AN EVALUATION OF THE IMPLEMENTATION OF THE NATIONAL CASE MANAGEMENT MODEL FOR CHILDREN ORPHANED AS A RESULT OF HIV AND AIDS IN ZIMBABWE.

BY

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ABSTRACT

HIV and AIDS continues be a major challenge in Zimbabwe and a huge drawback to the country's socio-economic development trajectory. Its impact is exacerbated by the protracted socio-economic and political crisis the country is experiencing. The study evaluates the implementation of the National Case Management Model, an intervention for children orphaned as a result of HIV and AIDS in Zimbabwe. Since inception in 2011, this model has not been evaluated despite current efforts to scale it nationwide. The study utilises a qualitative programme evaluation research design underpinned on the structural social work theory. It critically identifies and analyses the structure, roles of social workers, child caseworkers (CCWs), Lead CCWs, and process of the model. It observes that the model disproportionally vests specialised social work responsibilities to volunteer CCWs despite the fact that they have no social work training. The model experiences acute shortages of funding which adversely affects the length and quality of the training for CCWs and their remuneration. Due to lack of remuneration, the CCWs are demoralised. Despite the model playing a significant function in systematically identifying the orphans' needs and facilitating referrals, the referred children are not accessing the desired services. This is because most of the social safety nets are operating below capacity. Equally important, service provision from Non-Government Organisations is low due to limited funding that is emanating from the sharp drop in global aid. The model largely generates demand and community expectations which are however unmet. The study recommends social workers to customize the model to suit the Zimbabwean context, advocate for social safety nets and operational costs funding and facilitate the standardisation and certification of CCWs training.

DECLARATION OF ORIGINALITY

I Munyaradzi Muchacha declare that the entirety of the work contained therein is my own, original work, unless to the extent explicitly otherwise stated. I have not previously in its entirety or in part submitted it for obtaining any qualification at any university.

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SUPERVISOR'S DECLARATION

This thesis, which I have supervised, is being submitted with my approval.

…………………………………………….

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DEDICATION

I dedicate this piece of work to Thandiwe Differ, a strong women and mother par excellence. Tawana Muchacha and your siblings to come this is the standard and family benchmarks that we are setting for you.

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LIST OF ACRONYMS AND ABBREVIATIONS.

AIDS: Acquired Immune-Deficiency Syndrome.

BEAM: Basis Education Assistance Module.

CCW: Child case worker.

DCWPS: Department of Child Welfare and Probation Services.

FGD: Focus group discussion.

HIV: Human Immune Virus.

LCCW: Lead child case worker.

NAP for OVC: National Action Plan for Orphans and Vulnerable Children**.**

NGO: Non-Governmental Organisation**.**

UNICEF: United Nations Children's Fund.

UNAIDS: Joint United Nations Programme on HIV and AIDS.

CRC: Convention on the Rights of the Child.

ZIMVAC: Zimbabwe Vulnerability Assessment Committee.

CHAPTER ONE

CONTEXT AND BACKGROUND OF THE RESEARCH

1.1 Introduction

Case management is gaining prominence in Sub-Saharan Africa as an intervention to support and facilitate holistic and integrated access to services for children orphaned as a result of HIV and AIDS. This intervention emanates from the fact that most orphans have multiple needs that often go unmet (Roelen, Long and Edstrom, 2011). As expressed by Southern African Development Community (SADC) policy paper (2011:11), "the current delivery of services in each SADC Member State is too piecemeal, short term or inadequate to respond to the complexity of needs of orphans". Case management is a generic term, with no single and precise definition (Moxely, 1997). Hutt, Rosen and McCauley (2004) defined it as a way of identifying people's needs and connecting them to services. Moxely (1997) defined it as a social work approach to enable access to services in a coordinated, systematic and efficient manner. It also involves activities such as assessments, case planning, reviews, advocacy, referrals and psychosocial support (Hutt et al, 2004). Moxely (1997) highlights that it is a component of case work, a social work method concerned with enhancing social adjustment and functioning of individuals. The difference between case management and case work is that the former is concerned with coordinating access to services while the later is broader and involves many activities such as social diagnosis, counselling, therapies and psychosocial support (Moxely, 1997; Roelen et al, 2011).

Management Sciences for Health (2011) an international Non-Governmental Organisation (NGO) observes that most Sub Saharan African countries are piloting and implementing various case management models (Brooks, 2011). Based on outcomes, reach and impact, the most successful case management model is *Isibindi* in South Africa (Thurman, Yu and Taylor, 2009; Management Sciences for Health,

2011). *Isibindi* is a community based model that utilises community volunteers and structures to support and link children to service provision. Thurman et al (2009) evaluation of *Isibindi* concluded that this model it is not only innovative but also cost effective and sustainable intervention for orphans and vulnerable children in Africa. The South African Department of Social Development has since adopted *isibindi* at national level (Thurman et al, 2009).

Encouraged by *Isibindi* outcomes*,* the Government of Zimbabwe through the Department of Child Welfare and Probation Services (DCWPS) is implementing a similar model, the National Case Management Model (Government of Zimbabwe, 2010). Initiated in 2011, the National Case Management Model is one of the central interventions of the National Action Plan for Orphans and Vulnerable Children (NAP for OVC), a multi-pronged social policy that includes social cash transfers and medical and educational assistance (Government of Zimbabwe, 2010). The National Case Management Model is a community-based case work programme primarily for children orphaned because of HIV and AIDS, but also caters for other vulnerable children (Government of Zimbabwe, 2010; World Education, 2012). This model revolves around CCWs who are community volunteers responsible for systematically identifying orphaned children and their needs, provide support and facilitate access to service providers or resource systems. The CCWs also carry out home visits, needs assessments, counselling, case planning and coordination and facilitation of referrals (World Education, 2012). Their mandate is to undertake community based case work for orphaned and vulnerable children and their families (World Education, 2012).

The central argument of this dissertation is that the efficacy of case management is closely knit to the availability of resource systems, these resources broadly include funding for operational costs, qualified human resources and social safety nets (social protection schemes to cushion members of the society from vulnerability) (Moxley,1997). This is in light of the fact that case management is primarily a system that coordinates and links clients to services (Moxley,1997; Roelen, Long and Edstrom, 2011). Implicitly, one can only access a service if it is available. Zimbabwe is currently experiencing a deep-seated socio-economic crisis that is affecting government income and expenditure on social safety nets and social interventions (Mthetwa and Muchacha, 2013; Gandure, 2009). To that end, most of the social safety

nets and government care services are currently operating below capacity (Gandure,2009). In light of the situation described above, this study evaluated the National Case Management Model through a structural social work lens to ascertain the extent to which it is achieving its objectives in Zimbabwe's current context. Equally important, since its inception this model has not been evaluated to ascertain its implementation, structure and efficacy (World Education, 2012). To that end, this study serves to generate evidence to inform and influence policy and evidence based interventions for orphaned children in Zimbabwe and beyond.

1.2 Background and outline of the problem.

The HIV and AIDS pandemic has witnessed a phenomenal increase in the number orphans and vulnerability of children around the world (United Nations Children's Fund (UNICEF), 2012). UNICEF (2012) estimated that over 15,100,000 children are orphaned as a result of HIV and AIDS across the globe, of these children 7,800,000 are in the Sub Saharan Africa. In Zimbabwe, approximately 1.6 million children are orphaned as a result of HIV and AIDS (Government of Zimbabwe, 2010). The HIV prevalence rate in Zimbabwe is estimated to be 13.63 % (Government of Zimbabwe, 2010). The high mortality due to this pandemic has resulted in the loss of breadwinners, resulting in increased numbers of children in acute child poverty and challenging circumstances (Izumi and Carpano, 2007). Factors such as the dwindling extended family social fabric, macro-economic instability and formal unemployment estimated at 80% have exacerbated the situation (Gandure, 2009).

The Zimbabwe Vulnerability Assessment Committee (ZIMVAC), a systematic nationwide socio-economic barometer in Zimbabwe, notes that two-thirds of orphans live below the poverty datum line and are unable to access basic social services (ZIMVAC, 2010). In the same vein, Mushunje (2006) observed in her qualitative desk review and analysis of child welfare in Zimbabwe that orphaned children are often exposed to neglect, abuse and exploitation. To that end, the National Case Management Model in Zimbabwe is a response to these wide ranges of challenges faced by orphaned and vulnerable children. This background reflects the nature and extent to which the HIV and AIDS pandemic has affected children. To meet the needs

of these children it calls for the social work profession to implement structural solutions that addresses the root causes of the social problems. As structural theorists such as Wallenberg (2008) argue that structural problems needs structural solutions.

World Education Incorporated, an international child rights Non-Governmental Organisation (NGO) in Zimbabwe highlighted that the National Case Management Model has two major objectives (World Education, 2012). The first objective is to systematically identify the needs of orphans. The second objective is to facilitate access to services for these children at community level in a holistic manner (World Education, 2012). The anticipated outcomes of the programme include strengthened community based responses and improved well-being of children in domains such as protection, psychosocial and health wellbeing, education and nutrition (World Education, 2012; Government of Zimbabwe, 2010).

The development and implementation of the National Case Management Model in Zimbabwe emanated from the understanding that many orphans were not accessing basic social care services (World Education, 2012). Jimmat (a consultancy firm contracted by government and NGO partners to evaluate government and NGO interventions under National Action Plan 1 2005-2010) observed that children orphaned as a result of HIV and AIDS are hard to reach and have multiple needs which are often unmet (Jimmat, 2010). Similarly, Mushunje (2006) argues that orphaned children often have multiple needs, and these have to be tackled in a holistic and comprehensive manner. Jimmat (2010) recommended an intervention which would systematically and holistically identify these needs and link the children to service providers. To that end, the Government of Zimbabwe implements the National Case Management Model, and regards it as a major innovation and milestone in addressing the multiple and complex needs of orphaned children (Government of Zimbabwe, 2010).

It is imperative to highlight that the other factor that is contributing to reduced government funding of social sectors other than the economic crisis earlier highlighted is the neoliberal and austerity policy regime in Zimbabwe. After independence in 1980, this government instituted a robust welfare system characterised by elements such as universal education and health care (Gandure, 2009). However due to the Economic

Structural Adjustment Programmes the government has not only reduced funding for social safety nets but has imposed stringent means testing to the existing social safety nets (Kanyenze, Kondo, Chitambara and Martens ,2011). These drastic cuts to expenditures in social sectors are not unique to Zimbabwe but a global phenomenon as governments across the world are increasingly reducing social expenditures to facilitate economic liberalisation and economic growth (Sewpaul, 2013, Sewpaul and Hölsher, 2004). In 2009, only 1% of the total recurrent budget of the Government of Zimbabwe was invested in social protection (World Education, 2012). Because of this state of affairs, Gandure in her national situational analysis of women and children argued that efforts to address the situations of vulnerable children are thwarted by limited resources reaching the social sectors, including health, housing and education (Gandure, 2009). This picture reflects the deep-seated governance and structural problems in Zimbabwe. The NGO sector, which often compliments governments' efforts in service provision in Zimbabwe, is currently operating below capacity due to decline in funding (Kanyenze et al, 2011). This reduced funding emanated from the global economic crisis, which across the world witnessed a sharp drop in development aid. To that end, this thesis argues that the National Case Management Model has a huge task in such a resource constrained context.

Moxley (1997) argues that a well-functioning case management system requires qualified and motivated case workers. Due to shortage of funds in Zimbabwe, CCWs operate as volunteers, and are not paid stipends or allowances, yet they are the key workforce in implementing the model (World Education, 2012). *Isibindi* a similar model, pays case workers 1000 Rand per month (Thurman et al, 2009). Thurman et al (2009) argues that this financial motivation is one of the factors that have contributed to the success of *Isibindi*. Thurman and team also observed that this model has actually created an employment alternative for unemployed youths (Thurman et al, 2009). *Isibindi* case workers have a similar role to CCWs in Zimbabwe. This raises the question of how well CCWs in Zimbabwe are being motivated, when they do not receive financial incentives and operate in a much harsher economic climate.

It is also pertinent to note that globally case management is the domain of qualified social workers (National Association of Social Workers United States of America, 2012). The utility of volunteer community based CCWs in Zimbabwe seeks to ease

the current shortage of qualified social workers in Zimbabwe at community level. The Institutional Capacity Assessment of the then named Department of Social Services, conducted by Wyatt, Mupedziswa and Rayment, in 2010 that the proportion of social workers to orphaned and vulnerable children was very high especially in comparison to other countries in Southern Africa. They unearthed that “in Zimbabwe the ratio of children to government social workers as of 2010 was 49,587:1, compared with 1,867:1 in Botswana and 4,300:1 in Namibia” (Wyatt, Mupedziswa and Rayment, 2010; 12). In light of this circumstance, it is also the intention of this study to examine and understand the capacity of community CCWs in undertaking these social work roles in light of the fact that they are not ‘professional’ social workers.

1.3 Location of the study and context.

The study was undertaken in Epworth District, a high-density area in Harare, Zimbabwe. It is a residential suburb located 12 kilometres from the southern part of Harare Centre (Msindo, Gutsa and Choguya, 2013). It has an estimated population of 61,340 people distributed across seven wards (Zimbabwe National Statistical Agent, 2012). The history of Epworth is that in 1980, people who were struggling to pay rent in other areas of Harare went to occupy unutilized land in Epworth which was designated for non-residential purposes. In 1980 its population was around 20000 and by 1987 it had reached 35,000 (Msindo et al, 2013). Epworth District is predominantly occupied by poor families and households (Msindo et al, 2013). Due to the fact that the district was initially an informal settlement, Epworth residents experience acute challenges such as high unemployment, high child mortality rates and HIV and AIDS prevalence, and high numbers of orphaned children.

The Epworth District AIDS Action Committee estimates that there are over 3000 children orphaned due to HIV and AIDS in Epworth (Epworth District AIDS Action Committee, 2013). Due to this state of affairs and high risk factors in Epworth District, the government, together with other cooperating partners, systematically selected the district for the National Case Management Model. The programme is being implemented in Epworth by the Government of Zimbabwe Department of Child Welfare and Probation Services, with support from NGOs.

Despite efforts to formalize settlements in Epworth District and the establishment of the Epworth Local Board (local governance authority), informal squatter settlements in Epworth are on the rise (Msindo et al, 2013). In 2013, Msindo et al (2013) conducted a cross sectional qualitative study to establish the reasons for the rise in squatter informal settlements. They discovered factors such as delays in allocation of formal residential stands, family growth, political patronage, expensive residential stands and high rentals costs in other suburbs (Msindo et al, 2013). The implication of this surge in informal squatter settlements has been more limited access to social services, as existing services are placed under greater strain (Msindo et al, 2013).

1.4 Objectives.

The overall purpose of the study was to evaluate the implementation of the National Case Management Model for children orphaned as a result of HIV and AIDS in Epworth District, Zimbabwe.

The objectives were:

1. To understand and appraise the structure and process of the National Case Management Model in Zimbabwe.
2. To gain insight into the views of:

- 10 Caregivers' experiences of the extent to which the program has helped children orphaned as a result of HIV and AIDS in their care.
- 5 CCWs' experiences in implementing the programme.
- 5 Social workers' perceptions of the programme.
- Key informants' (Department of Child Welfare and Probation Services senior official and NGO **A** Coordinator) experiences in overseeing the implementation of the model.

1.5 Research questions.

1. What is the structure and process of the National Case Management Model?
2. What are the challenges and limitations in the implementation of the National Case Management Model for children orphaned as a result of HIV and AIDS,

from the views of 10 caregivers, 5 CCWs, 5 Social workers and 2 key informants?

1.6 Theoretical framework.

This study is underpinned by the structural social work theoretical perspective. This theory argues that social problems emanate from structural systems of human living (Mthetwa and Muchacha, 2013; Raniga, 2006; Adams, Dominelli and Payne, 2009). It views social problems as an outcome of social injustices, bad governance and limited political will to address social ills (Mullaly, 2007; Weinberg, 2008). This theoretical perspective also argues that major causes of social ills are unequal influence and access to resources systems in the capitalistic world (Mullaly, 2007; Weinberg, 2008). On the same note, Moreau (1989) quoted in Weinberg (2008) maintains that social problems are caused by unequal access to power and resources. This view emphasises that social problems are structural in nature and deep-seated in oppressive social and political systems (Dominelli, 2010; Sewpaul and Holscher, 2004). Those who have money and power dominate those who do not. To put this philosophical thinking into a practical context, it can be argued that the challenges faced by orphans emanate from lack of political power, and limited access to and control of resource systems (Dominelli, 2010).

According to Weinberg (2008) structural social work looks at structural barriers that hinder optimal human social functioning (Weinberg, 2008; Mthetwa and Muchacha, 2013; Wood and Tully, 2006; Sewpaul and Holscher, 2004). To that end, the focus is not on the individual pathology and circumstances but the key drivers of the status quo. This theory is grounded on the radical social work dichotomy, which argues that traditional social work such as social case work, is individualistic and not positioned to confront structural problems. According to structural social work theorists, social casework only deals with the “off shoots” of social problems and not the underlying factors (Mullaly, 2007; Weinberg, 2008; Rankopo and Osei-Hwedie, 2011). This theory criticises inequalities in social structures. Its ideology is socialist in nature and argues for equal distribution of wealth (Weinberg, 2008; Mullaly, 2007).

Mushunje (2006) in her qualitative review of the child protection system in Zimbabwe and the status of vulnerable children argues that orphaned children are subject to gross deprivation of rights and denied access to social services. It can be argued that the deprivation of rights for orphaned children emanates from the governance system in Zimbabwe, which is failing to fulfil its mandate of fulfilling the rights of children. The social work structural theory argues that the welfare of the vulnerable children is not prioritised by politicians, who instead prioritise investing in corridors of power and systems that consolidates their grip on power (Weinberg, 2008; Mullaly, 2007). Weinberg (2008) further posits that societal ills are more caused by inequalities in the social systems than by individual pathology (Mullay, 2007). This study arguing from the social work structural theory perspective highlights that if the society and the government invest enough in the lives of orphaned children, their situation would be better.

Structural social work theory further notes that there is a deliberate political choice to keep inequalities and insufficiency among politicians. In this regard, it can be argued that challenges faced by orphans can be alleviated, but the political resolve is not there to address them*.* (Weinberg, 2008; Ryan, 1976). This study understands and conceptualizes the socio-economic crisis in Zimbabwe as a structural crisis. The Government of Zimbabwe has a mandate and obligation to ensure that the rights of its citizens are fulfilled. In this regard the government has not only the responsibility to restore the economy, but also to ensure that vulnerable members of the society are cushioned from the adverse effects of a badly performing economy, through investing in social protection schemes. Zimbabwe's deteriorating economy has led to widespread closure of industries, increasing national budget and trade deficits and ballooning national debt (Government of Zimbabwe, 2010). This structural crisis increases the vulnerability of disadvantaged families and children.

