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INSTITUTIONAL CHILDCARE SERVICES IN HARARE, ZIMBABWE: EXPLORING EXPERIENCES OF MANAGERS, CAREGIVERS AND CHILDREN

by

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A thesis submitted to the

Department of Social Work

School of Human and Community Development

Faculty of Humanities

University of the Witwatersrand, Johannesburg

In fulfilment of the requirements of the Degree of Doctor of Philosophy (Social Work)

Supervisor: Dr. Edmarie Pretorius

November 2017

DECLARATION OF ORIFINALITY

I, PATIENCE CHINYENZE, hereby declare that this thesis is a product of my own work and I acknowledged all the sources that I used. This thesis has not been previously submitted for examination at any University.

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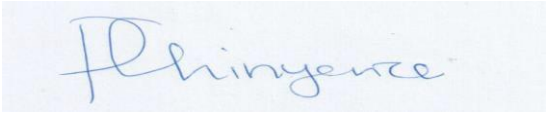
University of the Witwatersrand

Johannesburg



26 November 2017

Patience Chinyenze **Date**

DEDICATION

This study is dedicated to my late father, Agripa Tichaona Chinyenze.

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I would like to thank the Almighty God for making it possible for me to pursue PhD studies. I give Him all the glory and honour.

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ABSTRACT

Institutional care is one of the strategies used to provide quality care to vulnerable children. Services in institutional care are designed to provide children with a family environment, psychosocial services, and services that prepare children to adjust to the society and be responsible citizens after being discharged. Noteworthy is the fact that many scholars argue that institutional care is not good for children because of its detrimental effects on child development. In spite of this strong and negative argument, institutional care is still being recognized as an option for vulnerable children and is therefore still prevalent in many countries including Zimbabwe. This study was carried out to explore the experiences of managers, caregivers and children in childcare institutions in Harare, Zimbabwe.

The study was aimed at exploring and analysing the views of management, caregivers and children about psychosocial centred childcare services in institutions in Harare, Zimbabwe; and adopted three theories namely Psychosocial Theory by Erik Erikson, Attachment Theory by John Bowlby and Ecological Theory by Urie Bronfennbrenner. A qualitative approach that was descriptive and exploratory in nature and a multiple case study design was used. Participants included one director from the Department of Social Services, five key informants, twenty-four caregivers and twenty-four children, all from four childcare institutions in Harare. Individual interviews were conducted with a Director from the Department of Social Services and Directors of four childcare Institutions to explore their views on the nature of childcare services at the different institutions. In addition, a group of six caregivers per childcare institution participated in focus group discussions held to explore their experiences in terms of services being provided in the institutions in Harare, Zimbabwe. Furthermore, individual interviews were held with six children per childcare institution to capture their voices on the childcare services that they were receiving in institutions.

The findings from the study revealed that although institutional care is regarded as the last resort in Zimbabwe, more and more children are being placed in institutional care. Findings also revealed that some of the services provided in institutional care are appropriate and pro-child development. In this regard, as a result of provision of these services, children in institutional care were accessing their basic needs like shelter, food and education and were

assured of a home and family. In addition, institutions were providing psychosocial services to help children to deal with past and present issues and also to prepare for future life. The study gathered that, all these services were provided to create an environment conducive for child development and to equip children with skills critical in adulthood, adjust to the society and be responsible citizens after discharge from a childcare institution.

On the other hand, participants highlighted that there were several impediments to institutional care service delivery in Zimbabwe. These include, inadequate support from Probation Officers, minimal financial support from the government, children's lack of identity documents, limited efforts on discharge plans and course of action for children over 18 years of age, absence of an administrative body to run caregivers' affairs, non-inclusion of people at grassroots level in policy formulation and implementation. Participants highlighted that the aforementioned factors negatively affect the quality of services provided in institutional care.

In light of the above, Zimbabwe has institutional childcare services that are appropriate, but there are drawbacks that need serious attention. The study therefore recommended that there was need to address the drawbacks in order minimise detrimental effects on the quality of psychosocial-centred childcare services available in childcare institutions. In addition, the study also proposed formulation of a psychosocial support framework for use in childcare institutions.

Key Words: childcare, institutional care, family–based care, child development, psychosocial support

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LIST OF ACRONYMS USED IN THE STUDY

DSS	Department of Social Services
NAP I	National Action Plan for Orphaned and Vulnerable Children Phase I 2004-2010
NAP II	National Action Plan for Orphaned and Vulnerable Children Phase II 2011-2015
REPSSI	Regional Psychosocial Support Initiative
SADC	Southern Africa Development Community
UNICEF	United Nations Children's Fund
UNCRC	United Nations Convention on the Rights of the Child

CHAPTER ONE:
INTRODUCTION TO THE STUDY
ON INSTITUTIONAL CHILDCARE SERVICES

1.1 INTRODUCTION

Worldwide, the provision of institutional childcare services is a component of child welfare services for children without parental or kinship care. As part of the international community with concern to childcare, these services are also provided in Zimbabwe. Although the services are provided countrywide, this study was carried out at four childcare institutions in Harare, Zimbabwe. This chapter includes the background to the study, and describes the problem statement and rationale for the study. Research questions, the primary aims and secondary objectives of the study are presented, and a brief overview of the research methodology used, is given. The key concepts of the study are defined and the chapter subsequently closes with a brief outline on the organisation of the content of the thesis.

1.2 BACKGROUND TO THE STUDY

Globally, child protection is one of the key elements of social work practice which covers both family-based and institutional care. Family-based care entails social workers giving support to communities and monitoring care received by children staying with their biological parents (Browne, Hamilton-Giatritis, Johnson & Ostergren, 2006; Ross, 2011). It also includes kinship care, that is, where children get similar support and monitoring services while staying with members of the extended family (Deininger, Gracia & Subbarao, 2003; Green & Berrick, 2004; Mutambara, 2015; Mutangadura, 2003). On the other hand, institutional care involves looking after children who are placed in special designated residences because their families are not able to take care of them, or they have passed on (Barth, 2002a; Mhongera & Lombard, 2017; Muguwe, 2012; Powell et al., 2004). Presently, social workers are pro family based-care as opposed to institutional care, and in child and family care services the emphasis is on family preservation strategies so that children remain under the care of family members. Institutional care is regarded as the last option for protection of children because it is perceived to have detrimental effects on children (Browne et al., 2006; Morantz & Heyman, 2010).

In spite of the attempts to implement family preservation strategies, evidence suggests an increase in placement of children in residential care which is prompting the need for more children's homes, as social workers often do not have alternative options but to place children in institutions. As indicated by the Congressional Coalition of Adoption Institute (2011), there are over 4 million children in care worldwide and there is growing need for alternative or residential/institutional care. In sub-Saharan Africa, Acquired Immuno Deficiency Syndrome (AIDS) has resulted in an increased number of children in need of care (Johnson, 2005; Maestral International, 2011; UNAIDS, 2014; The Stephen Lewis Foundation, 2015). In Zimbabwe, extended family members assume the parenting role in the event of both parents passing on, and/or when the biological parents are not available, for example due to illness or other factors (Gwenzi, 2018; Masuka et al., 2012; Mushunje & Mafico, 2010). In this vein, if parents and relatives are unknown, or not able to look after children of deceased family members, institutional care becomes the only alternative option for care of children in difficult circumstances (Children's Act, 2001; Powell et al., 2004).

Institutions provide comprehensive care recommended by child experts, deemed critical for the social, physical, mental and emotional growth of children. Social workers practising in institutions play pivotal roles seeking to enhance the social functioning of children. As argued by Davis (1982, p. 45), "Part of the residential social workers' responsibilities must lie in ascertaining need, facilitating opportunity, monitoring responses and providing checks and balances essential for progress of the residents within the broadband of human growth". This confirms that institutions should not only protect children, but also enhance their development.

1.3 PROBLEM STATEMENT AND RATIONALE FOR THE STUDY

The problem of children in need of care is a global issue and is addressed by different legislations worldwide. In Zimbabwe, children in need of care under 18 years of age, are usually taken care of by members of the family and are placed in institutional care as a last option (Children's Act, 2001; Masuka, Banda, Mabvurira & Frank, 2012; Powell et al., 2004). This means that children, who are placed in institutions, leave their families and are looked after by caregivers who are employees of residential institutions. However, Morantz and Heyman (2010) note that institutionalisation separates children from their biological relatives, and does not provide the same support system that a child gets from the family.

There are concerns about whether the institutions can completely replace the family in terms of service provisions.

Institutionalised children may be deprived of their biological primary attachment figures by being placed in institutions, and this may negatively impact on children's sense of self, as well as their personality later on in adulthood. Research done by Bowlby showed that the institutional environment is not conducive to the development of the child's personality (Bowlby, 1951, 1969; Gordon, 1972). In light of the impact and relevance of services in temporary residential care, as observed by Connolly and Morris (2012), it is critical to do research about children who have experienced being in institutional care, since not much is known. Therefore, exploring and understanding the experiences of caregivers and children in institutional care might provide insight into the influence of institutional care on children's psychosocial needs during their development. According to Browne et al. (2006) and Riley (2012), institutional care does not provide an environment in which a child's social, emotional and psychological needs are properly met. In this vein, a research study done by UNICEF in Zimbabwe in 1992 revealed that institutional care causes children to feel discriminated against and labels them as different (outcasts), and does not facilitate sufficient opportunities for them to develop continuous bonds (Powell et al., 2004). In addition, the lack of cultural sensitivity observed and experienced in institutions run by international donors also poses different challenges to children placed in institutions or residential care (Masuka et al., 2012; Tolfree, 1995; Williamson & Greenberg, 2010). It is hoped that the research study will give both children residing in institutions and their caregivers the opportunity to narrate their experiences which is likely to result in recommendations in terms of creating and enhancing an environment in childcare institutions in Harare, Zimbabwe, so that the psychosocial and developmental needs of children are adequately addressed.

The study contributed towards the provision of a deeper insight into the quality of psychosocial services provided in institutions to enhance child development and adjustment. The findings of the study are likely to be used by childcare practitioners to analyse the relevance of services offered in institutions and to address gaps. Furthermore, the study might inform policy makers on the appropriateness or relevance of existing policies and procedures related to institutionalisation in Zimbabwe. In academia, the research will contribute to the existing body of knowledge on child welfare and protection services for children in institutional care.

1.4 PRIMARY AIM AND SECONDARY OBJECTIVES FOR THE STUDY

The primary aim of the study was to explore and analyse the views of management, childcare workers and children about psychosocial-centred childcare services in childcare institutions in Harare.

The secondary objectives of the study were:

- To establish the views of management on the nature of childcare services at the different childcare institutions in Harare, Zimbabwe.
- To investigate the perceptions of caregivers as direct providers of psychosocial support services in childcare institutions in Harare, Zimbabwe.
- To explore the experiences of children in institutional care as recipients of services provided in institutions.
- To determine how childcare institutions, provide services that equip children with life skills critical in child development.
- To propose recommendations regarding improving childcare services in institutions in Harare, Zimbabwe.

1.5 RESEARCH QUESTIONS

The following questions guided the research study:

- What are the views of management and caregivers in childcare institutions in Harare about the appropriateness of services provided in relation to the developmental needs of children?
- In what ways do the childcare services in childcare institutions equip children with life skills critical for their development?
- How do children experience the psychosocial support services provided in childcare institutions in Harare, Zimbabwe?

1.6 SIGNIFICANCE OF THE STUDY

The study was useful because it provided an opportunity for managers, caregivers and children in care institutions, to share experiences, thoughts and feelings towards childcare services in institutions (Grinell & Unrau, 2005: Punch, 2005). In addition, the findings inform the social work fraternity at large about the experiences and needs of the different groups of

participants. In turn, it is likely to inform interventions in childcare institutions. The findings from the study also undeniably added knowledge to academia and social work practice. In this regard, the researcher hopes that the study will enlighten childcare practictioners on the quality of institutional care services in childcare institutions; and this information is highly useful in policy formulation, implementation and evaluation (Fouche & Delport, 2011; Grinell & Unrau, 2005).

