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HIV/AIDS and child labour in Zimbabwe: A rapid assessment

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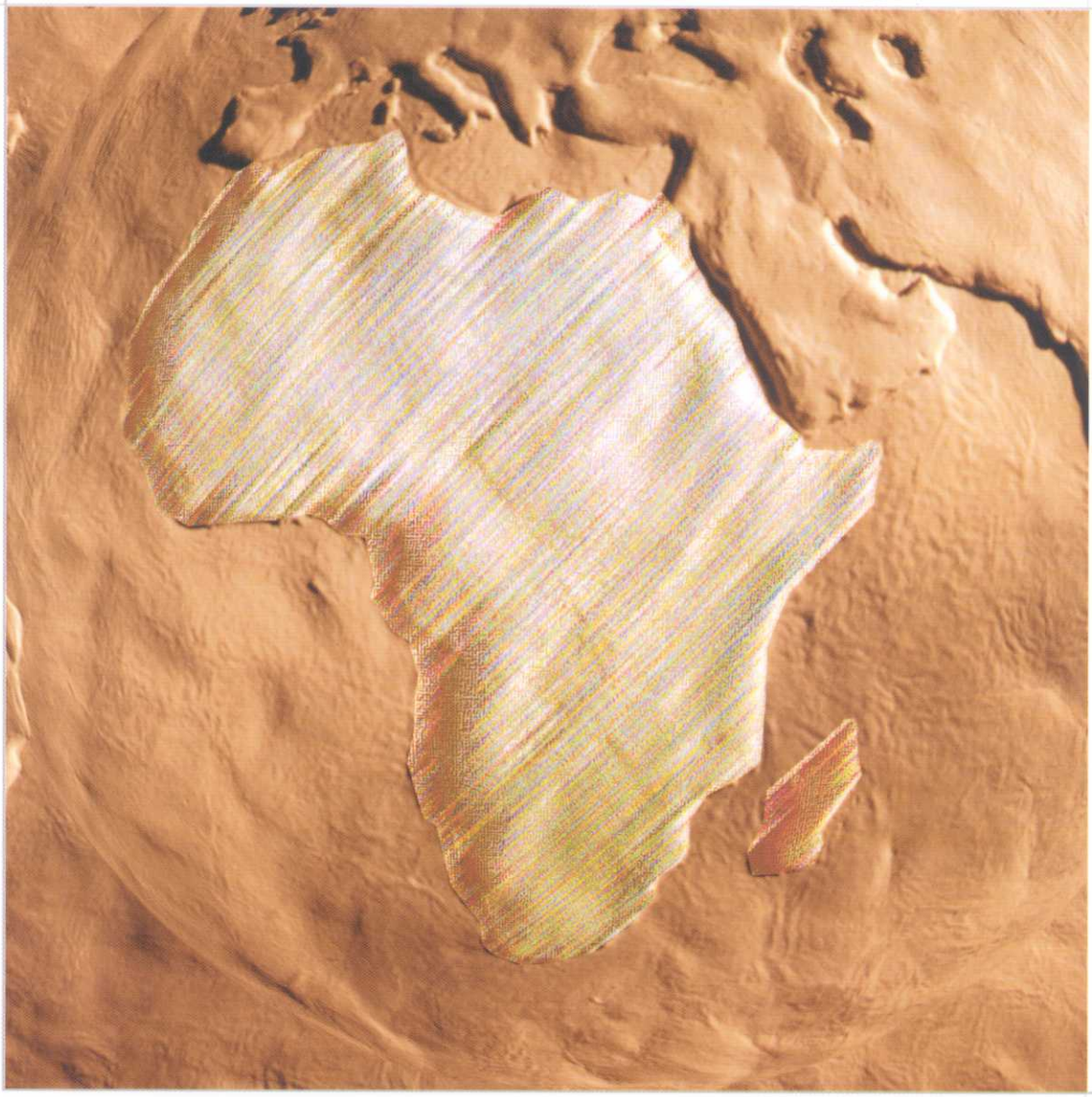

IPEC - INTERNATIONAL PROGRAMME ON THE ELIMINATION OF CHILD LABOUR

HIV/AIDS and child labour in Zimbabwe: A rapid assessment

by

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Contents

Page

Acknowledgements v

Executive summary vii

Acronyms xvii

1. Introduction 1

2. Background and context 2

   2.1. Demographic structure 3

   2.2. Human capital 3

      2.2.1. Health 3

      2.2.2. Education 5

3. The economy 7

4. The legal framework 11

   4.1. Domestic framework 11

   4.2. International protocols 12

5. Institutions involved in children's issues 14

   5.1. International organizations 14

   5.2. Local organizations 14

6. Children and work: Definition of terms 15

   6.1. Different notions of child labour 15

   6.2. Definition of working children 16

7. What we already know about orphans and child labour in Zimbabwe 17

   7.1. HIV/AIDS and orphanhood 17

   7.2. Working children in Zimbabwe 18

8. Rapid assessment targets: Selection criteria 20

9. Profile of the survey area 22

   9.1. Population size 22

   9.2. Population density 22

   9.3. Population growth 22

   9.4. Local economy 22

   9.5. Education 22

   9.6. Water and sanitation 23

10. Methodology 24
10.1. Sampling procedure 24
10.2. Data collection methods 24
10.3. Study team composition 24
10.4. Problems encountered 25
11. Results 26
11.1. Sample group profile 26
11.2. Educational status 26
11.3. Living conditions and well-being 27
11.4. Work and working conditions 29
11.4.1. Remuneration 32
11.5. Domestic work 33
11.6. Commercial sexual exploitation 33
11.6.1. Sexual activities 34
11.6.2. Income derived 34
11.6.3. Health care 34
11.6.4. Knowledge about HIV/AIDS 35
12. HIV/AIDS awareness among the children interviewed 36
13. Gender dimensions of orphanhood and child labour 37
13.1. Orphanhood 37
13.2. Child labour 38
13.3. Domestic work 39
14. Findings from interviews with key informants 40
14.1. Interview with the City of Gweru 40
14.2. Interview with MASO 41
14.3. Interview with the provincial welfare officer (PWO) 41
14.4. Interview with the headmaster of a secondary school 41
15. Summary and conclusions 43
16. Recommendations 45
Bibliography 47

Appendices

1. Child questionnaire 51
2. Key informants guide 62
3. Parents/guardian focus group discussion guide 63
4. Children focus group discussion guide 66

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Executive summary

Study objectives

HIV/AIDS has become one of the leading causes of death in sub-Saharan Africa among people aged between 20 and 50. This has resulted in an ever-increasing number of orphans, many of whom have turned to child labour – in some instances the worst forms of child labour – for survival.

This study investigates the nature and extent of both HIV/AIDS and child labour in Zimbabwe and the linkages between them. Recent research has addressed HIV/AIDS, orphans and, sometimes, child workers in Africa.[1] The current study seeks to further explore this link in specific areas and target groups in Zimbabwe with the aim of proposing strategic objectives and interventions for the elimination of child labour related to HIV/AIDS.

Study area

The study was conducted in the Gweru and Shurugwi districts of the Midlands Province. The Midlands Province was chosen partly because it has the highest prevalence of economically active children in Zimbabwe, and local farming and mining activities make much use of child labour. Shurugwi Rural district, on the other hand, was selected because this area reveals hidden, culturally condoned, dimensions of rural child labour such as non-paid work in the fields, cattle herding, and fetching water over long distances.

Methodology

Sampling procedure

Samples were chosen with the assistance of the City of Gweru, which is spearheading the CDC[2] programme in the Midlands Province; officials from the Better Schools Programme; and the Midlands AIDS Services Organization (MASO). The team also made use of local CDC staff that played a crucial role in mobilizing the target population. In Gweru, the selected sample covered, as much as possible, all of the area's 17 wards. In Shurugwi, the sample was drawn from two primary and two secondary schools.[3]

Key informants were drawn from government departments, non-governmental organizations (NGOs), local authorities and community leaders. Focus group discussion (FGD) groups were drawn from participants in all the areas sampled. Each FGD normally

[1] Among these are documents summarized in a publication for the July 2002 Barcelona Conference and for use in Rapid Assessments (UNAIDS, UNICEF, USAID, *Children on the brink 2002: A joint report on orphan estimates and programme strategies*; http://www.unicef.org/pubsgen/children-on-the-brink/index.html), and a study by Bill Rau identifying good practices in policies and programmes dealing with HIV/AIDS and child labour in sub-Saharan Africa.

[2] Children in difficult circumstances.

[3] The headmasters of these schools played a major role in the selection of the children to be interviewed.

consisted of ten to 12 working children or guardians/parents. Most of the FGDs were divided according to gender. Case studies examined instances where orphans served as child household heads or in exceptional cases of child labour, providing detailed accounts of the experiences of the children involved.

Data collection methods

The study applied:

- **in-depth interviews** with working children and their parents/guardians, applying the child questionnaire developed by the study team and the parents/guardian questionnaire provided by the ILO and subsequently tested, translated, and adapted locally; [4] and
- **semi-structured interviews,** used with key informants and when conducting FGDs and case histories.

Study team composition

The study team comprised five researchers and three research assistants. The team leader was an economist with considerable experience in poverty and policy-oriented studies, and the co-researchers included a gender expert, a sociologist, and two demographers. Two of the research assistants had social work backgrounds, and one had an economics background.

Problems encountered

- Identification of children involved in some forms of child labour – e.g. children engaged in prostitution or panning for gold – was hindered because of the illegality and attendant stigma of the activity.
- Some child workers were either busy at work (particularly those on farms) or had gone to school. In either case, it made it difficult to interview them during normal working hours.
- Some types of work performed by children were seasonal, and were thus difficult to investigate adequately.
- Believing the study would have financial benefits, some guardians wanted to be present during interviews, inhibiting free expression on the part of the children.

Results

Sample group profile

A total of 230 children were interviewed. Of these, 86 per cent were from Gweru district and 14 per cent were from Shurugwi Rural. About 74 per cent were from Gweru Urban, 14 per cent from communal areas, 8 per cent from commercial farms, 0.9 per cent from peri-urban areas, and 0.4 per cent from growth points. About 54 percent of the

[4] See Appendix I for the English version.

children were male and 46 percent were female. Ages ranged from 8 to 18 years, with a mean age of 14.2 years. Of the sample 230 children, 56 per cent were single orphans, 36 per cent were double orphans,[5] and 6 per cent had lost one parent but were unaware of status of the other. In all, 98 per cent of the children were orphans.

Educational status

All the children interviewed except one had been to school. About 73 per cent were still attending school at the time of the study, while 27.8 per cent had left school. Of those who had left school, 59.4 were female. About 46.9 per cent of those who had left school left at primary level; 53.1 per cent had dropped out of secondary school. The main reason given for not attending school was "unaffordable school fees" (85.9 per cent). A small number of children claimed that they were not interested in going to school, while 6.3 per cent cited long distances to school and lack of birth certificates as the reasons for not going to school. Among those who left school, 53.1 per cent were in the 10 to 14-year age group. Of those going to school, about 52 per cent had their school fees paid by parents or guardians, while 25 per cent and 21 per cent, respectively, said the school fees were being paid by relatives and government or by NGOs. About 1 per cent of the children said they were paying their own school fees. Most of the children (78.3 per cent) went to school daily. Those who missed school cited non-payment of fees (39.2 per cent) and work commitments (29.9 per cent) as their reasons for missing school. Only four children stated that they were totally disinterested in going back to school.

Living conditions and well-being

About 30 per cent of the children were living with grandparents, 28 per cent with their mothers, 14.8 per cent with their aunts or uncles, 4 per cent with their fathers, and 5 per cent with non-relatives. A relatively large number of children (56 per cent) had moved from one household to another one. Of these, 24.6 per cent had moved because their families had been resettled, 21.4 per cent said that they moved because both parents had passed away, 30 per cent moved because the father or mother had died, and 6 per cent moved because they were having problems with either the stepmother or other relatives with whom they were now staying.

The children stayed with families ranging in size from one to 12. The mean family size was 4.5. Most of the children (71.7 per cent) slept on the floor in their homes, while 22.2 per cent slept on beds and about 4 per cent slept in the streets. Some children lived in informal settlements, in dwellings made of paper, and others slept on shop verandas, in the open, or in drains. Some of the children used plastic bags as blankets at night. Some children were subsisting on one meal a day while others collected leftovers from restaurants.

The street children were subjected to physical and sexual abuse as well as beatings by older peers and security officers. Some of the children admitted using behaviour-altering substances such as glue to enable them to scavenge rubbish bins without being offended by the smell of rotting food.

About 31 per cent of the orphans had working parents or guardians, of whom 25.4 per cent were farmers, 23.9 per cent were general hand/domestic workers, 16.9 per cent were vendors, and 9.9 per cent were craftspersons. Of the total number of children, 26 per cent

[5] A "single orphan" is defined as a child that has lost one parent, while a "double orphan" is a child that has lost both parents.

wanted to be teachers, 21 per cent doctors or nurses, 10 per cent police officers, 7.8 per cent business persons and 5.7 per cent drivers.

Work and working conditions

Of the total 230 children, 83.9 per cent were working at the time of the study, while 50.4 per cent had worked before. Of this sample population, 34 per cent were vendors, 22 per cent were engaged in agriculture and 21 per cent were domestic workers. About 36 per cent were working in the streets, 28 per cent in the house and 29 per cent were working in the fields. Some children were doing more than one job,[6] and some were working in more than one location. Most of the children were working during the daytime, while fewer than 3 per cent were working at night. Most of those who worked at night were domestic workers and children in prostitution, while most of those who worked in the evenings were domestic workers, vendors and children in prostitution.

About 68 per cent of the children started working between the ages of 8 and 14, while about 8 per cent started working between the ages of 3 and 7 years. The need to supplement family income motivated 55.7 per cent of the children to start working, while 15.2 per cent wanted to raise money for school fees, 13 per cent wanted to be economically independent, and 5 per cent wanted to raise money to buy food. About 22.6 per cent of the working children had permanent jobs, while 43.9 per cent had short-term/casual jobs.[7] Among the latter group, 37.8 per cent worked during school holidays. Of the total, 65.8 per cent worked with adults, with 42.5 per cent of these getting the same remuneration as the adults.

The study revealed a relatively high prevalence (27.4 per cent) of workplace- and work-related illnesses and injuries. Types of injury included backaches, swollen legs and hands, asthma/coughs, bruises, malaria and sexually transmitted infections (STIs). A significant number of children (30.9 per cent) also reported having seen other children injured while at work.

About 55 per cent of the working children, whether in paid or unpaid work, claimed generally to like their jobs – 48 per cent said it was because of the remuneration they were getting, while others cited getting food, meeting other people, or the fact that the work was not strenuous. Those who disliked their jobs presented a variety of reasons, including starting work early, low wages, the arduous nature of the work, interference with schooling, risks of diseases like STIs/HIV, and other occupational hazards such as harassment and lack of protective clothing.

When asked whether they would encourage their siblings to do the same job, 30.4 per cent said they would because of the benefits they were getting in terms of food, money, and work experience. The rest said they would not because of low wages, strenuous and tedious work, work-related hazards and interference with schoolwork.

Although the children appreciated having free time, when asked what they did with it they referred to activities similar to work, among these hairdressing, craftwork, domestic work, and looking for food and jobs. About 30 per cent spent their spare time reading, while 22 per cent either played or watched TV, 16.5 per cent practised sports, and 12 per

[6] The total number by work category is greater than the sample size of 230, indicating that a number of children were performing more than one job.

[7] Short-term/casual jobs are part-time jobs.

cent did nothing. Some mentioned visiting friends and relatives and going to church as their pastime activities.

Many children wanted to be professionals such as doctors/nurses (22.1 per cent), teachers (26.5 per cent), and police officers (10.2 per cent). Others (10.6 per cent) expressed no aspirations beyond having families of their own.

FGDs revealed that, for some children, work started as early as 6 a.m. and ended at 6 p.m. In addition, most children did a lot of work at home before and after school.

Remuneration

The majority of the working children (64 per cent) were paid. Of these, 76 per cent were paid in cash while the rest were paid in kind. About 26 per cent of those paid in kind were given food, 14.7 per cent were given varying quantities of maize, 29.4 per cent were given school fees and 20.6 per cent were given clothing. All told, 41 per cent were working for food in one form or the other. Those paid in cash received amounts ranging from Z$10 to Z$6,500 (US$0.18 to $118.30). Those receiving monthly payment earned a mean income of Z$929 (US$16.90).

Most children (72 per cent) also had income from vending, craftwork, farm work, hairdressing, "boyfriends", or domestic work, earning from Z$13 to Z$3,000 (US$0.24 to $54.60) with a mean income of Z$455.56 (US$8.30). Most of the children (71 per cent) were not rewarded for doing exceptionally well. Among those so rewarded, about 53 per cent were given money, 24 per cent were given clothes, 14.5 per cent got food and 8 per cent received only praise. Most of the children (92 per cent) did not get paid when they were off sick.

Slightly more than half of the children who received cash payments for their work said they decided how their money was to be spent, while 46.5 per cent said parents or guardians made the decision for them. Of the total, 38 per cent spent their money on food and clothing, while 26.8 per cent gave it all to their parents or guardians, 12.3 per cent gave only part of it to parents and 14.5 per cent used it to pay school fees.

Domestic work

The majority of the children (85 per cent) did household chores. About 45 per cent were solely responsible for domestic chores. Most of those who participated in domestic chores were sisters, followed by mothers, aunts and brothers. A high percentage of children (74 per cent) were involved in the preparation and serving of food, and 82 per cent helped with cleaning utensils. A surprisingly low percentage of children (8-22 per cent) were involved in care for the elderly, the sick, and other children. Other domestic chores performed by the children included laundry, fetching firewood, herding cattle, doing minor repairs, shopping for the household and gardening.

The children normally spent an average of 3.7 hours per day on weekdays and 5.6 hours per day during weekends doing domestic chores. About 69 per cent of the children did domestic chores in other households. Of these, 70 per cent got paid an average of Z$425 (US$7.73) for working an average of 19.5 hours per week.

Commercial sexual exploitation

Out of the sample of 230 children, 23 were engaged in commercial sex work.

Children in prostitution are of particular interest in this study. This group is not only at high risk of getting HIV and AIDS, it is also especially likely to spread HIV.

All the children in prostitution were females aged between 15 and 18 years. Of the total, 13 began working in this activity for money, one was doing it for fun, two started after their parents had died, another two said that they engaged in this activity as a result of "frustration", while five said that friends introduced them to the trade. Of the 23 children in prostitution, 30.4 per cent started this trade at 17 years of age, 21.7 per cent started at the age of 16, while 8.6 per cent started at 12 and 13.