Lundy (2004) propounds that in the structural social work framework, the role of social workers is to confront political systems and demand social justice on behalf of the voiceless (Dominelli, 2010). In this light, the social work profession needs to become "the voice of the voiceless". In line with this argument, many African social work scholars are arguing for the implementation of the developmental approach to social

work as a sustainable and relevant approach to the social problems that emanates from political and structural systems (Lombard, 2007). Developmental social work reinforces the role of social work in championing fairness, justice and human rights and to the eradication of poverty and inequality. These are the social problems that take a centre-stage in developing countries including Zimbabwe (Lombard, 2007). Lombard (2007) argues that social work must be redefined to depart from its current liberal character and to adopt a more pragmatic, radical approach to enable it to give meaning to social development in Africa.

1.7 Research methodology.

This study utilised a qualitative methodology, this methodology was adopted and best positioned to capture the experiences, attitudes and perceptions of respondents pertaining to the implementation of the National Case Management Model.

Research design: The study followed a qualitative programme evaluation research design. This research design is relevant to the study because of its capacity to supply qualitative and reliable evidence regarding the operation of social programmes (Rossi, Lipsey and Freeman, 2004).

Samples and sampling method: Purposive sampling technique was utilised to select all the respondents who are the caregivers, CCWs, social workers (Government and NGO **A**) and key informants. A sample of ten caregivers was purposively selected to participate in the study from the target population of eighty caregivers who were registered in the Epworth District case management register and being targeted by the National Case Management Model. Five social workers (three from the DCWPS and two from NGO **B**) and five CCWs participated in the study from a total population ten social workers. A senior official from the DCWPS and the Coordinator from NGO **A** were selected as key informants. These two officials were selected, as they are the leadership responsible for the overall strategic management of the National Case Management Model. This places them at a unique position to provide valuable insights in the implementation of the National Case Management Model. The two NGOs **A** and **B** were targeted because they are supporting the government to implement the National Case Management Model. NGO **A** is the funding agency while NGO **B** is a

local organisation that also receives funding from NGO **A** support government social workers to implement the National Case Management Model.

Data collection methods and instruments: Data collection was conducted from 15 December 2014 to 15 January 2015. One focus group discussion (FGD) utilising a FGD guide was used to collect data from ten caregivers whose children were reached through the National Case Management Model. The FGD with caregivers was conducted in the vernacular language ,Shona. Semi structured in-depth interviews were conducted with five social workers, five CCWs and two key informants using an interview schedule. The semi-structured in-depth interviews for the CCWs were conducted in the vernacular language earlier mentioned, while those for the social workers and the two key informants were conducted in English.

Data analysis: The study utilised thematic analysis approach to analyse the data following the thematic analysis procedure articulated by Kondracki and Wellman (2002). This approach is relevant to, and mostly utilised in, research that extracts meaning from analysis of people's experiences. To that end, thematic analysis was utilised to understand to analyse the experiences of the CCWs, social workers, caregivers and key informants in the implementation and evaluation of the National Case Management Model in Zimbabwe.

1.8 Clarification of major concepts.

The key concepts relevant to the study are as follows:

i. Case management

Case management is a method of enabling access to services through systematic identification of needs and coordination of services (Management Sciences for Health ,2011).

ii. Child case worker

A volunteer selected at community level, trained by the DCWPS and supervised by the Lead Child Case Worker and social workers, to assist orphaned children and facilitate access to service provision.

iii. Psychosocial support

Psychosocial support is a continuum of care and support which influences both the individual and the social environment in which people live (UNICEF, 2009).

iv. Program evaluation

Rossi et al (2004) define programme evaluation research as the systematic application of scientific procedures to measure the impact and efficacy of social interventions and programs.

v. HIV

HIV stands for "Human Immunodeficiency Virus", a virus that leads to immune deficiency in humans.

vi. AIDS

AIDS stands for Acquired Immune Deficiency Syndrome this is a condition where by the immune system has been destroyed or weakened by Human Immunodeficiency Virus and is no longer in a full position to repel infections or diseases.

vii. Lead child case worker

The person responsible for supervising the CCWs at community level. They report to social workers from the District Department of Child Welfare and Probations Services.

1.9 Conclusion

This first chapter introduced the study and provided its context and background. The overall purpose, objectives, research question, and the research methodology were also outlined. The theoretical underpinning of the study, which is the structural social work theory, was also discussed and explored in relation to how it guides the study.

1.10 Synopsis of chapters

Chapter Two: Literature review

This chapter reviewed current literature on the status of orphaned children as a result of HIV and AIDS globally, regionally and in Zimbabwe. It further explored the international, regional and Zimbabwean responses to the plight of children orphaned as a result of HIV and AIDS. Finally, the chapter also examined the that are being employed for orphaned children.

Chapter Three: Methodology

In this chapter, the research methodology, research design, population and sample, data collection and data analysis are discussed. The research process overview was also laid out, in addition to a description of the research participants and methods of data collection and analysis were described as well. Issues relating to the reliability and validity in relation to the triangulated research design were also discussed and consideration of ethical issues was presented, including the way in which the study was conducted in adherence to standards of trustworthiness and authenticity presented.

Chapter Four: Understanding the structure and process of the National Case Management Model.

Chapter four described and analysed the structure and process of the National Case Management Model, using data primarily obtained from in-depth interviews held with purposively selected five CCWs, five social workers (three Government of Zimbabwe, DCPWPS and two NGO B), as well as from two key informants (NGO **A** Coordinator and DCWPS senior official).

Chapter Five: Institutional and structural challenges affecting the implementation of the National Case Management Model.

This chapter is a continuation of chapter four. It explored the experiences and perceptions of service users, social workers, CCWs and key informants. From these experiences, it established the institutional and structural challenges limiting the implementation of the model. These various perspectives were drawn together to cement and triangulate the analysis and findings.

Chapter Six: Summary and recommendations for social work interventions, policy reforms and future research.

Chapter six presented the major conclusions drawn from the study's findings. The summary of findings is first presented in relation to the objectives that were set for this study. It further considered possible recommendations that can be pursued by social workers to strengthen the National Case Management Model and making suggestions for further research.

CHAPTER TWO: LITERATURE REVIEW

CHILDREN OPHARNED AS A RESULT OF HIV AND AIDS: A GLOBAL, REGIONAL AND ZIMBABWEAN PESPECTIVE.

2.1 The global status of children orphaned due to HIV and AIDS.

The HIV and AIDS pandemic has ushered many social problems across the globe (Stover and Bollinger, 1999). Approximately 20 million people have perished to the pandemic around the world (Ghanashyam, 2010). Asia and the Sub Saharan Africa regions are disproportionally affected (Barnett and Whiteside, 2003). An estimated over 40 million people have been infected with HIV and AIDS in Asia and Southern Africa since the beginning of the pandemic. One of the major consequences of this epidemic is the increase in the number of orphans and vulnerable children (UNAIDS, 2010). An estimated 17 million children around the globe are orphaned due to HIV and AIDS. Of these 9 million are from the Sub Saharan Africa region (UNAIDS, 2010). These children are exposed to risk factors such poverty, deprivation and all forms of violence (Mushunje, 2006).

While the crisis of orphans is a global phenomenon, developing countries have a disproportionate number of orphaned children. For example in Haiti about 15 percent of children lost parents to the pandemic (UNAIDS and World Health Organisation, 2004). Cambodia has an orphan rate of 4.7 % while Vietnam and Thailand have 4.2 per cent orphan rate (UNAIDS and World Health Organization (WHO), (2004). UNAIDS and World Health Organization (WHO) (2004) observes that India has over 4 million children who have been left with no parents due to the epidemic. Despite their low populations, Latin America and the Caribbean regions in 2004 had an estimated 12.4 million children orphaned as a result of HIV and AIDS (UNAIDS and World Health Organization (WHO) (2004). In 2008, China had 1 million children orphaned as a result of HIV and AIDS (Ghanashyam, 2010).

Scholars around the world concur that children orphaned due to HIV and AIDS are disproportionately affected by pandemic in multiple ways (Guo and Sherr, 2012;

Cluver, Orkin, Boyes, Gardner and 2012; Gandure, 2009; Mushunje, 2006). These studies note that most of these children live below the poverty datum line and have limited access to social protection schemes (Guo et al, 2012; Cluver et al, 2012). For example, Tegucigalpa, the capital city of Honduras has witnessed a phenomenal 8% surge of street children who are children orphaned as a result of HIV and AIDS. Most of these children live in difficult circumstances (Ghanashyam, 2010). In India, an estimated half a million children involved in child prostitution are orphaned (Ghanashyam, 2010). Because these children lost their parents due to HIV and AIDS, they are widely discriminated and stigmatised posing a great challenge to their psychosocial well-being (Thurman, Snider, Boris, Kalisa, Nkunda, Ntaganira and Brown, 2005). As Ghanashyam (2010) highlights, "In South Asia many children are teased, discriminated and stigmatised because their parents have died of HIV and AIDS". Similarly, Monasch and Boerma (2012) notes that many children whose parents are with or have died of HIV and AIDS are widely discriminated by their friends due to societal myths that HIV can be spread through any contact or interaction. In addition, wide spread discrimination has been witnessed in India also due to lack of information and knowledge of the implication of discrimination on the psychosocial well-being of the discriminated children (Ghanashyam, 2010; Bharat, Aggleton and Tyrer, 2001).

UNAIDS (2010) global discrimination and stigmatisation survey, reported that a huge number of people globally were of the view that people living with HIV and AIDS do not deserve to be alive and as they are responsible for spreading the virus. This research further notes that that 28 % of the respondents were not comfortable interacting with a person infected with HIV. These were views of adults who were participants. Often the views and behaviour of adults influence those of their children. Hence children orphaned by HIV and AIDS can be discriminated by both adults and other children. This discrimination of children orphaned as a result of HIV and AIDS can be explained by the structural social work theory which posits that the society absolves itself from taking responsibility and action and instead places blame on the "victim" for the challenges they are experiencing (Weinberg, 2008; Hugman ,2010).

2.2 Global commitments to the situation of children orphaned due to HIV and AIDS.

Convention on the Rights of the Child (CRC).

The international community through the United Nations have instituted legislation to safeguard and advance the rights of children. This legislation is called Convention on the Rights of the Child (CRC) (United Nations, 1990). Despite the fact that one hundred and ninety-four countries have ratified the CRC, many of these countries especially African countries have not domesticated its provisions (African Child Policy Forum, 2008). The CRC envisions a society, which guarantees the rights of children and enabling them to reach their full potential as rights holders (United Nations, 1990). Article 4 of the CRC mandates governments to implement all the provisions of this law and ensure that resources are made available for its full implementation (United Nations, 1990). There are many reasons that limits the full implementation of the CRC. For example, many political leaders in Africa interpret the CRC and other international laws as an imposition on them by Western countries and the motive of rectifying is to avoid international aid sanctions (African Child Policy Forum, 2008). Because of this fact, they do not implement this international law as a form of protest. The other major reason for the limited adoption and implementation of the CRC in many developing countries is the lack of resources (African Child Policy Forum, 2008).

As part of efforts to stimulate the implementation of the CRC and harmonise international efforts and actions to address the effects of HIV and AIDS, in 2001 the international community came up with ambitious global goals to mitigate the impact of the pandemic. This framework is known as the United Nations General Assembly Special Session on HIV and AIDS. Goals 65, 66 and 67 of this framework primarily concerns orphans (Government of Zimbabwe, 2004). These goals speak to the need for governments to fund initiatives that safeguard the rights of orphans and the development of policies and action plans that outlines the government interventions and responses to the orphan crisis (Engle, Dunkelberg and Issa, 2008). Webb, Gulaid, Ngalazu-Phiri and Rejbrand (2006) evaluating the extent to which countries in Sub Saharan Africa have developed and implementing actions plans, highlights that most African countries lacks resources to implement comprehensive action plans. The

positive development was however that all the countries had developed actions plans. They concluded that despite the signing of this global commitment by many countries this has not yet translated to qualitative and quantitative positive outcomes on the wellbeing of the targeted populace (Webb et al, 2006).

2.3 The status of children orphaned as a result of HIV and AIDS in Africa.

Africa, especially Southern Africa is undoubtedly the HIV and AIDS pandemic "hotspot". The continent has witnessed huge mortality especially before the discovery of Antiretroviral medication which is now prolonging life (UNAIDS, 2010). UNAIDS (2010) further observes that over eight million children are orphaned due to the pandemic in Africa. In Cameroon 1,200,000 children are orphaned and vulnerable and over 300,000 (25%) are AIDS orphans (Nsagha and Thompson, 2011). In Lesotho, UNICEF (2009) notes that approximately 110,000-120,000 children are orphaned due to the pandemic. Of these children, 12,000 are living with HIV and AIDS. Stover and Bollinger (1999) in the Southern African region documented a range of impacts of HIV and AIDS on households with orphans. These include limited access to social care services, discrimination and psychosocial problems. They also observed that because some children stay with caregivers or parents who will be chronically ill often times are called to attend to their sick relatives and in the process miss school (Stover and Bollinger, 1999). Further to that, they are given the responsibility to pay for their fees. Due to this, they spend lots of time participating in livelihoods to generate income (Stover and Bollinger, 1999).

Children orphaned as result of HIV and AIDS face substantial challenges in accessing and continuing with education. In Ghana, Nsagha and Thompson (2011) noted that most orphans drop off from school when their parents die. These authors also observed that due to increased number of orphans and economic problems in Uganda, their families struggle to cope with the overwhelming number of orphans who needs assistance to access education. This affects both children in rural and urban areas. However, rural areas are disproportionally affected because education is taken for granted by other caregivers (Nsagha and Thompson, 2011). Similarly, Mishra and Bignami-Van Assche (2008; 12) observes that, "orphans are less likely to be enrolled in schools than non-orphans with whom they live with. Orphans who lived with distant

relatives and unrelated caregivers had lower school enrolment than those who lived with a close relative”.

It is cardinal to highlight that girls face more challenges to access education than boys do. As Gandure (2009) observes that in primary school, attendance and retention of the girl child will be very high. However, most of the orphaned girls drop in high school due to challenges such as early marriage, unplanned pregnancies and limited support from progress with education while preference is given to the boy child. Relatives often take advantage that the girl will have no parents and let her get married so that they can acquire bride price (Gandure, 2009).

Cluver (2012) randomised control trial in South Africa noted that children orphaned by HIV and AIDS are prone to risk such as child marriage, sexual exploitation, sexual abuse and prostitution. Thurman (2006) in Kwa Zulu-Natal, South Africa cross-sectional study on reproductive health of adolescents highlighted that orphans had early sexual debut compared to other children. Similarly, Hallman (2006) in South Africa observed that paternal orphans had higher chances of sexual debut than other children did. These studies reflects the sexual risks among orphaned children. As orphaned girls often, engage in relationship with older men to secure a livelihood. In most instances, these girls are sexually exploited without any remedy (Hallman, 2006). Thurman (2006) highlights that most of these girls do not report the matter to the police due to stigma attached to reporting a gender-based case. Further to that, the police often sympathise with the perpetrator than the reporting child (Thurman, 2006). This is evident that the challenges that orphans face are systemic and are almost at all the levels of the society. As the structural social work, theory argues, addressing these social problems calls for interventions that confronts structural factors such as poverty, gender discrimination and harmful and cultural practices (Weinberg, 2008).

Malnutrition is another grave challenge facing children orphaned as a result of HIV and AIDS due to shortage of food. In some instances, these children are deliberately denied food by the caregivers in favour of their own children (Poulter, 1997). Poulter, (1997) observed that most orphaned children in Zambia were stunted. Some of these orphans were staying with their grandparents who are no longer in the position to work and provide enough food to the children. UNICEF (2003) cross sectional nutrition

survey in Togo revealed that most orphans reported having one meal per day. UNICEF (2003) concluded that the major causes of poor nutritional outcomes amongst orphans includes poor harvests, lack of agricultural inputs and widespread poverty among the households that are taking care of orphaned children. This state of affairs reflects how it is important for the government to provide food relief to poor and labour constrained households. A closer look of these issues confronting orphaned children in Zimbabwe reveals that they are beyond the scope of casework, the predominant method of social work centred on enhancing an individual psychosocial functioning. As a way forward, invoking the structural social work theory is imperative to enhance an understanding of social problems beyond individual pathology. As Wood and Tully maintains that the social work profession is limited in its efficiency and relevance due to its obsession with individual pathology (Weinberg, 2008).

2.4 Legal framework and interventions for children orphaned as a result of HIV and AIDS in Africa.

African Charter on the Rights and Welfare of the Child.

This is the regional child rights treaty to safeguard the rights of children in the African context. Contrary to the CRC, the African Charter on the Rights and Welfare of the Child acknowledges societal responsibilities that children in Africa have such as respecting the African traditional values. For example, respect for elders and promoting community solidarity (Government of Zimbabwe, 2010). However, this legislation also protects children from harmful cultural practices. As Save the Children (2009; 10) puts it, "the Charter puts special emphasis on the protection against harmful social and cultural practices and the responsibility of children towards parents and the wider community. It also stresses the importance of the family as the natural unit and basis of society and, like the CRC, emphasises the responsibility of the parents for the upbringing and development of the child."

Despite this legislation being Afro-centric and that almost all, the African countries ratified it, Save the Children (2009) reports that most African countries are yet to domesticate the provisions of this important legislation. This owes to lack of will and resources that many countries face in the continent to implement interventions that

promotes or safeguard the rights of children. The structural social theory argues that political systems deliberately neglects meeting the needs of vulnerable members of the society as this strengthen their hold to power (Mullaly, 2007). For example, many political leaders in Africa spend lots of money supporting the police, state security and the army. These are strategic pillars of the state to utilise by politicians to cement their hold to power. As an example, the Zimbabwean government since 2005 has been spending not more than 10% of its expenditures on social sectors. Meanwhile state apparatus receive bulk of the budget (Gandure, 2009).

2.5 Interventions for children orphaned as a result of HIV and AIDS in Africa.

The HIV and AIDS pandemic has proved to be one of the major challenges in the Global South especially Africa. Many interventions have been implemented to address or mitigate the crisis but the demand for services is very high and resources are limited (Foster and Williamson, 2000). Most of the interventions in Africa to respond to the impact of HIV and AIDS are being implemented by international organizations. Kalemba (2000) highlights that that the most popular response to the plight of orphans and vulnerable children in Africa has been the placement of children in children's homes. He further notes that most of the children's homes are constructed and run by charities and faith based organizations (Kalemba, 2000). The criticism of children's homes is that they have not been able to empower children to sustainably stand on their feet after leaving the institutional facilities (Kalemba, 2000). More so, most of the children in children's homes often have challenges of psychosocial adjustment. Hence, the conclusion that children's homes are not conducive for the long-term placement of children. As Kalemba (2000 ;17-18) notes that " interventions such as establishing orphanages, providing handouts direct to orphaned children are quick fix solutions have no lasting effect and are themselves overwhelmed in due course and may cost a lot in opportunity costs". This reflects the importance of the development and implementation of community based child care interventions that enables children to remain in their communities in the care of their community members and relatives rather than being taken away from their community (Powell et al,2005). To that end, many African countries have been implementing various community based orphan care interventions (Thurman et al, 2009).