1.7 RESEARCH METHODOLOGY

The research used a qualitative approach which is descriptive and exploratory in nature. As explained by Creswell (2008, p. 46), qualitative research is "a type of educational research in which the researcher relies on the views of participants; asks broad questions; collects data consisting largely of words (text) from participants; describes and analyses these words for themes; and conducts the inquiry in a subjective biased manner". A qualitative approach and case study design suited this study because it involves exploration and the description of feelings, perceptions, meanings and experiences of both caregivers and children in institutional care and the views of management of the institutions. A detailed discussion on the research methodology applied is presented in Chapter 3.

1.8 DEFINITION OF RELEVANT TERMS USED IN THIS STUDY

Children refer to young human beings under the age of 18 years (United Nations Convention on the Right of the Child, 1989; Zimbabwe Children Act, 2001).

Child development refers to the physical, social and cognitive changes observed in the children as they grow and mature (Hook, Watts & Cockcroft, 2009; Levine & Munch, 2014). In addition, the study adopts the view that these changes are influenced by biological, environmental and social factors.

Social protection is defined as statutory-based services given to children and their families in a bid to meet the basic needs of a child (Blank & Handa 2008).

Child protection is defined by Loffel (2008, p.83) as "protective interventions and follow-up services which involve the use of state authority in cases involving abuse, abandonment, neglect, exploitation or destitution of children".

Childcare as explained by The Zimbabwean National Residential Childcare Standards (NRCCS) (2010, p. 6) denotes to "pro-child development activities that are done when looking after children so as to provide total care".

Institutional care as described by Powell (2006, p. 133), is "a group living arrangement for children, in which care is remunerated by adults who would not be regarded as traditional carers within the wider society". In this study, the words institutional care and residential care will be used interchangeably to refer to the aforementioned.

Family-based care refers to the non-statutory support and care that children get from their parents or relatives (Powell et al., 2004).

Psychosocial support refers to programmes and strategies that are used by practitioners to assist humans to deal with challenging psychological, emotional, spiritual and social issues in order to enhance social functioning (Gurupira & Chikutuma, 2017; Oysernman, 2007; REPSSI, 2007; Ritcher, 2006).

1.9 ORGANISATION OF THE THESIS

The thesis has been organised into the following chapters:

Chapter 1 covers a general introduction and overview, providing the background to the study and outlining the problem statement and rationale for the study. Research questions, aims and objectives are presented. A brief description of the research methodology used is mentioned and the relevant terms to the study are defined.

Chapter 2 explains the theoretical frameworks adopted in this study namely the Psychosocial Theory, Attachment Theory and Ecological Theory. In addition, these theories are discussed in the context of child development for children in residential care and the role played by caregivers to prepare and equip children with skills critical in adulthood.

Chapter 3 focuses on a literature review about child protection in general. This explanation is followed by a detailed discussion on the psychosocial needs of children and subsequent relevant psychosocial support that should be provided to children. More so, the chapter discusses existing child protection legislation at international level and various child protection strategies that are in use worldwide.

In Chapter 4 the study focuses on literature about institutional care, specifically in Zimbabwe and child protection strategies that are in use in Zimbabwe are described in detail. This chapter goes on to discuss institutional care for children, narrowing down to the models in use, legislations and the challenges experienced.

Chapter 5 describes the research methodology that was used in this study which incorporates the approach, the research design, sampling procedure, research instruments utilised, and the methods of data collection and analysis. The trustworthiness of the study, ethical considerations observed and the limitations and delimitations of the study are included in this chapter.

In Chapter 6 the analyses of empirical findings from the data collected from the key informants (managers of childcare institutions) are presented and discussed. Notably, the views from these managers were analysed based on the appropriateness of existing childcare services to the developmental needs of children.

Chapter 7 presents the data analysis and discussion of the empirical findings from the caregivers who look after children in institutions. As depicted by the title of the chapter, the findings discuss caregivers' experiences, and also analyses their views with regard to the appropriateness of childcare services provided in institutions.

In Chapter 8 the analysed data collected from children in institutional care are presented and discussed. It mainly focuses on children's experiences of the childcare services provided in the institutions. This chapter describes the meanings, feelings and thoughts expressed by children who are receiving the services that are deemed appropriate to their development.

Chapter 9 concludes the study. It discusses the attainment of the primary aims and secondary objectives of the study in relation to the main/key findings. Furthermore, it is a compilation of conclusions derived from the study and recommendations for policy-making on institutional care for children, the practice and future research, are made based on the findings of the study.

CHAPTER TWO:
THEORETICAL FRAMEWORKS FOR THE STUDY

2.1 INTRODUCTION

There are many theories on child development. This particular study has adopted three theoretical frameworks, namely The Psychosocial Theory, (Erikson, 1959), The Attachment Theory (Bowlby, 1969) and The Ecological Perspective of Child Development (Bronfenbrenner, 1979). These frameworks are relevant for this study as they focus on the different psychosocial stages of child development, the bonding between caregivers and children and the contribution of the social context in which a child grows up in relation to the development of the child. In this regard, the opportunity for children to develop relationships and form attachments during the different developmental stages is explored. The explanations that are linked to the theories touch on roles played by caregivers on children, to prepare and equip them with skills critical in adulthood or simply life skills. In addition, the theories explain psychosocial problems that children may experience when their needs are not met. Noteworthy, all three frameworks highlight that unmet needs and unresolved developmental issues are likely to affect the development of a child, initially during childhood and later in adulthood (Ainsworth & Bowlby, 1991; Bowlby, 1977; Bretherton, 1992; Bronfenbrenner, 1979; Jarolmen, 2014).

2.2 PSYCHOSOCIAL THEORY

One of the theories guiding this study is Erik Erikson's Theory of Psychosocial Development. Erikson's theory focuses on the psychosocial stages of human development and the crisis associated with each stage in the event of non-fulfilment (Hook, 2002; Jarolmen, 2014). At each stage of development, a child experiences desirable or undesirable outcome. These desirable and undesirable outcomes influence a child's psychosocial functioning and resultant actions and will be described in more detail.

The first stage, *Basic Trust versus Mistrust* focuses on the development of trust in children from birth to 12 months. In this stage, as explained by Erikson, children learn to trust parents/ caregivers for survival. As observed by Hook (2002), mothers and caregivers play a pivotal role in helping children to develop trust as they relate with them on a day-to-day basis. The same author cites Erikson (1963, p.270), asserting that "good maternal care results in the

baby learning once and for all to trust the mother, to trust himself or herself, and to trust the world". This means that mothers' and caregivers' actions and responses are critical as they can either build trust or mistrust. In this regard, as explained by Berk (2004), trust is built, for example, when mothers/caregivers feed children or attend to their needs promptly. Mistrust develops when babies go without food for longer periods and are ill-treated. In short, this theory affirms that trust is built when children's basic needs are met and mistrust develops if the same needs are not met. This means that in childcare work, caregivers assigned to work with babies aged 12 months and younger should treat children in ways that help to build trust. As a result, this may require them to provide babies with basic needs necessary at that age, like milk, signs of affection such as a kiss on the cheek, cuddling and many others.

Erikson argued that children who trust their caregivers will also trust the world without problems. Therefore, from the researcher's point of view, trust is an important factor in building relationships. Erikson's theory might be linked to Bowlby's Attachment Theory in the sense that a trustful relationship with a child often results in a secure attachment and vice versa. This means that children feel safe in the company of people they trust. However, in the context of children in institutional care, some may display mistrust due to past experiences encountered before or during the process of institutionalisation. Examples of such experiences are abandonment, and/or abuse or neglect at a tender age of 12 months or younger. To this end, some children physically and emotionally abused by their mother or female caregivers in the early stages of their lives, may find it difficult to trust all women in future. As discussed earlier on, children's experiences during this psychosocial stage can impact on future relationships with caregivers or anyone with whom they come into contact in the society. It is therefore important for childcare workers to address issues of trust in children aged one year and younger.

When linking Erik Erikson's *basic trust vs mistrust stage* in child development to the Ecological theory, it can be deduced that meaningful interactions happen when a child trusts a parent or caregiver. In the context of children in institutional care, the creation of a child-friendly environment results in good interactions between the child and caregiver. This environment may comprise areas where children can play freely with others or the caregiver, or an environment that is warm and full of age-appropriate toys.

The second stage, *Autonomy versus Shame and Doubt* centres on the notion of children exercising their independence and controlling their bodily functions resulting in the acquisition of confidence and self-control. It is relevant in the development of children aged one to three years (Berk, 2004). As mentioned earlier on, caregivers and parents should allow children to pursue their interests as long as the environment is safe. As noted by Hook (2002), denying children opportunities to be independent during this stage, can result in their being uncontrollable and repeating inappropriate behaviour without learning what is acceptable and what is not. This means that with autonomy children develop confidence and self-control, and denial of autonomy brings shame and doubt, culminating in the loss of confidence and control. In the context of children in institutional care, the mentioned feelings coupled with circumstances that made the children to be placed in institutional care are likely to result in psychosocial issues (Mhongera, 2017; Mutambara, 2015). It is therefore very important for childcare workers to ensure that care provided to children aged one to three years in institutions, recognises the importance of autonomy in children. This means that institutionalised children aged one to three years should be allowed to exercise their independence and learn how to control their bodily functions in an appropriate manner. Therefore, caregivers should allow children to exercise their independence within reasonable boundaries (Shore, 2003; Theilheimer, 2006; Torrelli, 1989) and by so doing, childcare institutions are likely to raise and prepare children who are confident and able to control themselves and adapt to societal expectations later in adulthood.

In linking the stage of *Autonomy vs Shame* with Bowlby's Attachment Theory, it can be concluded that children feel free to exercise their autonomy, especially in the presence of an attachment figure. On the other hand, the absence of an attachment figure may discourage the child from demonstrating character traits of independence.

The link of this stage with the Ecological Theory is that, in a good environment characterised by adequate space, warmth, security and supportive communication, children learn to control themselves (Department of Health and Ageing, 2010; French, 2007). Presumably, a bad environment, that is for example, overcrowded, cold, insecure and not supportive, is not conducive to child development as children may lack self-control, learn to depend and rely on others, and may do things that can result in their feeling ashamed or doubtful.

The third stage is known as *Initiative versus Guilt*. It focuses on children aged three to six years and their desires to initiate and experiment with new things. This is specifically coupled with learning to discover and understand gender identity, roles and cultural expectations. As children experiment with new things, their ability to do things on their own, develops.

Probably, in normal family scenarios this stage may entail asking children to do things based on their initiative. For example, allowing children to make choices, wash dishes, make toys based on their own thinking, believing in them when they want to accomplish a task. It is understandable that the institutional care scenario is made up of rules and regulations and the environment may be artificial (Anglin, 2004; Bullen, Taplin, Kertesz, Humphreys & McArthur, 2015). It is therefore important for children in institutional care to be allowed to take the initiative in certain things that are age appropriate. This is a critical skill in adulthood as people who take the initiatives tent to last long on jobs and are able to use it to come up with meaningful decisions. Thus, in institutional care, the three to six-year-olds should be allowed to take initiatives. This notion links up with the Ecological Theory (Bronfenbrenner, 2005; Bronfenbrenner & Morris, 2006; Paquette & Ryan, 2001) in the sense that a supportive environment is conducive for taking initiative. In line with the Attachment Theory, a secure caregiver to the child attachment style is also conducive for children taking initiative.