In terms of commercial venue, 43 per cent met their clients in nightclubs, 22 per cent met their clients at hotels, another 22 per cent in the streets and 13 per cent in bars. The children did not choose their clients by race, profession, or any other criteria other than the ability to pay for their services. When it came to luring schoolgirls into prostitution, a mixed school- and non-school-going children FGD identified taxi drivers as the main culprits. The children served their clients in clients' cars, hotels/lodges, houses, bushes, brothels and beer halls. Close to half of these children, 43.5 per cent, reported that most of the sexual activity took place in the homes of the clients and 30.4 per cent said that the bush was also a favourite place to conduct business.

These children reported engaging in a variety of sexual activities with clients, with 30.4 per cent of the children having had anal sex, 95.7 per cent engaging in vaginal sex, and 13 per cent practising oral sex. Among these same children, 47.8 per cent met one client a day, while the rest met two or more a day. Most worked independently, but 17.4 per cent were managed by pimps, who collected the money on their behalf. Only one girl out of the four with bosses learned from him how much he collected.

Children in prostitution earned incomes ranging from Z$300 to Z$2,500 (US$5.46 to $45.50) per client. Most earned about Z$500 (US$9.01) per client.

Only two out of 23 had medical aid; the rest had to pay their own medical bills. Most of them also indicated that they never had medical checkups.

The majority of the children (82.6 per cent) produced information on the occupational hazards of their work. Their sources of information were given as government health workers, NGO volunteers, colleagues, the media, counsellors, guardians and grandparents.

HIV/AIDS awareness among children in prostitution

Among the children in prostitution, 95.7 per cent were aware of HIV/AIDS. When asked about their last five sexual encounters, 65.2 per cent said they had consistently used condoms, while the remainder used them only erratically. Those who did not use condoms regularly cited as reasons: higher earnings (4.3 per cent), client refusals (8.7 per cent), condom unavailability (4.3 per cent), ignorance of condom use (4.3 per cent) and confidence in the sexual partner (8.7 per cent).

HIV/AIDS awareness among the children interviewed

Of the 230 children interviewed, 94.8 per cent were aware of HIV/AIDS. Few children (5.7 per cent) obtained the information from their parents, however, suggesting that most parents do not discuss HIV/AIDS with their children. About 24.3 per cent of the children obtained the information from their friends, 9.1 per cent from relatives, 39.6 per cent from the media, 55.7 per cent from schools, 4.3 per cent from medical facilities, 2.2 per cent from their workplaces and 3 per cent from peer educators. These figures

highlight the important role of both formal and informal education in HIV/AIDS prevention. The children were also aware of the various routes through which HIV/AIDS may be transmitted.

Of the 230 children, 43 had had sex. The average age at first sexual intercourse ranged from 7 to 18 years. The majority of children experienced sexual intercourse for the first time at 14 years of age. Abstaining from sex was the most frequently cited way of avoiding HIV/AIDS (60.4 per cent), followed by condom use (36.1 per cent),[8] avoiding shared needles and razors (13 per cent), limiting sexual partners (13.9 per cent) and avoiding sex with children in prostitution (6.5 per cent).

Reasons given for having had sex ranged from fun and experimentation to rape and abuse. To reduce the proliferation of HIV/AIDS, it is necessary to eliminate some of the reasons that people engage in sexual activities. Human nature would suggest that little can be done about the "fun and experimentation" elements, but a lot can be done through civic interventions about rape and abuse. On the other hand, condom use, avoiding shared needles and razors, limiting the number of sexual partners and avoiding sex with children are decisions made at an individual level, making them difficult to deal with. Awareness campaigns and peer education, however, can help.

Findings from interviews with key informants

The following is an overview of the information collected in interviews with key informants:

- Programmes related to HIV/AIDS and child labour that are designed at the top might not be suitable for conditions on the ground, and their planning and implementation should be decentralized.

- To maximize the actual amount reaching intended beneficiaries, governments should make more resources available directly to local authorities. These allocations should be based on orphan population rather than total population.

- There ought to be legislation protecting orphans, for example laws regarding acquisition of birth certificates. Lack of such documents mean that more and more orphans are unable to access schools or their parents' terminal benefits.

- More awareness campaigns targeting the rights of children – e.g. the right to own the houses of their deceased parents – are needed.

- Specialized training is needed to strengthen the capacity within local authorities to handle problems associated with orphanhood.

- Orphans in school typically lack proper uniforms, school fees, basic texts and exercise books, and food. School attendance is poor in this group, furthermore, due to the long distances that students have to travel to get to school and/or poor health.

- The basic education assistance module (BEAM) and the Better Schools Programme need expansion in terms of amounts allocated and coverage, and government supplementary feeding programmes for schoolchildren need to be reintroduced.

[8] It seems that more focus on prophylactics (male and female) is still necessary, given that only about one-third of the children were aware of this method.

Summary and conclusions

This study explored the nature and extent of both HIV/AIDS and child labour in Zimbabwe and the linkages between them. The link between HIV/AIDS and child labour was established through cause-of-death analysis.

In the first place, findings indicated a high correlation between orphanhood and child labour. (Within this rapid assessment sample, 98 per cent of the children were orphans and 84 per cent were working.) It remained to show whether there had been a high incidence of HIV/AIDS among the orphans' deceased parents.

Certain ailments and long illnesses are statistically correlated with HIV/AIDS. High HIV-prevalence rates have been reported among STI and Tuberculosis (TB) patients, for example, and, in these cases, we may talk about death from AIDS-related diseases. The sample in the study under review were asked to state the cause of their parents' deaths and to say whether the parents had been ill for long. The responses allowed researchers to conclude that high incidences of HIV/AIDS were indeed associated with high rates of orphanhood and, hence, with child labour.

These findings suggest that attacking the root causes of HIV/AIDS and its spread would have a significant effect in programmes to eliminate child labour.

But the proliferation of child labour can also be curbed in other ways. These include the development of child-friendly policies to attack the basic causes, other than orphanhood, of child labour. This entails addressing the problems of poverty among orphans and empowering communities to deal with the issues.

Recommendations

1. The planning and implementation of programmes should be left to local authorities who, by reason of their very location, are more acquainted with the problems on the ground. The role of the Government should be to disburse funds to local authorities.

2. The allocation of funds to local authorities should not be based on total populations, but rather on the actual number of children needing assistance in a given region.

3. Local authorities should be empowered, through capacity-building programmes (e.g. manpower development and empowering institutions by providing needed equipment and financial support) to deal with the problems in their own areas.

4. Orphaned children should be supported in their efforts to obtain birth certificates. This would give them access to the estates of their deceased parents, education and other government programmes targeting orphans.

5. Legislation is needed to protect orphans, ensuring that they are neither marginalized nor abused and exploited. An example of this is inheritance laws that give orphans first preference to their deceased parents' estates.

6. Laws do exist that give orphans the right to own their deceased parents' houses in urban areas, but most orphans appear unaware of this. More awareness campaigns promoting the rights of children would rectify the situation.

7. Schemes such as the supplementary feeding programme in schools should be revived, and the BEAM and Better Schools Programme should be expanded to ensure access

to food and educational materials by orphans and child workers suffering from the HIV/AIDS pandemic.

8. Checks and balances must be established to ensure that programmes are not executed along political or tribal lines, and heavy penalties should be applied against those mishandling resources.

9. Stiff penalties ought to be meted out to those found guilty of abusing children in general and orphans in particular, especially if these are law enforcement agents.

10. The Government should clearly stipulate unacceptable types of child labour and form a department (probably in the Ministry of Labour) that monitors child labour and penalizes people found guilty of perpetrating child labour, particularly its worst forms.

11. In a bid to reduce the incidence of deaths from HIV/AIDS, the Government should consider both subsidizing retroviral drugs and making them available over the counter.

Acronyms

BEAM	Basic Education Assistance Module
CADEC	Catholic Development Commission
CDC	children in difficult circumstances
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CSO	Central Statistical Office
CWF	Child Welfare Forum
DAAC	District AIDS action committee
ESAP	Economic structural adjustment programme
FGD	focus group discussion
GAPWUZ	General Agricultural Plantation Workers' Union of Zimbabwe
GAWUZ	General Agricultural Workers' Union in Zimbabwe
GDP	gross domestic product
GWAPA	Gweru Women's AIDS Prevention Association
ICDS	Inter-Censal Demographic Survey
ICES	Income, Consumption and Expenditure Survey
IDS	Institute of Development Studies
IPEC	International Programme on the Elimination of Child Labour
LAMA	Legal Age of Majority Act
MASO	Midlands AIDS Services Organization
NGO	non-governmental organization
PAAP	Poverty Alleviation Action Plan
PASS	Poverty Assessment Study Survey
PRF	Poverty Reduction Forum
SADC	Southern African Development Community
SIMPOC	Statistical Information and Monitoring Programme on Child Labour
STI	sexually transmitted infections
UDI	Unilateral Declaration of Independence

UNDP	United Nations Development Programme
WFCL	worst forms of child labour
WHO	World Health Organization
ZDAWU	Zimbabwe Domestic and Allied Workers' Union
ZDHS	Zimbabwe Demographic and Health Survey
ZIMPREST	Zimbabwe Programme for Economic and Social Transformation

1. Introduction

The International Labour Organization (ILO), through the International Programme on the Elimination of Child Labour (IPEC), has made a major commitment to the elimination of the worst forms of child labour. The Worst Forms of Child Labour Convention, 1999 (No. 182), together with Recommendation No. 190, was unanimously adopted by the ILO Conference in June 1999. Convention No. 182 requires ratifying countries to "take immediate and effective measures to secure the prohibition and elimination of the worst forms of child labour as a matter of urgency". Recommendation No. 190 states that "detailed information and statistical data on the nature and extent of child labour should be compiled and kept up to date to serve as a basis for determining priorities for national action for the abolition of child labour, in particular for the prohibition of its worst forms, as a matter of urgency".

Against this background, the ILO, through IPEC's Policy Branch, is conducting a series of qualitative investigations of the root causes behind child labour, focusing on its worst forms.

It has been commonly assumed that the sub-Saharan African HIV/AIDS pandemic is also a cause of child labour. IPEC decided to commission further research to clarify this link. Consequently, HIV/AIDS and child labour became the focus of four studies in southern and eastern African countries.[1] These investigations were to be conducted through the application of the rapid assessment methodology[2] developed by ILO/UNICEF. Rapid assessments are uniquely suited for these investigations. Balancing statistical precision with qualitative analysis, rapid assessments provide policy-makers – quickly and relatively inexpensively – with insights into the linkage, magnitude, character, causes, and consequences of HIV/AIDS and child labour. These insights can then be used to determine policies and programmes as well as strategic objectives and interventions for the elimination of child labour, in particular when linked to HIV/AIDS by way of death of parents, teachers, contamination through work environment, etc.

[1] South Africa, United Republic of Tanzania, Zambia and Zimbabwe.

[2] The field guide for rapid assessment is available at www.ilo.org/public/english/standards/ipec/simpoc/guides/index.htm.

2. Background and context

The emergence of HIV/AIDS since 1985 as a major cause of ill health has had a major impact on Zimbabweans. In 1990, the national seroprevalence rate among the population aged 15 years and older was 9.2 per cent. In 1994, it doubled to 18 per cent and increased to 19.4 per cent in 1995. In fact, sentinel surveillance data suggest that 25-29 per cent of the Zimbabwean population is HIV positive. According to WHO, Zimbabwe, together with Botswana, Malawi, Uganda and Zambia, is among the five most affected countries. In 1990, a total of 26,840 patients died of HIV/AIDS-related diseases. This figure rose to 124,071 in 2000, and is projected to increase to more than 137,000 in 2005 (Ministry of Health and Child Welfare, 1999).

The Ministry of Health and Child Welfare (MOHCW) estimates that about 2,000 people die every week from HIV/AIDS-related illnesses. In 1998, a total of 7,291 new cases were diagnosed and, of these, about 4 per cent were among people aged 50 years or older. About 70 per cent of the cases were of people aged between 20 and 49 years.

STI increases the risk of HIV infection, and high HIV-prevalence rates have been reported among STI and TB cases. Studies conducted at the sentinel sites show that seroprevalence among STI patients ranges from 24 per cent to 60 per cent.[1] Sexually transmitted infections remain a major problem contributing to the spread of HIV. In 1996, STI accounted for 5.8 per cent of all outpatient new attendance and more than 10 per cent of new attendance in the major cities.

TB, once thought to be virtually eliminated, almost tripled in incidence from 96.7 per 100,000 in 1990 to 267.5 in 1995 and 370 in 1998, with increases most marked in the adult population aged 30-55 years. A few surveys have detected about a 60 per cent positive rate of HIV infection among new TB cases. The MOHCW has introduced directly observed treatment (DOTS) aimed at improving the treatment, compliance and alleviation of pressure on hospital beds. The TB fatality rate increased from 6.2 per cent in 1989 to 10.9 per cent in 1995.

Between 57,000 and 100,000 children in Zimbabwe are living with HIV/AIDS infection. About 9 per cent of newborn babies are infected. Mother to child transmission occurs during pregnancy, delivery and, through breastfeeding, in the postpartum period. It is estimated that 25-40 per cent of HIV-infected pregnant mothers pass the virus to their infants this way. Data shows that about 30 per cent of pregnant women are infected with HIV/AIDS.

With a national AIDS rate of 25 per cent and the resulting morbidity and mortality, the impact of AIDS on children is especially obvious. It is estimated that 23.7 per cent (1,066,702) of all children under 15 years of age are orphans. It is expected that these figures will rise to 1,244,286 and 1,264,047 by the years 2005 and 2007, respectively. About 543,000 children have lost one or both parents to AIDS, and estimates show that there will be 910,000 orphans by 2010 (Hunter and Fall, 1998).

Orphanhood has led to a high incidence of child labour, as children find themselves with no option for survival beyond entering the labour market. Deteriorating economic conditions, poor health delivery systems and political instability exacerbate the plight of orphans. In some cases, HIV/AIDS orphans find themselves engaged in the worst forms of child labour.

[1] *National health strategy document for Zimbabwe*, 1997.

The worst forms of child labour may be fully appreciated only by examining the larger environment in which they appear – in this case, factors at the national level external to the children and their households such as demographic structure, human capital, economic environment, the political environment and the legal environment.

2.1. Demographic structure

The 1997 Inter-Censal Demographic Survey (ICDS) put the total population of Zimbabwe at 11,789,274 people, of which 48 per cent were male. The 1987 ICDS reported 8.7 million people, of which 49 per cent were male. This suggests an annual population growth rate of about 3.085 per cent. Applying this rate, then, we extrapolate a current population of about 13,789,274 people. About 69 per cent of the population resides in the rural areas, while 31 per cent are urban dwellers (ICDS, 1997).

Zimbabwe is now in the second stage of a demographic transition characterized by low mortality and continuing high fertility. The total fertility rate has fallen steeply from 7.8 in 1969 to 5.5 in 1988, 4.3 in 1994 and 4.0 in 1999. [2]

About 56 per cent of the population is 19 years or younger, while 44 per cent is 20 years and older. Given that the legal age of majority is 18 years, the population of children should be about 7.8 million (56.5 per cent of 13,789,274). The child dependency ratio, here defined as those aged 14 years or less as a percentage of the population aged more than 14 years, is therefore 78.6 per cent. This is a decline from the 1987 figure of about 98 per cent. This probably reflects the fact that 70 per cent of AIDS cases are found among people aged between 20 and 49 years. This suggests that there are more children than adults, implying an increase in orphanhood. Between 1987 and 1997 the old-age dependency ratio, defined as the proportion of those aged 65 years and above to the population between 15 and 64 years, remained fairly stable at between 6 per cent and 7 per cent.

2.2. Human capital

Human capital refers to level of human resources development in terms of health and education. Clearly, the state of health delivery systems have a bearing on the spread of HIV/AIDS, while the level of educational attainment affects poverty levels, and poverty is the major reason for early entry into the labour market. To the extent that a correlation between HIV/AIDS and orphanhood can be established, together with a further link between orphanhood and diminished access to education, then we can say that HIV/AIDS in Zimbabwe is contributing to poverty and to the increasing prevalence of child labour.

2.2.1. Health

Before independence, in 1980, provision of health services was fraught with racism and urban bias. The majority of blacks living in rural areas suffered from poverty-related

[2] CSO, 1995; ICDS, 1998; Zimbabwe Demographic and Health Survey (ZDHS) 1988, 1994 and 1999. This decline in fertility is attributed to the rapid increase in the use of modern contraceptives. The contraceptive prevalence rate (CPR), or the percentage of currently married women using a family planning method, is 54 per cent. The pill is the most commonly used method of contraception (35.5 per cent), followed by injectables (8 per cent) and female sterilization (3 per cent) (ZDHS, 1999). Consistently, the crude birth rate (CBR) declined from 48 per 1,000 in 1969 to 38.8 in 1992, 34.7 in 1997 and 30.8 in 1999.

communicable and nutrition-deficiency diseases (Gilmurray and Saunders, 1970; Agere, 1986; and Loewenson, 1991). Following independence, the new Government approved a white paper entitled "Planning for equity in health", which outlined the national health policy and was in line with the overall policy objectives in the "Growth with equity" policy document. [3]

A phenomenal change for the better in health service provision ensued during the first decade of independence, with concomitant changes in child mortality rates, maternal mortality and life expectancy.

Regrettably, most of the gains achieved in the first ten years of independence have been eroded by the impacts of HIV/AIDS drought, and the economic structural adjustment programme (ESAP). [4]

Analysis of trends in health indicators such as mortality rates and life expectancy best measures the impact of developments in the health sector. While Zimbabwe made impressive post-independence gains, these indicators have shown signs of deterioration from the early 1990s. This reflects a major decline in socio-economic conditions resulting from the initial impact of the structural adjustment programme and the drought of the early 1990s. Infant mortality rates (IMR) declined during the first decade of independence due to high budgetary allocations during this period. It decreased from 85 deaths per 1,000 live births in 1978 to 53 infant deaths per 1,000 in 1988. It increased in the 1990s, however, and in 1999 it stood at 65 (ZDHS, 1999). The leading causes of death for the under-one-year-olds were prenatal conditions, respiratory and intestinal infections, nutritional deficiencies and TB.

HIV/AIDS is now one of the leading causes of death of children younger than 5 years. The child mortality rate (CMR) rose from 26 per 1,000 in 1990 to 36 in 1997 and 39.6 in 1999 (ZDHS, 1999). Since the CMR reflects environmental factors affecting child health such as nutrition, sanitation, childhood communicable diseases and accidents occurring in and around the home, it can be assumed that exposure to these factors is increasing, particularly for children in especially difficult circumstances.