In many countries, the social work profession has played a significant role in the establishing of residential care facilities and the placement of children (Powell et al, 2005). For example in Zimbabwe social workers are the ones who approves the building of a new residential care facility, they also monitor these. They also provide a registration certificate, which is a legal document that allows the residential care facility to operate (Powell et al, 2005). Because of this background, one can conclude that the social work profession is playing a significant role in the sustenance and promotion of institutionalisation of children. This is despite vast evidence that institutionalisation is not only costly but is also harmful to the psychosocial development of children (Thurman et al, 2009). Because of this position of social work, the structural social work theory critics the traditional roles of social work in addressing social problems. Critical scholars such as Mullaly (2007) argue that social work such as social case work, is individualistic and not positioned to confront structural problems. Mthetwa and Muchacha (2013) shares the same argument that the social work profession in some instances has caused harm than good and has given little attention to the structural causes of social problems. Hence, the social problems persists unabated.

Proponents of community-based care argue that children who are raised in orphanages struggle to be self-sufficient as adults. As they do not acquire enough social skills for self-reliance. In addition, they do not have a social network outside that of the children's home (UNAIDS, UNICEF and USAID, 2002). To get rid of institutional care, Ethiopia is currently implementing a countrywide reintegration program, after finding that orphanages were not only costly but also unhealthy for the social and cultural development of children (UNAIDS, UNICEF and USAID, 2002). Instead, they argue, efforts to support orphaned children should focus on strengthening community networks and initiatives. In this view, community-based support can both enable the children to stay within their communities, and enable donors to support more children, as the cost of supporting a child in an orphanage is substantially more than supporting a child within its own community.

According to United Nations Integrated Regional Information Networks (2004) the government of Malawi is training orphaned and vulnerable children with vocational skills training, particularly life skills and farming skills. This training is critical so that

the children can be empowered to sustainably meet their needs. This is also a preparation for life long responsibilities. This skills training predominantly targets child headed households who have no any other alternative but to provide and fend for themselves. The programme the children with farming implements to start agricultural activities. As part of lifelong economic empowerment. However, many of these children have lost the faming implements provided to thieves and other members of the extended family who are greedy (United Nations Integrated Regional Information Networks, 2004). Some of the children, due to the challenging socio-economic situation were obliged to sell the implements. Due to these challenges, the success rate of this initiative is low (United Nations Integrated Regional Information Networks, 2004).

In Nigeria, community-based approaches have been found viable in addressing the challenges of orphaned children through leveraging on *Ubuntu,* an African philosophy that entails which involves a collective care for vulnerable members of the society (Nsagha and Thompson, 2011). The Government of Nigeria with support from NGOs establish and support community based structures known as Child Safeguard Committees (influential and senior community members that monitors the rights of children in the community). In instances where a vulnerable family or children need food, shelter or other essentials this committee mobilises community resources and provides the children and their families (Nsagha and Thompson, 2011). This model is however under threat due to the increase of families in vulnerability in Nigeria and the dwindling community resources.

Ghana, a neighbouring country to Nigeria implements a similar model through tapping on community charities and faith based organisations to support orphaned children at community level. These organisations support communities to implement livelihoods such as gardening and sewing to generate income to pay for school feeds and other needs (Nsagha and Thompson, 2011). In these livelihoods, community members volunteer their labour. This initiative witnessed a seventy percent increase in the number of children accessing education through money raised by community livelihoods (Nsagha and Thompson, 2011). This is a testimony that the community can play a significant and sustainable role if it acquires support from the government and its stakeholders.

In addition to the above-mentioned facts, it is evident that NGOs across the African continent are playing a very significant role in the care and support of orphans. They have become increasingly relevant in playing this role because of the fact that many governments have reduced funding for social problems due to factors such as the adoption of neoliberal policies and lack of funding. To that end, all most all African countries kinds of NGOs that are providing services to orphans and vulnerable children. Nyangara, Thurman, Hutchinson and Obiero (2009) evaluated interventions of four different NGOs in Kenya and Tanzania and concluded that these NGOs were playing a significand role in the provision of services such as psychosocial support, education and health. However, the major weakness across all the programmes implemented by these NGOs was the limited participation of the service users in programming. As they were only being recipients of assistance but with little or decision-making (Nyangara et al, 2009). The other crucial concern highlighted in this evaluation was that almost all the organisations were implementing piecemeal interventions, which were not addressing the holistic and multiple needs of orphans. For example, Catholic Relief Organisation, one of the organisations evaluated, was only providing school fees but not uniforms and stationery. Because most of the children had no stationery and uniforms did not attend school (Nyangara et al, 2009). This indicates the importance of holistic interventions. The other major gap was lack of collaboration and cooperation between government and these NGOs hence there was duplication of efforts. This lack of coordination limits the extent to which NGOs may make sustainable impact.

Contrary to the negative situation of disharmony between NGOs and the government noted above, the government of Cameron enjoys collaboration and partnership with NGOs in the provision of services to orphaned children. For example, the Ministry of Social Affairs, Ministry of Public Health and NGOs are collaborating to implement several interventions to support orphans within their families by pulling together resources and avoiding duplication of efforts. Some of the interventions implemented includes psychosocial support like counselling to children and to families or caregivers, case management, child protection and nutrition (UNICEF, 2011). Moreover, education and training was provided through fees payment and vocational training and life skills development. Through this partnership, 525 caretaker families of orphaned

children were supported to start and/or to enhance ongoing income generating activities through financial support (UNICEF, 2011). These were mostly petty trade, animal husbandry and production of food crops. These households were also trained on micro finance mechanisms (loans and savings) and are affiliated to local cooperative and credit unions. The major strength of this partnership between the government and NGOs is that there is coordination of efforts and room for holistic interventions (UNICEF, 2011).

The Ugandan government is implementing a community orphan care model for orphaned children whereby orphaned children stay in a community-based villages (clustered houses) called *Watoto* (Nsagha and Thompson, 2011; 10). These villages are a form of residential care but the difference with the traditional residential care facilities in that *Watoto* villages are constructed with the communities where the children hail from. Moreover, it is the community which collectively which is in the community and largely supported by that respective community. Nsagha and Thompson (2011; 10) explains, "*Watoto* places the most vulnerable children into community based children's villages and they live as families. Each family consists of eight children, a mother, and a father who cares for them. These care givers are called house parents". *Watoto* seeks to be a microcosm of a "normal" family and seeks to give the orphans an opportunity to be in a family with a father and mother like other children. Moreover, Watoto enables the orphaned children to continue residing in their communities of origin unlike traditional residential care homes, which in most instances move the children to other places where the care facility is located.

The South African National Association of Child Case Workers (NACCW) is credited for the development and implementation of the first and most successful case management model *(Isibindi)* in Sub Saharan Africa (Thurman et al, 2009). This model is implemented through partnership South African National Association of Child Case Workers (NACCW) and community based NGOs who recruits and support CCWs to facilitate access to childcare services (Thurman et al, 2009). *Isibindi* case workers facilitate access to government social grants, counselling, case work, and coordinate provision of services on behalf of the children and their families (Thurman et al, 2009). An outcome and output evaluation of *Isibindi* by Thurman et al (2009) highlights that not less than 22000 children have benefitted from this model. They also observed that

the programme has managed to meet the multiple needs for orphaned children. Furthermore, the case workers were highly motivated of their work, this was largely due to quality support and supervision and remuneration (Thurman et al, 2009).

The Malawian government with support from UNICEF is also implementing a case management model similar to *Isibindi.* Like *Isibindi* and other models, the Malawi model also utilises community volunteers as the front line workers in the identification of orphaned and vulnerable children and enabling access to different services through referrals (UNICEF, 2012). This model shares similar objectives and expected outcomes with the National Case Management System in Zimbabwe, which is also seeking to facilitate systematic access to services for children orphaned as a result of HIV/AIDS. UNICEF (2012; 16) explaining the Malawian model notes, “This approach uses community child protection committees, under which networks of community members can conduct primary interventions for minor cases and refer serious cases to the formal child protection system. The emphasis is on supporting communities to identify social norms that protect as well as those that make children more vulnerable and to develop a plan to address individual cases of neglect or abuse.” This explanation indicates that the Malawian model shares similar approach and values with the National Case Management Model and *Isibindi.* For example in the sense that all the three models are community centred and utilises grassroots structures. This approach has the advantages of reducing costs and promoting community ownership.

There are however gaps and limitations in the implementation of case management models in Africa (Roelen et al, 2011). For example, case management is an intervention imported from the West and is not niched to address the challenges that are peculiar to Africa (Roelen et al, 2011). Moreover, its approaches clash with local values and cultures (Silvawe, 1995). For instance, most case management models such as the National Case Management Model are centred on the individual rather than the whole family, extended family or the community. This is contrary to African values, which discourages individualism in favour of communalism and collective responsibility. As Silvawe (1995, 72–3) argues, “African society is characterized by the prevalence of the idea of communalism or community. The individual recedes before the group. The whole of existence from birth to death is organically embodied in a series of associations, and life appears to have its full value only in these close

ties. Individual initiative is discouraged . . . self-initiative or self-determination in resolving personal problems is collectively sanctioned by the community". This indicates how case management clashes with the local social terrain. This conflict between case management values and local culture pose a major threat to the effectiveness of case management.

While the utilisation of community volunteers may enable community ownership, there are also other challenges and limitations associated with this approach. In the Zimbabwe and Malawi scenarios, these volunteers are not paid any stipends. This is despite the major roles they play in the implementation of the models. As Roelen et al, (2011,18) points in their study pertaining to case management in developing countries that "the over-reliance on unpaid and overworked volunteers, and the challenges in terms of capacity to deliver effective referrals and case management, was a frequent theme in the interviews and in the literature". They further highlighted "resources are scarce, training is often minimal and the emotional impact is large given the need to deal with highly complex cases. Community volunteers are often the first to identify vulnerable children, but consequently have nowhere to send them and lack the appropriate means to provide follow-up (2011:18)." This indicates that the community volunteers are under resourced. In addition, are operating under very difficult circumstances.

2.6 The situation of children orphaned as a result of HIV and AIDS in Zimbabwe.

Due to the HIV and AIDS and the socio-economic and political situation, Zimbabwe is experiencing protracted and multiple social problems (Gandure, 2009). According to Mushunje and Mafico (2010), states this socio-economic crisis has increased the vulnerability of orphaned children as they face challenges in accessing social services. Government of Zimbabwe (2010) estimates that over one million children are orphaned in Zimbabwe. Orphaned children are amongst the most vulnerable social groups in Zimbabwe (Gandure, 2009). Many of them experience widespread psychosocial distress, economic deprivation and limited access to social services (Government of Zimbabwe, 2004; Gandure, 2009).

Two-thirds of orphans in Zimbabwe live below the poverty datum line and are unable to access social safety nets (Zimbabwe Vulnerability Assessment Committee, 2010). Dwindling of extended family social fabric, macro-economic instability and estimated 80% rate of unemployment has exacerbated the situation (Gandure, 2009). According to the Government of Zimbabwe (2010) violence and abuse of children especially orphaned children has increased. Mushunje and Mafico (2010) assert that children orphaned by AIDS in Zimbabwe suffer more frequently from illness abuse, sexual exploitation and psychosocial distress than children who are orphaned by other causes. Ebbersohn and Elof (2002) also notes that the psychosocial difficulties confronted by orphaned children include, loss of self-identity and social networks. The passing away of a parent can also lead to depression and behavioural problems as well as reduced self-esteem and self-confidence.

2.7 Legislation and social policies for the care and protection of children orphaned as a result of HIV and AIDS in Zimbabwe.

Children's Act (Chapter 5:06).

The Children's Act Chapter 5:06 of the year 2006, is the major law that safeguards the rights of children in Zimbabwe. This law like other social work policies and practices was modelled from the British legislation that safeguards the rights of children in United Kingdom (Powell et al, 2006). The Act mandates the government ministry responsible for social services and child welfare to specifically deal with matters pertaining to children. This legislation is largely curative and remedial in nature and it does not recognise the importance of strengthening families and communities to safeguard children (Powell et al, 2006). It encourages placement of children deemed in need of care in institutional care. This has led to increased number of orphaned and vulnerable children placed in institutional care in contrast to the National Orphan Care Policy of 1999 that emphasises communal childcare.

National Action Plan.

National Action Plan for orphans and vulnerable children is a major multifaceted social protection scheme and framework in Zimbabwe to cater for the needs for orphaned and vulnerable children. It has interventions such as education, health support, cash transfers and case management (Government of Zimbabwe, 2010). The action plan was developed to address the deteriorating situation of orphans. The first phase of this plan was from 2006 and 2010 and it is currently in its second phase (Government of Zimbabwe, 2010). The first phase (2006-2010) had the provision of shelter, psychosocial support and child protection as its key interventions; most of these activities were delivered by NGOs (Government of Zimbabwe, 2010). The outcome evaluation of the first phase by Jimmat a consultancy firm, pointed out that most of interventions under this phase were piecemeal, disjointed and failing to address the multiple needs of orphaned children (Jimmat, 2010). This evaluation recommended successor programs to have mechanisms to systematically meet the multiple needs of children orphaned. In line with this recommendation, the Government of Zimbabwe developed the National Case Management Model to facilitate holistic access to the services for vulnerable children (Jimmat, 2010). The current National Action Plans mentions cash transfers, Basic Education Assistance Module and the National Case Management Model as its key interventions (Government of Zimbabwe, 2010).

Basic Education Assistance Module (BEAM).

BEAM is an educational support social safety to support equitable access to education for orphaned. It falls within National Action Plan policy framework (Government of Zimbabwe, 2010). Due to the acute budget deficit currently facing the nation, the government has not been in the position to support BEAM. Currently it is funded through international aid (Gandure, 2009). Since reduced government funding for BEAM, more than five thousand children have dropped from school, as their caregivers could not afford the fees. The other challenge associated with BEAM is that it only provides school fees without stationery and school uniforms (Gandure, 2009). Because of this, many children who are receiving fees support are not attending school due to lack of stationery and uniforms.

2.8 Models of care and support for orphaned children in Zimbabwe.

The National Orphan Care Policy in Zimbabwe is the overarching policy for the care of orphans. It provides models for the care and support of orphans in Zimbabwe. The Government of Zimbabwe adopted the policy in 1999 to respond to the impact of HIV and AIDS on children (Government of Zimbabwe, 2004). The United Nations Convection on the Rights of the Child and the African Charter on the Welfare of the Child underpin this framework. The National Orphan Care Policy supports the Zimbabwean tradition of communal care for the vulnerable members of the community. It argues that the best place for any child to grow is in the family in their community of origin. It discourages the utility of residential care and recommends it as the last option only to be used in emergency circumstances (Mushunje, 2006). The implementation of this policy has been limited due to resource constraints of enforcing and supporting community based orphan care (Powell et al, 2006).

Extended family and community orphan care.

The frontline system for the care of orphaned children in Zimbabwe is the extended family and community care. In this arrangement, orphaned children continue to stay in their community of origin under the care of their kinship. This kinship-based care was the most utilised model for the care of orphans during the colonial era among the native populations and soon after independence (Mushunje, 2006). Mushunje (2006) further notes that the extended family and kinship support systems were once effervescent and heavily available in caring for orphaned and vulnerable children. The utility of this system has since dropped due limited capacities of the extended family in light of the economic crisis and increase of orphans (Mushunje, 2006). In this light, the African kinship care system can no longer be relied on. It has been observed that in some instances children now live on their own in child headed households with no parental care and support (Mushunje, 2006).

Some communities are still utilising the extended family and community orphan care model in which resources are pooled together for the benefit of the vulnerable members. Subbarao and Coury (2003) notes that many communities in Zimbabwe are still providing communal and traditional childcare with support from NGOs. However,

they note that most of these programmes are sporadic, piecemeal and lacks sustainability and ownership.

Foster care.

Foster care is another model of care for children orphaned as a result of HIV and AIDS and other vulnerable children. This model involves the placement of the child with a caregiver who acts as a guardian and in turn supported by the government through a child care grant (Gandure, 2009). The government is responsible for the recruitment, training, support and supervision of the foster parent and the placement of the child (Mushunje, 2006). Due to financial constraints experiencing the government, foster care model is currently being underutilised. This prevailing state of limited or non-resources being channelled can be explained by the structural social work theory that social problems are caused by unequal access to power and resources which prejudices the vulnerable members of the society and furthers the economic and social interests of the elite (Weinberg, 2008).

Adoption.

Adoption is another model of care and support for orphaned children. It involves permanent placement of children in a family. The placement is in line with the requirements and conditions spelled out in the Children's Act Chapter 5:06. There are no support grants, which are provided to the adopting families. The assumption is that the adopting families are positioned to adequately take care of the adopted children (Powell et al, 2006). According to this legislation, only qualified special workers can facilitate the adoption process. The challenge currently hampering this model of care is the acute shortage of social workers who facilitates the adoption process. This is in the background of a vacancy rate of over thirty-nine percent in the government Department of Child Welfare and Probation Services (Wyatt et al, 2010).

Institutional care.

Institutional care is regarded at policy level as the last model and alternative for the care and support for orphaned children (Government of Zimbabwe, 2010). Despite its

limitations to the psychosocial development of children, the government continues to utilise this model as the first line of care for vulnerable children who are in contact with the child protection system. Powell et al (2006) states that there are over fixity-six orphanages around the country. The government is mandated by law to support these residential care facilities with grants for the up keep of children and the facility. It is however important to note that payment of these grants have been erratic (Powell et al, 2006). There are currently 5000 children under residential care in Zimbabwe and most of the residential care capacities have exceeded their carrying capacity. In light of the fact that there are over one million orphaned children in Zimbabwe, the paltry capacity of children's homes proves that this model lacks sustainability and capacity to contain the orphan crisis in Zimbabwe (Government of Zimbabwe, 2010).

The National Case Management Model in Zimbabwe.