The fourth stage *Industry versus Inferiority* is usually evident in children aged six to eleven years. During this stage children are given space to work, acquiring new skills and learning how to conduct themselves and manage activities in general. As explained by Hook (2002), this stage's scope includes acquiring skills related to day-to-day activities like writing, reading and using utensils at home. This can either result in children feeling competent if they succeed or inferior if they fail.

In institutional care, this stage involves children taking part in house chores like cleaning, gardening, feeding chickens and others. The skills acquired at this stage are very critical in adulthood. Excelling in them instils confidence when surrounded by others. On the other hand, poor performance makes the child feel inferior. This means that children in institutions should be given opportunities to participate in activities at home or school. This helps them to feel competent and confident.

In linking the *Industry vs Inferiority* stage to the Attachment Theory, it is notable to comment that children may find it a lot easier to acquire new skills from people they are attached to.

They may shun skills possessed by adults to whom they are not attached. An everyday example is of children who enjoy Mathematics lessons in school because they like the teacher and vice versa. The same group of children may find a Geography lesson to be very boring because they do not like the teacher. The link between the Industry vs Inferiority stage and Ecological Theory is that children can acquire new skills and interact with skilled people well in an environment that is conducive to optimise child development in order to fulfil these milestones. Based on the aforementioned, it is ideal for institutional set-ups to attach children with members of staff who are competent in associating with children aged six to eleven years.

Identity versus Role Confusion is the fifth stage and is experienced during adolescence. At this stage, children are keen to define themselves and the roles that they are able to play in the society. As explained in Hook (2002, p.279), Erikson's definition of identity is "a sense of being at one with oneself as one grows and develops and to an affinity between the individual and his or her social roles and community ties".

It is during this stage that children often question themselves on issues, Who am I? Where did I come from? What am I going to do in in future? Where are my birth parents? What is my totem? and other questions (Erikson, 1968; Hoare, 2002; McAdams, Josselson, & Lieblich, 2006; Sokol, 2009). Usually questions related to this may be directed to guardians or caregivers. In the context of institutional care, it is appropriate that children are made aware of their backgrounds and their circumstances by the time they reach this stage. Therefore, it is vital for children to be informed about their biological parents (if information is available), circumstances leading to their institutional placement, and possible future plans. This stage can raise emotions for children with difficult backgrounds when they try to search for meanings about themselves and end up with many unanswered questions. For children in institutional care settings, it is ideal to have psychosocial interventions that help them to deal with painful emotional past experiences. Depending on preferences, the intervention tools should be varied to cater for both extroverted and introverted children so as to accommodate all personalities (Schueller, 2012; Seligman, Steen, Park, & Peterson, 2005).

2.2.1 Application of the psychosocial theory to this study

In summary, Erikson's Theory highlights that children may experience a conflict at each psychosocial stage of child development. Positive attributes are gained when a child

overcomes a challenge at each stage. On the other hand, negative emotions can be experienced when a child fails to overcome challenges. These negative emotions highlighted in Erikson's Theory form the basis for some of the psychosocial emotions that children experience in childhood and later in adulthood such as mistrust, shame and doubt, guilt, inferiority and role confusion. These, when unresolved, can be sources of stress and malfunctioning in adulthood (Berk, 2004; Erikson, 1968; Hoare, 2002).

In light of the above, Erikson's Theory has been adopted to explore how different childcare interventions in institutions are meaningful and provide an environment conducive for the psychosocial development of children. Although there are eight psychosocial stages of development from early childhood to late adulthood, the focus of this study will only be on the first five stages which are related to child development. Ideas from these stages are important in childcare practices and thus childcare practitioners should ensure that caregivers help children to overcome crises associated with each stage. Again, using Erikson's Theory, this study will explore and observe how institutional care and the caregivers influence the development of children on different developmental stages. It is likely that some children could have been placed in institutions after spending part of their early life at home with the family. Thus, by using Erikson's Theory, the study will explore whether institutions have mechanisms in place to assist children to adapt to institutional life without interfering with their psychosocial development.

2.3 ATTACHMENT THEORY

The Attachment Theory was developed by John Bowlby to explain the relationship between maternal deprivation and personality development (Ainsworth & Bowlby, 1991; Atwool, 2006; Bretherton, 1992). It is a valuable theory to recognise during this study. It was adopted to explain the relationship between institutional caregivers and children receiving care. In general, attachment is described by Bowlby as a connection that builds as a result of bonding between a child and a caregiver (Bowlby, 1977; Bretherton, 2006; Senior, 2002). This bond develops as a result of the continuous association between child and parent/caregiver. As such, the timing and type of care a child gets during the association, determines the level of attachment (Malekpour, 2007) and security. Thus, children feel secure when they have a strong bond with the caregivers and feel insecure when the bond is weak. Therefore, in his theory, Bowlby asserts that a child feels secure in the presence of attachment figures, and the absence of those figures creates a number of psychosocial issues. Bowlby also concurs that

the type of bonding determines the level of attachment, and is liable to produce different behavioural and emotional manifestations that may call for psychosocial intervention (Bowlby, 1940; Malekpour, 2007).

Attachment between a child and a caregiver develops in phases. To this end, Bowlby came with a framework for attachment phases, discussed as follows:

The pre-attachment phase is relevant to children from birth to one month. Children are free to interact with anyone.

In the attachment in the making phase, children learn skills on how to interact with people. The process of attachment starts here. Children learn to express themselves by voice and to listen.

The clear-cut attachment phase is experienced by children aged 8 months to two years. In this stage, babies miss their mothers and refuse to engage with people with whom they are not familiar.

The last phase is the goal corrected partnership which covers children two years and older. In this phase children tend to look for an attachment figure for a purpose. They can cry, shout or follow the figure. At this stage, children are also aware of other people's feelings and guided by inner feelings and expectations Bowlby, termed internal working models.

There are four attachment patterns. Using Mary Ainsworth ideas, who has built further contributions from Bowlby's theory, this study explored the four patterns as discussed next:

The securely attached pattern is seen in a caregiver-to-child relationship where the child feels safe and comfortable in the presence of an attachment figure who is the caregiver. This pattern is initially displayed in a parent-to-child relationship (Gearity, 2005; Malekpour, 2007). Children express disapproval, feel anxious and sorrowful when the attachment figure leaves them, (Ainsworth, 1978). The same author highlights that, upon return of the attachment figure, children feel relaxed and free from constraint. In this vein, an insecure attachment results in pressure and tension and on the other hand, a secure attachment results in psychological well-being that culminates into emotional stability (Schore, 2001; Thompson, 2000). This emotional stability forms the foundation for self-esteem and confidence. Therefore, secure attachments are important in child development and care.

An insecurely attached, avoidant pattern is observed with children who are not securely attached to their caregivers. They avoid them and find safety in strangers. This pattern develops especially when children do not have a significant person to whom they are attached due to either the environmental set-up or exposure to caregivers who do not provide proper care and do more harm than good (Greenough, Gunnar, Emede, Massinga & Shonkoff, 2001; Malekpour, 2007). Therefore, in an insecurely attached, avoidant pattern, children are not bothered by the presence of their attachment figures, avoid them and are not emotionally stable. They may present with a variety of emotions associated with insecurity like anxiety, intellectual retardation, anger, mistrust, depression, delinquency, aggression, negativity, immature behaviours and incompetence (Bowlby, 1940; Gearity 2005; Londervil & Main 1981; Speltz, Greenbag & DeKlyen, 1990; Warren, Huston, Egeland & Stroufe, 1997). These emotions affect the psychosocial wellbeing of children and hinder the process of child development. Regrettably, some of these emotions have been echoed in researches done on children in institutional care (Powell et al., 2004; Vorria et al., 2003).

An insecurely attached resistant pattern is displayed in a caregiver-to-child relationship where a child feels insecure and wants to be close to an attachment figure whose absence does not affect them. It is seen in children who have experienced care that is inconsistent and very unprotective, and who cannot recognise or respond to affection (Karen, 1994; Malekpour, 2007). This pattern sometimes results in emotional instability. In this vein, children with an insecurely attached resistant pattern do not feel safe, lack confidence, and cannot cope well when confronted with high levels of anxiety, pain and sorrow (Karen, 1994; Malekpour, 2007). Against this background, an insecurely attached, resistant pattern breeds negative emotions within children and affects their psychosocial well-being.

The disorganised pattern as the name sounds, develops when there is no order in the relationship. It is seen in a caregiver-to-child relationship in which the due caregiver's past painful experiences, or abuse and neglect, a child receives inadequate care, resulting in insecurity, confusion, fear and disruptive behaviour (Malekpour, 2007; Moss, Laurent & Parent, 1999; Papalia, Olds & Feldman, 1999).

In concurrence with the information provided, Bowlby (1969, p. 209) highlights that "So long as the child is in the unchallenged presence of a principal attachment figure, or within easy

reach, he feels secure. A threat of loss creates anxiety, and actual loss sorrow; both, moreover are likely to arouse anger".

2.3.1 Application of the attachment theory to this study

In light of Bowlby's Theory, in an ideal family setup, the attachment figures are the parents or members of the extended family, and in an alternative setup, family attachment figures are some form of caregivers. Children often feel secure in the presence of these attachment figures. If they have a good relationship and in the event of a mishap, children tend to report to attachment figures in order to get protection or defence (Ainsworth 1967; Bretherton, 1992; Schaffer & Emerson, 1964). An example is when toddlers are hurt by other toddlers, they quickly rush to their parents to report so that they can deal with the one who has actually hurt them. In addition, in some cases, children who are afraid of darkness feel secure in the dark in the presence of their parents.

In the context of institutional care, it is ideal for practitioners to recognise the importance of bonding between children and their caregivers. As such, care plans should be designed in such a way that caregivers can work with children from the time they are admitted to the institution. This would contribute towards helping children to build attachments that are secure. However, when children are forced by circumstances to leave their families, possibly ending up being placed in institutional care, they are separated from the figures in the family they might have been attached to (Morantz & Heyman, 2010; Powell et al., 2004). As a result, children may experience negative feelings highlighted by Bowlby (1951) like, anxiety, sorrow and fear, resulting in regression and other psychosocial issues. It is therefore important for employees in institutions to understand that the process of cutting bonds or severing relationships that happens when children leave their relatives and join institutions, produces a wide range of feelings. This understanding is critical as it helps institutional staff to provide proper support and care to children who may present with behaviours and emotional disturbances that may not be socially acceptable.

Attachment experiences in childhood ilnfluence a person's actions in adulthood. Based on Bowlby's Theory, as highlighted earlier on, the circumstances that force children to be institutionalised and separated from attachment figures are often accompanied by a wide range of feelings like anger, aggression, fear and anxiety. Bowlby notes that, if negative feelings are not dealt with during childhood, they can have detrimental effects on the social

functioning of the child later in adulthood (Ainsworth & Bowlby, 1991; Bolwby, 1977, 1989). Therefore, institutions should have psychosocial care programmes which help children to deal with feelings and issues associated with separation, loss, and grief among other issues. Programmes can include individual or group counselling, art therapy and memory work (Action for the Rights of Children Resource Pack, 2009; Save the Children, 2001, 2005). Such programmes will help children to cope with past painful experiences and also equip them with social skills critical in adulthood.

In exploring relevance to childcare, the Attachment Theory can be linked to the Psychosocial and Ecological Theories. Thus, with reference to the Psychosocial Theory, secure attachments develop as the caregivers attend to children's needs at each stage of their psychosocial development. This happens when children build trust, are given room to exercise autonomy, take initiative and acquire new skills in the process. In light of the Ecological Theory, it is important for childcare institutions to create an environment which nurtures the healing process of children who have been separated from their parents, guardians, or primary caregivers.