[3] In addition, the Government adopted the WHO slogan "Health for all by the year 2000" (Gumbo, 1995). Other developments in the health sector included a re-orientation towards primary health care (PHC) models, which the WHO describes as affordable, accessible and acceptable to various communities.

[4] In 2000, there were 1,449 health facilities in Zimbabwe, of which 1,316 were at the primary level, 92 at the secondary level, 12 at the tertiary level, five at the quaternary level and 27 at other facilities. There were a total of 24,396 hospital beds in Zimbabwe in 2000, which works out to 18 beds per 10,000 people. The *Zimbabwe human development report* (1998) showed that 8.8 per cent of the population did not have access to health care. Immunization rates for the major diseases showed major declines. The general decline is explained by the depreciation of the Zimbabwean dollar and a general decline in government expenditure on health. There has been a steady decline in admissions from 614,913 in 1995 to 396,511 in 1999. The bed occupancy rate was between 64 per cent and 70 per cent between 1995 and 1998. This shot up to 100 per cent in 1999, however, probably reflecting the extent of the HIV/AIDS pandemic.

The declines in both the rates of immunization coverage and bed occupancy in hospitals could be explained, in part, by increases in the prices of health provision. Taking the base index as 100 in 1995, the medical care general price index increased to 652 by March 2001. The increase in prices itself is explained by the depreciation of the Zimbabwean currency against the major foreign currencies. Reductions in government expenditure on health, the removal of subsidies and the introduction of cost recovery also contributed to these declines.

HIV/AIDs is directly affecting orphanhood, with the maternal mortality rate (MMR) having risen sharply from 283 maternal deaths per 100,000 live births in 1992 to an estimated 695 per 100,000 in 1999 (DHS, 1999). This change reflects the contribution of non-maternal factors such as HIV/AIDS. [5]

Life expectancy at birth (LEB) is widely used as an indicator of general health. The increase in the LEB from 56 years in 1980 to 61 in 1990 (Government of Zimbabwe, 1996; CSO, 1992) is associated with an overall initial decline in mortality from 10 to 6 per cent. The LEB in 1990 was higher for females at 62 than for males at 58. From the mid-1990s, there has been a levelling off and a real decline in LEB, which is expected, also due to HIV/AIDS, to fall to below 40 by 2002.

Child nutrition improved from 1980 to 1984; levelled off till the early 1990s; and thereafter declined, most markedly during the 1992 drought year. In 1980, the national underweight (below the line) average was about 21 per cent, and levels of underweight ranged from 50 per cent in the large-scale commercial farms (LSCF) to 6-10 per cent in urban areas. The national average for the underweight was 17.7 per cent in 1984, 16 per cent in 1985, and 11 per cent in 1988, rising again to 17 per cent in 1994 (ZDHS, 1988, 1994, 1999). Under-nutrition (stunting) among children has become less prevalent in the past decade, declining from 36 per cent in 1982 to 29 per cent in 1988 to 23 per cent in 1994.

This remains a serious issue, however, and the HIV/AIDS pandemic could seriously exacerbate the problem.

2.2.2. Education

Zimbabwe has achieved one of the highest education provisions and attainment indicators in sub-Saharan Africa, comparing favourably with countries with similar income levels on other continents (World Bank, 1996). At independence, democratized access to education became one of the new Government's key policy priorities. Primary education was made free of charge to enable children from lower socio-economic backgrounds to attend school. By 1990, most of the quantitative expansion of the education system was complete, and the focus changed to providing a higher quality of education. [6]

Access to education, however, is still limited in the remoter parts of the country, in farming areas and among children from less advantaged socio-economic backgrounds who cannot meet the costs of education, particularly at secondary-school level. Access has also become an issue due to existing disparities in the provision of facilities between different types of schools. [7] The number of books, other learning materials, qualified teachers and

[5] Other data show a rise in the maternal death rate from 73.6 per 100,000 in 1987 to 159.5 per 100,000 in 1994, contrary to DHS estimates of the MMR at 283 per 100,000 live births in 1992.

[6] To facilitate this expansion, financial allocation to the education sector rose from Z$121.6 million (US$2.21 million) in the 1979-80 financial year to Z$218 million (US$3.97 million) in the 1980-81 financial year. In 1985-86, Z$562.2 million (US$10.23 million) was allocated, and in 1989-90 the allocation for primary and secondary school education was increased to Z$1 billion, or US$18.2 million (Auret, 1990:27). To date, education has continued to receive generous allocations from the national budget, with concomitant increases in school enrolment. In 1979, school enrolment stood at just over 800,000. By 1983, it had risen to 2.5 million, with 419,553 of this number attending secondary schools.

[7] Disparities exist between urban and rural schools, rural district day schools and high fee-paying private schools, and between former group A and group B schools.

other resources has an impact on the quality of education that a school provides. In general, better-financed schools tend to produce better-quality education and therefore provide better opportunities for pupils. The cost of education increased tremendously between 1985 and 2001. With 1985 equal to 100, the cost of education index increased to 518 by March 2001.

Escalation of educational costs continues to limit educational opportunities for children from lower socio-economic backgrounds. Girls continue to be more disadvantaged than boys, particularly at the higher educational levels.

3. The economy

The general economic situation is probably the most critical determinant of child labour levels, especially of the worst forms of such labour. Poor economic performance manifests itself in poor health delivery systems, poor educational standards, high costs of living, declining employment and, eventually, high levels of poverty leading to child labour. It is the high level of poverty that leads children, particularly orphans, to join the labour force at an early age.

The Zimbabwean economy is more diversified than most in the region.[1] The economy, as measured by the ratio of the sum of imports and exports to GDP, presented an 89.2 per cent degree of openness in 1998.[2]

The domestic debt increased from Z$4,639 million (US$84.42 million) in 1985 to Z$11,318 million (US$205.97 million) in 1990. The budget deficit was about 10 per cent of GDP, this rather high figure being due to rapid expansion of social services, growing numbers of civil servants, a high defence budget and subsidies to parastatals. The fact that most government spending (85 per cent in 1998) was directed to current expenditure meant that the situation was unsustainable in the long term. The external debt, meanwhile, increased from US$786 million (Z$43,190.70 million) in 1980 to US$3,199 million (Z$175,785.05 million) in 1990. Debt service payments as a ratio of export revenue rose from 3.8 per cent in 1980 to 22.6 per cent in 1990.[3]

[1] It has well-developed manufacturing and farming sectors, a diverse mineral resource base, and a fairly well-developed road and communications network. The manufacturing sector ranked highest in terms of contribution to GDP. In 1999, manufacturing's share, at about 19 per cent, was followed by agriculture with 17.7 per cent, distribution, hotels and restaurants (17.4 per cent), transport and communication (9.1 per cent), and finance and insurance (7.4 per cent). The agricultural sector contributed about 26 per cent to employment, followed by the manufacturing sector with 15 per cent, education with 11.7 per cent and domestic service with 8.3 per cent.

[2] Exports accounted for 38.4 per cent, while agriculture contributed about 40 per cent of the total export earnings. Mining and tourism continue to be the second and third largest contributors, respectively, to export earnings. Tobacco is the single largest export earner, accounting for about 26 per cent of total export earnings (*Zimbabwe human development report*, 1999). Zimbabwean export earnings increased from US$1,750 million (Z$96,162.50 million) in 1990 to US$2,496 million (Z$137,155.20 million) in 1997. Since, earnings have declined to US$1,717 million (Z$94,349.20 million) in 2001 (Stanbic Bank of Zimbabwe Limited, *Quarterly Economic Review, 2001*). Exports increased at an annual average rate of 2.1 per cent during the period 1991 to 1998, against a target rate of 9 per cent per annum. During the latter half of the 1990s there was a market shift from the European Union as an export destination to the Southern African Development Community (SADC) region. Exports to the region now account for about 30 per cent of the country's total exports.

[3] Due to mounting socio-economic problems associated with these imbalances, in October 1990 the Government of Zimbabwe adopted the Economic Structural Adjustment Programme (ESAP) as a remedial strategy. This was to run for a five-year period up to 1995. This was succeeded by a sister reform programme, ZIMPREST, which was to run from 1996 to 2000. The major tenets of both ESAP and ZIMPREST were public enterprise reform, civil service reform, monetary policy and financial sector reform, trade and exchange market liberalization, domestic deregulation and investment promotion. Under the public enterprise reform programme, subsidies were targeted to decline from Z$629 million in 1990-91 to Z$40 million in 1994-95, and efficiency in public enterprises was to be improved through the privatization and/or commercialization of these enterprises. The outcome of this programme was poor performance by public enterprises. Losses incurred amounted to Z$2 billion in 1993-94 and $1.8 billion in 1994-95. Lack of compliance to

By 1995, all price and distribution controls in place prior to the ESAP had been removed. To cushion vulnerable groups from the initial impact of ESAP, the Social Dimension Fund was established in 1991 to provide safety nets for those earning less than Z$400 (US$7.28) per month. The Poverty Alleviation Action Plan (PAAP) was introduced to alleviate all forms of poverty.

In principle, liberalization should lead to an acceleration of growth and productivity through greater allocative efficiency and better resource allocation. In practice, however, with the exception of South-East and East Asia, the growth record of most other regions and countries during the 1980s and 1990s has been unimpressive. In the case of Zimbabwe, the growth rate was higher (at 4.1 per cent) during the UDI [4] period (1971-79) than during the first decade of independence (1980-99 at 3.1 per cent) or the reform period (1991-94 at 1.5 per cent). No clear trend emerges, with the growth rate generally fluctuating with the timing of the droughts of 1982-84, 1987, 1992 and 1995, which led to contractions of output. It is also uncertain whether the growth rate achieved in 1996 could be sustained with high inflation rates and large budget deficits.

The success or failure of reform programmes is best judged by looking at the impact of these programmes on growth and productivity, employment and poverty. The annual 1.5 per cent economic growth rate has remained lower than population growth, thus leading to a decline in per capita output growth rate. This, in turn, has led to a decline in living standards. In 1993, income per capita (Z$405 at 1980 prices; US$7.37 at current exchange rates) was lower than that in 1980 (Z$438; US$7.97). In 1998, economic growth was only 2 per cent, short of the 3 per cent target. [5]

The Reserve Bank of Zimbabwe's most recent estimated productivity index, for the economy as a whole, rose from the 1990 base of 100 to 103 in 1998. The sectoral productivity index for agriculture declined to 99 in 1997, whereas that for manufacturing declined to 90.5. The transportation, communications, distribution and hotels sectors accounted for the slight overall increase in the index (see Reserve Bank of Zimbabwe, *Weekly Economic Highlights*, 4 June 1999). Among tradable sectors, labour productivity in agriculture rose slightly during the 1970s and 1980s, but remained almost constant in manufacturing and services (Kanyanze, 1999; Weeks and Mosley, 1998).

Structural adjustment programmes (SAPs) and economic reform measures influence employment and its security in several direct and indirect ways. First, one of the main components of the conventional SAPs included reduction in public expenditures through retrenchment of public sector employees. Indirectly, worker retrenchments may occur in the private sector following liberalization. Prior to liberalization, many countries, including Zimbabwe, had explicit laws and regulations such as the Employment Act of 1980 that prevented employers from laying off workers without prior permission from the Government, and that defined penalties for wrongful dismissal (i.e. reinstatement with back pay and a fine or a prison sentence for the employer).

government policy resolutions by both Ministries and public enterprises had a negative impact on the fiscus. During ESAP the Government took over debts of public enterprises amounting to Z$4.23 billion with the aim of facilitating the commercialization and privatization of these enterprises. This contributed to the worsening of the budget deficit.

[4] UDI stands for Unilateral Declaration of Independence.

[5] This fall was mainly caused by declining output in manufacturing and mining. Manufacturing, which contributed only 17 per cent to GDP, also suffered major declines. The sector experienced a negative growth rate of –1 per cent in 1998 (op cit., Kaliyati et al.). More than a 60 per cent depreciation of the currency vis-à-vis the US dollar more than trebled the cost of imported raw materials, and hence of domestically produced goods.

Employment growth was much lower during the liberalization period (1991-94) than for the pre-liberalization periods of 1981-85 and 1985-90. [6]

Real wages have been declining in all sectors since liberalization was introduced in 1990. Declining real wages in construction, public administration, education and health have been particularly significant. Apart from wage flexibility introduced by the economic reforms, high inflation rates accounted for falling real wages. Although declines in real wages may make Zimbabwe's exports more competitive in world markets, they explain greater urban poverty and lower standards of living, especially since per capita incomes and industrial productivity have not grown (see table 1, below). Inflation averaged about 13 per cent during 1980-90. Liberalization policies introduced in 1990 and the subsequent opening of the economy led to price decontrols and the depreciation of the Zimbabwean dollar, which increased the rate of inflation to 21 per cent in 1991. Reportedly it is now higher than 122 per cent.

Table 1. Gross domestic product at constant 1990 prices – Annual growth rates

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
GDP at factor cost	1.8	1.5	5.9	3.6	7.2	5.0	–0.5	2.9	4.2	–0.2	10.4	1.5	2.0	0.8
GDP at market prices	2.1	1.1	7.6	5.2	7.0	7.1	–8.4	2.1	5.8	0.2	10.4	2.7	2.9	–0.7
GDP per capita growth rate	–1.0	–2.0	4.3	2.0	3.7	3.9	–11.2	–1.4	2.3	–3.1	6.8	–0.5	–0.3	–3.8

If we agree that the aim of socio-economic development is to improve the welfare of the people, then poverty levels and their trends may be viewed as summary measures of development. Socio-economic development can only be said to have taken place if there is a general improvement in the living standards of the population. It has already been pointed out that poverty is the main reason that individuals decide to enter the labour market at an early age.

[6] It is clear that the decline in employment started long before the ESAP was introduced in 1990. Employment was not rising much, except in 1988 when the manufacturing sector experienced a 5.6 per cent growth (Muzulu, 1995). Sachikonye (1993) noted that manufacturing employment registered only a modest increase of 36,000 new jobs between 1975 and 1988. Public sector employment increased phenomenally, however, near doubling from 48,900 to 91,400 during the same period. But this growth represented only about 18,000 new formal sector jobs per annum during the 1980s.

While public sector employment declined rapidly in the wake of liberalization (–4.6 per cent per annum during 1991-94), private sector employment growth in agriculture and manufacturing slowed, thus failing to compensate for major deceleration in the growth of public sector employment. This may be explained by falling labour productivity and low investment (Kanyenze, 1999). This partly accounts for the growth of employment in the informal sector. Knight (1996) concluded that the expansion of small and medium-sized enterprises in the informal sector in the 1990s was due to economic failure, rather than to the economic success of reforms. Growth in informal sector employment parallels decline in formal employment growth during the reform period and the serious droughts of 1992 and 1994-95. It is possible that the latter is somewhat underestimated, since a shift took place under reforms from permanent and full-time employment towards contract and casual or part-time employment. (The latter indicator is usually used to reflect labour market flexibility as a response to global competition.) Growth in formal employment between 1990 and 1995 failed to meet expectations, increasing by only 66,000 rather than 109,000. The bulk of the increase was accounted for by the private sector (where employment rose by 14 per cent in agriculture) followed by construction. In the public sector employment actually fell by 1 per cent as a result of ESAP (op. cit., Kaliyati et al.).

In Zimbabwe, few studies have attempted to quantify poverty or, even more, to compare poverty levels across time.[7] The 1991 ICES report showed that about 2.7 million people (25 per cent of the population) were poor. About 90 per cent of these lived in rural areas. Communal areas accounted for about 90 per cent of those deemed very poor. The urban poor constituted 10 per cent of the total poor. On the other hand, the 1995 PASS report revealed that 62 per cent of Zimbabwean households earned incomes below the total consumption poverty line, 46 per cent of Zimbabwean households had incomes below the food poverty line, the incidence of poverty was higher among rural households (72 per cent) compared to urban households (46 per cent), and the incidence of poverty was higher among female-headed households (74 per cent) compared to male-headed households (57 per cent). The disparities in poverty levels between 1990-91 and 1995-96 cannot be explained by methodological differences alone. We can therefore safely conclude that poverty increased during the reform period (1990-95).

Poverty has increased because of neo-liberal policies:

- the increase in domestic food prices relative to world prices after liberalization;
- the increase in inflation rates, which hurt the poor especially badly; and
- the fall in real wages following increased domestic and global competition and labour market flexibility.

After the economic reforms in 1991, food prices shot up, more than tripling between 1990 and 1994. Since the poor, especially the very poor, spend the bulk of their income on food – among the very poor, food consumption represents nearly 60 per cent of total consumption – substantial increases in food prices are likely to worsen their economic situation. After the withdrawal of subsidies, prices of essential food items such as bread and sugar are estimated to have increased by 40 per cent and 50 per cent, respectively, in 1993 (Minot, 1994, page 6). To make matters worse, prices of such goods and services as clothing and footwear, rent, rates, fuel and medical care also increased substantially).

[7] The major studies that quantified poverty in their analyses include the 1991 Income, Consumption and Expenditure Survey (ICES) study, the 1996 ICES study and the 1995 Poverty Assessment Study Survey (PASS). The 1991 ICES study used incomes to establish poverty lines against which people are judged to be either poor or non-poor. The 1996 ICES and the 1995 PASS studies used consumption to define poverty lines. Given these methodological differences, the 1991 ICES results are not quite comparable to either the 1996 ICES or the PASS results.

4. The legal framework

The domestic and international legal frameworks are major factors determining the extent of child labour in any given society.

4.1. Domestic framework

Zimbabwe is characterized by legal duality. Two forms of legal systems co-exist: customary law; and the general law, which is basically the Roman-Dutch law. Various laws deal with or affect children as citizens of Zimbabwe. For our purposes, the important legislation includes the Legal Age of Majority Act (LAMA) of 1982, the Child Protection and Adoption Act (1996, amended 2001), and the Sexual Offences Act (2001).

LAMA stipulates that, at the age of 18 years, Zimbabwean citizens reach the age of majority, meaning that they can enter into legal and social contracts without the aid and/or approval of paternal or parental authority regardless of their race, gender, ethnicity, religion, or any other social markers. They can also vote. In other words, they become full subjects who can participate in national politics at all levels except the presidency, which requires the incumbent to be 40 years or older. In reality, however, LAMA applies only to those young people who work and live in spheres of life that do not require rituals and public ceremonies such as marriage. Among young women in particular, this right is abrogated on cultural grounds, with parental prerogatives being given first priority. Many parents view LAMA as a source of problems in their bid to control young people 18 years and older but culturally deemed unfit to be independent. LAMA is seen as undermining parental prerogatives, especially when it comes to marriage.