As earlier highlighted, there very limited literature on the National Case Management Model, as this is a relatively new intervention. The only documentation found was an unpublished report produced by World Education (2012). World Education (2012) highlights that this model places the community at the centre stage of the care and protection of children orphaned as a result of HIV and AIDS (World Education, 2012). This is through the utility of community volunteers (CCWs) who reach out to poor and hard to reach families facilitating access to holistic child care services. World Education (2012) argues that this model is premised on the African humanism philosophy of collective communal care and support for vulnerable members of the community. This is in the sense children in need of care and support are identified and supported in their own communities. Further to that the CCWs hails from the same community in which they will be supporting these families. The CCWs also are part of broader village child safeguarding structures called the Village Child Protection Committees. The Village Child Protection Committees are a community based structure consisting of the village head man, local nurse, police, school head master, religious leaders, political leaders and the CCWs (World Education, 2012, Government of Zimbabwe, 2010). The role of the Village Child Protection Committee is to safeguard the rights of children at community level (Government of Zimbabwe, 2010).

The CCWs undergoes five days of child protection and care training that is provided by government and NGO social workers. After this training, the CCWs are expected to assume duty with continued supervision and capacity building from the social workers (World Education, 2012). The key result areas of the CCWs are to identify the children in need of care and support, conduct home visits and holistic assessments, care planning and coordination and facilitating referrals. The CCWs are also expected to provide psychosocial support to the children and their families. In summary the role of the CCWs is to conduct community based social case work with orphaned and other vulnerable children and their families (World Education, 2012).

2.9 Conclusion.

Literature indicates that the HIV and AIDS pandemic has induced an extraordinary rise in orphans and vulnerability of children at a global scale (Gandure, 2009). Zimbabwe has over a million orphans and vulnerable children (Government of Zimbabwe, 2010). Many of these children are living in abject poverty with little or no access to social services. Various interventions are being implemented across the globe to address the plight of these children. Zimbabwe has also followed suit through signing global commitments and developing policies and interventions to tackle challenges experienced by the orphaned and vulnerable children. Regardless of these efforts, national programs and policies, the lack of financial resources is hampering the attainment of the desired goals (Wyatt et al, 2010; Chogugudza, 2009).

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction.

Research methodology is the empirical procedure of solving a problem (Rajasekar et al, 2013). It is the procedure undertaken by researchers to unpack, describe, explain and predict a phenomenon (Creswell, 2009). It can also be viewed as a procedure to which knowledge is acquired. There are three prominent methodology paradigms. These are quantitative, qualitative and mixed methodologies. Quantitative is associated with numerical understanding of data while qualitative is concerned with understanding of respondent's feelings, emotions and perceptions of a subject matter. Mixed research methodology is a mid-way between qualitative and quantitative methodology (Creswell, 2009).

This study utilised the qualitative methodology approach. Qualitative research involves acquiring the experiences, attitudes and perceptions of the research respondents. It is suited to collecting information pertaining to values, opinions, behaviours and social contexts of particular populations (Creswell, 2009). It is imperative to highlight that qualitative research is best positioned in interpreting intangible issues such as attitudes, social norms and people's personal experiences. As it is a challenging task to empirically measure people's feelings, perceptions and subjective judgements. Qualitative research methodology largely involves interpreting the views of the participants and not the views of the researcher. To this end, it is clear that the focus is not necessarily on the meaning brought by the researcher or views in literature (Creswell, 2009). In concurrence, Parton (2002) argues that all perceptions are subjective hence, all research is subjective. Qualitative research is interested in deep understanding of phenomenon and not necessarily its quantity (Henning, 2004). To this end, the researcher utilised qualitative methodology to acquire in-depth descriptions and expressions of subjective feelings, emotions and meanings which respondents attached to the phenomenon under study.

3.2 Research design.

According to Johnson and Christensen (2010), a research design is the structure and frame of a research (Mack, Woodsong, MacQueen, Creg, and Namey, 2005). Creswell (2009) asserts that a research design is a structure, strategy and plan of a research. This study followed a qualitative programme evaluation research design (Creswell, 2009). This research design was deemed relevant to this study in light of its capacity and role in supplying qualitative valid and reliable evidence regarding the operation of social programmes. Rossi et al, (2004) views programme evaluation research design as an understanding of how social interventions are planned, operated and efficacy in meeting their objectives. Patton (2002) argues that qualitative programme evaluation research design evaluates interventions by exploring the views, attitudes and perceptions of service users and service providers on how a social intervention is functioning. This analysis of programme evaluation is complementary to the purposes of this study.

The justification of programme evaluation design includes the following: to determine if a program is achieving its goals, improve programme delivery, accountability to programme funders, the community, or the programme clients, inform policy and contribute to the base of knowledge (Weiss, 1998). Patton (2002) similarly notes that the role of programme evaluation is to establish the extent to which a social intervention is meeting its desired goals, to ascertain the worth of programme, improve programme and generate knowledge. Suvedi and Morford (2003) argues that programme evaluation is cardinal in establishing how a social programme is being implemented. In addition, how it can be improved and to derive lessons for the development of future interventions or influencing the adoption of the same intervention in a different context. Programme evaluation is also pertinent in determining whether the programme is appropriate for the target population, and whether there are any problems with its implementation and support. According to Rossi et al, (2004) it is very challenging to improve the implementation of social interventions without deriving lessons from evaluations. Programme evaluation serve as a dashboard to reflect what has gone well, what has gone bad, what needs to be improved and how it should be improved (Rossi et al ,2004). Suvedi and Morford (2003) asserts that programme evaluation outcomes are important in informing

program leaders and policy makers on the state of program, leading to more effective and improved program.

3.3 Target population.

The target population was 80 caregivers of children orphaned as a result of HIV and AIDS, who were currently on the Epworth District Case Management Register. The other target population was the 15 CCWs implementing the National Case Management Model in Epworth District. Also included in the target population were the 10 social workers (5 working for the Department of Child Welfare and Probation Services and 5 working for a local NGO **B**). The target population for the key informants was one DCWPS senior official and one NGO **A** Coordinator. These two officials were selected, as they are the leadership responsible for the overall strategic management of the National Case Management Model. This places them at a unique position to provide valuable insights in the implementation of the National Case Management Model. These two NGOs **A** and **B** were targeted because they are supporting the government to implement the National Case Management Model. NGO **A** is the funding agency while NGO **B** is a local organisation that also receives funding from NGO **A** support government social workers to implement the National Case Management Model.

3.3 Sampling and selection of participants.

A sample is a representative subset a defined population (Palys, 2008). Convenience and purposive sampling techniques were utilised to select the study respondents. A convenient sample of 5 social workers (3 DCWPS) and 2 from NGO **B)**, 5 CCWs and 3 CCWs who participated in the study, while the key informants were selected through purposive sampling. In convenient sampling, participants were selected based on their availability to participate in the study (Creswell, 2009). Through a purposive sampling approach participants were chosen on the strength that they were going to provide the required information (Creswell, 2009). To this end purposive sampling ensured that the researcher could hand pick key informants who had the required knowledge and would thus yield the required information. Creswell (2005) argues that through the purposive sampling method the researcher selects respondents because they can purposefully inform an understanding of the research problem or issue under study.

Boxil, et al (2007) describes purposive sampling as a conscious procedure of selecting respondents who are best position to provide the desired information.

Sample 1: Caregivers.

This sample comprised of caregivers of children that are being reached or assisted through the National Case Management Model. Convenience sampling was utilised to select 10 out of the 80 caregivers in Epworth District. The selection criterion was caregivers who are taking care of children orphaned as result of HIV and AIDS and who were on the National Case Management Model register in Epworth District. The researcher also acquired consent from the caregivers before undertaking the study. The participants were advised that those who decline to consent will be relieved from the study and they will not be affected from continuing to access the case management services. It was also explained to them that there were no monetary or material benefits attached to the participation.

Sample 2: Child case workers.

The researcher utilised convenience sampling method to select the 5 CCWs from Epworth District, who are part of the 15 CCWs implementing the National Case Management Model. This method of sampling was selected because it enabled the researcher to identify and select the respondents who were easily accessible and could travel to the venue of the interview with no costs to them or the researcher. For example the service users who stayed a walkable distance to the venue of the meeting. As Neuman (2000) notes that, the advantage of convenience sampling is that it allows the researcher to identify respondents who are easily accessible and available for the research. The researcher contacted the CCWs through the telephone to book for an appointment. It was explained to them that their participation is voluntary and does not affect their work. It was also explained that declining to participate would not impede their position, and they will be given the opportunity to sign a consent form if they wanted to participate in the study or withdraw. The researcher also explained to them that there were no materials or monetary benefits attached to participating in the study. There were no challenges experienced in selecting the CCWs. All the selected CCWs confirmed their willingness to participate in the research.

Sample 3: Government and NGO social workers.

This sample comprised of social workers involved in the implementation of the National Case Management Model. 5 social workers (3 from Department of Child Welfare and Probation Services and 2 social workers from NGO B) were conveniently selected. Convenience sampling was also utilised as the researcher sought the respondents who were easily available and accessible for the interview. It is important to reiterate that in line with the research protocol of this study, the actual names of the organizations will not be disclosed.

Sample 4: Key informants

This sample consisted of key informants; a senior official in the Department of Child Welfare and Probation Services and a Coordinator for NGO **A**. These key informants are some of the key personnel responsible for spearheading the implementation of the National Case Management Model.

3.4 Profiles of research participants

1. **CCWs.**

The study had five CCWs participants with almost similar demographic circumstances. All the participants were females. This reflects the high representation of women in care work. With regard to their level of education, two CCWs had reached ordinary level secondary education. The other three CCWs had only reached primary school education. In terms of age, three CCWs were between the age of 40-45 and only one CCW belonged to the 35-40 age group. This may indicate that care work is popular among older women.

2. **Government and NGO social workers.**

All the three government social workers and two NGO social worker respondents had a Bachelor of Social Work Honours Degree. This may be because by the fact that it is

illegal in Zimbabwe for one to practice as a social worker without social work training. The NGO social workers had more experience than government social workers. All the NGO social workers had experience of over two years of social work practice. Among the government social workers only one had over two years of experience while the other were new recruits. This may be due to the fact that NGOs may return staff that the government due to better remuneration and working environment. As most government social workers after gaining experience and practical training they move to the NGO sector.

3. **Key informants.**

The two key informants had a Bachelor in Social Work degree. However, the government key informant had a Masters in Social Work. All the key informants over five years of social work experience, including at management level.

3.5 Data collection methods.

Focus group discussions.

Data collection was conducted in the month of December in 2014. A focus group discussion (FGD) utilising a FGD guide was used to collect data from 10 caregivers whose children under their care were reached with the National Case Management Model (see appendix 10). The FGD with caregivers was conducted in the vernacular language of Shona. The tape recorded information and written transcripts were later translated into English. This data collection method was utilised because it allows data to be collected at the same time from various people. This meant that the researcher could collect from this target group within one day. Furthermore , the other advantage of FGD is that they allow stimulation of ideas among the respondents (Mark et al, 2005). This data collection methods has also its challenges. The major challenge identified by is that there could be some members in the group who may not be comfortable discussing personal matters among many people (Nauman,2000). Furthermore, it limits data that can be acquired at individual level and further probing may be challenging due to the need for avoiding exposing personal information (Boyce and Neale ,2006). Equally important there could be other members in the group who

dominates the discussion then limiting the representativeness of the data (Mark et al, 2005). This method FGDs with the caregivers were conducted at Epworth Local Board community hall.

Semi-structured in-depth interviews.

Semi structured in-depth interviews were utilised to collect data from the five social workers, five CCWs and two key informants using an interview schedules (see appendix 5, 3, 9). The interview schedules questions were aligned closely aligned to the objectives of the study. Neuman (2000) asserts that the advantage of face to face interviews is high response rate and advantageous length of the interview. Interviews are also flexible, and the interviewer can control the sequence of questions as well as introduce probing questions (Boyce and Neale ,2006). Furthermore, interviews enables one to observe non-verbal cues (Mark et al, 2005). This method however has also its disadvantages such as it has high costs such as of travelling and setting up the meeting (Boyce and Neale ,2006). Mark et al (2005) highlights that the other major disadvantage of interviews is that they have so much flexibility leading to inconsistences and the interviewer to be asking different questions to the same target group. Moreover, as Neuman (2000) points out interviews take a lot of time to organise , prepare and arrange.

The semi-structured interviews for the CCWs were conducted in the vernacular language of Shona while those for the social workers and key informants were conducted in English. The interviews with CCWs were held at Epworth Community Hall. Social workers and key informants were interviewed at their offices.

3.6 Data analysis.

The researcher utilised thematic analysis approach to interpret, analyse and present data from this study. It should be borne in mind that that the terminology “thematic analysis”, “content analysis” and “qualitative content analysis” have been used interchangeably in research literature implying that they are the same thing (Guest et al ,2012). Contemporary literature research argues that these terms although similar

in most aspects have different meanings and applications and should be treated as such (Guest et al, 2012).

Thematic analysis is a rich description and analysis of data through systematic and structured data coding and identification of themes (Kondracki and Wellman, 2002). The major strength of thematic analysis is that it can pattern qualitative data and identify its implicit and explicit meaning (Guest et al, 2012). The major weakness of thematic content analysis is that it often leads to paraphrasing and generalisation of the research findings and its application often lacks rich theoretical grounding (Braun and Clarke, 2006).

This study utilised thematic analysis procedure proposed by Kondracki and Wellman (2002). This approach is relevant and mostly utilised in researches to extract meaning and analysis people's experiences. To that end, thematic analysis was utilised in this study to understand to analyse the experiences of the CCWs, social workers, caregivers and key informants in the implementation of the model in Zimbabwe.

After data collection, convectional data analysis was initiated by repeatedly going through the raw data. This is called the data familiarization stage. This was meant for the researcher to gain sense and direction of the data. Kondracki and Wellman (2002:8) maintain that this initial process assists the researcher to have a picture of where the data "is coming from and going". Tesch (1990) argues that at this stage one needs to do as if he or she is reading a novel.

The next stage of the process was then coding of the raw data. Coding is the process capturing of a prominent specific idea and encoding it. In this process, the researcher was watchful of the need to extract the deeper meaning of the data and give a true understanding of the data. Coding did set pace for future analysis ensuring that all key and relevant data was extracted and it's latent and explicit meaning was extracted. This process also involved compressing voluminous raw data into useful smaller representative categories.

After coding, the researcher used the codes to build up the themes. A theme is a prominent and common pattern of the data. Themes were constructed from the

recurring patterns of codes. Although the theme is regarded as uniform, it often had different angles and dimensions of the same subject matter (Tesch, 1990). Braun and Clarke (2006:82) explains a theme as 'a theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set' . The last stage was the review of themes. This process involved analysis of data in themes in comparison to the study theoretical framework and the prevailing literature. This review enabled the extraction of emerging themes and sub-themes, which systematically synchronised, analysed and packaged (Patton, 2002). This approach enabled the researcher to have an interpretation of the detailed descriptions of the National Case Management Model**.**

3.7 Validity, credibility and trustworthiness of data.

The credibility of the study was enhanced by triangulation. The purpose of triangulation is that data produced through applying different methods can be compared in order to confirm or refute other results (Flick, 2007). Vos (2005), describes triangulation in qualitative research the utilisation of multiple perspectives, data sources and views. Trianguation of methods assist in the collection of quality dependable data.

The focus groups enabled the researcher to view the phenomenon under investigation from various angles, and allowed for different interpretations and perspectives. The multiple perspectives emphasised the variety of sources, and gave greater confidence in ensuring the dependability of the study. Tape recording of the interviews and focus groups helped to ensure the validity of the study, through replaying of the recorder and continuous cross examination of the data. As a result, potential gaps were addressed and it ensured validity of the material.

The researcher gave a social work educator at a local university the processed data to carry out a peer review and cross examination, to ensure that there were no errors that the researcher would have overlooked. Errors that were identified by the reviewer were investigated and rectified. The researcher also ensured that he presented original statements and views of the study respondents in the course of data presentation and analysis. This enhanced the reliability and trustworthiness of the

data, since the original views were captured, limiting the author's own adjustments and loss of key information.

The researcher is a qualified social worker and was involved in the implementation of the model under evaluation in this research. In this regard the researcher had a professional relationship and prolonged engagement with the caregivers, and this limited the caregivers from providing flawed information as they were aware that the researcher was well versed with their circumstances.

3.8 Ethical considerations.

To ensure academic integrity of this study, the researcher followed a plethora of measures and ethical procedures. The research received ethical approval from the University of Kwazulu-Natal, Human Social Science Ethics Committee (see appendix 11 for the ethical clearance). The ethical considerations the researcher upheld were informed consent, confidentiality, anonymity, voluntary participation and protection from harm.

Informed consent.

This process involved informing the interviewee of the name of the interviewer and the institution to which he was attached. The degree programme was briefly discussed, as were its values and principles. After introductions, the interviewer explained the purpose of the interview. It was made very clear to the interviewee that the interview process was not an assessment on how effective the respondent was in meeting their key result areas, but that the study was for academic purposes. The interviewees were given the chance to express whether they understood the purpose of the interview or not. As was explained in the preceding sections, consent was obtained for various aspects, with the major one being consent to carry out the interview. Equally important, all the participants signed the consent form in agreement to take part in the study (see appendix 1-7 and 12). As Wiles (2007) notes that serves a contract between the researcher and the respondent that the researcher has received go ahead from the respondent to proceed with the data collection process.

Confidentiality and anonymity.

The researcher ensured that the information obtained from participants was not disclosed to a third person without the approval of the participants themselves. Research data was kept in the strictest confidence. The principle of anonymity was observed in the study by not capturing any information which could reveal the identity of the participants. Boote and Chambers (2015) emphasises the need for ensuring that there is nowhere in the research where the names and identity of the respondents were disclosed. So the study ensured that during data collection and compilation of data not identify of the respondents is disclosed or discussed. As Wiles (2007) argues that at every point of the research, respondents should be aware that thy can with draw at any moment convenient to them. The respondents were also informed that their names and identity would not be disclosed. As such chapter, 5 and 6 (data presentation and analysis chapters) anonymous codes are used to mention the contributions of the respondents.

Voluntary participation.

Boote and Chambers (2015) highlights that all forms of research should have voluntary participation of respondents. Coercion is tantamount to unethical research practice. To that end, participation was without coercion, and participants were free to withdraw from the interview at any point during the research process without facing negative consequences. Further to that the despondence were given the opportunity to with draw from the study at any moment convenient to them. They were assured also that withdrawing from the research would not affect their relationship with the National Case Management Model.

Protection from harm.

The interviews were conducted in convenient places, and the researcher ensured that all the venues had adequate ventilation and no distractions. As notes that it is an ethical imperative to ensure that, the environment to where the data collection transpires is conducive and does not pose as a danger. Further to that, it was ensured that the questions that were asked would not lead to any psychosocial harm to the respondents. Especially for the respondents who are coming from disadvantaged circumstances.