The Theory of Attachment is valuable in that it contributes to the knowledge and understanding of the development of attachment and coping mechanisms developed by a child in institutional care. It also explains the importance of secure caregiver-to-child attachment patterns. However, it is sad to know that, in spite of exposure to knowledge on attachment, children in some institutions have been exposed to caregiver-to-child relationships that do not promote the development of secure attachment patterns, largely due to large caregiver-to-child ratios and the continuous change of caregiver shifts (Bakermans-Kraneburg et al., 2011; Zeanah, Smyke, Koga & Carlson 2005). In this vein, research studies carried out on children in institutional care revealed insecure, disorganised attachment patterns and lack of attachment. In addition, separate research studies done with children from the Metera Baby Center in Athens, Greece and St Petersburg institutional care in Russia, revealed that a greater number of children raised in institutional care presented with disorganised attachment patterns (The St Petersburg-USA Orphanage Research Team, 2008; Vorria et al., 2003). Moreover, studies done in the Ukraine, Romania and Bucharest produced findings that displayed more lack of attachment in children raised in institutional care, than those looked after by parents (Dobrova-Krol et al., 2009; Zeanah et al., 2005). This shows that services provided in some institutional care settings may not be adequate enough to

create secure attachments, which are critical in child development (Demeter, 2015). Therefore, it is critical for childcare practitioners to ensure that institutions fill the gap created by inadequate national childcare services that do not promote the development of secure attachments.

2.4 ECOLOGICAL PERSPECTIVE

The Ecological Perspective was developed by Urie Bronfenbrenner to explain the effect of the environment on child development. As indicated by the name "ecology", this theory postulates that the physical and social setting have an influence on child development (Bronfenbrenner, 1977; Bronfenbrenner & Morris, 2006). In this vein, this theory views the different systems in the child's environment and interactions within the social context as critical factors in child development.

As noted by Bronfenbrenner in Donald, Lazarus and Lolwana (2010), development is shaped by interactions that children have with people surrounding them, and the environment in which a child lives, also affects development. In this vein, Bronfenbrener's Ecological Perspective outlines five systems in the environmental contexts that influence child development namely, *microsystem*, *mesosystem*, *exosystem*, *macrosystem* and *chronosystem* (Bronfenbrenner, 1994; Donald et al., 2010; Rathus, 2006). The *microsystem* involves the child's relationship with other people in the immediate environment such as at home, school and afterschool clubs (Bronfenbrenner, 1977; Bronfenbrenner, 1994; Dawes & Donald, 2004). The *mesosystem* entails the interactions of different microsystems such as home, school, clinic or the General Practitioner Practice. The *exosystem* constitutes the systems that do not have direct contact with the child, but that affect the quality of childcare provided like childcare committee and parents' workplaces (Dawes & Donald, 2004; Gabarino, 1995). The *macrosystem* involves interactions linked to the way of life and beliefs based on the cultural context. Examples include the church, mosque and shrines. The *chronosystem* takes into cognisance the "environmental changes that occur over time and have an effect on the child" (Rathus, 2006, p.25). Notably, a change or conflict in one of the environmental context mentioned, can affect what happens in other contexts (Bronfenbrenner, 2005; Paquette & Ryan, 2001). For example, conflict at home is likely to affect what happens to a child at school, his/her contributions in the childcare committees, beliefs and value systems. These systems are shown in Figure 1.

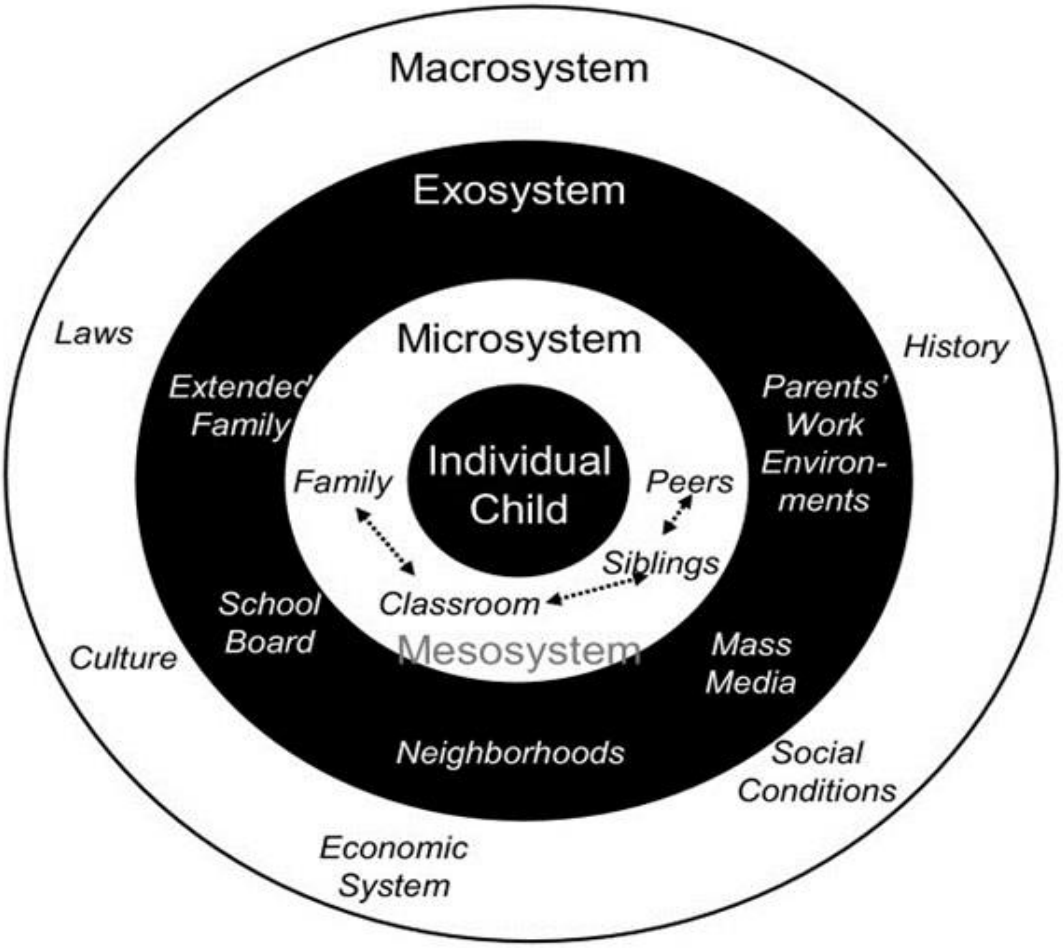

Figure 1: Bronfenbrenner's Nested Systems

Using Bronfenbrenner's theoretical explanations, the environment for a child in institutional care may comprise many facets as outlined in Figure 1.

The diagram shows the pictorial view of Bronfenbrenner's nested systems to explain the role of the environment and interactions for children in institutional care. As indicated on the diagram, the child is at the centre, and immediately after the child is the *microsystem* comprising of the school, peers, neighbourhood area, health services and church group. Notably, the child does every day activities and engages in various roles like child, pupil, friend, neighbour, and relationships like caregiver-to-child, teacher-to-child, neighbour-to-child (Berndt & Ladd, 1989; Dawes, & Donald, 1994; Donald, 2004).

The second circle comprises the *mesosystem* which involves the interactions of the various microsystems and their influences over each other. In this vein, a child with a problem at home can get significant assistance from the school, a neighbour or peers (McLoyd & Wilson, 1990; Richter, 1994; Rutter, 1985).

The third circle shows the *exosystem*, comprising of systems that a child in institutional care may not have contact with, but which affect the quality of care provided to children in institutional care (Bronfenbrenner, 1999; Marshal, 2004). Such systems may include Child Protection Committees and Institutional Care Committees. These systems have an influence on the quality of care. The Committees can for example draft the benchmarks of childcare interventions and guidelines. The legal services provide the stipulations for assisting children in need of care, while social welfare may be deemed the custodian of children in need of care (Children's Act, 2001; Powell et al., 2004). In the same line of thinking, the neighbourhood can provide emotional support to a child who is not getting that same support from an institution. Against this background, in Zimbabwe, in a bid to involve the outside community, the Matthew Rusike Children's Home liaises with well-wishers from the neighbourhood to volunteer to foster children on a temporary basis during school holidays (Matthew Rusike Pamphlet, n.d). In a nutshell, the *exosystem* is largely responsible for the formulation of policies and programmes that are used in childcare sectors and institutions.

The last circle shows the *macrosystem* which is composed of cultural, political and material contributions that leave an impact on the child and includes the ways of life of a particular ethic group, beliefs and international instruments like the Convention on the Rights of the Child (Dawes & Donald, 2004; Levine et al., 1994). Thus, in the context of institutional care, services provided should be influenced by the Convention on the Rights of Children, indigenous expectations and beliefs so that institutions raise a child who will fit into the society.

The last system is the *chronosystem* as indicated earlier on, includes the transformation that may happen over time during the process of child development, and are sociohistorical and experienced in the family or country of residence (Carter & McGoldrick, 1989; Dawes & Donald, 2004; Rathius, 2006). These changes that may come as a result of wars, or economic

depression, shape the environmental context for child development and leave an impact on the child (Dawes & Donald, 2004).

Bronfenbrenner's Theory can also be linked to other child development theories discussed earlier on, like Erikson's Psychosocial Theory and John Bowlby's Attachment Theory. It is clear from Erikson's psychosocial stages, that the environment that a child is born into and in which he/she resides, should be designed in such way it will be conducive to the proper psychosocial development of children. As outlined in the Attachment Theory, it is evident that well bonded relationships that warrant security, are built in an environment that is supportive. Against the aforementioned as explained earlier on, the ecosystemic perspective by Bronfenbrenner (1999) illustrates that the environment within which a child grows up, is a major contributory factor in child development. Thus, in an institutional set-up, the child's environment which is made up of services and care provided by caregivers, influences the development of children. The child's interactions with the service providers, also has an effect on the development of that particular child. The institutional environment and the child's interactions with this environment, definitely affects the child's health and well-being, and this may result in institutions producing children with unique personalities and aspirations.

2.4.1 Application of the ecological theory to this study

As highlighted earlier on, the social context influences child development. In this regard, Bronfenbrenner maintains that there are four dimensions within the social context that influence developments, which are person factors, process factors, context and time (Bronfenbrenner, 1999; Bronfenbrenner & Ceci, 1994; Bronfenbrenner & Morris, 2006). Person factors denote to the personality or character of the child and caregiver, process factors are the reciprocal actions in the family, context factors refer to various institutions like the family or school, and lastly, the time factor refers to the different things that happen as time moves on (Bronfenbrenner, 1977; Donald et al., 2010). Therefore, using this information, this study assumes that the development of children in institutional care is influenced by ecological factors as shown in Figure 2.