The Child Protection and Adoption Act (1996, amended in 2001) stipulates, inter alia, the circumstances under which and how children may be adopted or fostered, the composition of a juvenile court, and laws regarding the institutionalization of children. It also deals with neglected, abused and abandoned children. Issues dealt with in this Act include the following:

- *Juvenile courts.* These are composed as stipulated in the law, and they are not open courts (i.e. open to members of the public). Persons deemed by the courts to be professionals in child welfare assess the cases heard in these courts. The courts can prosecute parents and guardians where abuse or ill-treatment is the issue.

- *Child protection.* Children are deemed in need of state protection when seen begging on the streets or involved in public entertainment for purposes of collecting money from members of the public, wearing filthy clothing infested with vermin, or when neglected and ill-treated (that is, provided with inadequate food, shelter and clothing, and inadequately supervised, for children, or attended, for infants). Girls, in particular, are deemed in need of state protection when at risk of sexual exploitation. This normally leads to the State either taking action against the adults concerned or removing the children and putting them into care (temporarily or for a long time) through police or probation officers' intervention or the courts, depending on the case.

This Act sets unrealistically high standards for child care, given the prevailing economic and social context. If one proceeds strictly according to this Act, poverty and the escalating cost of living means the majority of children in Zimbabwe need protection.

Sexual Offences Act (2001). In Zimbabwe, the age of sexual consent is 16. This means that, although a person is legally deemed a minor at 16, he or she is deemed fit to

make decisions, provided the individual is of sound mind, whether or not to have sexual intercourse. At any age younger than 16, consent given by the person is deemed invalid at law, and sexual intercourse is viewed as "statutory rape". (This affects more girls than boys.) The Sexual Offences Act of 2001 therefore prohibits sex of any kind with persons below 16 years. The offence extends to those who lure or incite under-16s into sex or into commercial sexual exploitation. This includes people who run brothels as well as those who patronize brothels or pimps.[1] The Act also details what constitutes rape or non-consensual sex, describing the types of sexual acts that should be labelled as rape. It makes it clear that all sex offenders shall be subjected to an HIV test to ascertain whether they might have infected their victims, in which case the sentence is heavier.

If this law is to be effective, however, people must report offences to the police, and victims must be willing to testify. But families often keep the abuse secret, sex and sexuality being conventionally private matters, while transgressions of sexual norms, though prevalent, are seen as bringing shame to the whole family. Neither does the law address factors such as poverty that lead children, especially girls, into prostitution. This also makes it difficult to identify all incidences of sexual offences.

Other laws that relate to children include the following.

The Citizenship Act (1996) deals with children's right to citizenship regardless of the circumstances of their or their parent's birth, ethnicity or gender.

The Criminal Procedure and Evidence Act (1996) stipulates that children below the age of 15 cannot be tried in a regular court. Where children are victims of heinous crimes such as rape, they give evidence through the Victim Friendly Courts *in camera* to protect them from intimidation.

Although the Constitution of Zimbabwe includes a Bill of Rights, section 23 says that these rights can be abrogated on the basis of cultural rights (McFadden, 2001). This means discrimination may be legitimized on "cultural" grounds.

4.2. International protocols

Zimbabwe, a full member of the United Nations, has signed and ratified international Conventions made by the United Nations and other international organizations relating to children and the disadvantaged in general. These include the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), in 1990; the Convention on the Rights of the Child (CRC), in 1991; the Minimum Age Convention, 1973 (No. 138), in 2000 – for which Zimbabwe specified that the general applicable minimum age for admission to employment is 14 years; and the Worst Forms of Child Labour Convention, 1999 (No. 182), also in 2000.[2]

[1] Those who make a living from collecting cash returns from sexual encounters by third parties with children.

Child abuse is sometimes motivated by strange beliefs or customs. Young girls may be sexually abused, for example, in the belief that they can cleanse ailing males of their diseases, even more surely than otherwise exposing them to HIV/AIDS infection.

[2] Zimbabwe has ratified the Minimum Age Convention, 1973 (No. 138), which stipulates a minimum age of 15 for admission to employment. Developing countries may initially set this age at 14, which Zimbabwe has done. Thus, where it concerns the worst forms of child labour, the cut-off

Zimbabwe is also a signatory to the African Charter on Human and People's Rights, which not only defines the rights of people on the African Continent (articles 1-26), but also emphasizes the duties and obligations of all individuals in claiming their rights in a manner that does not abrogate the rights of others (articles 27-29).

CEDAW clearly defines discrimination as any form of exclusion, denigration, or trivialization of women whatever the basis, whether cultural or religious. The Convention makes it clear that, regardless of the bases of these discriminatory practices and their rationalization, they have to be eliminated in all sectors of social life. The CRC opposes any form of discrimination against children for any reason, and advocates parents and guardians as the primary care-givers, recommending state intervention only where parental assistance is unavailable. It also states that, whatever the circumstances, children have to maintain contact with their parents and be united with their family at a favourable time. The CRC calls on States to prevent trafficking in children, commercial sex work by children, and child labour in general. It also calls on States to provide children with education, health care and social security. Among other things, the CRC holds the State responsible for the realization of children's rights, for their protection and for their survival. [3]

Under international law, and by virtue of being a member of the United Nations and the ILO and having ratified international Conventions, Zimbabwe is bound to ensure that the treaties are applied in the national legal order. No legal mechanism exists in the current Constitution, however, that enables the incorporation of these tenets of international law into national legislation. If appropriate constitutional changes were made, then it would be possible for relevant international law to be incorporated into local laws.

Besides the fact that Zimbabwe has no constitutional room to adopt the laws, limited resources make it difficult for the State to cater fully for children. Hence the prevalence of street children with little food, no shelter and filthy clothing who beg publicly in the streets even where national laws themselves proscribe this. Children's welfare and protection therefore depends not only on the legal environment and political will, but also on availability of resources at the household, community and national levels.

age is 18 years, while generally children in Zimbabwe may lawfully take up non-hazardous employment from the age of 14.

[3] At times, areas of conflict appear within the international protocols. For example, the CRC article 30 makes reference to the protection of cultural identity, the African Charter's article 17 says that the State has to protect the cultural life of people and to protect the "moral" and "traditional" values of communities. This raises some controversies, especially where these cultural norms hurt children, such as with early marriage or lack of access to health care. Besides, it means that discrimination against girls can continue with impunity, so long as it is justified on cultural grounds. More so, article 29 of the African Charter says that each person has to respect his or her family and parents, which essentially means that the rights of children are curtailed or dependent on family values. All these international instruments require creative interpretation if they are to benefit children, particularly in developing countries.

5. Institutions involved in children's issues

A number of institutions, both local and international, are directly or indirectly involved in children's welfare.

5.1. International organizations

The ILO's International Programme on the Elimination of Child Labour (IPEC) is the world's largest technical cooperation programme addressing child labour. IPEC inspires, guides, and supports national initiatives. A number of international organizations, including UNICEF, UNESCO, WHO, UNDP and the ILO, work hand in hand with the Government and local NGOs on issues that affect children.

5.2. Local organizations

Local international NGOs such as Redd Barna and Save the Children Fund (UK), working mainly in partnership with local NGOs such as Street Ahead (catering for the needs and the rights of street children in Harare), the Child Protection Society (catering for the needs and the rights of orphans and other vulnerable groups), and other institutions such as sector trade unions like the Zimbabwe Domestic and Allied Workers' Union (ZDAWU) and the General Agricultural Plantation Workers' Union of Zimbabwe (GAPWUZ), have also been involved in initiatives to meet specific needs and rights of working children.

One of the most unfortunate outcomes of the AIDS pandemic is the increasing numbers of AIDS orphans resulting from the death of one or both parents. Most of these orphans fail to find refuge in "extended families", and, in most cases, they have to work to survive. Most institutions dealing with orphans in Zimbabwe do not distinguish between AIDS and non-AIDS orphans. These include Tsungirirai, Family AIDS Caring Trust, Zimbabwe Red Cross Society, Commercial Farmers' Union, Catholic Health Care Services, Matebeleland AIDS Council, Bekezela Community Home-Based Care, and MASO.

A number of government Ministries are directly or indirectly involved with children, including those of Health and Child Welfare; Public Service, Labour and Social Welfare; Education; and Gender, Youth and Employment Creation.

Current child labour programmes are narrow in scope, since almost all initiatives, including those of the Government, focus mainly on advocacy. These activities are being conducted under the auspices of the Child Welfare Forum (CWF). The CWF should be enabled to develop clear-cut programmes of action to combat child labour.

6. Children and work: Definition of terms

6.1. Different notions of child labour

Perspectives on children in the social sciences and development in general has changed over the years. The prevailing view is one of children as innocent, mentally and physiologically frail, and therefore as needing protection (Mills, 2000:11).

Child "innocence" often means simply that children are less knowledgeable than adults – and this notion lies at the centre of child abuse. On the one hand, those opposing child abuse say innocence must be preserved. On the other, people who abuse children prey on their victims because of this assumed innocence (lack of knowledge and experience), luring them into activities and lifestyles abhorred by mainstream society. Mills highlights the fact that society stigmatizes children who have knowledge, such as that of sex and sexuality, that is considered out of bounds (Mills, 2000:15).

Child work versus child labour. People abhor, on the grounds of child workers' supposed frailty, the involvement of children in waged work. But Mills and others have discussed class implications in the notion that children have to be protected. After all, it is only affluent middle- and upper-class people who can afford to support leisured and protected children. Among the poor and in peasant societies, where production is labour intensive and returns relatively low, the survival of the family depends on the labour input of children. This kind of participation in work, seen in literature as a form of socialization or apprenticeship, is referred to as "child work" (Mills, 2000; Mangoma and Bourdillon, 2001). When poverty intensifies and all members of the community expend more work for dwindling returns, children also have to contribute more labour.

"Work done by children" is generally seen as acceptable but, when this work interferes with the growth of the child by interrupting school and normal physical development, it is defined as "child labour".

Child *labour*, in this view, occurs outside the home for purposes of earning a wage and often in working conditions unadapted to the "frailty" of children. In reality, however, it may be difficult to draw the line between acceptable apprenticeship and child labour. When a sex worker raises a child in the role of mother, sister or other guardian, the child may be more quickly initiated into commercial sex exploitation. This type of situation is of obvious concern, especially in the face of HIV/AIDS. We should use caution and due sensitivity when we apply these concepts, realizing that things are not as clear-cut in practice as they are when we deal in abstractions.

ILO Convention No. 182 defines the worst forms of child labour as any work that, by its nature or employment conditions, is detrimental to a child's physical, mental, moral, social or emotional development. For the purposes of the Convention, a child is defined as any person under the age of 18. The worst forms of child labour are understood to include those types of work for children described in Article 3 of ILO Convention No. 182:

- all forms of slavery or practices similar to slavery, such as the sale and trafficking of children, debt bondage and serfdom, and forced or compulsory labour, including forced or compulsory recruitment of children for use in armed conflict;

- the use, procuring or offering of a child for prostitution, for the production of pornography or for pornographic performances;

- the use, procuring or offering of a child for illicit activities, in particular for the production and trafficking of drugs as defined in the relevant international treaties; and

- work which, because of its nature or the circumstances in which it is carried out, is likely to harm the health, safety or morals of children.

In determining the types of work referred to under Article 3(d) of the Convention, and in identifying where they exist, consideration should be given, inter alia, to:

- work that exposes children to physical, psychological or sexual abuse;

- work underground, under water, at dangerous heights or in confined spaces;

- work with dangerous machines, equipment and tools, or which involves the manual handling or transport of heavy loads;

- work in an unhealthy environment which may, for example, expose children to hazardous substances, agents or processes, or to temperatures, noise levels and vibrations damaging to their health; and

- work under particularly difficult conditions such as work for long hours or during the night, or work where the child is unreasonably confined to the premises of the employer.

6.2. Definition of working children

According to the ILO, an "economically active" person is anyone who spends at least one hour per week on any activity for pay, profit and/or family gain, including unpaid family work.

The Ministry of Public Service Labour and Social Welfare has, in defining "working children" and "child labour", introduced three other important criteria:

- one must be seen to be working more than three hours per day before one is considered "economically active";

- children aged 15 and older may engage in some forms of work in accordance with statutory Instrument No. 72 of the 1997 Labour Relations Act (Employment of Children and Young Persons); and

- a child engaged in domestic duties must work for more than five hours per day before it is considered "child labour".

7. What we already know about orphans and child labour in Zimbabwe

7.1. HIV/AIDS and orphanhood

The HIV/AIDS pandemic is the main factor, it is generally believed, in the increased incidence of child labour. Little research exists, however, on the relationship between HIV/AIDS and child labour.

A future without child labour (June 2002), a recent working paper prepared by Bill Rau for inclusion in the ILO Global Report, states that HIV/AIDS is "emerging as a key factor affecting children and the pattern of child labour across the world". HIV/AIDS is having an impact on the size, composition and quality of the labour force (ILO, 2000). Evidence from Uganda (Kumali, et al., 1996) and Zimbabwe (Forster, et al., 1995), and projections by Gregson, et al. (1994) has shown a positive linear relationship between HIV/AIDS and orphanhood.[1] According to WHO (1995), about 10 million children have been orphaned since the advent of HIV/AIDS. A study in Manicaland Province, in Zimbabwe, found that 8.9 per cent of the households had orphans, and 6.8 per cent of total children aged 0-14 years had been orphaned. The study also showed that about 61 per cent of the orphans lived with surviving parents, 80 per cent with their mothers after the death of the father, and 17 per cent with fathers following the death of the mother (Forster, et al., 1995).

The Ministry of Health and Child Welfare estimates that at least 1.5 million out of 13 million people are living with HIV. One in every four sexually active persons is HIV positive (UNAIDS/WHO, 2000). Since 1985, when the first case of AIDS was identified in Zimbabwe, the problem of HIV/AIDS has grown at an alarming rate. According to the National AIDS Coordination Programme (NACP, 1998) a cumulative total of more than 1.5 million people have contracted HIV, and more than 400,000 have developed AIDS. Zimbabwe is one of the worst affected by AIDS in the world, with a total of 2,000 deaths a week due to HIV/AIDS-related illnesses. Between 57,000 and 100,000 children are living with HIV in Zimbabwe, it is estimated, and about 9 per cent of newborn babies are infected with the virus.

Adult mortality due to HIV/AIDS in sub-Saharan Africa has led to a greater number of orphaned children. It is estimated that 23.7 per cent (1,066,702) of all children under 15 years of age in Zimbabwe are orphans. These figures are expected to rise to 1,244,286 and 1,264,047 by the years 2005 and 2012, respectively. By 1997, about 543,000 children had lost one or both parents to AIDS, and it was estimated that the figure would be more than 800,000 by 2000 and 910,000 by 2010 (Hunter and Fall, 1998).

Although HIV/AIDS has had an impact on all sectors of society, children, followed by women, have been most affected. Beyond the loss of their parents, many orphaned children are left with no way to satisfy their basic needs, and this is the root cause of child labour.

Inter-Censal data in 1997 found 74,622 working children between the ages of 10 and 14 years, and estimated the numbers of disabled children at 150,000; children in institutions at about 5,000; abused children at 3,500; and street children at about 1,000.

[1] The ILO defines an orphan as a child who has lost a mother. In this study, an orphan is defined as a child who has lost one parent (single orphan) or both parents (double orphan).

Traditionally, orphans in Zimbabwe, as elsewhere in Africa, have been cared for by the extended family system. This family-based kinship system, however, has been eroded by urbanization and socio-economic change, and, where it still exists, it has been stretched to the limit by the AIDS pandemic. Poverty and cash shortages mean that the extended family is finding it difficult to provide these orphans with clothing, shelter and education.

At the same time it is rare, for cultural reasons, for orphaned children in Zimbabwe to be adopted or fostered by non-relatives. In many cases, furthermore, foster children suffer a measure of neglect and deprivation. Even where they are being looked after by the extended family, it is common to find orphans stunted and malnourished. These orphans face a relentless struggle for survival, basic education, and love and affection, and lack protection against exploitation, abuse and discrimination. The girls, in particular, are more vulnerable to HIV infection through domestic sexual abuse by relatives and other community members as well as through commercial exploitation.

Programmes to assist orphans have been only ad hoc and fragmented, and they have lagged behind those aimed at others, such as disabled children, in difficult circumstances. Proactive planning is needed in anticipation of the large numbers of orphans who will require much support in future. Even though recent UNICEF and ILO studies have dealt with the subject, more data is required to determine the magnitude of the problem of orphanhood in Zimbabwe, as well as the impact of the AIDS pandemic on the welfare of orphaned children.

7.2. Working children in Zimbabwe

In 1999, the Government, in partnership with the ILO, embarked on a national survey of working children. This National Child Labour Survey found that 26.3 per cent of the 4,667,599 children were involved in economic activity (see table 2, below). Over 90 per cent of the economically active children resided in rural areas, with the age cohort 10 to 14 years accounting for the majority of the children involved in economic activities. Most of the children (88 per cent) were not paid for their labour.

Table 2. Working status of Zimbabwean children (aged 5-17 years)

Status	Number of children	Percentage
Total number of children economically active, without time limit	4 667 599	100.0
Children (5-17)	1 225 686	26.3
Children (5-14)	826 412	17.7
With time limit (at least 3 hours)		
Children (5-17)	657 444	14.1
Children (5-14)	406 958	8.7
Non-economic/housekeeping	140 050	3.0

Source: *National Child Labour Survey* (1999).

About 81 per cent of the economically active children aged 5-17 were attending school on a full-time basis, and about 1 per cent were attending on a part-time basis. Approximately 19 per cent of these children were not attending school. A 7 percentage point difference was observed between the rural and urban areas, where non-attendance, at 25.3 per cent, was highest in urban areas.

About 88 per cent of the economically active children aged 5-17 came from households with incomes below Z$2,000 (US$36.40). The involvement of children in economic activities decreased to less than 1 per cent as income increased to above Z$3,000

(US$54.60). Males were proportionately more involved in economic activities (53.4 per cent) than were their female counterparts (46 per cent).

Furthermore, as household size increased so did the incidence of child economic activities, which peaked as family size reached five to six members. This group accounted for 33.4 per cent of all economically active children aged 5-15. Thereafter, the incidence dropped to about 20.4 per cent of the children for family sizes of nine members and more. In addition, almost half (44.9 per cent) of all the economically active children came from female-headed households.

About 66 per cent of the working children reported that they had no problems with their work. More children in rural areas were having problems with their work than were those in urban areas. The major reasons given for this were that "the pay was too low" or "the work was too hard for them".