3.9 Limitations of the study

The study did not target children for ethical purposes. However, this served as a limitation as the voices of children who are the major target of the research are not captured. It is important to highlight that while the caregivers may know a lot of information about the children under their care, they cannot be in a position to fully represent the views of the affected children themselves.

The study was only qualitative and this poses as a limitation since other crucial elements of the National Case Management Model such as outputs or not anything with numerical significance was given much attention by this research. For example, the study did not measure issues such as the period that each child take to get a service and measurement the psychosocial well-being of the children who were under the National Case Management Model. These numerical indicators could also have helped the study to have both a quantitative and qualitative picture.

The research was only conducted in Epworth District, despite that the National Case Management Model is a national initiative. A national wide or a larger study was not managed due to resource limitations. This is a major limitation since this sample is small to provide a national picture.

3.10 Conclusion.

This chapter outlined the philosophy and the research approach that was used in this study. This study utilized the qualitative methodology to evaluate the implementation of the National Case Management Model for children orphaned as a result of HIV and AIDS in Zimbabwe. This methodology was utilised so that the research could capture the experiences, attitudes and perceptions of the study respondents pertaining to the implementation of this programme. Qualitative program evaluation research design was used, as the research sought to evaluate the implementation of the National Case Management Model. Therefore, the explorative design was used, since it ensured that data gathering was intense and comprehensive. The main reason for adopting the in-depth interview approach was that it allows the process of data gathering to

accumulate the required data. Furthermore, the interview guide was very flexible in collecting the data, and the audio recording of interviews ensured that no data was missed. To ensure that high standards of data remained unequivocal, the researcher followed various validity benchmarks. Ethical considerations such as informed consent, voluntary participation and anonymity were also attended to.

CHAPTER FOUR

UNDERSTANDING THE NATIONAL CASE MANAGEMENT MODEL STRUCTURE AND PROCESS.

4.1 Introduction

The design, structure and process of a social intervention exhibit a special role in its effectiveness and attainment of desired outputs and outcomes (Roelen et al, 2011). In view of the importance of structure and process in programme effectiveness and efficiency, this chapter discusses and analyses these elements of the National Case Management Model. The outcomes of this chapter will assist in generating a body of knowledge that will aid in refining and scaling up the model. Further to this, it is hoped that it will aid the programming of interventions that target children orphaned as a result of HIV and AIDS and (other vulnerable children). In this regard, Thurman et al, (2009) note that there is currently limited knowledge in Africa pertaining to the functioning of programmes that target orphans and vulnerable children. In this respect, this and ensuing chapters addressed this shortage of information.

This chapter is focused on the presentation, interpretation and analysis of data obtained primarily from in-depth interviews held with 5 CCWs, 5 social workers (3 DCWPS and 2 NGO), and from 2 key informants (NGO **A** Coordinator and DCWPS senior official). The major themes identified and explored in this chapter are:

- Exploration of the National Case Management Model structure.
- Analysis of roles and responsibilities in the National Case Management Model structure.
- Outline and analysis of the National Case Management Model process.

4.2 Theme 1: Exploration the National Case Management Model structure.

There was consensus among study respondents that the principal feature of the National Case Management Model structure is the CCWs (community volunteers) who are responsible for identifying and linking children to various resource systems at community level, or doing para–social work at grass roots level. The anchoring of the National Case Management Model on community based CCWs was largely viewed

by the study respondents as an act of innovation to mainstream active community participation in child welfare. This could be identified in the view of the *Government social worker 2* who remarked that:

> "*children in need are primarily identified and assisted in their communities at the village level by the CCWs*".

NGO social worker 2 held the similar views pertaining to community participation that:

> "*the community at large can identify itself with the model because its members are playing a key role*".

In concurrence with these above views, World Education (2012) maintains that the National Case Management Model is community driven and centred, in the sense that the model is spearheaded by local community volunteers. World Education (2012) further argues that the utility of CCWs is a great innovation in facilitating active community ownership and participation in the care and protection of children at community level. Thurman et al (2005) in support of the need to facilitate active community participation in social interventions argued that many programmes for orphans in Southern Africa have failed to generate community ownership and participation, leading to apathy and lack of sustainability. To address this, he recommended that the community should be actively involved as a key stakeholder in programmes. Community participation is generically defined as the active involvement of the community in the process of identifying needs, exploring solutions, making decisions and plans that seek to bring sustainable development in the community (Thurman et al, 2009).

Government social worker underlined the view that the linchpin of the model is the CCWs, whilst others have a supporting role:

> **"***at the top of the hierarchy of the model are the Directors ensued by social workers, then the LCCWs who supervise the CCWs, followed by CCWs at the bottom who does most of the work, these are the "foot soldiers" who drive the model. The strategy is of utilising these community cadres/CCWs in addressing community problems. They are for the community, in the community and by the community".*

The above quote reflected on the fact that structure of the model includes also directors, social workers and the LCCW. However, it also makes clear from her sentiments that the model revolves around the CCWs while other players involved play a supporting function.

NGO Key informant in support of the above assertions stated that:

> "*the pivot of the model is the CCWs who are the key drivers. The structure of the programme is that almost every dimension of the programme revolves around the CCWS because they are the ones who identify the child, linking them with services and ensuring that they get that service."*

Government social worker 2 added that:

> "*CCWs are a part of the village Child Protection Committees (CPCs) structure and discuss cases that can be addressed or dealt with at the community level with the village CPC. If the household and child need services not offered in the community, the CCW refers the case to other service providers".*

This structure of the National Case Management Model resembles that of *Isibindi* case management model in South Africa. The striking similarity between the Zimbabwean and South African perspectives is the community based volunteer case worker, who anchors the model through enabling assistance to vulnerable children at community level (Thurman et al, 2009). This design means that care and support for orphaned and vulnerable children and their families is mainly provided through community based cadres (Thurman et al, 2009).

The study observed that at community level there is also a cadre called LCCWs.

> *Government social worker 3* contended that *"in this model there is also a LCCW who is responsible for supervising and supporting other CCWs. A LCCW does not receive a different training from the CCWs but he/she is a CCW selected among other CCWs to play a leadership and supervising function*".

It was observed that the LCCW reports directly to the social workers. Additionally, the government and NGO social workers meet monthly with CCWs for support and supervision, to discuss cases, and to assess how the programme is progressing. The meetings provide feedback on referrals made to the social workers, as well as those

made to other service providers outside the district. An analysis of the functions of the LCCW is in the impending chapter.

4.3 Theme 2: Analysis of roles and responsibilities in the National Case Management Model structure.

Research participants identified three main players in the case management setup, which are child case workers (CCW), lead child case worker (LCCW), and social workers (Department of Child Welfare and Probation Services and Non-Governmental Organisations). This section described and analysed roles of these respective cadres.

Child case worker (CCW):

There was consensus amongst CCWs and social workers (government and non-governmental) that the major responsibility of the CCWs is to identify and arrange support for children orphaned as a result of HIV and AIDS and other vulnerable children at community level, through community surveillances. These include children in child-headed households, children who are out of school, abused children, children on Anti-Retroviral Therapy, disabled children, and children affected by violence, abuse or exploitation.

In many countries, these responsibilities of CCWs are undertaken by qualified social workers (Moxely, 1997). This due to the fact that providing specialised support to vulnerable children calls for the application of skills, knowledge, professional expertise and understanding of child development, which is typically the domain of social workers.

Identifying orphans and vulnerable children, conducting assessments and facilitating referrals is another critical role that is being played by the CCWs at community level. As CCW 2 maintained: "*my job is to go around looking for orphans and vulnerable children and conducting assessments and facilitating their access to services".* Jimmat a consultancy firm, who evaluated programmes implemented before the National Case Management Model, maintain that most of the programmes were not reaching the needy (Jimmat, 2010). It is important to acknowledge that orphaned and

vulnerable children are often hard to reach and that they have multiple needs that call for a holistic assessment and effective linkage system to the service providers (Thurman et al, 2009). In that respect, CCWs carry out community surveillance and outreaches to reach out to the children, and conduct assessments to identify all the multiple needs of the child and link them to available service provision.

NGO social worker 2 outlined that after consultation with the family, the CCWs open a case file for each child and refer the child to the appropriate service provider. Subsequently, they continually follow up on the child to ensure the child has received the service until the case is closed. They also provide psychosocial support and counselling to the families and their distressed families.

As *NGO, social worker 1* explained:

> "*each CCW works with a number of households at any given time. The CCWs conducts home visits and manages the child's case file, monitoring them and acting as their advocates on issues with which they need assistance until the case is closed, they also provide counselling and psychosocial support"*

In addition to the above roles, CCW 4 informed the study that she is responsible for:

> *"conducting assessments, case planning, referrals, case conferences and training and capacity building of the community Child Protection Committees on child protection".*

As earlier mentioned, the above roles assigned to CCWs are normally the domain of trained and qualified social workers, who apply social work ethics, principles, skills, and draw on an expansive knowledge base to conduct technical activities such as assessments, case planning, and facilitating conferences. As Moxely (1997) highlights that case management is a technical intervention that calls for the application of many social work skills. As he notes that the fundamental social work skills in case management are planning, organizing and managing the services system, directing and controlling, negotiation, brokerage, contracting with other service providers, reporting, and evaluating the service system's effectiveness (Moxely ,1997). Therefore, CCWs should have these skills to execute their assigned roles and responsibilities or function.

The assigning of huge roles and responsibilities to CCWs emanates from the fact that there are not enough social workers to carry out this function. For instance, the Institutional Capacity Assessment of the Department of Child Welfare and Probation conducted by Wyatt and team in 2010 identified that the country had very high proportion of social workers to vulnerable children (Wyatt et al, 2010). Furthermore, assigning of such significant roles to the CCWs is a reflection of the failure of government to employ enough social workers to carry out these functions. While one may argue that CCWs strengthens community based care for orphans, this structure should not be a replacement for professional social work services.

Lead child care worker (LCCW):

LCCs are also CCWs however, with an extra responsibility of supporting and supervising the CCWs in their wards. This study identified that there was no clear procedure or selection process for the LCCW, and the selection was largely based on the discretion of the social worker.

> *NGO social worker 2 explained: "The LCCWs are responsible for supervising other child case workers and collecting and collating the summary sheet of cases that each CCW handles, they are selected by social workers".*

> *Government social worker 1* had this to say, *"The summary sheet details the number and nature of cases that each case worker would have handled as well as the referrals made. The LCCW presents the summary sheet of cases at monthly ward area CPC meetings, where complicated cases are discussed, and then sends a copy of the report to the government and NGO social workers".*

The presence of the LCCWs in the case management structure can be understood an innovation in the National Case Management Model, in the sense that the CCWs have someone readily available to supervise and support them at community level, and this augments the shared responsibility of the social workers. The possible disadvantage and threat of having the LCCWs in the structure is that an additional role may create

unnecessary bureaucracy. Their presence also raises the risk that their support to the other CCWs may be unprofessional and misguided, since the LCCWs do not receive any further specialised training in leadership or clinical supervision.

Government social workers (Department of Child Welfare and Probation Services):

The government social workers' role in the model is to coordinate and manage the entire case management process in the district. They are also responsible for coordinating the logistics of the referral process, as well as responding to referrals for assistance rendered by government DCWPS and those offered by other service providers. The government social workers explained their roles as follows:

> "*The government social workers meet with all CCWs and their LCCWs once a month to discuss cases and how to solve challenges that the CCWs face"* (*Government social worker1).*

> *"We provide training to CCWs on case management and sensitize and oversee the proper coordination and operations of ward and village area CPCs". (Government social worker 2)*

Non-Governmental Organisation social workers

The role of NGO social workers is to assist the Department of Child Welfare and Probation Services social workers in implementing the case management program in the district, as well as addressing the capacity and resource gaps in the government system through the identification and provision of material, logistical and training support. The NGO social workers are in constant communication with government social workers and other NGOs operating in the area. They exhibit a special function in the training, mentoring, capacity building and monitoring of CCWs. As *NGO social worker 2* explained:

> "*Our main role in the case management model is to support and provide technical backstopping to the government Department of Child Welfare and Probation Services staff and the child case workers".*

4.4 Theme 3: Outline and analysis of the National Case Management Process.

The study noted that the National Case Management Model is characterised by various stages, each seeking to facilitate the child's access to a continuum of care services until the case reaches its logical conclusion. Below is the discussion of the various stages in the National Case Management Model process.

1. **Identification of Orphaned Children**

CCWs rely on surveillance, home visits and consultations with community members, local community organizations and other CPC members to identify orphaned and vulnerable children in need of assistance. As *CCW 3* mentioned,

> *"The identification of the children orphaned as a result of HIV and AIDS is the first step in the case management process and it is a routine exercise. This step begins when someone alerts a CCW, DCWPS or NGOs about a potential child protection case. This information can come from anyone but it is the responsibility of the person who receives the information (CCW) to take action*".

The identification of orphans and vulnerable children is a very important stage in the case management process. As pointed out earlier, orphaned and vulnerable children are often hard to reach clients and extra efforts are needed to identify them (Jimmat, 2010).

The importance of the identification of orphaned and vulnerable children was emphasised by *CCW 4* who noted**,**

"Whenever CCWs discover a child of school going age who is not in school this is a concern and we try to take measures. We are always on the lookout for these kind of children and through our surveillances we have identified many".

1. **Assessment Process**

CCWs and social workers revealed that assessment collects more information about the needs of the child across eight domains – family, survival, general health, development, social history, behaviour, education and aspirations. Further to that, it gathers information pertaining the capacity of the caregivers. This information largely comes from various sources such as relatives, stakeholders, neighbours, teachers and community leaders. As *Government, social worker 2* mentioned:

> *"the assessment looks at how well the child's family (parents and extended family or other recognized primary caregiver) can look after him or her. The assessment should gather information from as many people as possible including the child and family but also neighbours, community leaders and other agencies such as education, health etc."*

The assessment stage is important in the sense that it assists in holistically identifying the needs of the child. This assists in facilitating the process of meeting the needs of children in a holistic manner. As Moxley (1997) maintains that clients with multiple needs face challenges in locating various resource systems that they need and that case management has a special role of identifying these needs and coordinating access to appropriate service. Furthermore, Jimmat (2010) found in their evaluation of Zimbabwe's programmes and interventions before the case management model, that services were disjointed and only addressed a part of the children's needs, not their needs as a whole.

2. Opening of case files and categorisation

At this stage, the CCW conducts a home visit to interview the child, caregivers and neighbours, to understand the situation of the child. They then open a case file.
NGO social worker 2 highlighted:

> *"The CCW will then conduct a needs assessment and open a case file for each child that has critical unmet needs."*

Government social worker 3 added:

“after the opening of the file the case is categorised, it is a key activity in the case management process of determining the response required. All cases that are identified as having potential protection concerns are referred to us by the CCWs. Once the case is received we respond accordingly.”

3. Referral and Service Provision

Once a case file has been opened, the CCW draws up a case plan and use the locally developed referral mechanism and tool to facilitate a referral for the child and family to the appropriate service provider.

Government social worker 2 noted that the referral protocol tool provides guidance on available service providers in the district and contains 'benchmarks' to assist the case worker to identify when an adequate service has been provided to meet the child's need. He also pointed out that depending on the gravity and severity of the case, the case is either addressed at community level or referred to other service providers. He also noted that CCWs can also identify members in the community who can assist the child, including church members, community leaders and business people.

4. Case Review

The review is a process of evaluating the progress that has been made in facilitating access to services for the child and the overall management of the case.

As the *NGO, social worker 1* maintained, “*case review provides an opportunity to reflect on how the implementation of the plan is progressing, to consider (together with the assessment) whether the plan remains relevant; and if not, and make necessary adjustments to the plan which should be documented in the Care Plan*”

5. Case Closure

This is the last stage concerned with the closure of the case and is reached when the case has reached a logical conclusion. Below are the detailed explanations of the *NGO social worker* pertaining to considerations for case closure.

"A case can be closed at the point at which work with the child ends because the:

- *situation is resolved, i.e. the case plan has been completed, the child's protection needs have been met and the child no longer requires support,*
- *case has been transferred to another organization,*
- *child moves out of the area and cannot be located despite significant efforts,*
- *child becomes 18 years old (unless there are good reasons to remain involved, such as additional vulnerabilities),*
- *Child dies".*

The description of the case management process described above presents a comprehensive system with potential to facilitate holistic and continuous care services for children. It tallies with the description of an effective case management process described in literature review, such as case identification, planning, implementation, referrals, review and evaluation (Hutt et al, 2004).

4.5 Conclusion

The structure and process of an intervention exhibits a pivotal role in its functioning and effectiveness. This chapter examined the process and structure of the National Case Management Model. It noted that this model is a community-based child care programme largely anchored on CCWs, mandated to identify and assist vulnerable children in their communities to access care services. The major strength and innovation evident from this structure is the aspect of community engagement and participation, which Thurman et al (2009) views as the missing link and aspect in many social interventions. The study noted that the major potential threat associated with this is that the CCWs are predominantly social work roles. This is a drawback, since CCWs are not formally trained in social work and their lack of knowledge and experience may compromise outcomes for children, particularly if they are not adequately trained and supervised. The model however had had an elaborate and comprehensive case management process.

CHAPTER FIVE

STRUCTURAL AND INSITITUTIONAL CHALLENGES TO THE IMPLEMENTATION OF THE NATIONAL CASE MANAGEMENT MODEL.

5.1 Introduction

This chapter is a continuation of Chapter four but includes the perspectives of the service users who in the context of this research are the caregivers of the children who are being assisted through the National Case Management Model. This chapter largely seeks to identify the institutional and structural challenges to the implementation of the National Case Management Model by analysing the experiences of the respondents (caregivers, social workers, CCWs, social workers and key informants). The major themes identified and explored in this chapter are:

- Experiences and limitations in the implementation of the National Case Management Model.
- Social workers' perceptions of the implementation of National Case Management Model.
- Social workers' perceptions on CCWs training and capacity.
- Child Care Workers motivation.

5.2 Theme 1: Experiences and limitations in the implementation of the National Case Management Model.

The section specifically focuses on the experiences of service users in accessing three major expected outcomes of the National Case Management Model .Education, psychosocial and birth registration were the services selected. As indicated by the National Action Plan for Orphans and Vulnerable Children that the National Case Management Model should facilitate access to these services (Government of Zimbabwe, 2010).