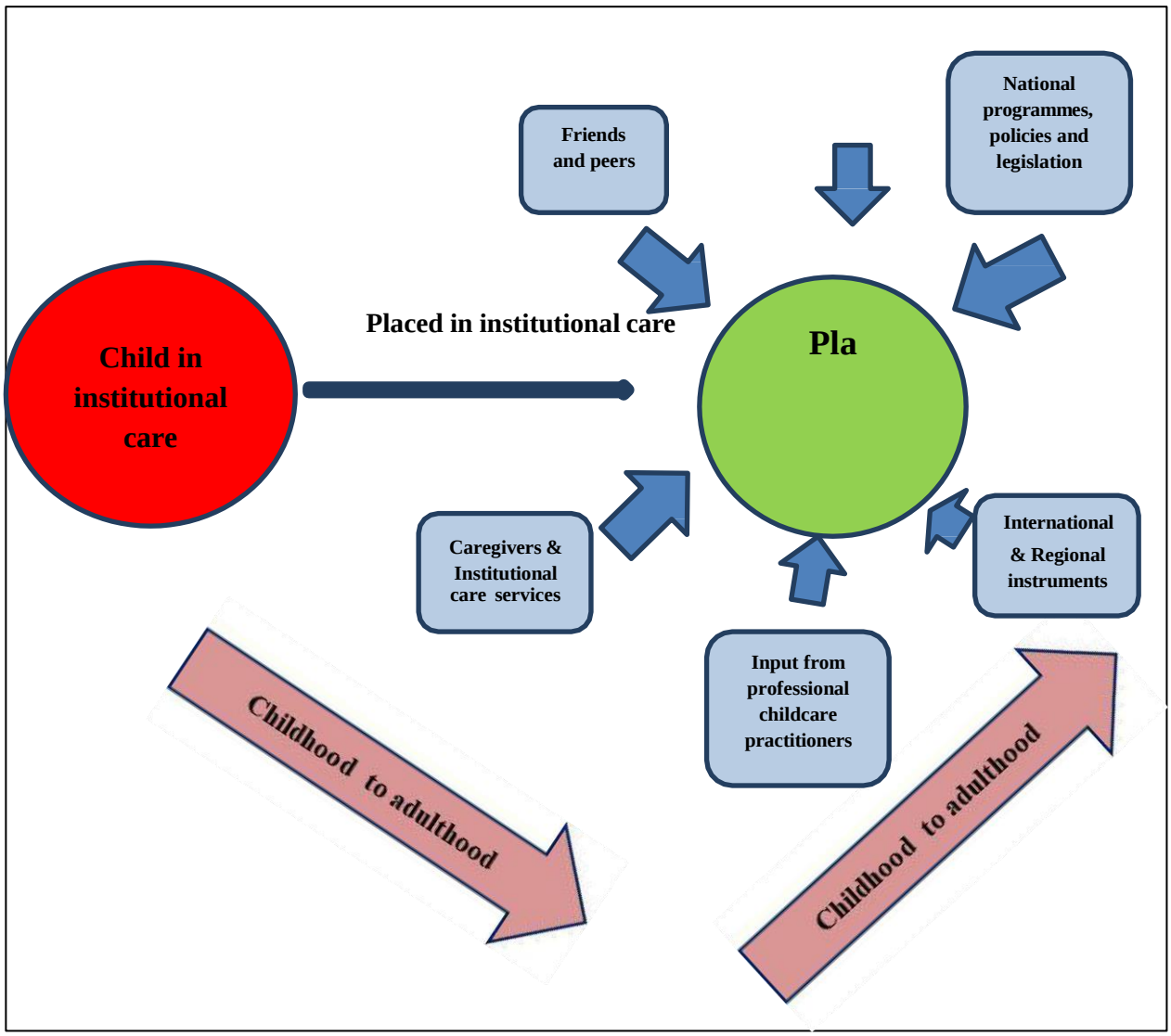

Figure 2: The Ecological factors for a child in institutional care

Source: Author's own construct

This study therefore concurs with Bronfenbrenner's views that ecological factors have an influence on child development as indicated in Figure 2. In this regard factors like international and regional instruments, national programmes, policies and legislation, cultural context, caregivers and institutional services, input from childcare practitioners, friends and peers have an impact on the quality of childcare service. Thus, they tend to formalise proccedures, protect children against abuse, and ensure that their rights are upheld (African Charter 1999; Children Act, 2001; Roby, 2011; Ruppel, 2009; UN, 2011; UNCRC, 1989). These factors will be discussed in detail in the next chapter.

2.5 CRITIQUE AND THE INTEGRATION OF THEORIES

Therefore, the three theories discussed in this chapter are significant in childcare work. In the context of institutional care, the Attachment Theory can be used to explain attachment issues presented by children from their relationships with biological parents and caregivers in childcare institution (Bakermans-Kraneburg et al., 2011; Bowlby, 1969; Zeanah, Smyke, Koga & Carlson 2005). In addition, the Psychosocial Theory can be used to investigate emotional and psychological issues that children experience during development (Erikson, 1968; Hook, 2002; Jarolmen, 2014). Furthermore, the Ecological Theory can be used to explain the environment provided by institutional care services which include peers, the school and the abstract environment that is shaped by childcare policies and frameworks (Bronfenbrenner, 1999; Bronfenbrenner & Ceci, 1994; Bronfenbrenner & Morris, 2006; Donald et al., 2010). In light of this, it can be argued that childcare services are not underpinned by one theory, but as portrayed in this study by various theories, and practitioners should intergrate them in order to offer consolidated effective childcare services.

2.6 CHAPTER SUMMARY

This chapter has discussed the three theoretical frameworks adopted in this study, namely Psychosocial Theory, Attachment Theory and Ecological Theory. It explored how these theories explain various aspects of child development which are critical and influence social functioning later in adulthood. Furthermore, this chapter focused on the roles that can be played by caregivers in order to meet children's psychosocial needs and enhance their social functioning. The next chapter will focus on children's physical and psychosocial needs. In addition, it will cover childcare international & regional instruments, childcare strategies in use internationally and lastly the role of social protection in child protection.

CHAPTER THREE:
THE CARE AND PROTECTION OF CHILDREN

3.1 INTRODUCTION

Globally, protection and care of children is particularly high on the agendas of most countries. In this vein, child protection and care efforts are meant to ensure that children grow up in an environment that is conducive to their developmental and psychosocial needs. Such environment should warrant security, continuum of proper care, and provision of all children's needs. This chapter will describe relevant theoretical perspectives applicable when doing research in the field of protection and care of children. To this end, basic physical and psychosocial needs of children during development will be explained, and the meaning of the protection of children, appropriate instruments in child protection, and the different roles of instruments will be examined. Different pro-active, statutory and non-statutory strategies in child protection will be described. Legislation relevant to childcare and child protection will be emphasised, and the role of social protection in child protection will also be discussed. Finally, the role of social protection in child protection will be highlighted.

3.2 PHYSICAL AND PSYCHOSOCIAL NEEDS OF CHILDREN DURING DEVELOPMENT

Child development is a critical component of any study in childcare. This section will explore child development and the psychosocial needs relevant throughout the development of children. Although the psychosocial needs of children in general will be explored, the context of children in institutional care is the main focus of the study. Awareness of developmental issues is central in the field of institutional care of children. Development in children is a complex process and it comprises three domains which are physical, cognitive and social-emotional (Eccles, 1999; Hook et al., 2009; Levine & Munsch, 2014). These three different, but interrelated domains are explained next.

The physical domain focuses on changes that happen in the body of a child from conception up to young adulthood. The child's brain and all other parts of the body change in size over time, and significant changes are observable in the early months of development and during adolescence (Eccels, 1999; Giedd, 2008; Lenroot & Giedd, 2006). In this vein, as children grow, for example, their height increases over time.

As highlighted above, a second aspect in child development is referred to as the cognitive domain. It focuses on the child's understanding and ability to acquire knowledge, to organise and work with information, and to solve problems (Ackerman & Browne, 2010; Forbes & Martin, 2003). Therefore, the cognitive domain is useful in child development as it helps children to acquire and develop specific levels of understanding of new knowledge. As stated earlier, children go through the different stages of development, and changes are observable in relation to the development of the cognitive domain. It is important for parents, guardians and caregivers to be knowledgeable about this domain and attentive during the development phases, so that early detection of possible cognitive developmental problems can take place (Gardner & Shaw, 2008; Hook, 2002; Levine & Munsch, 2014). For instance, cognitive developmental problems such as Down syndrome and learning difficulty (National Down Syndrome Society, n.d; Spivey, 2006).

The social-emotional domain is the third aspect in child development that has to be considered by parents, guardians and caregivers. It focuses on children's interaction with others and the development of the ability to become aware of and recognise their personal emotions and the emotions of others (Hook, 2002; Levine & Munsch, 2014; National Research Council & Institute of Medicine, 2000). This domain influences and determines how the child relates with others, deals with his/her own and other people's emotions, such as anger, happiness, discontent and shyness (Coplan, Findlay & Nelson, 2004; Macnmanis, Kagan, Snidman & Woodward, 2002; Schmidt & Fox, 1994). The development of three child development domains is affected by a number of factors such as genetics and the environment, which will be discussed next.

From a biological point of view, the development of children is a process, and to a certain extent, genetically determined. During development, a process of maturation takes place and there are certain milestones that children reach which are influenced by their genes from birth to achieving adulthood (Bee & Boy, 2004; Hook, 2002). These milestones might be physical achievements, such as sitting, walking and talking, or emotional milestones such as developing self-awareness, the ability to reason and reflect, gaining self-confidence and assertiveness.

Secondly, the environmental and social experiences children encounter as they grow up, also affect their development. Environmental factors include physical structures like buildings, the

houses they live in, the types of schools they attend, and the neighbourhoods (deprived or wealthy) to which they are exposed. Social experiences that contribute to and influence the child's development include the child's interactions with family members, siblings, peers and teachers. In addition, family, cultural and societal values and expectations also influence and mould who the child becomes. Therefore, the environmental exposure and social engagements experienced by children, like living in a warm and caring environment with support and reassurance or affirmation, positively affect development (Kidsmatter, n.d). In this line of thinking, it can be argued that negative experiences like staying in an unstable environment, rejection, abandonment, loss of a loved one, neglect or abuse, influence their development negatively (Brauner & Stephens, 2006; National Research Council & Institute of Medicine, 2000; Sameroff & Fiese, 2000). In concurrence, the environment in which a child grows up has lasting implications on the development and type of personality later in adulthood (Bronfenbrenner, 1994; Pringle 1985). Thus, people's behavioural manifestations are often linked to the environment in which they grew up, and experiences that they went through. This view is supported by a neuroscientist and developmental psychologist, Charles Nelson, who postulates that experiences after the first year of birth have an impact on the development of the brain and in turn on the overall development of a child (Levine & Munsch, 2014). To this end, the environment to which children are exposed and the experiences they go through, affect the way they behave, think or react to situations. It can be argued that a child who has been abused sexually by an adult, risks re-victimisation as a result of psychological distress (Hamilton & Browne, 1999; Finklehor, Ormrod & Turner, 2007; Messman-Moore & Long, 2000).

In concurrence with the abovementioned point, it can further be argued that different environmental contexts result in unique effects on a child's care, protection and development in general. Therefore, there is a disparity between the development of children who are living in developed countries and those in developing countries (Dunn, Jareg & Webb, 2003; Gratham, Glewwe, Ritcher & Strupp, 2007; The International Child Development Steering Group, 2007). The two settings provide different environmental contexts and forms of support, care and protection for children. This is largely due to the fact that, developed countries are well resourced and therefore provide a wide range of childcare services (Bradely & Corwyn, 2002; Dunn et al., 2003; Shanks, Kim, Loke & Destin, 2010; Totsika & Slyva, 2004). Developed countries provide child support grants to families in need and

childcare practitioners adhere to guidelines and legislations. However, the reverse is true for developing countries where for example, some childcare departments operate with meagre resources, are understaffed and therefore may not adhere to or meet guidelines and policies (Burnett, 2010; Masuka et al., 2012). An example is that of Zimbabwe, where research studies revealed that the Government runs a Child Welfare Department that does not have adequate resources, is understaffed and therefore does not provide childcare services as stipulated in policies and guidelines due to resource constraints (Chibwana & Gumbo, 2014; Masuka et al., 2012; Powell et al., 2004). This results in poor service delivery and as a result, some of the children in developing countries present with stunted growth because of malnutrition due to poverty (Grantham et al., 2007; Walker et al., 2007). More so, because of poverty, parents and relatives fail to meet basic childcare needs like food, shelter and clothing. This increases vulnerability in children, and therefore in developing countries some children end up in institutions to curb the effects of poverty-stricken environments in which they are growing up (Bilson & Cox, 2007). Therefore, childcare provisions and services in developed countries are different from those in developing countries.