About 3 per cent of the children reported having had work-related injuries frequently, while 10 per cent said occasionally and 61 per cent said seldom. The frequency of injury/illness in rural areas was comparable to the national rates. A high proportion of injuries occurred in agriculture (52 per cent), while transport had the lowest proportion (1 per cent). In rural areas, 56 per cent of the injuries occurred in agriculture, while fewer than 1 per cent were in mining and transport. The situation was quite different in urban areas, where the injuries ranged from 2 per cent in agriculture to about 11 per cent in manufacturing and other sectors.

The conditions described above are increasingly commonplace in Zimbabwe. Many children find themselves losing their innocence because of poverty, family breakdown due to divorce, second marriages of their parents and HIV/AIDS, which leaves children without care-givers or incapacitates the parents to a point where they cannot look after their children. Children then must resort to work. They beg in the streets, engage in agricultural activities, work as hawkers and vendors in the informal sector and clean cars. Some are exploited for commercial sex.

One study notes that family crisis prevents children from benefiting from reliable parental protection or guardianship or from enjoying their own innocence (Cox, 1996:172). The crisis might involve violence in the family, unavailability of parents or parental proxies, or inability of parents to provide for the children's basic needs. In such crises, children often end up having to partake in the adults' experiences (Cox, 1996:174). They "lose their innocence". Mangoma and Bourdillon (2001) reiterate this point when they say that children are likely to be involved in wage work where " ... families lack resources … where there are no state welfare payments and where self-employment and low wages are widespread … [and] where the household head is unemployed" (Mangoma and Bourdillon, 2001:14).

One might add that, where underemployment is prevalent, even if parents work the returns from that labour might be so low that it is insufficient to provide for their children.

8. Rapid assessment targets: Selection criteria

The pilot survey was conducted in the Epworth area. This area covers urban, peri-urban and rural areas, and it lies about 30 kilometres from Harare. The main survey was carried out in the Gweru and Shurugwi areas of the Midlands Province. The Midlands Province, and Gweru in particular, was chosen because of the local farming and mining activities and the fact that the Midlands Province has the highest concentration of economically active children between the ages of 5 and 17. The entire Midlands Province has a total of 7,884 orphans, of which 38 per cent are double orphans. Gweru Urban alone has more than 4,000 orphans (see table 3 below).

Forms of child labour investigated in Gweru included working street children,[1] farm workers, domestic workers and children in prostitution. Children from commercial farms were of particular interest since they were most likely to be engaged in the worst forms of child labour (WFCL).

Children from Shurugwi Rural were chosen to reflect the experiences of rural orphaned children and the dimensions of rural child labour. Children in Shurugwi were likely to be involved in the nearby gold-panning activities. Gold panning was described as a WFCL because the nature of the work is extremely hard and highly dangerous. Rural areas were also likely to expose hidden, culturally condoned forms of child labour. These included non-paid work in the fields, cattle herding and fetching water over long distances.

[1] Most of the children sampled, as it happened, were street vendors.

Table 3. Children in especially difficult circumstances in Gweru Urban

Ward	Double orphans	Single orphans	Child-headed households	Chronically ill patients	Disabled children	Child parents	No birth certificate	Out of school	Orphans under elderly care	Neglected children	Ward total	Per cent of total orphans
1	23	11	0	7	3	0	0	63	50	30	187	2.87
2	9	78	4	5	5	0	30	54	18	0	203	3.11
3	70	124	10	11	8	18	75	199	25	18	558	8.55
4	28	92	1	0	5	1	5	0	7	0	139	2.13
5	58	215	5	19	15	4	8	19	45	13	401	6.15
6	201	356	1	9	8	1	13	153	10	100	852	13.06
7	132	187	16	30	15	2	27	18	16	23	466	7.14
8	74	71	22	20	4	3	13	56	65	1	329	5.04
9	100	200	11	0	17	0	8	330	53	0	719	11.02
10	95	300	4	10	3	0	12	13	50	3	490	7.51
11	70	135	4	40	6	7	8	15	11	9	305	4.67
12	93	97	4	8	18	4	11	19	34	6	294	4.51
13	49	68	5	7	2	0	25	31	38	9	234	3.59
14	17	115	9	5	1	1	16	16	12	0	192	2.94
15	36	418	6	12	11	0	18	12	15	1	529	8.11
16	56	15	6	6	15	2	60	250	8	0	418	6.41
17	29	68	3	9	3	0	12	19	15	51	209	3.20
Total	1 140	2 550	111	198	139	43	341	1 267	472	264	6 525	100.00
Per cent of total orphans	17.47	39.08	1.70	3.03	2.13	0.66	5.23	19.42	7.23	4.05	100.00	

9. Profile of the survey area

9.1. Population size

According to the 1992 population census, the Midlands Province had a total population of 1,307,769 or 12.6 per cent of Zimbabwe's total population of 10,401,767. The male population comprised about 49 per cent of the total population. Gweru Urban, with about 9.79 per cent of the total population in the Midlands Province, had a population of 128,037. Shurugwi Rural, with about 6 per cent of the total provincial population, had a total population of 80,450.

9.2. Population density

The province had a population density of 27 persons per square kilometre. The distribution of the population by district in 1992 indicated that the population density in the Midlands Province ranged from 15 persons to 37 persons per square kilometre. Gweru had a population density of about 35 persons per square kilometre, ranking third after Zvishavane Rural and Mberengwa with 37.41 and 36.86 persons per square kilometre, respectively. On the other hand, Shurugwi Rural had a relatively low population density of 23.72 persons per square kilometre (CSO, 1993).

9.3. Population growth

Gweru had a rate of natural population increase of 2.76 per cent, while Shurugwi Rural had a relatively lower rate of 2.01 per cent. The Midlands Province had a fairly young population, with the 5 to 9 year age group comprising 16 per cent of the total population. The main reason for this phenomenon was the relatively high fertility and high, but declining, mortality. The total fertility rate for the Midlands Province was estimated at 6.3 per cent. Shurugwi had a fairly high fertility rate of 6.1 per cent, while Gweru Urban had a relatively low fertility rate of 4.3. The overall crude death rate for the province was 9.9 deaths per 1,000 people. Shurugwi Rural had a high crude death rate of 10.54 deaths per 1,000.

9.4. Local economy

The greatest contributor to the local economy is mining, followed by agriculture, manufacturing, hotels and restaurants, and transport and communications. In 1992, the Midlands Province had an unemployment rate of about 15 per cent. If communal farm workers were excluded from the economically active group, however, the unemployment rate rose to 28 per cent. The "unemployed" category included more males (64 per cent) than females (36 per cent). Similar trends were observed among the employed. Gweru Urban had an unemployment rate of 24.55 per cent, compared to Shurugwi's rate of about 5 per cent.

9.5. Education

More females than males had never been to school, and there were more males at school than females in the province. Among those who had left school, females outnumbered males, and there were proportionately fewer females at each higher

educational level. The enrolment ratio for the province was 56, and the literacy rate was 82 per cent. Gweru Urban had the highest literacy rate (95 per cent); the rate in Shurugwi was 87.16 per cent (CSO, 1993).

The Midlands Province has a large number of schools. Particularly in rural areas, however, children have to travel long distances to school. This suggests that the number of schools in rural areas is still far from adequate.

9.6. Water and sanitation

According to the 1992 census data, almost all households in urban districts had access to safe water. In Gweru Urban, only 305 households out of 29,198 (about 1 per cent) had no access to safe water. In Shurugwi Rural, on the other hand, as many as 3,820 out of a total of 15,295 households (about 25 per cent) had no access to clean water. The proportion of households that mostly used flush toilets was higher in urban areas (94 per cent) than in rural areas (4 per cent). Most urban dwellers had access to toilet facilities, with only 2 per cent having no access. In rural areas, about 65 per cent of the households were without access to toilet facilities. In Gweru Urban, only 0.6 per cent of the households had no access to toilets, compared to the Shurugwi Rural proportion of 33.27 per cent.

10. Methodology

10.1. Sampling procedure

Samples were chosen with the assistance of the City of Gweru, which is spearheading the CDC[1] programme in the Midlands Province; Officials from the Better Schools Programme; and the (MASO). The team also made use of local CDC staff, who played a crucial role in mobilizing the target population. In Gweru, the selected sample covered, as much as possible, all the area's 17 wards. In Shurugwi, the sample was drawn from two primary and two secondary schools.[2] Wherever possible, selection aimed to cover the following categories of orphans: working street children,[3] farm workers, domestic workers and children in prostitution. With children in prostitution and street working children, the study team had to visit the target groups in beer halls, nightclubs and the streets.

Key informants were drawn from government departments, non-governmental organizations (NGOs), local authorities and community leaders. FGD groups were drawn from participants in all the areas sampled. Normally, each FGD consisted of ten to 12 working children or guardians/parents. Most of the FGDs were divided according to gender. Case studies examined instances where orphans served as child household heads or in exceptional cases of child labour, providing detailed accounts of the experiences of the children involved.

10.2. Data collection methods

The study applied:

- *in-depth interviews* with working children and their parents/guardians, applying the child questionnaire developed by the study team and the parents/guardian questionnaire provided by the ILO and subsequently tested, translated and adapted locally;[4] and
- *semi-structured interviews*, used with key informants and when conducting FGDs and case histories.

10.3. Study team composition

The study team comprised five researchers and three research assistants. The team leader was an economist with considerable experience in poverty and policy-oriented studies, and the co-researchers included a gender expert, a sociologist and two demographers. Two of the research assistants had social work backgrounds and one had an economics background.

[1] Children in difficult circumstances.

[2] The headmasters of these schools played a major role in selecting the children to be interviewed.

[3] Most of the children in the sample fell into this category.

[4] See Appendix III for the English version.

The research team also sought the services of officials from the City of Gweru, which is spearheading the CDC programme in the Midlands Province, officials from the Better Schools Programme, and the staff from the MASO. These three organizations are in the forefront in terms of working with children, particularly orphans, in the Midlands Province. The team made use of local CDC mobilizers as well, who also played a crucial role in mobilizing the target population. In Shurugwi, the study team benefited from the services of school headmasters and the local councillors and community leaders in the identification and choice of the target group.

A three-day training workshop was conducted before the actual research began, with the view of enhancing the understanding and skills of the research assistants.

10.4. Problems encountered

- Identification of children involved in some forms of child labour – e.g. children engaged in prostitution or panning for gold – was hindered because of the activity's illegality or attendant stigma. Even known children in prostitution were reluctant to reveal their activities. Those operating in the streets at night were reluctant to meet the research team, fearing that they might turn out to be plainclothes police officers.

- Some child workers, on the other hand, were either busy at work (particularly those on farms) or had gone to school. In either case, it made it difficult to interview them during normal working hours.

- Some types of work performed by children were seasonal, and were thus difficult to investigate adequately. The study was conducted during a non-farming season, for example, and children who normally work in the fields were elsewhere. This may have produced misleading impressions regarding the day-to-day child labour experience.

- Believing the study would have financial benefits, some guardians wanted to be present during interviews, inhibiting free expression on the part of the children.

- In one area of Gweru Urban, the study was disrupted because of political differences. In this instance, the mobilizers from a ward with an opposition party councillor were trying to mobilize the target group in a ward with a ruling party councillor. This considerably affected the progress in the data collection process.

11. Results

11.1. Sample group profile

The City of Gweru is currently developing a register of all the children in especially difficult circumstances. To date, they have covered Gweru Urban (see table 3 above). The table shows that Gweru has a total of 6,525 children in the CDC programme. Of these, 17.5 per cent are double orphans (i.e. both parents are deceased), 39 per cent are single orphans, 2 per cent are heads of households and 7 per cent are orphans under elderly care. At the time of writing, it was not clear whether the children with no birth certificates and those who were out of school were also orphans.

A total of 230 children were interviewed. Of these, 86 per cent were from Gweru while 14 per cent were from Shurugwi Rural. About 74 per cent were from Gweru Urban, 14 per cent from communal areas, 8 per cent from commercial farms, 0.9 per cent from peri-urban areas and 0.4 per cent from growth points. Ages ranged from 8 to 18 years, with a mean age of 14.2 years. About 54 per cent of the children were male (see table 4 below).

Table 4. Distribution by age and sex

Age	Frequencies by age		Frequencies by sex				Percentage of females in age group
			Male		Female		
	Number	Percentage	Number	Percentage	Number	Percentage	
8	5	2.2	2	1.6	3	2.8	60.0
9	5	2.2	3	2.4	2	1.9	40.0
10	14	6.1	10	8.1	4	3.8	28.6
11	16	7.0	6	4.8	10	9.4	62.5
12	22	9.6	14	11.3	8	7.5	36.4
13	26	11.3	18	14.5	8	7.5	30.8
14	27	11.7	12	9.7	15	14.2	55.6
15	33	14.3	16	12.9	17	16.0	51.5
16	31	13.5	20	16.1	11	10.4	35.5
17	31	13.5	14	11.3	17	16.0	54.8
18	20	8.7	9	7.3	11	10.4	55.0
Total	230	100.0	124	100.0	106	100.0	46.1

Source: City of Gweru.

11.2. Educational status

All the children interviewed except one had been to school. About 73 per cent were still attending school at the time of the study, while 27.8 per cent had left school. Of those who had left school, 46.9 per cent had left school at primary-school level and 53.1 per cent had dropped out of secondary school.

The main reason given for not going to school was “unaffordable school fees” (85.9 per cent). A few children claimed that they were not interested in going to school, while 6.3 per cent gave as their reasons long distances to school or lack of birth certificates. Among those who left school, 53.1 per cent were in the 10 to 14 year age

group. Of those attending school, about 52 per cent had their school fees paid by parents or guardians, while 25 per cent and 21 per cent, respectively, said the school fees were being paid by relatives and government or NGOs. About 1 per cent of the children said they were paying their own school fees. Most of the children (78.3 per cent) went to school daily. Those who missed school cited non-payment of fees (39.2 per cent) and work commitments (29.9 per cent) as their reasons for missing school. Only four children stated that they were totally disinterested in going back to school.

FGDs revealed that some orphans went to school in tattered clothes, while fear of stigmatization forced others to go to night school. Some orphans did not have other items required at school, such as covers for books and stationery. Caregivers from Shurugwi Rural appreciated the support orphans were getting through the BEAM programme, although its coverage was limited. Some of the guardians who did not have access to BEAM had to sell cattle in order to provide education for the children. As a stopgap measure, some children were resorting to using second-hand uniforms from school leavers. The problem of fees was exacerbated by a drought that forced people to sell livestock in order to buy food. In general, nevertheless, guardians appreciated the need for education, saying that, among other things, it made children more disciplined and more cooperative when it came to domestic chores.

Separate FGDs with orphaned girls and boys confirmed the above sentiments. They also confirmed that some had dropped out because of financial problems, reflecting insufficient coverage by the BEAM programme. FGDs with street children revealed a darker picture, where the children not only dropped out of school but also lived in the streets. “My mother could not pay fees”, according to one child, “since she was seriously ill. When she died, that was the end of the road for me”.

When school-going children were asked about regularity of school attendance, 78.3 per cent said they went to school daily, while the remainder said they missed school at least once a week. Reasons for missing school ranged from non-payment of school fees and lack of food, to ill health of the child or parent, work commitments and transport problems. The two most commonly cited reasons were non-payment of fees (39.2 per cent) and work commitments (29.9 per cent). A sizeable number (17.5 per cent) missed school to look after sick relatives/parents.

Four children stated that they were totally disinterested in going back to school, and another two, having failed to produce birth certificates, could not be admitted to any school. When asked whether anyone in their families had dropped out of school, 29.6 per cent responded affirmatively. Of those children who reported having had school dropouts in their families, 47.9 per cent were boys and 52.1 per cent were girls. The majority of the children (78.1 per cent) who had dropped out of school wanted to go back. About 59.4 per cent of respondents who had dropped out of school were female. It was also noted that 57.7 per cent of the girls who left school were aged 10-14 years, compared to 46.6 per cent for boys in the same age group. It should be noted, however, that the sample contained more boys than girls.

11.3. Living conditions and well-being

About 30 per cent of the children were living with grandparents, 28 per cent with their mothers, 14.8 per cent with their aunts or uncles, 4 per cent with their fathers and 5 per cent with non-relatives. A relatively large number of children (56 per cent) had moved from one household to another one. Of these, 24.6 per cent had moved because their families had been resettled, 21.4 per cent said that they moved because both parents had passed away, 30 per cent moved because the father or mother had died and 6 per cent

moved because they were having problems with either the stepmother or other relatives they were now staying with.

The children stayed with families ranging in size from one to 12. The mean family size was 4.5. Most of the children (71.7 per cent) slept on the floor in their homes, while 22.2 per cent slept on beds and about 4 per cent slept in the streets. Some children lived in informal settlements in dwellings made of paper and others slept on shop verandas, in the open or in drains. Some of the children used plastic bags as blankets at night, and some were subsisting on one meal a day while others collected leftovers from restaurants.

Some street children complained of occasional police harassment. They admitted, however, that some street children did steal to survive. When the police round up street children, they do so indiscriminately. "I was once taken to the central police station", said one child, "where I was locked up in a cell, caned and left to sleep unfed". The city council police also harass street dwellers, at times burning their belongings including food and blankets. The younger children of the streets were vulnerable to beatings by older street children. Security personnel at some fast-food outlets, seeing them as a nuisance, also physically abused the children. When the children were injured, they lacked the money to access health care.

Female children in prostitution sometimes used the boys as pimps. Homosexual sex, reportedly, was also prevalent among street children. At night, the older boys who shared sleeping space with the younger often raped the latter with impunity. Allegedly, officials such as police officers also participated in the homosexual abuse.

A prevailing homophobia in Zimbabwe makes interventions difficult. In seeking protection, abused children have no one to report to. Although the children are aware that the sexual relations they are having transmit STIs and HIV, they do not seem to be in control of the situation.

In addition to vulnerability to sexual and physical abuse, the children also witnessed a lot of violence on the streets in the form of brawls and violent crime.

Case 1. Eighteen-year-old girl heading a household

She lost both parents, her father in 1992 and her mother in 2001. When the mother was alive, they rented a room at a plot in Gumtree, Gweru. She is the fifth-born of a family of ten children. When the father died, she was in Grade 4. Thereafter, none of her siblings went to school because the mother could not afford it.

During her mother's protracted illness, they sold all the assets they had to pay for her health care. She worked as a domestic worker to assist with her mother's expenses. The white couple she worked for went to Canada, leaving her kitchen utensils which she subsequently sold to pay for her mother's visit to a private doctor. They were expelled from the house they were renting, and moved to an informal settlement to live in a plastic shack, where the mother subsequently died. Her relatives came to collect the body, leaving the children because their father had not paid bride wealth. One of her elder sisters, born in 1977, died in 2001, and her husband died five months later leaving a two-year-old child. Her elder brother, born in 1971, also died of TB in 1995, and she has one surviving elder brother, who is a street vendor.