1. **Educational assistance**

Gandure (2009) observed that many orphaned and vulnerable children were not accessing education in Zimbabwe due to the thin reach of the education social safety net in Zimbabwe. She also noted that many children drop out of school, especially the girl child at secondary level, as their guardians fail to pay higher school and examination fees. This was confirmed by three caregivers in the FGD who stated that children under their care dropped out of school for various reasons, chief among them being failure to pay school fees due to affordability issues and failure to secure educational needs such as stationery and uniforms, and the payment of examination fees. Although all the children were eligible for the Basic Education Assistance Module (an education element of Zimbabwe's social safety net, which pays school fees for children orphaned because of HIV and AIDS and other vulnerable children in accordance with set selection criteria), none had benefited from this assistance, because of the funding constraints experienced by this facility.

One caregiver explained, *"I have many children under my care; unfortunately, I can't send them all to school, the government should at least provide education for the orphaned children, the CCW has been pointing that BEAM is currently not functional and in our area there are no NGOs which provides education support where we can be referred for help".*

Another Caregiver in the FGD weighed in that, *"I was informed that my daughter has been accepted for BEAM but up to date she has not been enrolled in school, we were then referred to another NGO for support but we were told that they will contact us but they have never done".*

Another caregiver had however a different experience from those of the above respondents. The child under her care managed to secure education support however, as the situations above she did not attend school because the child had no stationery or uniforms. She narrated that:

> "*Although I was assisted by the CCW through the case management model for the child under my care to enrol into the BEAM programme, my child has still not been going to school because BEAM did not provide uniforms and text*

books and she had no uniform, she was embarrassed to go to school without uniforms and shoes. She was uncomfortable going to school; it was a traumatic experience for her as she felt different and isolated"

This respondent's comment demonstrates that provision of school fees is not always enough, as children also need stationery and uniforms, especially since schools sometimes send back home children who are not wearing a uniform. The CCWs and caregivers admitted that the BEAM social safety net was struggling, as it could not help many children to access education. Despite this being, a major need of among most of the children orphaned. The government social workers also pointed out that BEAM is operating far below capacity and cannot accommodate many children. NGO key informant echoed,

"The government is vividly failing to meet the educational assistance demand that caters for all the children orphaned as a result of HIV and AIDS, this can only be averted if more funding is channelled into BEAM".

The Government key informant is support of the above sentiments noted:

"*Without resource systems as we are experiencing, the case management has only raised demand for child care services, as more and more children are being identified and assessed."*

This apparent lack of resources is limiting the case management model in enabling orphaned children to access education. Structural social work theory would assert that this is because politicians and political systems in Zimbabwe and other developing countries do not priorities the welfare of vulnerable persons (Mullaly, 2007). It is vividly apparent from the narrations above that there have been concerted efforts by CCWs to identify orphaned children and assist them to access education, but BEAM is too thin to reach many children. *CCW 2* highlighted:

"*children orphaned as a result of HIV and AIDS are failing to access education despite our efforts of linking them with this service, BEAM is not working and the best we are doing is only documenting the children who are failing to access*

education so that in the event that the social safety net resumes we will refer those children, the current state of affairs is that there are no funds to support the children to go to school, further to that most of the NGOs that used to provide education support have no funds.

All the caregivers in the FGD except one confirmed that although they were initially assured that their children would get education support, this was not attained. The CCWs suggested that the case management model has been successful in identifying children who are not accessing education in the community and most now have case files. As *NGO, key informant* noted:

"*we have been very ambitious in our rolling out of the programme nationally, however the circumstances on the ground are pointing that the government has no capacity for a programme of this magnitude that covers all the children orphaned as a result of HIV and AIDS so the problem will continue".*

In light of the acute shortage of resources in most African countries, many African scholars have proposed the adoption of developmental social work approach to deal with these structural challenges. Developmental social work emphasises supporting clients to develop coping mechanisms (Midgley and Conley, 2010)

2. Psycho-social support

Improved psychosocial well-being of children orphaned as a result of HIV and AIDS is another major anticipated outcomes of the National Case Management model (World Education, 2012). It is expected that CCWs provide this psycho-social support when they conduct home visits. According to Government of Zimbabwe (2004) many orphaned children experience psychosocial distress due to loss and grief and other social problems they experience. *Government social worker 3* explained that:

"Home visits by the CCWs are a psychosocial function and through home visits the CCWs should spend time, interact and emotionally support the children orphaned as a result of HIV and AIDS and their distressed families to cope psychologically with their problems."

The researcher investigated if this service was being provided through the routine home visits. Most caregivers confirmed meeting or being visited by CCWs at least once a fortnight. Most of the caregivers noted that the home visits by the CCWs were very useful to them and it was supporting their psychosocial well-being, most emphasized that home visits should continue and they are an essential part of the programme. *CCW 4* informed explained their psychosocial activity as follows:

> *"I often visit the children and their families even though with nothing material to take to them, these visits are very important, families and children value them, they see that they are appreciated and loved and they get someone to talk to them and give them hope".*

However, another caregiver in the FGD had a different perspective on the CCWs home visits: She pointed out the CCWs spent most of their time writing her note. Hence, there was little or no psychosocial support provided during this visit as she concentrated on filling the forms rather than on psychosocial interaction. This gap was also identified by *Government social worker 2* who mentioned:

> "*the CCWs conduct their routine home visits but some have limited knowledge on how to utilize the home visit as a psychosocial support function".*

The study noted that home visits serve as an important platform not only for data capturing but also for providing psychosocial support. Thurman et al (2009) evaluation of the *Isibindi* case management model in South Africa observed that the case workers were instrumental and helpful in the provision of psycho-social support and many children had positive psycho social outcomes. While there were concerns that some CCWs were not utilizing this platform to offer psychosocial support there was consensus among the FGD respondents that the home visits were for the most part essential and effective in the provision of psychosocial support. This can be identified from another caregivers view that:

> "*The CCW has helped me very much to improve the relationship that I have with the child I'm taking care of, she visited and left me and the child under my*

care with a good relationship, we always had quarrels and I was now contemplating to send her and stay with other family members, she has been very supportive and empathetic to our situation. The CCW is very friendly, you can talk her easily and she can help you very much more that even your relatives.

3. Birth Registration

Birth registration assistance is also a major expected outcome of the model (World Education, 2012). Seven of the ten caregivers mentioned that their children have no birth certificates. They bemoaned the fact that because of this, these children were unable to take part in either extra curriculum activities such as sports or to take exams since birth certificates are needed for these activities. Below are the sentiments and experiences with regard to birth registration support.

NGO social worker 2 pointed out that:

> *"the biggest barrier to the realization of birth registration is limited financial resources on the part of the caregivers to afford bus fares to acquire birth certificates. Often the registrar general's office required certain individuals to congregate and present themselves simultaneously at the registry office to facilitate the processing of a birth certificate for a child. On many occasions the requested family members would be staying far apart from each other, with implications on both travelling costs and time*".

A caregiver in the FGD stated that her grandchild failed to take part in sports in Harare because she had no birth certificate. She lamented that:

> *"the issue of birth registration is a big problem up to now it's not yet out, the CCWs promised that they will help her get one unfortunately its now about six months since we have engaged the CCW."*

Another caregiver shared the same frustration by airing that:

"*we were given the order to travel to the registration centre which is very far way from here, unfortunately we could not make it because we do not have the transport money".*

In explanation of this prevailing situation, the *Government Key informant* noted that

"We have a serious challenge with regard to bus fares for birth registration we currently do not have any available cash to provide them to travel to the designated registration points, in the past years we used to provide money for transportation but we no longer have those resources".

The CCWs noted that birth registration is a serious challenge and they have limited capacity of influencing the process. As *CCW 3* noted:

"*Caregivers are complaining that they are not receiving the services they have being referred to by us (the CCWs) and they are being very frustrated, we are no longer reliable, the community is losing confidence in us*".

Similar to access to education, birth registration process was stalled by limited resources as caregivers were failing to afford transport charges to the birth registration offices, which may be located far from their homes even though they have been referred by the CCWs. Birth registration is a basic human right and under normal circumstances the government should ensure accessibility of birth registration services to the community where people are located. The failure of the government to make this service available at community level can be explained by the structural social work theory that argues that it is a deliberate ploy of government and political systems to maintain insufficiency for the vulnerable members of the society while on the other hand the politicians are enriching themselves at the expense of the masses (Wallenberg, 2008).

5.3 Theme 2: Social workers' perception of the National Case Management Model as a social work tool.

There was consensus among social workers (government and NGO) that case management was effective in identifying vulnerable children and their needs.

However, they raised that children were not receiving the services they require. They noted that children were only identified, assessed and referred but not getting any assistance at the end. O'Leary and Squire (2009) brings an interesting dimension to the above criticism of case management, he argues that, "Case management systems need to be viewed realistically. They do not offer a solution to basic questions of resources or causes of problems. A case management system will not stop problems such as unaccompanied children occurring, but it will provide a basis for a structure to help protect children". Case management should serve as a mechanism to identify needs and coordinate provision of available services, rather than being viewed as a service itself (O'Leary and Squire, 2009).

This provides clarity that case management does not develop resources it only serve to identify the clients, assess their needs and refer to appropriate service providers (Hutt et al, 2004). *Government social worker 1* concurred,

> "*Case management is effective only in identifying, assessing and referring children to service providers, accessing of the services is another issue and that is the sticking point, to be honest at the moment and most of the children referred are not getting any meaningful service. It's a pity, this is the biggest problem".*

The respondents concurred that case management is best in developed countries where there are significant levels of service provision and service providers have high levels of capacity. They also pointed out that in developing countries it is a different case as the model was frustrating the community by referring them continually to services that are either dysfunctional or non-existent, with the result that the community loses confidence in social work and its models. As *Government social worker 2* enunciated that:

> "*Case management is the best intervention with regard to the identification of children and holistic assessments of needs but the challenge is that it does not guarantee if a child will ultimately receive the service. The fact is that the little resources available are being outwitted by demand and sadly case management is raising demand which is being unmet".*

NGO social worker 1 concurred that:

> *"case management is best is developing countries where there are vast services and service providers are working at full capacity, in developing countries it's a different case here we are frustrating the community by referring them continually to services that are no longer dysfunctional or which are non-existent, at the end the community will lose confidence in social work, this needs to be rectified".*

The model is being hampered by limited services provision and social safety nets. The failure of the government to ensure that services for children including critical safety nets is explained by structural social work theory as arising from inconsiderate, oppressive political and social systems (Mullaly, 2007). The theory argues that the underpinning roots of "social problems are differential control of resources and political power inherent in capitalistic societies" (Mullaly, 2007:119). In this regard it can be argued that the challenges faced by children orphaned as a result of HIV and AIDS emanates from limited access and control to resource systems and lack of political power to enhance social change. Mushunje (2006) notes that children orphaned as result of HIV and AIDS in Zimbabwe are subject to oppression and deprivation by systems that deny them access to education, health, housing and water and sanitation.

5.4 Theme 3: Social workers' perception on CCW training and capacity.

The training and capacity of case workers is pertinent in the efficiency of a case management system. The *Isibindi* model in South Africa ensures that case workers are fully equipped through a comprehensive training programme that leads to certification and registration of the case managers with a regulatory board (Thurman et al, 2009). Contrary, this study noted that the training of CCWs in the National Case Management Model is five days in duration. The duration of this training raises credibility challenges in light of the functions of CCWs in the National Case Management Model. The duration of the training was deemed limited by social workers

and potentially insufficient to allow CCWs to effectively handle a case management role. Respondents also suggested that the training lacked quality and was not in any way similar to the training offered in South Africa.

> *Government social worker 1* revealed a concern that *"there was no academic or professional qualifications produced or demanded during the recruitment process. After the community selection exercise prospective CCWs were then trained by NGO and government social workers over five working days on basic child welfare and child protection work and they were released to start working as CCWs".*

Key highlights from the *Isibindi* Model are the importance of academic qualifications, intensive training, examination and formal registration with a professional body (Thurman et al, 2009). The *Isibindi* case management model thus utilises professionally trained care workers and there is continuous professional development. Contrary the Zimbabwean model features low levels of training, which is not accredited by any examination board (although authorized by the Council of Social Workers). The above research findings on CCWs selection and training clearly reflect a departure from international best practices in case management.

NGO social worker 1 notes the impact of this on the CCWs' ability to complete fulfil their role, and again suggests the reason for this is low levels of resources:

> "*Recording of all work done is standard practice and must be adhered to in case management. The CCWs to execute their duties utilizes professional and technical tools to record their progress in any given case for which a file has been opened the case management tools CCWs are expected to fill are challenging, the major problem is that the training was limited and short due to lack of resources".*

Acknowledging the technical challenges experienced in handling tasks in the model *CCW 3* pointed:

"*The papers that we are expected to write are too many and are difficult to understand since they are in English language and technical, if you are to write everything that is required you will spend a lot of time at one household*"

There was consensus amongst the social workers that most CCWs are failing to adequately fulfil their responsibilities documentation and assessments. This was attributed to the fact that in addition to low levels of training they are often not educated and were just chosen in the community because of their popularity. *Government social worker 3* noted if the CCWs were receiving standardised training and adequate support and supervision they would perform better. This would allow them to capitalize on their placement in the community to deal with child welfare issues at community level. It can be noted that the challenges CCWs were experiencing with case management tools emanates from limited training and low literacy among CCWs.

It was noted that case management is an important component of an effective child welfare system, it exhibits a special function in the provision of services that enhance the well-being and social functioning of vulnerable children and their families (Thurman et al, 2009). However, despite the case management process in the National Case Management Model being well-designed, it is clear from this study that it can only be effective and sustainable in a context where there are functional social safety nets to refer clients to.

5.5 Theme 4: Child caseworker's motivation.

According to Moxely (1997) case management is heavily reliant on motivated staff or case managers. This section serves to explore how the government is motivating CCWs and the implications for practice. It was observed that the CCWs are given a bicycle, hat, bag and t shirt as their incentives. They operate as volunteers and they are not given any monetary incentive or benefit. It was observed that due to this state of affairs the CCWs were demoralized. Below are the views of the social workers and CCWs on the motivation of the CCWs:

Government social worker 2 noted that:

"Bicycle, hat, bag and t shirt are not enough surely these cannot fully motivate anyone, child protection is a challenging job which is emotionally draining, the CCWs needs to be enumerated so that we can have their full attention, the economy is currently bad and this means that most CCWs will be busy running around to earn a living, this should be raised".

CCW 3 pointed out that:

"the major challenge that [the CCWs] have is that they are not paid and that at times they use their own resources to do their work. At several incidents I use my personal money to repair the bicycle they have provided us, they are not repairing these bicycles at all, most of the times when the bicycle is broken down I use my personal money to use public transport to visit clients who are far"

The social workers raised that that the issue of incentives is central to this model and should be looked into as soon as possible. It was also mentioned that commitment by many CCWs had drastically dropped compared to earlier days when the programme was launched.

This frustration and demotivation can be observed from the views of *CCW 5*:

"my family needs to eat and as the bread winner I need to supply enough food and other resources, my family do not eat hat, t shirt, and bag that we are being provided as our package. My son was sent from school three times for fees payment defaults, I feel very much embarrassed, I do not have the money, how can I assist other children to access education when mine is failing, the community is not going to take me seriously while I try to help them because they are seeing that I'm in the same predicament as them"

From the above sentiments, the study noted that lack of incentives had a detrimental impact on CCWs motivation. Their counterparts in South Africa (*Isibindi* model) are paid a monthly salary and case management and youth work has become a competitive para-profession. It has actually created jobs for young people and they are well-motivated (Thurman et al, 2009). The failure of the government of Zimbabwe

to provide incentives for the CCWs reflects the limited with by this government to adequately support social care systems in Zimbabwe. As Midgley (1995:157) highlights that "...developing countries' political elites have no intention of redistributing income and wealth to eradicate mass poverty. They use social work as a palliative and as a means of camouflaging the material basis of deprivation".

5.6 Conclusion

The major highlight from this chapter is that the implementation of the National Case Management Model is riddled with structural challenges. The first major challenge is that social safety nets are currently below capacity and many children who are being case managed are not gaining access to services despite the CCWs making referrals. It was also noted that the NGO sector was experiencing shortage of funding to meet the current demand. In particular, the assessment of the model in regard to provision of access to education and birth registration services suggested that in both cases, resource limitations have severely hampered access for vulnerable children, despite the best efforts of CCWs. Furthermore, due to the identification, surveillance and assessments that characterise case management, the programme has raised demand (and hope) for services at community level and this demand is currently unfulfilled.

The second major challenge is that the programme does not have enough funding to provide adequate training and incentive for the CCWs. This contrasts with the comprehensive and formally certified training provided under the South African *Isibindi* model, which also provides a monthly salary to CCWs. Owing to shortage of resources, in Zimbabwe CCWs only receive 5 days training. This is not enough to adequately empower them to fully discharge their roles as evidenced by the challenges CCWs face in implementing the case management process and filing the required paper work. There was also a low morale among CCWs since they do not receive any financial support. The model did appear to be delivering benefits in terms of psychosocial support, with many caregivers stating that this was effective and essential. However, concerns were also expressed that low levels of training were inhibiting provision of effective support by some CCWs. Low morale amongst CCWs also threatens this provision.

CHAPTER SIX

SUMMARY OF FINDINGS AND RECOMMENDATIONS FOR SOCIAL WORK INTERVENTIONS ,POLICY REFORMS AND FUTURE RESEARCH.

6.1 Introduction

The HIV and AIDS pandemic resulted in phenomenal increase in both the number of orphans and their vulnerability (Gandure, 2009). Zimbabwe has approximately over one million orphans and vulnerable children (Government of Zimbabwe, 2010). In 2011, the government of Zimbabwe launched the National Case Management Model (a community-based casework mechanism) to facilitate comprehensive and systematic access to services (Government of Zimbabwe, 2010). The implementation of this model has however been not evaluated to ascertain if its goals are met (World Education, 2012). It is against this background that this qualitative study evaluated this model.

This final chapter presents the major findings and conclusions of the study. The summary of findings will be presented first in relation to the objectives that were set for this study. The last part will consider possible recommendations that can be pursued by various social workers to strengthen the model or improve interventions for orphans and vulnerable children.

6.2 Summary of findings.

Objective 1: To understand the structure and process of the National Case Management Model in Zimbabwe.

The major thrust of this section was to examine both the case management structure and the major processes involved.

With regard to structure, it was clear that National Case Management Model is anchored on CCWs who are responsible for identifying vulnerable children in their communities, and helping them to access care services. The major strength and innovation evident from this structure is the aspect of community engagement, which Thurman et al (2005) views as the missing link in many social interventions. He

observed that programmes for orphaned children in Africa have failed to generate community ownership and participation leading to apathy and lack of sustainability (Thurman et al, 2009). The CCW approach overcomes this problem by facilitating a high level of community ownership and involvement from the outset.

As the major weakness of the research, it was noted that the model vests CCWs with roles and responsibilities which are in the domain of qualified social workers. There is potential risk that the use of CCWs, who receive low levels of training and supervision to undertake core social work functions, will detrimentally affect quality of service provision.