Again, in the environmental context, discrepancies in development can be seen in children who are raised by their biological family members and those in alternative care. The biological family presents a natural scenario and childcare provisions are usually met by parents. On the other hand, the institutional care setting presents a substitute family scenario which is modelled to resemble the biological family. This substitute family environment is prone to changes anytime as children are sometimes moved from one substitute family to another, or there is continuous change of caregivers (Iwane & Hill, 2000; The St Petersburg-USA Orphanage Research Team, 2008). It has been argued that the frequent exposures to changes in caregivers and/or institutional care settings are likely to affect the socio-emotional development of children in institutional care (The St Petersburg-USA Orphanage Research Team, 2008; Vorria et al., 2003). Therefore, children who are growing up in their biological family structure are more likely to have a better integrated development process due to the stability they experience in comparison to those children growing up in institutional care who are continuously confronted with instability due to the many changes in their environment and those who are caring for them (Dozier, Wallin & Shauffer, 2012; Smyke, Dumitrescu & Zeanah, 2002; Zeanah, 2000).

Furthermore, social issues affect child development. Poverty, malnutrition, wars and the presence of infectious diseases are some of the factors that influence child development negatively (Bilson & Cox, 2007; Powell et al., 2004; Walker et al., 2007; Wallin & Shauffer, 2012a). Previous research revealed that lack of food due to poverty, can result in pregnant women giving birth to children with health challenges like deficits in the composition and functioning of the thyroid or brain (Sarafino & Armstrong, 1980). As highlighted earlier, poverty also results in low household economies, which in turn results in parents and guardians failing to access resources to meet the basic needs of the family and children. As a result, children are likely to get malnourished, and this then affects their physical growth and cognitive and social development. Furthermore, this may in turn affect their performance in schoolwork or in future employment or their confidence in the society (Grantham et al., 2007; Walker et al., 2007).

The health status of primary caregivers is also another critical factor in child development. In cases where parents are actively involved in wars or are very ill due to infectious diseases like HIV and AIDS, provision of basic childcare needs poses challenges, and the parental role in terms of care, support and guidance is often compromised and not carried out adequately. As a result, these children are likely to develop and grow up without proper parental care. This impacts negatively on their developmental processes and social functioning later in life (Miller & Murray, 1999; Paris, DeVoe, Ross & Acker, 2010), resulting in psychosocial problems like low or lack of self- esteem, inferiority complex, incompetence and poor social skills. For these reasons, caregivers of children in alternative care go through medical check-ups to avoid them infecting children with infectious diseases, and also to ensure their psychological ability for caregiving work (Department of Human Services, 2014; Powell et al., 2004).

As explained, it is evident that the provision of basic needs and psychosocial care of children contribute towards their well-being during childhood and later on in adulthood. This view is concurred by Maslow in his Personality Theory that focuses on the psychological health of a person. Maslow presented his theory in a pyramid with five stages that are arranged in order of priority namely *physiological* (e.g. air, food, water), *safety and security* (need for a safe environment), *love and belonging* (love, affection and belonging) *esteem* (self-respect and respect from others resulting in self-confidence) and *self-actualisation* which is achieved when all the aforementioned needs are met (Maslow, 1970; Neher, 1991; Simons, Irwin and

Drinnien, 1987). This theory postulates that when all needs are met, a person functions well in the society and therefore acts as a responsible citizen in society. Linking Maslow's Theory to child development, it can be argued that when children's physical, psychological and social needs are met, their well-being is enhanced. However, if not met their well-being is affected and it is likely to manifest in low or no self-confidence, delinquent behaviour, disrespectful behaviour or poor performance in schoolwork, to mention but a few (White et al., 1990).

Psychosocial needs are less tangible (concrete) than basic physical needs. Meeting children's physical and psychosocial needs enhances their development and contributes towards their psychosocial well-being in the long run. Psychosocial needs include love, security, exposure to new experiences, praise as well as recognition and responsibility (Bowlby, 1969; Pringle, 1985). These needs have been explored in depth by various authors, like John Bowlby who developed the Attachment Theory to explain that attachment is valuable in child development as it fills the need for security in children and therefore enhances proper child development (Bowlby, 1969). Furthermore, as stated by Erikson in his Psychosocial Theory, exposure to new experiences is also important as it helps children to acquire new skills. In light of the provision of psychosocial needs, in another theoretical view, Bronfenbrenner, in his Ecological Theory argues that psychosocial needs are met when children live in an environment that is secure, loving and composed of factors that are pro-child development (Bronfenbrenner, 1979; Cluver, Fincham & Seedat, 2009; Ross, 2011). Therefore, an environment that is secure and loving is important as it enhances proper child development.

The need for love and security surpasses all other psychosocial needs children have, and is therefore critical in child development. Love is shown through unconditional affection, sensitivity and provision of good care. Research has revealed that children who were raised in families where there was limited or no love, often demonstrate emotions that are linked to their adverse experiences encountered during childhood years, like anger, fear and insecurity (Bowlby, 1969; Collins & Read, 1990; Gurupira & Chikutuma, 2017; Hunt, 2009; Malekpour, 2007; Oates, 2007). Against this background, it can be argued that parents, guardians and caregivers should provide love and security to children so that they can in turn build good relationships with their caregivers and other people even later in life in adulthood (Groh et al., 2014; Malekpour, 2007; Waters & Cummings, 2000). Therefore, in the context of institutional care, it is crucial for caregivers to demonstrate affection and love as well as

create an environment that is safe, as this helps children to deal with past painful experiences linked to neglect, abuse and abandonment, as well as other psychosocial factors that might have affected them.

In addition to love and security, age appropriate exposure to new experiences is critical in child development. It stimulates curiosity and creativity, assists with the process of discovering themselves and their own abilities, enables them to acquire new skills, and to become confident and assertive (Eccles, 1999; French, 2007; Goldstein, 2012; Pringle, 1985). This is achievable if parents, teachers, guardians and caregivers are willing to let go and allow children to explore their environments. If children are confined to one place and not introduced to new experiences, it impedes on their development. They are likely to become withdrawn and may have challenges when interacting with peers later in life (Eccles, 1999; Pringle, 1985).

During the process of child development, praise, recognition and affirmation appear to be vital elements to facilitate the well-being of the individual in the long run. In this regard, appropriate praise and recognition build children's self-esteem as it makes them feel that they are capable of doing things that are acceptable and decent. Thus, at home and in schools, praise and affirmation often result in children repeating the actions that they have been praised for (Henderlong & Lepper, 2002; The Parent Practice, 2011). These behaviours comprise, for example, assisting another in need of help, excelling in homework, and displaying respectful and appropriate behaviour at school. On the other hand, lack of praise, affirmation and recognition, demoralises children resulting in negative self-perception, poor self-esteem, and possibly negative or deviant behaviour in children (Ellwell & Tiberio, 1994; Manning, 2007). Furthermore, inappropriate praise that has evaluative connotations is sometimes shunned by children and may produce negative reactions from children (Faber & Mazlish, 1995).

Lastly, the need for responsibility is critical in child development. When this need is fulfilled, children feel that they are capable of doing something which is meaningful. As such, tasks that are age appropriate like cooking, staying behind with a younger sibling and participating in projects at home are developmental and cultivate a sense of responsibility within children (Bateson, 1972; Ochs & Izquierdo, 2009; Weisner, 1979). Performing various tasks at home and at social gatherings prepares them for similar responsibilities later in adulthood.

Children who present with unmet physical and psychosocial needs are likely to be affected emotionally and cognitively, and this can result in their experiencing various psychosocial issues which may spill over to adulthood. It can be argued that a number of the children who are placed in institutional care might have been victims of limited or hardly any physical and psychosocial care (Dozier et al, 2012; Dunn et al., 2003) that might have resulted in their experiencing psychosocial challenges. They are likely to present backgrounds which affected their physical, cognitive and socio-emotional development. This might be evident in their behaviour and emotions like low self-esteem, instability, fear, irritability, anger, restlessness, lack of confidence, over-friendliness towards strangers (Browne, 2009; Powell et al., 2004; Tizzard, 1977). From the literature it is evident that especially instability that refers to continuous unplanned changes a child is experiencing as an individual or in a family, may affect the child negatively, change the child's behaviour and influence the child's development processes (Cavanagh & Huston, 2006; Sandstrom & Huerta, 2013; Zeanah, Smyke, & Dunitrescu, 2002). Therefore, it is important when children are placed in alternative mcare like institutional care, that childcare staff should create a safe environment that allows children to express issues affecting them. Furthermore, the provision of psychosocial care helps children to work through and deal with the various social and psychological issues related to their past painful experiences and backgrounds before reaching adulthood (Ritcher, Foster & Sherr, 2006). However, some institutions do not provide the expected psychosocial care. This is evident especially in institutions that are understaffed and under-resourced, which then provides inadequate psychosocial care to children resulting in children not having the opportunity to deal with various psychosocial issues (Van IJzendoorn et al., 2011).

It is apparent that non-provision of psychosocial needs is likely to have detrimental effects on the growth and development of children. In their attempt to promote or ensure that children go through their developmental milestones, practitioners use various psychosocial interventions, care and support, to protect children and help them to deal with the negative effects (REPSSI, 2007; Richter, Foster & Sherr, 2006). An exploration of the term psychosocial shows that it has been conceptualised from points of views that are both psychological and practical.

As noted by Hook, Watts and Cockroft (2002, p. 6), the psychological views on the concept psychosocial refer to "a person's sense of identity and self, to their sexual, moral, and

psychological growth, within a particular socio-cultural context". In line with this, identity defines the total person - who the person is, where he or she comes from and belongs, the roles he/she plays, experiences of the past, and present experiences that contribute to their being and who they are (Neisser, 1993; Oysernman, 2007; Stets & Burke, 2003). This implies that the various identities present in a person, are based on the aforementioned. Against this background, identities are used to explain a person or self-concept (Baumester, 1998; Forgas & Williams, 2002; Neisser, 1993). Identity and self-concept are very important to all human beings. Therefore, for children in alternative care and specifically institutions, a search for identity calls for more information on and understanding about how the child perceives him or herself, where the child comes from, what the child was exposed to, and where the child feels he or she belongs. Noteworthy is the fact that identity is also embraced in a person's culture. Thus, children in institutional care from African countries who attach particular value to culture, are likely to conceptualise their identity in terms of social and cultural expectations. For example, in Zimbabwe, the Shona culture indirectly requests people to identify themselves in terms of totems (Bourdillon, 1976; Gelfand, 1979; Makamure & Chimininge, 2015). Thus, children raised in institutional care and not in their families' communities, in particular, those with unknown parents and relatives, may find it very challenging to explain their identity. From the researcher's point of view, this in the end is likely to cause a wide range of emotional feelings like loneliness, lost, emptiness, confusion and depression, which in turn might affect their socio-emotional development.

In addition to the psychological view on the psychosocial aspect discussed above, there is another aspect to psychosocial which is demonstrated by care interventions. Care interventions that may help children deal with psychosocial challenges will be described.
Richter et al. (2006, p.16), define the care part of the term psychosocial as "a range of intervention tools, processes and programmes delivered to children in difficult circumstances to address non-material needs". These tools, programmes and processes that are implemented, aim at providing opportunities for children to engage with, work through and develop skills to cope with various issues they might experience. Children in institutional care may present with psychosocial issues linked to poor attachment and delayed development like low self-esteem, withdrawal symptoms, poor social skills and lack of confidence (Browne, Hamilton-Giacritis, Johnson & Ostergren, 2006; Powell et al., 2004; Zeanah et al., 2005). For these reasons, in an institutional care setting it is critical to have

interventions that are designed to help children deal with different psychosocial challenges they might experience. It is important for practitioners and caregivers to tap into theoretical knowledge about the physical and psychosocial needs of children, attachment issues and learn to understand how the environment in which children have been born and socialised, affects their behaviour to assist them to provide the needed interventions and services. Examples of psychosocial care interventions that help children include individual and group counselling, programmes building self-awareness and confidence, or dealing with anger management and developing life skills like problem-solving, are possibilities to explore and implement (Action for the Rights of Children Resource Pack, 2009; Save the Children 2001; Save the Children, 2005).