She lives in the shack left by her mother with four male siblings, one of whom is mentally retarded, and a two-year-old nephew left by her sister. She works as an egg vendor at the main bus terminus. She misses work to care for her mentally retarded young brother, who is unwell. One of the younger brothers begs in the street to supplement household needs. He sniffs glue, and she has no control over him. She had a boyfriend who wanted to marry her, but left her because of her family responsibilities. Like all her siblings, she has no birth certificate, so the government Social Welfare Department provides no assistance.

Many children exposed to unhealthy tasks admitted the use of behaviour-altering substances such as glue. Sniffing glue apparently suppresses one's sense of smell, thereby enabling the children to scavenge in rubbish bins without being offended by the smell of

rotting food. It also makes them "feel warm" and therefore better able to withstand the cold at night.

Asked whether the children's parents/guardians were working, 24 per cent said yes, 39 per cent said no, and 37 per cent said "not applicable". [1]

Among those with working parents/guardians, 25.4 per cent said the parents/guardians were farmers, 23.9 per cent said general hand/domestic work, 16.9 per cent said vending and 9.9 per cent said craftsperson. The percentages of those who said their parents/guardians were hairdressers, gold panners, businesspersons, dressmakers, technicians or civil servants ranged from 1.4 per cent to 5.6 per cent.

Case 2. Twin street boys aged 11 years

Both parents were dead, the father having died last, of TB, commonly an HIV/AIDS-related disease. His was a protracted illness, unresponsive to treatment. He was put in isolation in hospital, where he later developed sores all over his body. He was released into home-based care, and the woman he had just married (stepmother to the children) was unwilling to look after him. He became a burden on the two children till relatives returned him to hospital for fear that he would die at home with the children. In February 2002 he died in hospital, where the children were not allowed to view his body. They were in tears as they related their story. They also looked ill, the swollen lymph nodes behind their ears a possible indication of untreated TB.

Before his death, the father had worked as an electrician for the city council. He owned the two-room house in Mkoba High-density Suburb, where the children currently live alone. After his death, the stepmother abandoned the children and went to Botswana.

The children continued to go to school until May 2002, when they were expelled for non-payment of fees. Shunned when they asked relatives for assistance, they became street children. Embarrassed by the fact that they had been expelled, they did not want neighbours to know. They used to wake up at 6 a.m., clean their small house, water the garden and walk 10 kilometres into town pretending that they were still going to school. They joined other street children, helping them to sell vegetables and fruit. The other children tried to pressure them into sniffing glue, but they refused, despite the fact that the others laughed at them. They were not paid after helping other children to sell their wares, and had to beg and/or scavenge to meet their daily food needs. Their relatives still shun them. At home, there is no electricity because bills were not paid. No one knows what happened to their father's terminal benefits; perhaps the stepmother took these before she abandoned the two boys.

11.4. Work and working conditions

Of the 230 children interviewed, 83.9 per cent were working at the time of the study, while 50.4 per cent had worked before. Out of this sample population, 34 per cent were vendors, 22 per cent were engaged in agriculture and 21 per cent were domestic workers (see table 5 below).

[1] Of those who said no, 14 indicated that their guardians were working as farmers, general hands/domestic workers or vendors. Two of those who indicated that the question was inapplicable actually showed that their guardians were employed, respectively, as a craftsperson and a general hand/domestic worker. This might have been because "employment" is generally taken to mean *formal* employment. Our definition of employment, however, included both formal and informal, paid and unpaid work. We can therefore add these to the children who said their guardians/parents were working. With this minor adjustment, we end up with 30.9 per cent of the children with working parents/guardians.

Table 5. Types of work performed by child interviewees

Type of work	Number	Percentage
Mining/quarrying/gold panning	11	3.4
Agriculture	72	22.4
Children in prostitution	23	7.1
Construction	3	0.9
Handicraft	3	0.9
Domestic worker	69	21.4
Vending	109	33.9
Own household business	2	0.6
Car guarding/washing/shoe shining	10	3.1
Unpaid worker in household business	14	4.3
Public work	3	0.9
Cook	1	0.3
Carrying luggage	1	0.3
Brick moulding	1	0.3
Total	322	100.0

The total number by work category is greater than the sample size of 230, indicating that a number of children were performing more than one job. As table 6 (below) shows, about 36 per cent were working in the streets, 28 per cent in the house and 29 per cent were working in the fields. Again, the total number is greater than the sample size implying that some children were working in more than one location.

Table 6. Child labour sites

Place of work	Number	Percentage
House	74	27.9
Fields	77	29.1
Factory	2	0.8
Bar	6	2.3
Streets	96	36.2
Bus terminus	2	0.8
Mine	5	1.9
Dump site	3	1.1
Total	265	100.0

Most of the children were working during the daytime; fewer than 3 per cent worked at night (see table 7 below).

Table 7. Time of day during which work is performed

Time of day	Number	Percentage
Morning	164	36.0
Afternoon	182	40.0
Evening	94	20.7
Night	15	3.3
Total	455	100.0

Analysis of combined times worked shows that 67 children were working the whole day including evenings, while 39 were working only in the afternoons, 24 in the mornings, 11 in the afternoon and evenings, and eight were working in the evenings. Eight children were working at night, while two worked during the evenings and night. Most of those working at night were domestic workers and children in prostitution; most of those working in the evenings were domestic workers, vendors and children in prostitution.

About 68 per cent of the children started working between the ages of 8 and 14, while about 8 per cent started working between the ages of 3 and 7 years. The need to supplement family income motivated 55.7 per cent of the children to start working, while 15.2 per cent wanted to raise money for school fees, 13 per cent wanted to be economically independent and 5 per cent wanted to raise money to buy food. About 22.6 per cent of the working children had permanent jobs, while 43.9 per cent had short-term/casual jobs. Among the latter children, 37.8 per cent worked during school holidays. Of the total, 65.8 per cent worked with adults, with 42.5 per cent of these getting the same remuneration as adults.

The study revealed a relatively high prevalence (27.4 per cent) of workplace- and work-related illnesses and injuries. Types of injury included backaches, swollen legs and hands, asthma/coughs, bruises, malaria and sexually transmitted infections (STIs). A significant number of children (30.9 per cent) also reported having seen other children injured while at work.

About 40 per cent of the children reported they had good relationships with their bosses, while 5 per cent said they did not, 3 per cent preferred not to say, and 52 per cent said the question was inapplicable. A similar pattern was observed for relationships with adults, other children and customers.

About 55 per cent of the working children, whether in paid or unpaid work, claimed generally to like their jobs – 48 per cent said it was because of the remuneration they were getting, while others cited getting food, meeting other people or the fact that the work was not strenuous. Those who disliked their jobs presented a variety of reasons, including starting work early, low wages, the arduous nature of the work, interference with schooling, risks of diseases like STIs/HIV, and other occupational hazards such as harassment and lack of protective clothing.

When asked whether they would encourage their siblings to do the same job, 30.4 per cent said they would because of the benefits they were getting in terms of food, money and work experience. The rest said they would not because of low wages, strenuous and tedious work, work-related hazards and interference with schoolwork.

Although the children appreciated having free time, when asked what they did with it they referred to activities similar to work, among these hairdressing, craftwork, domestic work, and looking for food and jobs. About 30 per cent spent their spare time reading, while 22 per cent either played or watched TV, 16.5 per cent practiced sports and 12 per

cent did nothing. Some mentioned visiting friends and relatives and going to church as their pastime activities.

Many children wanted to be professionals such as doctors/nurses (22.1 per cent), teachers (26.5 per cent) and police officers (10.2 per cent). Others (10.6 per cent) expressed no aspirations beyond having families of their own.

FGDs revealed that, for some children, work started as early as 6 a.m. and ended at 6 p.m. FGDs with mixed school- and non-school-going children indicated that most did significant amounts of work at home before and after school. One participant who stayed with an uncle who owned a plot reported that she worked in the fields before going to school.

11.4.1. Remuneration

The majority of the working children (64 per cent) were paid. Of these, 76 per cent were paid in cash while the rest were paid in kind. About 26 per cent of those paid in kind were given food, 14.7 per cent were given varying quantities of maize, 29.4 per cent were given school fees and 20.6 per cent were given clothing. All told, 41 per cent were working for food in one form or the other. Table 8 (below) shows the distribution of payments received by duration of work. Those paid in cash received amounts ranging from Z$10 (US$0.18) to Z$6,500 (US$118.29). Those who received payment monthly had the highest mean income, followed by those who received payment per session and those who got paid per customer. (Of course, the accuracy of the latter statement is dependent on the number of customers or sessions per month.)

Table 8. Distribution of payments received by duration of work

	Monthly	Weekly	Daily	Hourly	Per session	Per customer
Mean	929	267	232		356.67	181.82
Standard error-mean	153	55.78	38.53		143.3	58.37
Median	750	200	150		500	100
Mode	11 000	200	200		500	20
Range	6 450	480	980		430	490
Minimum	50	20	20		70	10
Maximum	6 500	500	1 000		500	500
Number of people	48	10	40	0	3	11

Most children (72 per cent) also had an income from vending, craftwork, farm work, hairdressing, “boyfriends” or domestic work, earning from Z$13 to Z$3,000 (US$0.24 to $54.60). The mean income received was Z$455.56 (US$8.30), with a standard error of mean of Z$74.55 (US$1.36). The median value of the additional income was Z$200 (US$3.64), while the mode was Z$100 (US$1.82). Most of the children (71 per cent) were not rewarded for doing exceptionally well. Among those so rewarded, about 53 per cent were given money, 24 per cent were given clothes, 14.5 per cent got food and 8 per cent received only praise. Most of the children (92 per cent) did not get paid when they were off sick.

Slightly more than half of the children who received cash payments for their work said they decided how their money was to be spent, while 46.5 per cent said parents or guardians made the decision for them. Of the total, 38 per cent spent their money on food and clothing, while 26.8 per cent gave it all to their parents or guardians, 12.3 per cent gave only part of it to parents and 14.5 per cent used it to pay school fees.

Case 3. Seventeen-year-old orphan boy working as a vegetable vendor

The boy is in the third year of secondary school in a rural area. He has lost both parents – the father in 2001 from TB, and the mother in 2002 after a "short illness". He is the third child in a family of six children. He has younger siblings aged 13, 9 and 6 years. He lives with a 20-year-old sister, and the others live with an uncle in Kwekwe (a town in the Midlands Province).

He grows vegetables after school, during the holidays and on weekends. He sells the produce in the village to earn money for their subsistence and for household income. He earns Z$200 (US$3.64) per day from his vegetable sales. During the school holidays in the farming season, he and his sister work in other people's fields from 6 a.m. to 6 p.m. This is arduous work that leads him to suffer from backache. The pair also sell firewood fetched from the nearby forest, selling it for Z$100 (US$1.82) per wheelbarrow. The money is used to buy food and pay fees. He likes school because he is hopeful that an education will enable him to prosper in life. However, at present life is beset with many difficulties, including a lack of food and clothing.

11.5. Domestic work

The majority of the children (85 per cent) performed household chores. About 45 per cent were solely responsible for domestic chores. Most of those who participated in domestic chores were sisters, followed by mothers, aunts and brothers. A high percentage of children (74 per cent) were involved in the preparation and serving of food and 82 per cent helped with cleaning utensils. A surprisingly low percentage of children (8-22 per cent) were involved in care for the elderly, the sick and other children. Other domestic chores performed by the children included laundry, collecting firewood, herding cattle, doing minor repairs, shopping for the household and gardening.

The children normally spent an average of 3.7 hours per day on weekdays and 5.6 hours per day during weekends doing domestic chores. About 69 per cent of the children did domestic chores in other households. Of these, 70 per cent got paid an average of Z$425 (US$7.74) for working an average of 19.5 hours per week.

11.6. Commercial sexual exploitation

Out of the sample of 230 children, 23 were engaged in commercial sex work. Children in prostitution are of particular interest in this study. This group is not only at high risk of getting HIV and AIDS, it is also a group which is likely to spread HIV.

All the children in prostitution were females aged between 15 and 18 years. Of the total, 13 began working in this activity for money, one was doing it for fun, two started after their parents had died, another two said that they engaged in this activity as a result of "frustration", while five said that friends introduced them to the trade. Of the 23 children in prostitution, 30.4 per cent started this trade at 17 years of age, 21.7 per cent started at the age of 16, while 8.6 per cent started at 12 and 13.

In terms of commercial venue, 43 per cent met their clients in nightclubs, 22 per cent met their clients at hotels, another 22 per cent in the streets and 13 per cent in bars. The children did not choose their clients by race, profession, or any other criteria other than the ability to pay for their services. When it came to luring schoolgirls into prostitution, a mixed school- and non-school-going children FGD identified emergency taxi drivers as the main culprits.

The children served their clients in clients' cars, hotels/lodges, houses, bushes, brothels and beer halls. Close to half of these children, 43.5 per cent, reported that most of the sexual activity took place in the homes of the clients, and 30.4 per cent said that the bush was also a favourite place to conduct their business.

11.6.1. Sexual activities

These children reported engaging in a variety of sexual activities with clients, with 30.4 per cent of the children having had anal sex, 95.7 per cent engaging in vaginal sex and 13 per cent practicing oral sex. Among these same children, 47.8 per cent met one client a day, while the rest met two or more a day. Most worked independently, but 17.4 per cent were managed by pimps, who collected the money on their behalf. Only one girl out of the four with bosses learned from him how much he collected on her behalf.

11.6.2. Income derived

Children in prostitution earned incomes ranging from Z$300 (US$5.46) to Z$2,500 (US$45.50) per client. Most earned about Z$500 (US$9.01) per client. Given that most of the children said they saw one client a day, we may conclude that they earned an average of Z$500 (US$9.01) per day or Z$15,000 (US$273) per month, assuming that they got clients daily (see table 9 below).

Table 9. Distribution of payments received by children in prostitution

	Per client		Per night		Per day		Per session	
	Z$	US$*	Z$	US$	Z$	US$	Z$	US$
Mean	957.14	17.42	923.08	16.80	1 200	21.84	1 075	19.56
Standard error-mean	294.28	5.36	131.15	2.39			497.28	9.05
Median	500	9.01	800	14.56			750	13.65
Mode	500	9.01	500	9.01			300	5.46
Range	2 200	40.04	1 700	30.94			2 200	40.04
Minimum	300	5.46	300	5.46			300	5.46
Maximum	2 500	45.50	2 000	36.40			2 500	45.50
Number of people	7		13		1		4	

* Exchange rates current as of 21 Oct. 2002.

11.6.3. Health care

Only two out of 23 had medical aid; the rest (73.9 per cent) had to pay their own medical bills. Most of them (78.3 per cent) also indicated that they never had medical checkups.

The majority of the children (82.6 per cent) produced information on the occupational hazards of their work. Their sources of information were given as government health workers, NGO volunteers, colleagues, the media (TV, radio and newspapers), counsellors, guardians and grandparents.

About 34.8 per cent of the children had suffered illness. Asked to elaborate on the type of illness, 39.1 per cent said that they had suffered from sexually transmitted diseases/infections (STDs/STIs). Generally these diseases are associated with promiscuity, and the relatively small number of reported cases could reflect a common sense of shame and stigma associated with STIs.

Case 4. Seventeen-year-old girl in prostitution

She lost both parents within five months of each other four years ago. She was the only child, and was left in the care of a distant relative who ill-treated her. At 14 years of age, she fell in love with a man who got her pregnant, and she had twins, a boy and a girl. The man died in a car accident before the children were born. She had not met any of the man's relatives, so she could not go to them after her boyfriend's death, as she would traditionally have done, to announce her condition. She could not even attend his funeral at his rural home. Her relatives expelled her after she gave birth, and she had no means to care for herself and her newborn children. She looked for a room, and some friends advised her to go into prostitution as the only form of employment open to her, given her lack of education, technical skills and urgent need for money. She currently works in prostitution.

She served her clients in her one-room dwelling in the presence of her twins, now aged 3 years. While she solicited for clients, the children were left alone behind closed doors. She had sores all over her body and looked sick, although she claimed she always used a condom. As clients, she preferred schoolboys and old men, who were generally gentler and kinder to her. She charged less money per client and per session compared to other children in prostitution interviewed in this study. This perhaps pointed to her desperation. Other men often demanded that she return their money after sex, saying "it was not worth it". Some clients beat her up in her home in front of her children.

11.6.4. Knowledge about HIV/AIDS

Among the 23 children in prostitution, 95.7 per cent were aware of HIV/AIDS. The girls learned about HIV/AIDS from friends and co-workers (47.8 per cent), the media (21.7 per cent), counsellors (17.7 per cent) and voluntary organizations (8.7 per cent). Most of the girls (87 per cent) said they used condoms.

When asked about their last five sexual encounters, 65.2 per cent said they had used condoms consistently, while the remainder (34.8 per cent) used them only erratically. Those who did not use condoms regularly cited their reasons as higher earnings (4.3 per cent), client refusals (8.7 per cent), condom unavailability (4.3 per cent), ignorance of condom use (4.3 per cent) and confidence in the sexual partner (8.7 per cent).

When the girls were asked whether they would encourage their siblings to enter the same profession, the majority (60.9 per cent) said that they would not. The reasons given ranged from the risks involved (26.1 per cent) to the fact that the profession was not easy. In general, all the children were aware of occupational hazards of prostitution and commercial sex exploitation.

12. HIV/AIDS awareness among the children interviewed

Of the 230 children interviewed, 94.8 per cent were aware of HIV/AIDS. Few children (5.7 per cent) obtained the information from their parents, however, suggesting that most parents do not discuss HIV/AIDS with their children. About 24.3 per cent of the children got the information from their friends, 9.1 per cent from relatives, 39.6 per cent from the media, 55.7 per cent from schools, 4.3 per cent from medical facilities, 2.2 per cent from their workplaces and 3 per cent from peer educators. These figures highlight the important role of both formal and informal education in HIV/AIDS prevention.

The children were also aware of the various routes through which HIV/AIDS may be transmitted. About 80.4 per cent thought that sexual intercourse was the main mode of transmission, while 18.3 per cent believed it was the use of unsterilized needles, 17.8 per cent said sharing razor blades, 4.8 per cent said blood transfusions, 4.3 per cent said mother-to-child transmission and 0.9 per cent said breast feeding. Few children believed that HIV/AIDS is also spread through holding hands and kissing. Almost one-third of the children (28.7 per cent) erroneously thought that mosquito bites could transmit HIV/AIDS.

