levy waivers from BEAM (Nyawashaand Chipunza, 2012). Moyo (2010) found that school feeding programs have increased the school attendance of many vulnerable children. Shirichena School within the Chegutu District recorded an enrollment of 90% as compared to the rate of 50% before the implementation of the school feeding program by the Consortium for Southern Africa Food Emergency. This has led to a reduction in the rate of dropouts, while increasing performance and school duration, thereby reducing the burden on families. The government of Zimbabwe has also established the Education Transition Fund (ETF), which is to support with the teaching and learning materials for all schools (National Action Plan for Orphans and Vulnerable Children Phase II 2011-2015).

Challenges

In as much as the community, government and non-government agencies have implemented various policies to help OVCs, there is no assurance that the stigma and discrimination can be totally wiped out. Through My dreams project, SAFAIDS (2011) gave narratives of how some of the infected children were treated and despised by their own family and school mates. After losing both parents, Kurauone, one of the participants from the project, narrated that her grandmother who later became her guardian, went about telling everyone how she had been left with a sick person who has succeeded in diminishing her happiness. This is disturbing, and heart breaking and will become difficult for children facing similar discriminations especially from closer family members to cope. As indicated by Mastrojohn, Smith and DiSorbo (2009), the antiretroviral drug cannot produce effective results if the persons living with HIV/AIDS do not receive any helping hand from interested parties, particularly family, or if they are stigmatized and discriminated. However, areas where the community is able to lend helping hands to OVCs, the continuous increase in the rates of OVCs mean that there will be a burden on the community (Skovdal *et al*., 2013). One other challenge is that cash transfer implementation can be extremely problematic, it is easier to

neglect many vulnerable families, especially those in the rural areas. In areas where the people have informal occupations and where the poor are not regarded important, target can be difficult (Mushunje and Mafico, 2010). Again, the amount received may not be sufficient for the upkeep of the family. From Nyawasha and Chipunza (2012), a participant from the study indicated that "there is the need for the government to periodically review this money we are getting; it is not enough to me*et al*l our needs. We do not have parents to look up to and sometimes we go without food or electricity as the US$20 is not enough" (p. 12). There is also a tendency that children who live with an extended family member may not benefit from the cash transfer. Men who act as representatives of cash transfer beneficiaries usually spend the money on their personal needs, neglecting the children's need. Also, cash transfer can also cause jealousy among community and family members. In some communities, members who do not receive the cash transfer do not see eye-to-eye with the beneficiaries, creating contempt among them.

When children are identified as vulnerable and eligible for cash transfer, various members of the extended family contend and fight to claim custody of that child to benefit from the cash transfer (Skovdal *et al*., 2013). Although the prevalence rate of HIV/AIDS in Zimbabwe is decreasing, it is still among the highest in Africa and the world, and this means that there will be more orphans and vulnerable children to be taken care of. Cultural, social and religious beliefs can become barriers in the prevention and control of the disease. According to HIV and AIDS in Zimbabwe (2016), about 40% of women from the 2010-2011 Zimbabwe Demographic Health Survey (ZDHS) indicated that their husbands were justified if they beat them for arguing with them, burning food or refusing sex, among others and this means that it will be difficult for married women to initiate condom use or refuse sex, and this will aggravate the spread of HIV/AIDS.

Implications

HIV/AIDS has a detrimental impact not only on the infected individuals or affected families but the entire growth and development of a nation. Specifically, it impacts the social sector, productivity, level of poverty, governance, resource allocation and human development, and in Zimbabwe where about 240,000 children were infected by HIV/AIDS in 2001 and as many as 890,000 were orphaned by HIV/AIDS in 2012, the situation becomes alarming. Not only will the survival of these children be difficult, but their health, the development of their communities and the future of the country will be at stake if continuous and sustainable projects are not implemented either to reduce the risks of infection or provide resources to ease the burden of OVCs and their families and/or caregivers.

Children of 0-3 years are 3.9 times more likely to die within 2 years of the death of the mother, whether through HIV/AIDS or not (UNICEF, 2006). Children who are orphaned by HIV/AIDS are more vulnerable than children who are not, they experience psychological, emotional and physical loss and these factors have enormous effects on their current circumstances and their future. Stigma, discrimination and the loss of parents and/or caretakers creates emotional meltdown, coupled with the painful physical loss they experience, and this may influence their decisions and choices. On the issue of economic or financial situations, OVCs are not able to afford necessities like food, clothing and hygienic living environment, those who are able to get these basic needs mostly miss out on proper healthcare and tend to perform poorly and often get interrupted in school due to sickness. Most of these children live on the streets or in the orphanages and therefore need to be provided for, which means that the government must set aside funds to provide for them; free school feeding, tuition free schooling, cash transfers and for those infected with HIV/AIDS, antiretroviral drugs must be provided to help them survive. There will therefore be limited resources for other developmental and infrastructural projects that may address the issues of healthcare, unemployment and inflation in the country (Nyawashaand Chipunza, 2012, Skovdal *et al*., 2013 and UNICEF, 2006). Most of the orphans and vulnerable children live with extended family relations. However, most of them end up in poorer households or with poverty-stricken caretakers, specifically the grandmothers who may not be able to provide the basic amenities and so tend to indulge in risky behaviors to fend for themselves. UNICEF (2006) indicate that orphaned girls have higher rates of reproductive health problems, pregnancy and HIV infection than those who are not orphaned. These individuals will not be healthy or even have the skills to work to improve their lives and increase the country's productivity and eventually growth, but continuously drain the economy of its resources through diversion for the production of drugs.

Recommendations

Although it is important to provide for orphans and vulnerable children, the first and important thing is to seek ways to reduce the HIV/AIDS infection rate in Zimbabwe. Education and information about the transmission and prevention of HIV/AIDS must be heightened and the myth surrounding the disease destroyed, which will aid in the reduction of stigma and discrimination. Some preventative measures such as the use of condoms and participation in test and counselling services must be encouraged especially among the youth. For those already infected, they must also be educated to indulge in safe sexual practices to prevent reinfection and antiretroviral drugs must be readily available for them to help prolong their lives and also reduce mother-to-child transmission. All programs and projects must be tailored to suit the needs of the OVCs based on their circumstances so that supportive environment can be created for them to make healthy life choices and decisions and acquire skills that can enable them survive in future, and this can only be done if there is sufficient knowledge and understanding of their local situations and needs (UNICEF, 2006). Again, these projects must be measured for effectiveness, for example, the cash transfer scheme and the street children fund that has been implemented to aid orphans and vulnerable children in Zimbabwe need to be assessed for efficacy over the period of implementation.

Conclusion

The HIV/AIDS prevalence rate in Zimbabwe is among the highest in Africa, wherefore higher number of orphans and vulnerable children who face economical, educational, health, nutritional, psychological and emotional problems. The abuse of substances, gender inequality and certain cultural practices like property grabbing exacerbate their circumstances making it difficult for them to cope. As a result, various projects have been implemented by the government of Zimbabwe and other organizations to helpmeet their needs, which include school feeding and educational support, cash transfer, street children

fund and various emotional and psychological interventions. For OVCs to have the maximum benefits of the various interventions, there is the need to target those in rural areas and on the streets, while tailoring implemented projects to suit their local needs, which must be assessed periodically for effectiveness.

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