In summary, it is evident that a variety of factors within the context of children contribute to their development and who they become in future. In the context of all children, inclusive of those in institutional care, child development is affected by genetic make-up, the environment that they live in and psychosocial care. Therefore, it is important for institutional care practitioners to have knowledge on child development and the factors that affect it.

3.3 CHILD PROTECTION INTERNATIONAL INSTRUMENTS AND LOCAL LEGISLATION

3.3.1 Defining child protection

There is no single definition of child protection, although most allude to it as ensuring that children are safe and under good care. The United Nations Children's Fund (UNICEF) (as cited in the Inter Agency Group on Child Protection Systems in Sub Saharan Africa, 2012) defines "a child protection system as the set of laws, policies, regulations and services needed across all social sectors – especially social welfare, education, health, security and justice – to support prevention and protective responses inclusive of family strengthening" (p.14). This means that various sectors are involved in developing and implementing mechanisms designed to protect children. In the context of in children institutional care, there are policies and regulations that guide the services provided in institutions (Chandiwana, 2009; Gurupira & Chikutuma, 2017). From a legal perspective, protection of children involves all actions that are done to protect children from significant harm caused by parents or guardians or anyone with parental responsibilities like abuse, neglect and ill-treatment (Children's Act, 2001: Lofell, 2008). These interventions are designed based on a country's context,

preference and financial resources available. As a result, child protection services vary from country to country. Noteworthy, the responsibility of looking after children lies with the biological family of the child, but certain circumstances put children at risk or make them vulnerable like abandonment, neglect, abuse, family conflicts, domestic violence, disability and many others (African Charter 1999; Children Act, 2001). The aforementioned have detrimental consequences on child development, hence children should be protected as soon as a need arises. In this vein, child protection services are provided as informal or formal care. Informal childcare involves the care that excludes the legal input, where children are looked after by relatives or well-wishers as per request from family members, the child or other people; and on the other hand, for example in South Africa and Zimbabwe, the extended family takes care of children whose parents are deceased (Gwenzi, 2018; Deininger, Gracia & Subbarao, 2003; Masuka et. al., 2012; Mushunje & Mafico, 2010; Mutangadura, 2003). Formal childcare is statutory and involves planned actions from childcare practitioners, and the justice system (Roby, 2011; UN, 2011). Against this backdrop, formal childcare adheres to stipulations outlined on the international and regional instruments, as well as local legislation and policies which are going to be discussed next.

3.3.2 Child protection instruments at international level

The notion of designing child protection instruments can be traced back to early 20th century. To this end, the process of designing child protection international instruments is done inclusive of all Heads of States worldwide. These will in turn ratify the provisions of the instruments and enforce child protection legislation and policies that suit their countries' context. This section seeks to discuss the international instruments on child protection that were adopted from 1924 up to date.

The Geneva Declaration on the Rights of the Child (1924), also known as the Geneva Declaration, was drafted by a British teacher, and founder of Save the Children Fund, Eglantyne Jebb (Keber-Ganse, 2009; Mulley, 2009). The same website highlights that the instrument was designed after the First World War for the purpose of enforcing the member states to protect children, especially bearing in mind the effects of the World War 1. This declaration was adopted by the League of Nations on the 26th of September 1924. It is the first instrument on the rights of the child that was put in place so that member states would ensure that basic needs of children were met, and adoption of this instrument marked the

recognition by the League of Nations to streamline child rights in western countries (Manful & Manful, 2013; Ruppel, 2009). However, this development excluded many African countries like Zimbabwe and South Africa which were under colonial rule (Muthoga, 1992).

With regard to implications on child protection, the Geneva Declaration affirmed adults as the duty bearers in childcare. Its preamble had a clause which asserted that adults had the responsibility of doing their best for the sake of all children (Geneva Declaration on the Rights of the Child, 1924; Kaime, 2009). This shows that member states that participated in the Declaration, recognised the importance of raising children well so that they would in turn excel in adulthood. Presumably, the member states that adopted this instrument were expected to streamline the Geneva Declaration on the Rights of the Child provisions to their child protection services and programmes. Noteworthy, is the fact that although childcare institutions were operating in the 1920s, the Declaration on the Rights of the Child was silent on the rights of children in institutional care. Furthermore, it did not have provisions for other forms of childcare which were in existence like adoption and fostering of children. This may imply that during that time, all children issues were put under one blanket. There was no recognition of specific groups of children like children who had been adopted or were in foster and institutional care. Therefore, it can be argued that during that time, childcare issues were not attended to holistically at international level. As a result, one may conclude that, services and activities in childcare institutions lacked international input, and were designed using ideas and views from local childcare practitioners and national legislation only.

The Declaration of the Rights of the Child (1959) was a follow-up of the Geneva Declaration on the Rights of the Child which was adopted by 78 members of the United Nations General Assembly. It was the second international instrument that covered the rights of children. Its purpose was to outline the rights of the child, hence it recognised the provisions stated in the Geneva Declaration of Rights (Declaration on the Rights of the Child, 1959). In addition, it was more detailed than the Geneva Declaration on the Rights of the Child (Fortin, 2005). In this vein, the Geneva Declaration had a preamble and five points that focused on the well-being of children, their right to development, assistance, relief and protection (Geneva Declaration, 1924). On the other hand, the Declaration on the Rights of the Child (1959) had a preamble and ten principles (Declaration on the Rights of the Child, 1959; Kaime, 2009), which have been paraphrased and listed as the rights to:

(i) equality, without distinction on account of race, religion or national origin,
(ii) special protection for the child's physical, mental and social development,
(iii) a name and a nationality,
(iv) adequate nutrition, housing and medical services,
(v) special education and treatment when a child is physically or mentally handicapped,
(vi) understanding and love by parents and society,
(vii) recreational activities and free education,
(viii) be among the first to receive relief in all circumstances,
(ix) protection against all forms of neglect, cruelty and exploitation,
(x) be brought up in a spirit of understanding, tolerance, friendship among peoples, and universal brotherhood.

A comparison of the content on the Geneva Declaration on the Rights of the Child (1924) and that on the Declaration on the Rights of the Child (1959) shows that, as highlighted earlier on, the latter had more detailed coverage on child protection as is narrated in its preamble and ten principles. This section will compare and contrast the five points on the Geneva Declaration on the Rights of the Child (1924) and the Declaration on the Rights of the Child (1959).

Noteworthy is the fact that both documents recognise that children had rights that needed to be observed; implying that they recognised that non-adherence to child rights had detrimental effects on child development. In addition, the two documents also recognised that adults had the responsibility of providing proper care to children. However, the Declaration on the rights of the Child (1959), had more detailed information regarding child protection duty bearers, as it specifically stated that "parents, voluntary organisations, local authorities and governments were expected to recognize child rights" (Kaime, 2009). It can be argued that although the Geneva Declaration on the Rights of the Child (1924) lacked detail in its content, it paved the way for solutions to deal with child protection issues, and on the other side, the Declaration on the Rights of the Child (1959) was more detailed since it was a follow-on instrument that was built upon what had been covered before.

There are similarities and difference on five points stated in the Geneva Declaration on the Rights of the Child (1924) and the ten principles stated in the Declaration on the Rights of the Child (1959). Both documents recognised the importance of observing child rights and good care to children and that adults had key roles to play. However, the Geneva Declaration, had

points which were referred to as ‘items’, and the Declaration on the Rights of the Child had ‘principles’ which can be loosely defined as rules or guidelines that had to be followed. This means that in the latter, there was some indirect call for the duty bearers to adhere to the guidelines or the principles when handling child protection issues. A closer look at the points and principles shows that although both of them focused on child rights, the items on the Geneva Declaration were too broad and lacked detail as compared to the principles on the Declaration of Child Rights (1959) as highlighted earlier on. Against this backdrop, the principles recognised various important facts; that there was need for input from the law, there was need to recognise child rights, the right to a name and nationality, rights for children with special needs, and to emphasise that parents had a critical responsibility in child protection. The principles also recognised that it was vital to protect children from “neglect, exploitation, cruelty and child labour”. From a researcher’s point of view, the adoption of the child protection provisions in the Declaration on the Rights of the Child (1959) might have marked the recognition by member states that they had a responsibility of protecting children from harm and creating a suitable environment for child development.

However, the Declaration on the Rights of the Child (1959) had its shortcomings. Noteworthy is that, just like the Geneva Declaration on the Rights of the Child (1959), it did not have a definition of childhood (Ruppel, 2009). In addition, although the Declaration of the Rights of the Child (1959) focused on a number of areas of concern in child protection, it did not have provisions for care strategies that were in existence, like adoption, foster care and institutional care. It just mentioned that they should be cared for by the society and public authorities, but no attention was paid to procedures to be followed and even other childcare options that were available.

The other international instrument on child protection is the International Labour Organisation (ILO) Convention on Minimum Age of Admission to Employment (1973). Its purpose embraced the stipulated minimum age for employment so as to guard against child labour. It exhorted state parties to enforce policies with guidelines on the minimum age of employment which should not be less than the age at which a child is expected to complete compulsory schooling. The instrument stated that children aged 14 or 15 years should not be at work, but can do light duties two years before they reach 18 years (Blank & Handa, 2008). The Convention on the Minimum Age of Admission set limitations with regards to

employment and acted as a yardstick for child labour. This instrument was therefore used to protect children against child labour.

This instrument's implication on child protection was that it covered detailed information with regard to child labour, unlike the Declaration on the Rights of the Child (1959). Furthermore, it also discussed in detail, employment conditions making a clear case against child labour. From the researcher's point of view, this instrument prevented people from abusing children by employing them at a tender age, when they are expected to be enjoying their childhood and engaging in age appropriate activities.

The United Nations Convention on the Rights of Children (UNCRC) 1989 is one of the instruments ratified by many countries, meaning its provisions have been included in national pieces of legislation for various countries. It has more detailed information as compared to the Declaration on the Rights of the Child (1959) and the Geneva Declaration on the Rights of the Child (1924). Against this backdrop, the UNCRC sets out child rights and binds member states to uphold them, defines a child as a person whose age is not more than 18 years and addresses nearly all child protection issues (Brett, 2009; Kaime, 2009; UNCRC, 1989). In addition, the UNCRC content is also inclusive of children in alternative care. One of its demands linked to children in alternative care, affirms that the state has a responsibility for protecting and assisting children who will not be staying in a family environment (UNCRC, 1989). To this end, all nations are bound by the instrument to ensure that such children are protected and that their rights are upheld, and this calls member states to set aside budgets and design child protection legislation and policies so as to meet those children's basic needs like food, clothes and education, just to mention but a few (Ruppel, 2009; UNCRC, 1989).

This UNCRC has several implications on child protection. The fact that it was ratified by many countries except East Timor, Somalia and the United States of America, means that it works as a common document that guides child protection activities worldwide and strongly appeals to member states to consider various child protection issues in their policies and pieces of legislation (Fortin, 2005; Kaime 2009). However, it has been criticised as a document that suits the western context rather than developing countries, since the provisions suit the western cultural context (Boyden, 1990; Dawes & Donald, 2004).

3.3.3 The Optional Protocols

The Optional Protocols to the Convention on the Rights on the Child provide procedures for handling certain areas of child protection. The protocols in existence are discussed in detail. The Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography (CRC-OPSC) instrument was adopted in 2000 and its focus is on the provision and enactment of policies that guard against selling children, child prostitution and pornography (CRC-OPSC, 2000; Ruppel, 2009). This means that child protection systems should recognise child pornography, and the sale of children for prostitution as illegal acts against children. To this end, member states incorporate the provisions of this protocol in their policies and programmes.