Of the 230 children, 43 had had sex. The average age at first sexual intercourse ranged from 7 to 18 years. The majority of children experienced sexual intercourse for the first time at 14 years of age. Reasons given for having sex ranged from fun and experimentation to rape and abuse (see table 10 below).

Table 10. Reasons for first experience of sexual intercourse

Reasons for first sexual encounter	Number of children	Percentage
Rape/abused	12	27.9
For fun	12	27.9
To get money for food	8	18.6
Experimenting	4	9.3
To get shelter	4	9.3
Missing values	3	6.9
Total	43	100.0

Among the children who reported having had sex, only 16 (37.2 per cent) had used condoms as protection. Quite a large proportion of the children (59.6 per cent) said that there were prevention programmes in their schools or workplaces. Most of the children (87.8 per cent) were aware that something could be done to avoid HIV infection. As possible measures, they cited abstaining from sex, use of condoms, avoiding sharing needles and razors, limiting the number of sexual partners and avoiding sex with children in prostitution.

More than half the respondents (61.7 per cent) also knew of places where they could get tested for HIV/AIDS. Only 10.4 per cent said they were tested for HIV/AIDS, however, and 8.7 per cent said they had been informed of their HIV status. Most of the children (67 per cent) knew that a healthy-looking person could be HIV positive. When asked whether HIV-positive people were discriminated against, 57.8 per cent said yes. They cited neglect, verbal and physical abuse, sexual abuse, being prevented from going to school, and being under-fed as some of the ways in which they were discriminated against.

13. Gender dimensions of orphanhood and child labour

Various sections of this study have examined the gender dimensions of orphanhood and child labour. These findings are consolidated here with the view of clarifying the roles played by males and females in orphanhood and child labour.

13.1. Orphanhood

The study in part examines orphanhood and its causes by gender. We also look at the roles played by males and females in the upkeep of orphans. Table 11 displays orphanhood data by gender of the deceased parent.

Table 11. Orphanhood by gender

Sex of orphan	Mother dead (%)	Father dead (%)	Double orphans	Sample size
Male	15.0	41.0	36	123
Female	11.0	47.0	38	102
Both sexes	13.0	44.0	37	225
Don't know whether father/mother is dead	3.1	3.1		
Sample size	37.0	105.0	83	

Of the 225 children who lost either one or both parents (see table 11 above), 54.7 per cent were male. Of the males, 36 per cent were double orphans, 15 per cent had lost their mothers and 41 per cent had lost their fathers. Among the female orphans, 38 per cent were double orphans, 11 per cent had lost their mothers and 47 per cent had lost their fathers. Among both sexes, 37 per cent are double orphans, 13 per cent had lost their mothers and 44 per cent had lost their fathers. It therefore appears that most orphanhood is due to the death of fathers. Most of the children did not know the ages of their parents at the time they died. The few who did know indicated that their mothers died between the ages of 30 and 40, while the fathers died between the ages of 35 and 57. Clearly those who were dying were of working age, indicating that the orphans were being robbed of their breadwinners.

Of the total sample, 29.6 per cent were being looked after by grandparents, 28.3 per cent by their mothers, 14.8 per cent by uncles/aunts, 4.3 per cent by sisters, 3.9 per cent by fathers, 3.9 per cent by brothers and 4.3 per cent of the orphans were looking after themselves (see table 12 below).

Table 12. Guardianship of orphans

Person looking after orphan	Percentage
Fathers	3.9
Mothers	28.3
Sisters	4.3
Brothers	3.9
Guardians	2.6
Grandparents	29.6
Aunt/uncle	14.8
Non-relative	5.2
Self	4.3

In FGDs with parents, some participants reported that grandparents, generally grandmothers, took care of children in the event that their parents had died. In the aunt/uncle category, it was mainly the aunts who took care of the orphans. All in all, 77 per cent of the orphans were being looked after by mothers, sisters, grandmothers or aunts. It seems clear that the burden of orphanhood fell heavily on women.

13.2. Child labour

Among working children, 55.5 per cent were male while 44.5 per cent were female. Table 13 (below) shows types of work performed by gender. More than half the children (both male and female) were engaged in vending, domestic work, or agriculture. More males than females were employed in agriculture, and more females than males were engaged in domestic work and unpaid family business.

Among those who were working, 64 per cent were getting paid for their work and, of these, 54.7 per cent were male. Among those who were paid in cash, females had a higher mean monthly income (Z$1,011.11; US$18.40) than did males (Z$882.76; US$16.04). More females (ten) worked at night than males (five). The 23 children engaged in prostitution were all female.

Table 13. Types of work performed, by gender

Type of work	Male (%)	Female (%)
Mining/quarrying/panning	4	5
Agriculture	36	23
Construction	3	0
Handicraft	2	0
Domestic work	23	32
Vending	54	52
Own household business	1	0
Car guarding/wash	7	0
Unpaid worker in household business	3	14
Public works	2	0
Cook	0	1
Carrying luggage	1	0
Brick moulding	1	0
Sample size	101	81

13.3. Domestic work

About 85 per cent of the children performed domestic chores. Of these, 49 per cent were males, while 51 per cent were females. Most of the children (both male and female) cooked/served food and cleaned utensils/house. More females did child-minding and caring for the sick and the elderly than did males. More males were engaged in gardening than were females.

14. Findings from interviews with key informants

14.1. Interview with the City of Gweru

Most government programmes targeting children in especially difficult circumstances, including orphans, are delivered through the local authorities. Currently, Gweru has five such programmes. These are shown in table 14, below.

Table 14. Current programmes with approximate budgets

Programme	Approximate annual budget	
	US$ million	Z$ million
CDC	2	109.90
AIDS action	2	109.90
Youth development	5	274.75
Peer education	1	54.95
Sports		

All of these schemes focus in particular on orphans, who comprise between 30 per cent and 75 per cent of the target children.

The *CDC programme* is a capacity-building project that enables communities, through their mobilizers, to identify problems faced by children in especially difficult situations, analyse the problems, and suggest ways of solving them. In deserving cases, the children are referred to social safety nets in the Department of Social Welfare or to sources of help such as CADEC, the BEAM project and public works programmes.

The *AIDS Action Programme* provides material food assistance through the National AIDS Council.

The *Youth Development Programme* aims to provide youths with the skills to start income-generating projects.

The *Peer Education Programme* provides forums, for example strategically located Youth Friendly Corners, for children to discuss problems with their peers. Funding is through local authorities, UNICEF, and the Government by way of the CDC programme. programmes targeting orphans that are not channelled through local authorities include the Better Schools Programme and schemes that are directed through provincial and district AIDS action committees (DAAC). DAACs are mainly concerned with AIDS awareness, prevention and interventions.

In executing these programmes, the City of Gweru works hand in hand with MASO, the BEAM project, the Department of Social Welfare, the Ministry of Education, and Children's Homes.

The planning and implementation of programmes should be decentralized. Programmes designed at the top are not always suitable for conditions on the ground. The Government should make resources available directly to local authorities rather than to line ministries, since the latter may too often pursue their own agenda. It was also pointed out that there ought to be legislation protecting orphans, for example new laws regarding

acquisition of birth certificates. Lacking these documents, an ever-increasing number of orphans are unable to access schools or their parents' terminal benefits. More awareness campaigns are needed that promote the rights of children, an example being the right of urban orphans to own the houses of deceased parents.

14.2. Interview with MASO

Local authorities argue that planning and implementation of programmes should be decentralized, and MASO agrees. In this view, there ought to be legislation protecting orphans, for example legislation regarding the acquisition of birth certificates. An ever-growing number of orphans, furthermore, are unable to access their parents' terminal benefits. MASO also expressed the need for more awareness campaigns targeting the rights of children, for instance the right of urban orphans to own deceased parents' houses.

14.3. Interview with the provincial welfare officer (PWO)

The PWO denied any need to decentralize programmes targeting orphans, arguing that there would be too much chance of irregularities in the allocation of available resources. Local authorities, on the other hand, suggested that, while considerable sums of money are allocated to orphan programmes, due to bureaucratic procedures the actual amounts that reached intended beneficiaries were very small. In response, the PWO pointed out that allocation to local authorities was based on total rather than on orphan populations. This may skew allocations, since the size of the general population does not necessarily reflect the orphan population.

He cited lack of capacity within local authorities as the major source of the problems, and indicated a need for capacity building in these agencies. He also denied that children were having problems obtaining birth certificates, saying that if the children come to his office then this would not be a problem.

14.4. Interview with the headmaster of a secondary school [1]

The headmaster pointed out the following as generic problems faced by orphans at his school:

- lack of proper uniforms;
- lack of school fees;
- lack of basic textbooks and exercise books;
- lack of food; and
- poor school attendance due to the long distances that students had to travel to get to school and/or poor health.

[1] The headmaster was also a counsellor in his home area.

He expressed gratitude for the assistance the orphans were getting through the BEAM project and the Better Schools Programme, but was quick to suggest the inadequacy of these programmes in terms of amounts allocated. More than half of the children enrolled at his school were either single or double orphans. Hunger was one major problem faced by orphans, and he believed the Government should re-introduce supplementary feeding programmes to schoolchildren.

15. Summary and conclusions

This study explored the nature and extent of both HIV/AIDS and child labour in Zimbabwe and the linkages between them. The link between HIV/AIDS and child labour was established through cause-of-death analysis.

It was often difficult to get people to talk about whether or not the death of their loved ones was due to HIV/AIDS. This was, in part, a result of unwillingness to talk about the issue. Beyond that, HIV/AIDS is not an official cause of death. HIV/AIDS itself is not a disease – it only weakens the immune system, thereby increasing one's vulnerability to opportunistic diseases such as TB that eventually prove fatal.

Certain ailments and long illnesses, however, are statistically correlated with HIV/AIDS. High HIV-prevalence rates have been reported among STI and TB patients, for example, and, in these cases, we may talk about death from AIDS-related diseases. The sample in the study under review were asked to state the cause of their parents' deaths and to say whether the parents had been ill for long. The responses allowed researchers to conclude that high incidences of HIV/AIDS were indeed associated with high rates of orphanhood and, hence, with child labour.

Of the sample 230 children, 56 per cent were single orphans, 36 per cent were double orphans and 6 per cent had lost one parent but were unaware of status of the other. All in all, 98 per cent of the children were orphans, and 84 per cent were working. What we needed to establish was the causes of their parents' deaths and determine the HIV/AIDS prevalence rate. Children indicated cancer, pneumonia, witchcraft, swollen limbs, headache/abdominal pains, long illness, TB/asthma, fever/malaria, accident, food poisoning, diabetes, short illness, mental problems, liver problems and suicide as the causes of their parents' death. The diseases from this list that are often AIDS-related include cancer, pneumonia, long illness, TB/asthma and fever/malaria. If we agree that these diseases are AIDS-related, then the AIDS prevalence rate would be 36 per cent. The relation between fever/malaria and AIDS is debatable, however. Excluding this category reduces the AIDS prevalence rate to 32 per cent. Either way, the AIDS prevalence rate is much higher than the 25 per cent normally quoted by Ministry of Health and Child Welfare officials. We can therefore safely conclude that high rates of HIV/AIDS prevalence are associated with high rates of orphanhood, and hence with child labour. Attacking the root causes of HIV/AIDS and its spread would therefore have a significant effect on the levels of child labour.

It follows that child labour can be combated by attacking the root causes of HIV and AIDS.

Asked how HIV/AIDS can be prevented, most children suggested abstaining from sex, condom use, avoiding shared needles and razors, limiting the number of sexual partners and avoiding sex with children. Reasons given for having had sex ranged from fun and experimentation to rape and abuse. To reduce the spread of HIV/AIDS it is necessary to eliminate some of the reasons that people engage in sexual activities. Human nature would suggest that little can be done about the "fun and experimentation" motives, but a lot can be done, through civic interventions, about rape and abuse. On the other hand, condom use, avoiding shared needles and razors, limiting the number of sexual partners and avoiding sex with children in prostitution are decisions made at an individual level, making them difficult to deal with. Awareness campaigns and peer education, however, can help.

The above discussion centred on establishing links between HIV/AIDS prevalence and child labour through its impact on orphanhood, and exploring how child labour can be

harnessed through interventions that are aimed at curbing the spread of HIV/AIDS. But the proliferation of child labour can also be curbed other ways. These include developing policies that are child friendly, attacking the root causes of child labour. These include addressing the problems of poverty among orphans and empowering communities. The discussions with key informants made it clear that some of these efforts are under way.

Problems exist, however, with the magnitude, coverage and efficiency with which these programmes are executed. Greater financial allocations are needed for programmes addressing issues related to HIV/AIDS orphans. More funds would help increase coverage, and so would more efficient execution of the relevant programmes. The latter objective would entail reducing the political dimensions of such schemes, among other things imposing penalties on those who would execute programmes in line with political agendas. In reducing administrative and execution costs and red tape, efficiently run programmes would maximize the actual benefits reaching the target group.

16. Recommendations

1. The planning and implementation of programmes should be left to local authorities which, by reason of their very location, are more acquainted with the problems on the ground. The role of the Government should be to disburse funds to local authorities.

2. The allocation of funds to local authorities should not be based on total populations, but rather on the actual number of children needing assistance in a given region.

3. Local authorities should be empowered, through capacity-building programmes, to deal with the problems in their areas.

4. Rules and regulations governing the acquisition of birth certificates should be made more flexible specifically to allow orphaned children to obtain these documents, thereby giving them access to their parents' deceased estates, as well as to education and other government programmes targeting orphans.

5. Legislation is needed to protect orphans, ensuring that they are neither marginalized nor abused and exploited. An example of this is inheritance laws that give orphans first preference to their deceased parents' estates.

6. Laws do exist that give orphans the right to own their deceased parents' houses in urban areas, but most orphans appear unaware of this. More awareness campaigns promoting the rights of children would rectify the situation.

7. Schemes such as the supplementary feeding programme in schools should be resuscitated, and the BEAM project and Better Schools Programme should be expanded to ensure access to food and educational materials by orphans and child workers suffering from the HIV/AIDS pandemic.

8. Checks and balances must be established to ensure that programme execution is not carried out along political or tribal lines, and heavy penalties should be applied against those mishandling resources.

9. Stiff penalties ought to be applied to those found guilty of abusing children in general and orphans in particular, especially if these are law enforcement agents.

10. The Government should clearly stipulate unacceptable types of child labour and form a department (probably in the Ministry of Labour) that monitors child labour and penalizes people found guilty of perpetrating child labour, particularly its worst forms.

11. In a bid to reduce the incidence of deaths from AIDS, the Government should consider both subsidizing retroviral drugs and making them available over the counter.

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Appendix I

Child questionnaire

Introduction and consent

The International Labour Organization (ILO), through the International Programme on the Elimination of Child Labour (IPEC) and the Statistical Information and Monitoring Programme on Child Labour (SIMPOC), is conducting studies in a number of African countries regarding HIV/AIDS orphanhood and child labour. The studies combine quantitative and qualitative analysis through primary and secondary data and through rapid assessments, providing policy-makers with insights into the magnitude, character, causes and consequences of the worst forms of child labour. These insights can then be used to determine strategic objectives and interventions for the elimination of the worst forms of child labour in each of the countries or regions. These include designing and targeting policy packages aimed at the elimination of the worst forms of child labour, and to implement, monitor and evaluate these programmes.

We are a group of researchers from the University of Zimbabwe who are carrying out this study on behalf of the ILO. Your participation in this study is of vital importance. We are therefore inviting you to participate in this study because, as members of the local community, you have ideas on how best we can:

- help orphans in general, and AIDS orphans in particular; and
- prevent worst forms of child labour that might arise from orphanhood in our country.

A pilot study is being conducted in Epworth, while the full study will be carried out in Gweru and Shurugwi Districts of the Midlands Province. Your experience and opinions can help policy-makers and leaders learn how to control and, eventually, even eliminate child labour.

The information you give us will remain strictly confidential. Your name will not be shown when the results of this research are published. Your part in our research will last approximately one-and-a-half hours. If you agree to participate, we will talk about your ideas. You are free to refuse to answer some of the questions, but we hope you will cooperate, because your opinions are valuable to us.

Please contact Mrs. Chizororo or Dr. Madzingira (University of Zimbabwe, Institute of Development Studies, P.O. Box MP 167, Mt. Pleasant, Harare, or telephone 307900/6) if you have any problems or questions about this research. Alternatively, you can contact Dr. J. Kaliyati on cellphone number 091-245614.

Identification

Name of district	
Study area	1. Urban 2. Growth Pt. 3. Communal 4. Commercial farm 5. Peri-urban
Date of interview	
Name of interviewer	

Background information

Sex	1. Male 2. Female
Age (completed years)	
Place of birth (name of district)	

B1. Where do you live?		
B2. Have you always lived there?	1. Yes 2. No	Yes> Q/B6
B3. If no, why did you move?	Open_____	
B4. Where did you live before? *(Specify city or village only.)*		
B5. Whom did you live with before? *(Check all persons that apply.)*	1. Father 2. Mother 3. Sister(s) *specify younger/older* 4. Brother(s) *specify younger/older* 5. Guardians 6. Employer 7 Grandparents 8. Uncle/aunt 9. Non-relative 10. Other (specify)	□ □ □ □ □ □ □ □ □ □
B6. Whom do you live with now? *(Check all persons that apply.)*	1. Father 2. Mother 3. Sister(s) *specify younger/older* 4. Brother(s) *specify younger/older* 5. Guardians 6. Employer 7. Grandparents 8. Uncle/aunt 9. Non-relative 10. Other (specify)	□ □ □ □ □ □ □ □ □ □

Note: Interviewers should repeat questions B3-B4 as many times as necessary.

B7 How many people do you live with?

B8. If child lives with any person other than both parents: where is your mother/father?

B9. List your siblings in birth order/how many brothers/sisters/ age

Siblings (in birth order)	Age (completed years)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
Total brothers _____ Total sisters _____	

B10. Where do you sleep?