Furthermore, with regard to the roles in the case management structure, the LCCWs are responsible for supervising the CCWs. Government social workers and NGO social workers coordinate the programme, provide logistical backstopping and conducts trainings for CCWs. Equally important they provide support and monthly supervision to the LCCWs and CCWs. The LCCWs do not receive any specialized training in clinical supervision and are thus not positioned to provide quality support and supervision. Further to this, the workload of the LCCWs is high as they are expected to manage their own cases while also taking a supervisory role with the CCWs.

With regard to the case management process, the model had a comprehensive process. The process involved various steps, which tally with expectations for good practice in the academic literature (Thurman et al, 2009). The process starts with the intake stage, where initial screening is conducted, which establishes basic information about the child and the reason for the concern. Second, planning of the necessary interventions takes place. Third, we see implementation of the planned intervention in collaboration with the relevant service providers and community case workers. Fourth, on completion of all planned interventions, a review of the child's care plan is conducted; and finally, when the review concludes that all issues of concern regarding the child's welfare have been addressed, the case is closed. However, the CCWs complained that this process was too technical and involved lots of cumbersome paperwork and documentation.

Objective 2. To gain insight into the views of:

- 10 Caregivers' (guardians) experiences on the extent to which the programme has helped children in their care.
- 5 CCWs experiences in implementing the programme.
- 5 Social workers' perceptions on the effectiveness of the programme.
- Key informants' experiences in overseeing the implementation of the model.

To enunciate and document narratives and experiences of the CCWs to understand the challenges and limitations in the implementation of the model, the researcher focused on three services (education, psychosocial support and birth registration) since these are the most sought-after services by children orphaned as a result of HIV and AIDS (according to case registers). These selected services are also prioritised by the National Action Plan, which is the overarching policy which underpins the National Case Management Model.

It was clear from the testimonies of the caregivers that children under their care are experiencing challenges in accessing education despite being identified and referred to appropriate services by the CCWs. Lack of school fees was observed to be the major reason why these children are not in school. The government's major education social safety net (BEAM) was found to be dysfunctional and lacking in resources. As a result, the CCWs had no effective service to refer children in need of education support. This state of affairs would be explained by structural social work theory as arising from the lack of prioritization of social sectors by politicians (Mullaly, 2007).

Those children requiring birth registration experienced similar problems. Lack of a birth certificate effectively bars children from participating in sports and examinations since a birth certificate is a prerequisite for these activities. Caregivers complained that registration centres were too far away, meaning that they could not afford the necessary bus fares. Resources were not available to provide bus fares despite CCWs correctly identifying vulnerable children with this need.

With regard to psychosocial support, it was found that many CCWs were providing psychosocial support through their routine home visits. Caregivers appreciated these home visits and viewed them as a successful outcome of the model. However, it was observed that some of the CCWs were not utilizing the home visits function to provide psychosocial social support but rather concentrating on data collection. This could be attributed to lack of training and supervision. Furthermore, there was concern that the model's failure to facilitate access to education and birth registration could undermine confidence in the entire system, reducing the ability of CCWs to provide psychosocial support. The programme thus raises demand (and hopes) which went unfulfilled.

Social workers' perception of the National Case Management Model as a social work tool.

The major sentiment from both government and NGO social workers was that case management was currently only effective in identifying children and their needs and facilitating referrals. However, the shortage of resource systems was negating this strength. Orphans were currently only being identified, assessed and referred but were not receiving meaningful assistance, because the required services were unavailable. To that end, it was emphasised by social workers and the key informants that case management is only helpful in identifying the children's needs. It was also identified that case management may be more effective in developed countries, where the concept was initially conceived; because these countries have greater resource systems (Case management emanated in developed countries to coordinate service providers and avoid competition and duplication in social service provision (Moxley, 1997). The failure of the government to ensure that services for children including critical safety nets is enunciated by the structural social work theory that social problems arise from the inconsiderate, oppressive political and social systems (Mullaly, 2007).

Social worker's perception of the CCWs training and capacity.

The study observed that the training of CCWs is five days in duration. This duration was deemed limited and inadequate by the social workers consulted for the study. Furthermore, there were no academic or professional qualifications produced or

demanded during the recruitment process and it was observed that the training programme was not accredited by any examining board: no examinations were written and no certificates were issued. This contrast with the South African *Isibindi* model, which deploys trained and accredited youths and care workers. In this model initial academic screening of prospective care workers is followed by standardised, accredited training and subsequent formal registration with a professional body such as the National Association of Child Case Workers of South Africa, which sets one on a child care work career path (Thurman et al, 2009). This is a missing element in the National Case Management Model, which compromises the provision of quality services for vulnerable children.

CCWs motivation.

According to Moxely (1997) case management is heavily reliant on motivated staff and case workers. It was observed that CCWs were given a bicycle, hat, bag and t -shirt as their incentives; other than that they operate as volunteers and are not given any monetary incentive or benefit. Social workers noted that in the present economic climate, providing for their own families was likely to be the primary concern for many CCWs, and the lack of stipend could thus prevent them fulfilling their role as a CCW. It was also noted that there was reduced appetite amongst CCWs to do their work because they lacked motivation. Respondents observed that bicycle, hat, bag and t-shirt are not sufficient to fully motivate CCWs to carry out what is a challenging and emotionally draining activity.

It was also observed that on several occasions CCWs had no choice but to use their personal money to repair the bicycle they had been provided with, and most of the time when the bicycle was broken down they had to use personal money for public transport if they needed to visit clients. CCWs said that they should be paid a stipend so that they would be motivated to do their job with enthusiasm. The lack of stipend in Zimbabwe contrasts with the South African *(isibindi)* model, where CCWs are paid a monthly salary and case work has become a competitive para-profession, which has created community jobs for young people (Thurman et al, 2009).

6.3 Implications and recommendations for social work interventions, policy reforms and future research.

Recommendations for social work interventions.

Advocacy for more programme and social safety nets government funding.

The implementation of the National Case Management Model is limited by lack of resources. The failure of the government to ensure that services for children including critical safety nets is enunciated by the structural social work theory that social problems arise from the inconsiderate, oppressive political and social systems (Mullaly, 2007). The theory argues that the underpinning roots of social problems are "differential control of resources and political power" inherent in capitalistic societies (Mullaly, 1997, p.119). In this regard it can be argued that the challenges faced by children orphaned as a result of HIV and AIDs emanates from limited access and control to resource systems and lack of political power to enhance social change.

In light of the background, this study recommends that social workers advocate for the Government of Zimbabwe to prioritise the funding of social safety nets. It is perhaps relevant to note that Zimbabwe is endowed with significant mineral resources (such as diamonds and other precious minerals) and could channel proceeds from these into the financing of social safety nets (Gandure ,2009). Botswana, a country similar to Zimbabwe, has a broad based and comprehensive social protection system which is currently being largely financed by proceeds from diamond mining. Zimbabwe should learn from this success story, illustrating how natural resources can facilitate social development and poverty alleviation (Gandure, 2009). This argument is in line with the developmental social work thinking that developing countries need to tap their existing resources (including natural resources) to facilitate socio-economic development. It is important for CCWs to be financially remunerated, in order to give them the motivation necessary to make the programme effective. Moxely (1997) emphasised that case management is heavily reliant on motivated staff or case managers. It was observed that CCWs are not currently given sufficient remuneration and instead operated as volunteers, and this meant that there was reduced appetite and motivation amongst CCWs to do their work.

Promote sustainable livelihoods

Social workers in Zimbabwe needs to initiate interventions that promotes family reliance, this will reduce considerable the number of families and children on or in need of social safety nets. In line with the indigenisation of social work and social development agenda social workers needs to explore livelihoods and economic strengthening initiatives. The structural social work theory argues that the theory argues that the underpinning roots of social problems are “differential control of resources and political power” inherent in capitalistic societies (Mullaly, 1997:119, Weinberg, 2008). In this regard social workers needs to be agents of sustainable social change and facilitate redistribution of resources. Lundy (2004: 57) propounds that in the structural social work framework the role of “practitioners is to explore the socio-political and economic context of individual difficulties and to help collectivize personal troubles and to enter into a helping process that facilitates critical thinking, consciousness-raising, and empowerment”. The theory examines the processes by which inequality is maintained and brings into focus the broader dimensions that require social workers to move beyond traditional approaches to a proactive and radical approach. Inspired by the structural social work theory this research recommends that social workers should identify sustainable livelihoods that may be undertaken by families.

CCWs can also play a role in supporting families to initiate and run small scale income generating initiatives such as agriculture. In this vein social workers may also link the caregivers to micro-finance institutions and borrow small low interest loans to initiate businesses. Mupedziswa (2001) argues that the social work profession in Africa for a variety of reasons, the most compelling of which is the fact that, due to a general lack of resources, Zimbabwe (and indeed Africa as a whole) can hardly afford the luxury of continuing to employ the remedial interventions, which over the years has proved to be particularly less effective. In this line of thought the challenge for social work is to transform itself so that it focuses on the root cause of social problems (Wood and Tully, 2006).

Implement resource mapping strategies.

Related to the above discussion, it is a fact that many developing countries have acute resource constraints and social workers need to think "outside the box" and be innovative in developing resource systems. For example, resources do not only need to be sought from the government, there are also small-scale resource systems such as churches, faith-based organisations, community-based organisations, business people, traditional leadership structures and cooperatives (Twikirize et al, 2013). There is a need to explore how these structures can support children orphaned as a result of HIV and AIDS at community level. This would require CCWs to be trained in resource mapping so that they can identify the above opportunities. Resource mapping seeks to identify all existing resource systems, together with the criteria for client eligibility for each system. A resource map may be utilised to identify gaps in the referral pathway and the provision of services, as well as to facilitate collaborations (O'Leary and Squire, 2009). This approach would also require CCWs to be trained in advocacy so that they can advocate for their clients to access non-traditional service providers. These initiatives would indigenise the case management system so that it is appropriate to the current conditions and circumstances in Zimbabwe.

Provide standardised and certified training for CCWs.

The study also noted that the training of the CCWs was far from meeting international best practice standards such as those of the *Isibindi* model in South Africa (Thurman et al, 2009). Training period for the CCWs should be increased and certified mechanisms should be introduced so that the CCWs receive recognised training in child care. In the *Isibind*i case management model prospective care workers are subject to academic screening, and then receive standardized and accredited training which sets them on a child care career path, with continuous professional development and subsequent formal registration with a professional child and youth care body (Thurman et al, 2009). This study recommends that the social workers spearheading the implementation of the National Case Management Model follow the *Isibindi* model and introduce certified training that leads to registration with a professional body. This

professionalization of the CCWs will safeguard the system against unethical practices and also assure quality service provision. Gaining access to sufficient funds for this will require advocacy with the Government.

Increase the role of qualified social workers in the model.

Finally, it is worth noting that case management by CCWs should not replace professional social work services but complement them. The prevailing state of affairs is that CCWs have been tasked with many responsibilities that would typically be undertaken by a qualified social worker. This situation largely arose from the severe shortage of social workers in the Department of Child Welfare and Probation Services (the Institutional Capacity Assessment of the Department of Child Welfare and Probation conducted by Watts et al in 2010 found that Zimbabwe has an acute shortage of social workers). This research underlines the contribution that CCWs can make particularly in ensuring community participation and identifying hard to reach children however it argues that sufficient training and regular supervision by qualified social workers is necessary to ensure they operate effectively. It thus recommends that social workers through their professional and regulatory bodies should ensure that specialised "social work'' roles should be reserved for qualified social workers. In this dispensation the role of the CCWs will be to identify vulnerable children and conduct preliminary assessments, while further assessment, case planning and implementation can be undertaken in tandem with a qualified social worker. This proposed structure may be limited by the current shortage of social workers and

Policy reforms.

It was evident from the study that the National Case Management Model is currently lacking a robust and sound policy framework and quality assurance benchmarks as evidenced by gaps such as limited training for CCWs, lack of CCWs motivation, acute shortage of resources for social safety nets and operational costs. These should be explained or addressed from policy to implementation level. Quality assurance is a very important element in case management and overall social work. There are many areas in the National Case Management Model which showed that quality service provision and policy benchmarks are lacking. Firstly, the programme lacks quality

benchmarks on the provision of psychosocial support as evidenced by adhoc practices, secondly there are no mechanisms of mainstreaming child participation, thirdly there is no standardized support and supervision of CCWs framework and practice, fourth there is lacking referral pathway and feedback to the caregiver's protocol. The sixth gap is that the model has a generic approach it has not specific ways of dealing with sensitive cases such as of child sexual abuse and children living with HIV and AIDS.

This above state of affairs could be improved by clear and robust regulations and policy framework guidelines. It is also recommended that the government develop the National Case Management Model policy framework. This policy should articulate among other issues how the model with be harmonised with the existing resource systems, the motivation, support and supervision of the CCWs, and the role of social workers and other key stakeholders in the implementation of the model.

The task for future research.

This study was not exhaustive hence there is need for further research and exploration of issues that arose from this study. It was found that case management was not being useful, as it could not meet its objectives due to acute shortage of resources and dysfunctional safety nets and limited service provision from the NGO sector. To that end, this study therefore recommends future research to explore how case management may be customised and indigenised so that it can be relevant to in a climate of acute shortage of resources and structural challenges. The other priority area for future research should be to explore how social workers can be capacitated to challenge social injustices perpetrated by unjust political systems in Zimbabwe (Weinberg, 2008). This study recommends that further research to explore how social workers can move from traditional social work methods and explore radical approaches that confront political systems to facilitate social change.

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Appendix 1: Informed consent form for caregivers *(English)*

Participant no.

Greetings! My name is Munyaradzi Muchacha. I am working on a study to evaluate the implementation of the National Case Management Model for children orphaned as a result of HIV and AIDS in Zimbabwe.

Purpose of the study

The study is conducted in fulfilment of the University of Kwa Zulu Natal Master of Social Work Degree. The study is **An Evaluation of the implementation of the National Case Management Model for children orphaned as a result of HIV and AIDS in Zimbabwe.**

I am requesting that you participate in this study because your information, contribution and suggestions will be of tremendous importance as it will enable the generation of literature on case management in Zimbabwe and will propose recommendation to improve the model. Please be honest and fair as that will lead to a clear picture of implementation status and the findings will be useful for making recommendations and suggestions to be used for improvement and development of other interventions.

What participation involves

If you agree to participate in the study, you will be interviewed in order to answer a series of questions in the questionnaire / interview guide prepared. Your participation will take place at a time and place that is convenient to you. Your involvement will take approximately 45 minutes.

Confidentiality

I assure you that all the information collected from the interview will be respected, treated confidentially, and used for the purpose of the study only. Your answers, opinion and suggestion will be valued for the improvement and better implementation; your name will not be written in the report/document. All information collected from the interview will be entered into computers with only the interviewee number. I do not expect that you will come to any harm as a result of participating in this study. There may be some questions you are not able or comfortable to answer. Please feel free to say “I don’t know”. You may decline to answer any particular question and may stop the interview at any time.

Right to withdraw and alternatives

The information you provide will contribute towards the refinement of the National Case Management Model. The study will contribute to the existing literature by generating information on the case management model utilised in Zimbabwe. Taking part in this study is completely voluntary. You can stop participating in this study at any time, even if you have already given your consent. Declining to participate or withdrawing from the study will not affect you from accessing the case management system.

If you give consent to participate in this study by answering questions, please sign this form to show that you have read the contents.

I.............................. (full name) on ……………………… (date) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

If you have any questions, please feel free to contact me:

MUNYARADZI MUCHACHA E-mail: munyaradzimuchacha@gmail.com**+263 775 880 996**. Alternatively, contact my supervisor

Dr Tanusha Raniga
Department: School of Social Work
Howard College,
UKZN
Tel: 278 283 08211.
Tanushar@ukzn.ac.za

Or alternatively HSSREC Research Office
Ms P Ximba, Tel: 031 260 3587
Email: ximbap@ukzn.ac.za

Thank you for your time!

Appendix 2 Informed consent for caregivers *(Shona*)

Gwaro rekubvuma kupinda mutsvagurudzo

Wadiwa mupinduri

Ndinotenda nekubvuma kwenyu kupinda mutsvagurudzo iyi. Tsvagurudzo iyindeye zvidzidzo zvangu zvegwaro repamusoro re Masters zvandiri kuita nebazi re Social Work re Univhesiti yeKwaZulu-Natal, ku South Africa. Musoro wetsvagurudzo unoti:**An Evaluation of the implementation of the National Case Management Model for children orphaned as a result of HIV and AIDS in Zimbabwe.**

Munhaurirano iyi yamava kupinda, munotarisirwa kupindura mibvunzo mishomana pamusoro pekuchecheudza sedonzvo rekudzvivirira utachiona hunokonzera chirwere cheShuramatongo. Ini semutsvagurudzi ndinokuvimbisai nemwoyo wose kuti zvichataurwa zvicharamba zviri pakati pedu chete zvakavanzika uye ifaniro yangu kukuremekedzai kubudikidza nekuchengeta zvatataura pakati pedu. Ikodzero yenyu pane ino nguva kuti muzive kuti kupinda kana kubuda mutsvagurudzo iyi isarudzo yenyu uye hapana chakashata chingakuwirai nekuda kwesarudzo yenyu iyi. Kana mapinda, hamutarisirwi kuti mutsanagure chikonzero chekuti mazofungirei kubuda mutsvagurudzo iyi nokuti ikodzero yenyu kuita zvamada panguva iyoyo pasina kutya kana kuvhunduka.

Nzvimbo nenguva yekuita nhaurirano yenyaya iyi ngaive yamakasunungukira imwi uye nguva inogona kuva maminitsi makumi mana anoraudzira.

Mabvuma kupinda mutsvagurudzo iyi isai runyoro rwenyu apa kuratidza kuti maverenga gwaro rino mukanzwisisa uye mukagutsikana.

Ini…………………………………………………………..(zita rizere) musi wa………………………………… ndinobvuma kuti ndanzwisisa donzvo retsvagurudzo uye ndazvipira kupinda mutsvagurudzo iyi.

Mune mibvunzo ndibai **MUNYARADZI MUCHACHA** pa **E-mail:** munyaradzimuchacha@gmail.com kana nharembozha **+263 775 880 996**.kanakuti mutungamiri wetsvagurudzo yangu kuchikoro kwangu:

Dr Tanusha Raniga
Department: School of Social Work
Howard College,
UKZN
Tel : 278 283 08211.
Tanushar@ukzn.ac.za

Kana kuti HSSREC Research Office
Ms P Ximba, Tel: 031 260 3587
Email: ximbap@ukzn.ac.za
Ndatenda nenguva yenyu! Nyiyabonga !