1. Bed
2. Drain
3. Floor inside the house
4. Street
5. Other (specify)

Education

E1. Have you ever been to school?	1. Yes 2. No *(If no, go to E12)*	
E2. Are you currently attending school?	1. Yes 2. No	
E3. How regularly do you attend school?	1. Every day 2. Once per week 3. Twice per week 4. Three times/week 5. Four times/week 6. Five times/week 7. Depends on the season 8. Once a week 9. Twice a week 10. Three times a week 11. Four times a week 12. depends on the season	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
E4. Are there any days you miss school?	1. Yes 2. No	☐ ☐
E5. If yes, what makes you miss school?		
E6. Who pays for your education?	1. Myself 2. Friends 3. Parents/guardians 4. Relatives 5. Education is free 6. Others (specify)	☐ ☐ ☐ ☐ ☐ ☐ ____

Only if E2 = Left school: E7. What is the main reason you left school?	1. School is too far 2. Cannot afford school 3. Family does not allow schooling 4. Not interested in school 5. School not suitable or safe 6. Illness or disabled (self) 7. To help in household 8. To take care of ill family members 9. To work for wages 10. To work in own business for income 11. Other	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ _____
E8. When did you leave school?	Open_____	
E9. How old were you when you left school?		
E10. What grade or form were you when you left school?	Grade _____ Form _____	
E11. Would you like to go back to school?	1. Yes 2. No 3. DK	☐ ☐ ☐
E12. What is the main reason preventing you from going to school?	1. School is too far 2. Cannot afford school 3. Family does not allow schooling 4. Not interested in school 5. School not suitable or safe 6. Illness or disabled (self) 7. To help in household 8. To take care of sick family members 9. To work for wages 10. To work in own business for income 11. Other	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ _____
E13. Did someone (else) in your family drop out of school?	1. Yes 2. No	
E14. If yes, specify who?	1. Brothers (specify number) _____ 2. Sisters (specify number) _____	
E15. Can you read?	1. Yes 2. No	
E16. Can you write?	1. Yes 2. No	

Orphanhood

A1. Is your mother still alive?	1. Yes 2. No	Yes > skip to Q/A6
A2. What did she die from?	Open_____	
A3. Did she lie in bed for many weeks before she died?	1. Yes 2. No	
A4. How old was she when she died? *(In years.)*	_____	
A5. When did she die?	_____	
A6. Is she able to work outside the house?	1. Yes 2. No	
A7. How does she spend her day?	Open_____	

A8. Is your father still alive?	1. Yes 2. No
A9. If no, what did he die from?	Open_____
A10. Did he lie in bed for many weeks before he died?	1. Yes 2. No
A11. How old was he when he died? *(In years)*	
A12. When did he die?	
A13. If both parents are dead, who is your guardian? *(Relationship to guardian.)*	
A14. Is your guardian working?	1. Yes 2. No
A15. What work does he/she do?	

Domestic work

H1. Who does household chores in your household?		
Only if he/she performs domestic work: H2. What kind of domestic work do you do? *More than one answer allowed.*	1. Cooking/serving food for household 2. Cleaning utensils/house 3. Minor household repairs 4. Shopping for household 5. Caring for the old 6. Caring for the sick/infirm 7. Child minding (feeding, childcare, taking to school, etc.) 8. Other (specify)	1. 2. Yes No Yes No Yes No Yes No Yes No Yes No Yes No _____
H3. How many hours do you usually work each day on weekdays?	*(Number of hours)*	
H4. How many hours do you usually work each day on weekends?	*(Number of hours)*	
H5. Do you do paid domestic work in another household?	1. Yes 2. No	
H6. How many hours do you work during the week?	*(Number of hours)*	
H7. How are you paid?	1. Cash 2. In kind (specify) _____	
H8. If cash how much?	Amount in Z$	

Working history

L1. Are you currently working?	1. Yes 2. No
L2. Other than what you are doing now, did you ever work before?	1. Yes 2. No
L3. For how long have you been working?	*(Specify month/year.)*

L4. What is/was the reason you started working?	1. To gain experience/acquire training 2 Supplement family income 3. Help pay family debts 4. Help in own household enterprise 5. Earn money to establish own business 6. No school nearby 7. To pay school fees 8. To be economically independent 9. Others (specify) _____
L5. What kind of work do/did you do? *Leave it open, and use the following categories to probe.*	1. Mining and quarrying/panning 2. Agriculture work 3. Commercial sexual worker** 4. Construction 5. Handicraft 6. Domestic work 7. Vending 8. Paid worker in own household-operated enterprise 9. Car guarding/car washing; shoe shining 10. Unpaid worker in own household farm or business ***Adapt the phrasing to the local culture.*
L6. What is the tenure of your job?	1. Permanent 2. Short term/casual 3. Seasonal/school vacation 4. Work(ed) for different employers on daily/weekly basis 5. Other (specify) _____
L7. How long have you been in this job?	
L8. How old were you when you started this job?	

Working conditions

W1. Do you work with adults?	1. Yes 2. No
W2. Do you get paid the same as adults?	1. Yes 2. No
W3. Where do you do most of your work? (e.g. fields, house, factory, etc.)	1. n the house 2. n the fields 3. In a factory 4. In a bar 5. In the streets 6. Other (specify)
W4. What time of the day do you work?	1. Morning 2. Afternoon 3. Evening 4. Night
W5. Have you ever suffered any injury or illness as a result of your work?	1. Yes 2. No
W6. What type of injury/ illness?	Open
W7. How many times did you get injured or ill?	
W8. Have you ever seen other children suffer any injury or illness as a result of their work?	1. Yes 2. No

W9. What is/was your relationship with the following people?

Person	Relationship		
	Good	Bad	Neutral
1. Your employer			
2. Your customers			
3. Adults that you work with			
4. Other kids you work with			
5. Other (specify)			

W10. Do you like this job?	1. Yes 2. No
W11. Explain answer given in W10.	
W12. What do you dislike most about your work?	
W13. What do you like most about your work?	
W14. Would you want your sisters or brothers to follow your footsteps? Explain.	
W15. What do you do during your spare time?	
W16. What would you want to do when you are older?	

Remuneration

R1. Are/were you paid for the work you are/were doing?	1. Yes 2. No
R2. How are/were you paid?	1. In cash (how much) _____ 2. In kind (specify) _____ 3. Per customer 4. Per day 5. Per hour 6. Other (explain)
R3. Do you have other sources of income?	1. Yes 2. No
R4. If yes, what is the source?	
R5. How much do you get from this source?	
R6. What do you do with your money?	1. Give it all to parents/guardian 2. Give part of it to parents/guardian 3. Buy medicine 4. Spend it on food, clothing, etc. 5. Pay school fees (for who?) 6. Leisure 7. Other (specify) _____
R7. Who decides on how the money you earn is to be spent?	1. Self 2. Parents/guardian 3. Friends 4. Employer 5. Other (specify) _____

R8. Do/did you get time off when you are/were sick?	1. Yes 2. No
R9. Do/did you get paid if you are sick?	1. Yes 2. No
R10. Are you rewarded for working exceptionally well?	1. Yes 2. No
R11. If yes, how are you rewarded?	

For children who work in prostitution

X1. Please tell me how you started to work.		
X2. At what age did you start?		
X3. When did you start?		
X4. Where do you get your clients?	1. Hotel 2. Brothel 3. Street 4. Nightclub 5. Lodges 6. Other (specify)	
X5. Where do you operate from?	1. Car 2. House 3. Bush 4. Brothel 5. Offices 6. Hotels/lodges 7. Other (specify)	
X6. What kind of people are your clients? *(race, profession, origin)*		
X7. What do you do with your clients? *(Probe: anal, vaginal, or oral sex)*		
X8. How many clients do you see per day/night?		
X9. Do you have a boss who organizes your business for you?	1. Yes 2. No	
X10. If yes, does the boss collect the money for you?		
X11. If the boss collects the money for you, does he/she inform you how much he/she will have collected?	1. Yes 2. No	
X12. Do you have a payment arrangement with your boss?	1. Yes 2. No	
X13. How much are you paid?	1. Per client 2. Per night 3. Per session 4. Per day	How much? _____ _____ _____ _____
X14. Are you provided with the following facilities/benefits by your employer?	1. Clothing/uniforms 2. Accommodation 3. Transportation 4. Meals 5. Free medical treatment 6. Regular health checks 7. Easy loans 8. Assistance when you get into trouble with the law	

X15. Do you have medical aid?	1. Yes 2. No
X16. If not, who meets your medical bills?	
X17. Do you get off days?	1. Yes 2. No
X18. Have you received any kind of information about the possible health dangers or diseases you could be exposed to in your job?	1. Yes 2. No
X19. If yes, who provided the information?	1. Employer/manager/pimp 2. Government health worker 3. Department of Labour official 4. Other government officials 5. NGO volunteers 6. Colleagues in the same line of work 7. Media (TV, radio, newspapers) 8. Other (specify)
X20. How often do you have health/medical checkups?	1. Monthly 2. Quarterly 3. Bi-annually 4. Annually
X21. If regularly arranged, who arranges your checkups?	1. Employer/manager 2. Government 3. NGO 4. Yourself 5. Others (specify) _____
X22. Have you ever had any illness related to your work?	1. Yes 2. No
X23. If yes, what was the nature of the illness?	
X24. Who paid for your medical treatment?	1. Employer/manager 2. Yourself 3. Others (specify) _____
X25. Do you know about HIV/AIDS?	1. Yes 2. No
X26. If yes, how did you learn about HIV/AIDS?	1. From employer/manager/pimp 2. From the media (TV, newspapers, radio) 3. From friends/co-workers 4. From government officials 5. From voluntary organizations 6. Others (specify) _____
X27. Do you know what you can do to protect yourself against HIV/AIDS	1. Yes 2. No
X28. Does your place of work (employer/manager/pimp) provide you with a supply of condoms?	1. Establishment provides and insists/enforces use of condom 2. Establishment does not provide but insists/enforces use of condom 3. Establishment does not provide but encourages use of condom 4. Establishment does not care
X29. During the last five times you had sex with a customer, how many times was a condom used?	*(Indicate times.)*
X30. If a condom was not used, why not?	1. Customer pays more 2. Customer refused to use 3. No condom available 4. Did not know/care about use of condom 5. Other (please explain) _____

X31. If you had sisters or girl children, would you encourage or discourage them if they wanted to enter this line of work?	1. Encourage them (why) _____ 2. Discourage them (why) _____

HIV/AIDS

D1. Have you ever heard of HIV/AIDS?	1. Yes 2. No
D2. Who informed you about it?	1. Parents 2. Friends 3. Relatives 4. Media 5. School 6. Medical facilities 7. Workplace 8. Other (specify)
D3. How is HIV/AIDS transmitted?	1. Sexual intercourse 2. Unsterilized needles 3. Breast milk 4. During birth/pregnancy 5. Blood transfusion 6. Shared razor blades 7. Kissing 8. Holding hands 9. Supernatural powers 10. Do not know 11. Other (specify)
D4. Have you ever had sex?	1. Yes 2. No
D5. If yes, how old were you?	
D6. What was your reason for having sex?	
D7. Did you use anything to prevent pregnancy or STIs?	1. Yes 2. No
D8. f yes, what did you use?	1. Condom 2. Pill 3. Other (specify)
D9. Are there HIV/AIDS prevention programmes in your workplaces/school?	1. Yes 2. No 3. Do not know
D10. If yes, specify	1. Information 2. Discussion/education 3. Availability of condoms 4. Voluntary testing 5. Counselling 6. Care and support services 7. Peer education 8. Other (specify)
D11. Is there anything a person can do to avoid getting HIV/AIDS?	1. Yes 2. No 3. DK
D12 What can people do to protect themselves from getting HIV?	1. Abstain from sex 2. Use condoms 3. Avoid sharing needles, razor blades, etc. 4. Limit number of sexual partners 5. Avoid sex with prostitutes 6. Avoid sex with persons who have many sexual partners

D12. Can a person get AIDS from mosquito bites?	1. Yes 2. No 3. DK
D13. Do you know of a place where you can go to get such a test to see if you have AIDS?	1. Yes 2. No 3. DK
D14. I do not want to know the results, but have you ever been tested for HIV?	1. Yes 2. No
D15. I do not want you to tell me the results of the test, but have you been told the results?	1. Yes 2. No
D16. Is it possible for a healthy-looking person to have AIDS?	1. Yes 2. No 3. DK
D17. Do you think people with HIV/AIDS are treated differently?	1. Yes 2. No
D18. Specifically how are they treated differently or badly?	1. Neglected, isolated, avoided 2. Verbal abuse 3. Physical abuse 4. Sexual abuse 5. Not allowed to go to school 6. Made to do more chores 7. Underfed, deprived 8. Other (specify)

Appendix II

Key informants guide

Interviewee _____
Name of organization _____
District _____
Interviewer _____

Background of organization

Contact details: Physical address, telephone, email address, year started, main funders, number of professional staff.

Overall objectives/mission statement

Target groups.

Programme activities related to children.

How HIV/AIDS is incorporated into the organization's programme activities.

Outreach activities.

Details about project implementation (for child activities only)

Identification of children needing assistance.

Whether number of children is increasing or decreasing.

Monitoring of child-related activities.

Networking/collaboration with other organizations

Probe: Government, NGOs, civil society, other stakeholders.

Problems facing the organization in implementing child-related activities

Policy recommendations/suggestions

Appendix III

Parents/guardian focus group discussion guide

Introduction and consent

The International Labour Organization (ILO), through the International Programme on the Elimination of Child Labour (IPEC) and the Statistical Information and Monitoring Programme on Child Labour (SIMPOC), is conducting studies in a number of African countries on HIV/AIDS orphanhood and child labour. The studies combine quantitative and qualitative analysis through primary and secondary data and through rapid assessments, providing policy-makers with insights into the magnitude, character, causes and consequences of the worst forms of child labour. These insights can then be used to determine strategic objectives and interventions for the elimination of the worst forms of child labour in each of the countries or regions. These include designing and targeting policy packages aimed at the elimination of the worst forms of child labour, and to implement, monitor and evaluate these programmes.

We are a group of researchers from the University of Zimbabwe who are carrying out this study on behalf of the ILO. Your participation in this study is of vital importance. We are therefore inviting you to participate in this study because, as members of the local community, you have ideas on how best we can:

- help orphans in general, and AIDS orphans in particular; and
- prevent worst forms of child labour that might arise from orphanhood in our country.

A pilot study is being conducted in Epworth, while the full study will be carried out in Gweru and Shurugwi Districts of the Midlands Province. Your experience and opinions can help policy-makers and leaders learn how to control and, eventually, even eliminate child labour.

The information you give us will remain strictly confidential. Your name will not be shown when the results of this research are published. Your part in our research will last approximately one-and-a-half hours. If you agree to participate, we will talk about your ideas. You are free to refuse to answer some of the questions, but we hope you will cooperate, because your opinions are valuable to us.

Please contact Mrs. Chizororo or Dr. Madzingira (University of Zimbabwe, Institute of Development Studies, P.O. Box MP 167, Mt. Pleasant, Harare, or telephone 307900/6) if you have any problems or questions about this research. Alternatively, you can contact Dr. J. Kaliyati on cellphone number 091-245614.

Background information on participants

Please complete for each participant in the focus group.

Information about the orphan									
Age	Sex	Parental survivorship	Relationship to guardian	Marital status	Place of birth	Where do you currently live?	Occupation/ type of work	Still attending school	Grade attending/ attained

Information about the guardian						
Age	Sex	Marital status	Relationship to orphan	Education	Employment status	Nature of work

1. Can you tell us why you, and not other relatives, are looking after these children?

2. Can you describe the problems or difficulties you are experiencing in sending the affected/infected children to school?

3. If the child has left school, can you share the main reasons for leaving school?

4. If the child has never been to school, can you share the main reasons preventing the child from going to school?

5. Can you describe the problems you are experiencing with school dropouts?

6. How do the children spend their time?
   Probe: Attending school
   Never been to school
   Drop out

7. Tell us about the nature of their work?
   Probe: Type of work
   Part time/full time
   Starting time
   Finishing time
   Working hours

8. Is there a difference in care/treatment of own child or other?
   Probe: Hours doing household chores
   Vending
   Abuse (sex, violence, etc.)

9. How is the child's income spent?

General questions:

10. Do you discuss about illnesses and death of the child's parent(s)?
    Probe: Why?
    Why not?

11. Suggestions and solutions/policy recommendations.

Thank you for your time.

Appendix IV

Children focus group discussion guide

Introduction and consent

The International Labour Organization (ILO), through the International Programme on the Elimination of Child Labour (IPEC) and the Statistical Information and Monitoring Programme on Child Labour (SIMPOC), is conducting studies in a number of African countries on HIV/AIDS orphanhood and child labour. The studies combine quantitative and qualitative analysis through primary and secondary data and through rapid assessments, providing policy-makers with insights into the magnitude, character, causes and consequences of the worst forms of child labour. These insights can then be used to determine strategic objectives and interventions for the elimination of the worst forms of child labour in each of the countries or regions. These include designing and targeting policy packages aimed at the elimination of the worst forms of child labour, and to implement, monitor and evaluate these programmes.

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The information you give us will remain strictly confidential. Your name will not be shown when the results of this research are published. Your part in our research will last approximately one-and-a-half hours. If you agree to participate, we will talk about your ideas. You are free to refuse to answer some of the questions, but we hope you will cooperate, because your opinions are valuable to us.

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Background information on participants

Please complete for each participant in the focus group.

Age	Sex	Parental survivorship	Place of birth	Where do you currently live?	Parent or guardian	Occupation/ type of work	Still attending school	Grade attending/attained

1. Can you describe your living conditions?

Education

2. Could you please describe your schooling routine?

3. Can you describe the problems or difficulties you are experiencing with your schooling?

4. If you have left school, can you share the main reasons for leaving school?

5. If you have never been to school, can you share the main reasons preventing you from going to school?

6. Can you describe the problems you experienced after leaving school? Are these problems a result of dropping out of school?

7. Working conditions.

8. Can you tell us about your work?
   Probe: Type of work
   Part time/full time
   Starting time
   Finishing time
   Working hours

9. For how long have you been working?

10. Can you share the main reasons that you work?

11. What do you like/dislike about your work?

12. What problems do you often come across at work and how do you deal with them?

13. Have you ever had work-related illness or accident?
    Probe: Nature of illness/accident/injury
    Medical treatment
    How you dealt with the illness/accident/injury

14. Can you tell us about your income and how you spent it?
    Probe: Cash or in kind?

HIV/AIDS

15. What do you understand about HIV/AIDS?
    Probe: Transmission
    Prevention
    Protection

16. Can you describe the HIV/AIDS prevention programme within your work workplace/school/community?

17. Can you describe a person you know who has AIDS and what he or she looks like?

18. Can you describe your experiences of discrimination against you because you are affected or related to someone infected with HIV/AIDS?

For children in prostitution

19. Can you tell us how you started work as a commercial sex worker?
    Probe: Abuse

20. What benefits do you get from your activity?
    Probe: Cash
    In kind

21. Can you explain the protection measures you implement to protect yourself against sexually transmitted infections including HIV/AIDS?

22. If you had sisters/brothers, what would you say to them if they wanted to enter this activity?

Thank you for your time.