Appendix 3: Informed consent for CCWs (English).

Interviewee no.

Greetings! My name is Munyaradzi Muchacha. I am working on a study to evaluatethe implementation of the National Case Management Model for children orphaned as a result of HIV and AIDS in Zimbabwe.

Purpose of the study

The study is conducted in fulfilment of the University of KwaZulu Natal Master of Social Work Degree. The study is An Evaluation of the implementation of the National Case Management Model for children orphaned as a result of HIV and AIDS in Zimbabwe.

I am requesting that you participate in this study because your information, contribution and suggestions will be of tremendous importance as it will enable the generation of literature on case management in Zimbabwe and will propose recommendation to improve the model. Please be honest and fair as that will lead to a clear picture of

implementation status and the findings will be useful for making recommendations and suggestions to be used for improvement and development of other interventions.

What participation involves

If you agree to participate in the study, you will be interviewed in order to answer a series of questions in the questionnaire / interview guide prepared. Your participation will take place at a time and place that is convenient to you. Your involvement will take approximately 45 minutes.

Confidentiality

I assure you that all the information collected from the interview will be respected, treated confidentially, and used for the purpose of the study only. Your answers, opinion and suggestion will be valued for the improvement and better implementation; your name will not be written in the report/document. I do not expect that you will come to any harm as a result of participating in this study. There may be some questions you are not able or comfortable to answer. You may decline to answer any particular question and may stop the interview at any time.

Right to withdraw and alternatives

The information you provide will contribute towards the refinement of the National Case Management Model. The study will contribute to the existing literature by generating information on the case management model utilised in Zimbabwe.

Taking part in this study is completely voluntary. You can stop participating in this study at any time, even if you have already given your consent. Declining to participate or withdrawing from the study will not affect you from accessing the case management system.

If you give consent to participate in this study by answering questions, please sign this form to show that you have read the contents.

I.............................. (full name) on ……………………….(date) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

If you have any questions, please feel free to contact me:

MUNYARADZI MUCHACHA E-mail: munyaradzimuchacha@gmail.com**+263 775 880 996**. Alternatively, contact my supervisor

Dr Tanusha Raniga
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Tanushar@ukzn.ac.za

Or alternatively HSSREC Research Office
Ms P Ximba, Tel: 031 260 3587
Email: ximbap@ukzn.ac.za

Thank you for your time!

Appendix 4: Informed consent for CCWs (Shona).

Gwaro rekubvuma kupinda mutsvagurudzo

Wadiwa mupinduri

Ndinotenda nekubvuma kwenyu kupinda mutsvagurudzo iyi. Tsvagurudzo iyindeye zvidzidzo zvangu zvegwaro repamusoro re Masters zvandiri kuita nebazi re Social Work re Univhesiti yeKwaZulu-Natal, ku South Africa. Musoro wetsvagurudzo unoti: **An Evaluation of the implementation of the National Case Management Model for children orphaned as a result of HIV and AIDS in Zimbabwe.**

Munhaurirano iyi yamava kupinda, munotarisirwa kupindura mibvunzo mishomana pamusoro pekuchecheudza sedonzvo rekudzvivirira utachiona hunokonzera chirwere cheShuramatongo. Ini semutsvagurudzi ndinokuvimbisai nemwoyo wose kuti zvichataurwa zvicharamba zviri pakati pedu chete zvakavanzika uye ifaniro yangu kukuremekedzai kubudikidza nekuchengeta zvatataura pakati pedu. Ikodzero yenyu pane ino nguva kuti muzive kuti kupinda kana kubuda mutsvagurudzo iyi isarudzo yenyu uye hapana chakashata chingakuwirai nekuda kwesarudzo yenyu iyi. Kana mapinda, hamutarisirwi kuti mutsanagure chikonzero chekuti mazofungirei kubuda mutsvagurudzo iyi nokuti ikodzero yenyu kuita zvamada panguva iyoyo pasina kutya kana kuvhunduka.

Nzvimbo nenguva yekuita nhaurirano yenyaya iyi ngaive yamakasunungukira imwi uye nguva inogona kuva maminitsi makumi mana anoraudzira.
Mabvuma kupinda mutsvagurudzo iyi isai runyoro rwenyu apa kuratidza kuti maverenga gwaro rino mukanzwisisa uye mukagutsikana.

Ini…………………………………………………………..(zita rizere) musi wa…………………………………… ndinobvuma kuti ndanzwisisa donzvo retsvagurudzo uye ndazvipira kupinda mutsvagurudzo iyi.

Mune mibvunzo ndibai **MUNYARADZI MUCHACHA pa E-mail:** munyaradzimuchacha@gmail.com kana nharembozha **+263 775 880 996**.kanakuti mutungamiri wetsvagurudzo yangu kuchikoro kwangu:

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Kana kuti HSSREC Research Office
Ms P Ximba, Tel: 031 260 3587

Email: ximbap@ukzn.ac.za

Ndatenda nenguva yenyu!Nyiyabonga !

Appendix 5: Informed consent for social workers

Interviewee no.

Greetings! My name is Munyaradzi Muchacha. I am working on a study to evaluate the implementation of the National Case Management Model for children orphaned as a result of HIV and AIDS in Zimbabwe.

Purpose of the study

The study is conducted in fulfilment of the University of KwaZulu Natal Master of Social Work Degree. The study is An Evaluation of the implementation of the National Case Management Model for children orphaned as a result of HIV and AIDS in Zimbabwe.

I am requesting that you participate in this study because your information, contribution and suggestions will be of tremendous importance as it will enable the generation of literature on case management in Zimbabwe and will propose recommendation to improve the model. Please be honest and fair as that will lead to a clear picture of implementation status and the findings will be useful for making recommendations and suggestions to be used for improvement and development of other interventions.

What participation involves

If you agree to participate in the study, you will be interviewed in order to answer a series of questions in the questionnaire / interview guide prepared. Your participation will take place at a time and place that is convenient to you. Your involvement will take approximately 45 minutes.

Confidentiality

I assure you that all the information collected from the interview will be respected, treated confidentially, and used for the purpose of the study only. Your answers, opinion and suggestion will be valued for the improvement and better implementation; your name will not be written in the report/document. All information collected from the interview will be entered into computers with only the interviewee number. I do not expect that you will come to any harm as a result of participating in this study. There may be some questions you are not able or comfortable to answer. Please feel free to say “I don’t know”. You may decline to answer any particular question and may stop the interview at any time.

Right to withdraw and alternatives

The information you provide will contribute towards the refinement of the National Case Management Model. The study will contribute to the existing literature by generating information on the case management model utilised in Zimbabwe.

Taking part in this study is completely voluntary. You can stop participating in this study at any time, even if you have already given your consent. Declining to participate or withdrawing from the study will not affect you from accessing the case management system.

If you give consent to participate in this study by answering questions, please sign this form to show that you have read the contents.

I.............................. (full name) on ……………………….(date) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

If you have any questions, please feel free to contact me:

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Or alternatively HSSREC Research Office
Ms P Ximba, Tel: 031 260 3587
Email: ximbap@ukzn.ac.za

Thank you for your time!

Appendix 6: Informed consent for key informants

Interviewee no.

Greetings! My name is Munyaradzi Muchacha. I am working on a study to evaluate the implementation of the National Case Management Model for children orphaned as a result of HIV and AIDS in Zimbabwe.

Purpose of the study

The study is conducted in fulfilment of the University of KwaZulu Natal Master of Social Work Degree. The study is An Evaluation of the implementation of the National Case Management Model for children orphaned as a result of HIV and AIDS in Zimbabwe.

I am requesting that you participate in this study because your information, contribution and suggestions will be of tremendous importance as it will enable the generation of literature on case management in Zimbabwe and will propose recommendation to improve the model. Please be honest and fair as that will lead to a clear picture of

implementation status and the findings will be useful for making recommendations and suggestions to be used for improvement and development of other interventions.

What participation involves

If you agree to participate in the study, you will be interviewed in order to answer a series of questions in the questionnaire / interview guide prepared. Your participation will take place at a time and place that is convenient to you. Your involvement will take approximately 45 minutes.

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Right to withdraw and alternatives

The information you provide will contribute towards the refinement of the National Case Management Model. The study will contribute to the existing literature by generating information on the case management model utilised in Zimbabwe.

Taking part in this study is completely voluntary. You can stop participating in this study at any time, even if you have already given your consent. Declining to participate or withdrawing from the study will not affect you from accessing the case management system.

If you give consent to participate in this study by answering questions, please sign this form to show that you have read the contents.

I.............................. (full name) on ……………………… (date) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

If you have any questions, please feel free to contact me:

MUNYARADZI MUCHACHA E-mail: munyaradzimuchacha@gmail.com**+263 775 880 996**. Alternatively, contact my supervisor

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Or alternatively HSSREC Research Office
Ms P Ximba, Tel: 031 260 3587
Email: ximbap@ukzn.ac.za

Thank you for your time!

Appendix 7: Interview schedule for social workers.

This interview guide is not rigid but rather fluid as new aspects worth pursuing may emerge during the interview session with some participants. However, the following questions serve as a general guide of the area around which the discussion revolves.

The questions are not necessarily going to follow the sequence below and not all of them may be asked, or neither all of them will be pursed with each participant.

Identification particulars of the interviewee and Socio demographic data:

a) Education level: …………………..………………………………
b) Age……………………………….....Sex:
c) How long have you been in this position? Years …………… months …………….

The Case Management Process.

a) What are your roles in the National Case Management Model?
b) May you describe how the National Case Management Model is being implemented? *(probe for key activities, structure and strategies)*
c) How are the communities involved in the Case Management Model activities?
d) How adequately does the training for CCWs cover and convey the different areas of skills and knowledge that are required for case work?
e) What are the challenges being you currently facing in the implementation of the case management model)?

Experiences and perception of the programme.

a) Tell me about your experiences as a social worker working in the case management model.
b) Is case management an effective social work tool?
c) Is the case management model helping out in addressing the needs of OVC?
d) How do you think the case management model needs to be improved?
e) Is community case work relevant to needs of children orphaned as a result of HIV and AIDS?

Appendix 8: Interview schedule for CCWs (English and Shona).

Identification particulars of the interviewee and Socio demographic data:

a) Education level: …………………..……………………………………………

Makadzidza kusvika papi ?

b) Age………………………………......

Munemakore mangani ?

c) Sex: ………………………………

d) How long have you been a CCW?Years …………… months.…………….

Mave nenguva yakareba sei muri CCW ? makore ……….. mwedzi ………..

e) What is your experience with working with children prior to being CCW…...…………

Maimboshanda nevana here musati mave CCW ?

f) How many cases are you dealing with at a time……………………………

Mune macase manganic panguva imwe chete ?..............................

g) What is your understanding of Case Management? (*Probe to get the general understanding of case management)*

Chii chinonzi case management? Bvunzisisa kunzwisisa kwavo kwe case management

h) Tell me about your experiences as a CCW in implementing the National Case Management Model?

Nditaurei kushanda kwenyu sa CCW

i) How do you identify children, households and their needs?

Munowana sei vana vamunobatsira , uye zvavanoda ?

j) What are your roles in the National Case Management Model?

Basa renyu mu case management model nderei ?

k) How do you meet the needs of children through the National Case Management Model?

Munobatsira vana sei ?

l) How long does it take for a child to get a service through the case management system?

Zvinotora nguva yakareba sei kuti mwana awane rubatsiro ?

m) How are the communities involved in the Case Management Model process?

Community yenyu inopinda sei mucase management programme?

n) How are you supported by social workers to implement the case management programme?

Munobatsirwa sei ne masocial workers kuita case management?

o) Do you think that the support is enough?

Rubatsiro rwamunowana rwakakwana ?

p) Is community case work relevant to needs of children orphaned as a result of HIV and AIDS?

Case management inokwanisa here kugardzirisa matambudziko anosangana ne vana vakafirwa ne vabereki ?

q) What are the challenges are you facing in the implementation of the National Case Management Model?

Ndezvipi zvigozhero zvinosanganiwa nazvo mubasa renyu ?

r) What would you recommend to improve the programme?

Ndezvipi zvingaitwa kusimudzira hurongwa hwe case management?

Thank you very much for your participation!

Appendix 9: Interview schedule for key informants.

Section A

1.What is your level of education?

2. What is your experience?

Section B

a) What is the structure and process of the National Case Management Model?
b) What are the expected results from the implementation of the National Case Management Model?
c) Are the current efforts of the National Case Management Model enough in meeting the needs of OVC?
d) Is the case management model helping out in addressing the shortage of social worker?
e) How do you think the case management model needs to be improved?

Thank you very much for your participation

Appendix 10: Focus group discussion for caregivers (English and Shona).

a) Tell me about your experiences as a caregiver of a child who is getting assistance through the programme.
   Ndipeiwo tsanangudzo dzekubatsirwa kwamuri kuitwa ne case management programme?
b) What are the services are you getting through the case management model?
   Muri kuwana rubatsiro rwakaita sei kuburikidza ne case management?
c) To what extent are the needs of your children being met through the National Case Management Model? (Probe if the case management model ensuring that children receive wrap around services?
   Muri kuona chirongwa che case management chichi batsira vana kusvika pakadini
d) What are the challenges your children facing in receiving services in the National Case Management Model?
   Ndezvipi zvigozhero zvamuri kusangana nazvo mukuwana rubatsiro kuburikidza nechirongwa che case management?
   Community inopinda muhurongwa hwecase management nenzira ipi How timely is the delivery of services?

Kuwana rubatsiro muchirongwa ichi kunochimbidza zvakaita sei?

e) How do you think the programme can be improved?

Munofunga kuti chirongwa che case management chingavandudzwa sei ?

f) Is the National Case Management Model relevant to needs of children orphaned as a result of HIV and AIDS?

Munofungawo here kuty chirongwa che case management chinokwanisa kupedza matambudziko anosanagana nenana vasina vabereki ?

Appendix 11: Research approval letters and ethical clearance

05/08/2014

Ref: Munyaradzi Muchacha Research

Dear Colleague

The evaluation of the National Case Management Model is long overdue, your study is pertinent and our Strategic Information Management Department has approved your research.

Please share with us the findings of your study as soon as you are done. We are happy to support you with any logistics necessary.

NB: May you not by any chance involve children as you have outlined in your proposal.

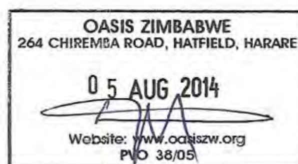
Regards

Lloyd Moyo

Monitoring and Evaluation Specialist

Oasis Zimbabwe

+263 773 933 121



Oasis Zimbabwe

264 Chiremba Road, Park Meadowlands, Harare

NATIONAL ASSOCIATION OF SOCIAL WORKERS
Makombe Government Complex
Block 3 Room 83
Harare
Phone: 04 79 001

Cell 0776 388 742

Email: nasw.hararebranch@gmail.com

05 August 2014

Dear Mr Muchacha.

I have gone through your proposal.

We have decided to allow you to conduct your study. The team here will give you the full support.

All the bests with your studies, please share with us your findings.

Kind Regards

C Mupangani
NASW Harare Regional Coordinator

0776 388 742

Board Members

Michael Mukwaiwa (HSW), N Muridzo (HSW, MSW) C, Dziro (HSW, MSW), C Mopangani (HSW), Ł Muchemwa (HSW, MSW).

08 December 2014

Mr Munyaradzi Muchacha (214582393)
School of Applied Human Sciences – Social Work
Howard College Campus

Dear Mr Muchacha,

Protocol reference number: HSS/1534/014M
Project title: An evaluation of the implementation of the National Case Management Model for children orphaned as a result of HIV and AIDS in Zimbabwe

Full Approval – Expedited Approval

With regards to your application for ethical clearance received on 19 November 2014. The documents submitted have been accepted by the Humanities & Social Sciences Research Ethics Committee and **FULL APPROVAL** for the protocol has been granted.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

....

Dr Shenuka Singh (Chair)

/ms

Cc Supervisor: Dr Tanusha Raniga
Cc Academic Leader Research: Professor D McCracken
Cc School Administrator: Ms Ausie Luthuli

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
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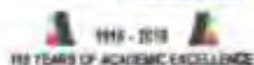
Website: www.ukzn.ac.za



Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

Appendix 12: Copy of signed consent form.

Informed consent form for caregivers *(English)*

Participant no. I

Greetings! My name is Munyaradzi Muchacha. I am working on a study to evaluate the implementation of the National Case Management Model for children orphaned as a result of HIV and AIDS in Zimbabwe.

Purpose of the study

The study is conducted in fulfilment of the University of Kwa Zulu Natal Master of Social Work Degree. The study is **An Evaluation of the implementation of the National Case Management Model for children orphaned as a result of HIV and AIDS in Zimbabwe.**

I am requesting that you participate in this study because your information, contribution and suggestions will be of tremendous importance as it will enable the generation of literature on case management in Zimbabwe and will propose recommendation to improve the model. Please be honest and fair as that will lead to a clear picture of implementation status and the findings will be useful for making recommendations and suggestions to be used for improvement and development of other interventions.

What participation involves

If you agree to participate in the study, you will be interviewed in order to answer a series of questions in the questionnaire / interview guide prepared. Your participation will take place at a time and place that is convenient to you. Your involvement will take approximately 45 minutes.

Confidentiality

I assure you that all the information collected from the interview will be respected, treated confidentially, and used for the purpose of the study only. Your answers, opinion and suggestion will be valued for the improvement and better implementation; your name will not be written in the report/document. All information collected from the interview will be entered into computers with only the interviewee number. I do not expect that you will come to any harm as a result of participating in this study. There may be some questions you are not able or comfortable to answer. Please feel free to say "I don't know". You may decline to answer any particular question and may stop the interview at any time.

Right to withdraw and alternatives

The information you provide will contribute towards the refinement of the National Case Management Model. The study will contribute to the existing literature by generating information on the case management model utilised in Zimbabwe. Taking part in this study is completely voluntary. You can stop participating in this study at any time, even if you have already given your consent. Declining to participate or

withdrawing from the study will not affect you from accessing the case management system.
If you give consent to participate in this study by answering questions, please sign this form to show that you have read the contents.

I...N Moyo...... (full name) on ...03/Jan/2015.... (date) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

If you have any questions, please feel free to contact me:

MUNYARADZI MUCHACHA E-mail: munyaradzimuchacha@gmail.com**+263 775 880 996**. Alternatively, contact my supervisor

Dr Tanusha Raniga
Department: School of Social Work
Howard College,
UKZN
Tel: 278 283 08211.
Tanushar@ukzn.ac.za

Or alternatively HSSREC Research Office
Ms P Ximba, Tel: 031 260 3587
Email: ximbap@ukzn.ac.za

Thank you for your time!