The other protocol is the Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict (CRC-OPAC). It was adopted in May 2000 and articulates child rights with regard to protection during armed conflicts, including the minimum age for recruitment by the army (CRC-OPAC, 2000; Ruppel, 2009). As a result, it is an offence for states to employ children in the army.

The last optional protocol is the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the UN Convention against Transnational Organized Crime which was adopted by the UN General Assembly in 2003 and seeks to protect children against trafficking and organised crime (Ruppel, 2009). Child protection systems are therefore designed inclusive of measures on the protection of children against trafficking.

The ILO Convention on the Worst Forms of Child Labour 1999 was adopted by the United Nations so that member states would put policies and legislation against the worst forms of child labour that include slavery, serfdom, prostitution, pornography and other work detrimental to the development of children, just to mention but a few (Ruppel, 2009). To this end, member states recognise child labour as harmful to children and therefore have put pieces of legislation and policies to deal with issues on child labour in place. The provisions in this instrument are different from those stated in the Minimum Age of Conventions (1973) in that the latter defines a child as someone who is under 18 years and not eligible for employment, and the former allowed employers to contract children who were 15 years and older. To this end, the ILO Convention on the Worst Forms of Child Labour (1999) had

similar provisions as those stated under a section on child labour in the Minimum Age of Conventions (1973), in that child labour is regarded as detrimental to child development and should therefore be avoided. However, the difference is that the 1999 instrument is very specific as it defines the child and detailed information on the forms of child labour.

3.3.4 Child protection instruments at regional level

The child protection instruments that have been adopted at regional level vary from one region to another, depending on context and preferences. This section seeks to discuss the regional instruments adopted in the sub-Saharan region.

The Declaration on the Rights and Welfare of the African Child (1979) was adopted by the Member States in the Organisation of African Unity (O.A.U) in Monrovia, Liberia from 17 to 20 July 1979. The main purpose of this instrument was to come up with stipulations relevant to the African child and thus, unlike other preceding instruments, it promoted the rights of the African child (African Charter, 1999; Kaime, 2009). The Declaration on the Rights and Welfare of the African Child was therefore, the first instrument which recognised the needs and context of the African child. In this vein, the instrument affirmed that African states should develop African arts and language so as to increase the exposure of children thereof, and in addition, African States were expected to be wary of some cultural practices that disrupt child development, like early child marriages and female circumcision (Declaration on the Rights and Welfare of the African Child, 1979; Ruppel, 2009). It also recognised the importance of helping vulnerable children, establishing day care centres in impoverished areas, and the notion of non- governmental organisations working in partnership with the government.

The Declaration on the Rights and Welfare of the African Child had some implications on child protection. To this end, as explained in one of its provisions, Members States were expected to recognise the needs of the African child. Presumably, since this was the first instrument (Declaration on the Rights and Welfare of the African Child, 1979; Kaime, 2009), it meant child protection efforts started to incorporate the African context in policies and programmes. Furthermore, the idea of having international non-governmental organisations working in partnership with the government, indirectly forced the International Non-Governmental Organisations to incorporate indigenous norms and values in their work. In addition, this led to the preservation of the African spirit and context, resulting in children

growing up in an African environment. The Declaration also made strides to ensure that Member States address African contextual issues related to early marriages and circumcision which were prevalent in Africa (Kaime, 2009, Ruppel, 2009). However, as noted by the researcher, the Declaration and Welfare on the Rights of the African Child had no provisions for children placed in institutional care.

The African Charter on the Rights and Welfare of the Child (ACRWC) 1990 was adopted by the African countries and builds up from the Declaration and Welfare on the Rights of the African Child (1979). It was set up to ensure that the rights of the African child were recognised and upheld (Muthoga, 1992; Ncube, 1998; Rwezaura, 1994; Wako, 1988). The ACRWC preamble attaches value to the notion of a child growing up in a family environment. It affirms that such an environment is suitable for child development per se, especially personality development (ACRWC, 1989; Ruppel, 2009). In addition, the instrument assumes that an environment lacking happiness, love and understanding is not good for children; hence Member States should ensure that children grow up in environments that are good and conducive to development.

The African Charter stipulates that children have the following rights: the right to a name, nationality, religion, privacy and education, and they should be protected from all forms of exploitation, abuse and other harmful social and cultural practices (ACRWC, 1989; Kaime, 2009). Thus, the Charter's Article 25 considers alternative care in the form of foster care or institutional care as options for helping children without parents or families. The article further stipulates re-unification in cases where a child has been separated from the family due to natural disasters or armed conflicts. The same Article 25 Section 3 notes that in cases where alternative care is regarded as an option, children should then be looked after in an environment which promotes their cultural context. This shows that the Charter recognises the importance of preserving the child's background when implementing child protection strategies. Therefore, in line with the charter, kinship care is preferred as compared to institutional care. Presumably this is due to the fact that institutional care is a western concept which provides an artificial environment that is exclusive of African values (Masuka et al., 2012; Tolfree, 1995; Williamson & Greenberg, 2010;).

The African Youth Charter (AYC) (2006) was adopted by the Heads of State and Government of the African Union to enact policies which mainstream youth activities. Thus, in the charter, the youth are defined as persons aged 15 - 35 years of age. As explained in the

preamble of this charter, his age group has an important role in societal development (Efem, 2007; Ruppel, 2009). Thus, youth should participate in societal programmes and adhere to demands. With regard to implications in child protection, this means that practitioners who deal with children especially in institutions, should not protect only them, but prepare them to be responsible citizens in the near future.

The Declaration Plan of Action of Africa Fit for Children (2001) has been adopted to ensure that Member States design a Plan of Action for children who need protection. All the Member States in the sub-Saharan region have Plans of Action for children who are vulnerable (Declaration Plan of Action Fit for Children, 2001; Ruppel, 2009). For example, South Africa has the National Plan of Action for Children, 2012-2017, which guides all the parties involved in main-streaming child protection issues (Department of Women, Children and People with Disabilities, 2012).

The Southern African Development Community (SADC) Treaty (1992) was adopted by countries in Southern Africa comprising Zimbabwe, Zambia, Swaziland, Tanzania, Seychelles, Namibia, Angola, Mozambique, Madagascar, Lesotho, Botswana and the Democratic Republic of the Congo, South Africa and Malawi, and was amended in August, 2001 (SADC, 2001; SADC Treaty, 1992; Saurombe, 2012). As observed by Ruppel (2009), the SADC treaty "envisages a common future, a future in a regional community that will ensure economic well-being, improvement of the standards of living and quality of life, freedom and social justice, and peace and security for the peoples of Southern Africa". Ruppel further notes that the treaty does not have direct protective measures for children, but has human rights measures which when implemented, result in the creation of a good environment for children.

The SADC Protocols namely the SADC Protocol on Education and Training (2000), the SADC Protocol on Gender and Development and the SADC Protocol on Health as explained by Ruppel (2009), also legally bind the Member States to put in place policies and regulations to ensure quality education, promotion of gender issues and equity, and meeting the health-related needs of children (Ruppel, 2009; The SADC Protocol on Trade, 1996; SADC Protocol on Education and Training, 2000; SADC Protocol on Gender and Development, 2008).

At regional level, as in the case of sub-Saharan Africa, various parties in the region are involved in the formulation and implementation of policies namely; government and non-governmental organisation leaders, Children's Committees and regional organisations like The African Policy Forum, Plan International, REPSSI, Save the Children, Terres des Homes, World Vision and UNICEF (Inter-Country Agency Group on Child Protection Systems in sub-Saharan Africa, 2012).

However, each African country has its own legislation on child protection in this regard. Literature reveals that nearly all countries have legislation called the Children's Act which guides practitioners when handling children's issues. This Act is in existence in South Africa, Botswana, Namibia and Zimbabwe. Although this legislation shares the same name in many countries, its stipulations and comprehensiveness differ from country to country. Thus, in spite of the inclusiveness of common child protection strategies, the explanation and implementation differ. For example, a comparison of the Zimbabwean and South African Children's Acts shows that the South African document is very comprehensive with clear and detailed information on definitions and procedures. A detailed discussion on the Zimbabwean Children's Act (2001) and child protection strategies will be covered in Chapter 4. Therefore, in conclusion, the above-mentioned international and regional child protection instruments and local pieces of legislation guide strategies to protect children. It is worthwhile to note that some countries have flouted the demands of the instruments despite being signatories. Such cases are Uganda, Mozambique, Chad, Palestine and Sudan where children were recruited into the armed conflicts, thereby violating the provisions in UNCRC, and forcing to perform soldiers' duties and responsibilities, thus disrupting the process of child development in the said children (Child Soldiers Global Report, 2008). As a result, the protection of children remains a critical issue in those countries. It is therefore ideal for Member States to enforce strict measures so that all countries adhere to provisions in the instruments. In this regard, child protection instruments foster a conducive environment for child development that is echoed in the Ecological Theory discussed in the previous chapter. To this end, such an environment results in secure attachments between children and caregivers as highlighted in the Attachment Theory. It also empowers children to overcome challenges they may encounter during development and as adults as indicated in the Pyschosocial Theory (Ainsworth & Bowlby, 1991; Bronfenbrenner, 1999; Bronfenbrenner & Ceci, 1994; Bronfenbrenner & Morris, 2006; Bowlby, 1969; Donald et al., 2010. However,

apart from child protection instruments, there are other child protection strategies that are guiding practitioners and these will be explored next.

3.4 FAMILY PRESERVATION AS STRATEGY OF CHILD PROTECTION

Views on child protection are closely linked to those on childhood and family studies. Early philosophers like Charles John Locke believed that a child is born with an empty mind, what he termed "tabula rasa" (Ezzel, 1991; Zigler & Stevenson, 1993). Locke believed that the child then acquires knowledge and skills from its environment with guidance from adults. As a result, the actions of a child are a function of what that particular child learnt from the environment. Traditionally, the role of looking after children was in the hands of biological parents or immediate family members. Proponents of Functionalism in Sociology like Talcott Parsons argue that the role of socialisation of children lies with the family (Elliot, 1991; Freeman & Showel 1953). If the family fails to perform its expected role, the child may be affected in one way or another, resulting in social, psychological and emotional stress. The family is therefore regarded as the best institution to foster the socialisation and growth of a child. This view is echoed by proponents of foster kinship care and even childcare practitioners, largely because those who grow up in their families maintain their identity and cultural values (Doolan & Nixon 2003; Jacobs, Shung-King & Smith, 2005; National Orphan Care Policy, 1999). Family preservation therefore maintains that a child grows up with biological parents or relatives. In this regard, it can be argued that child protection instruments strive to preserve families so that children will remain in custody of biological parents or relatives.

It is against this background that child protection specialists regard family preservation as the first and most preferred alternative in safeguarding the interests of the child (Blank & Handa, 2008; Ministry of Labour & Social Services 2010; Muguwe, Taruvinga, Manyumwa & Shoko, 2011; Mushunje & Mafico, 2010; Powell et al., 2004). However, as implied by the word preservation, should there be any threats of family disintegration with possible significant harm to the child, the onus lies with practitioners to intervene in the best interests of the child. This can be achieved through the provision of family therapy sessions, budgeting skills, parenting skills and material support in form of school uniforms and fees, food packs and cash to start income generating projects (Child Welfare Pre-Service Training, 2012; Williamson & Greenberg, 2010).

Lack of preservation strategies sometimes results in family disintegration. In this vein, there are arguments that affirm that one of the causes of institutional care is family disintegration due to poverty (Dozier, Zeanah, Wallin & Shauffer, 2012; Powell et al., 2004; Walker et al., 2007). In this regard, it is important to deal with poverty so as to reduce the number of children who end up in institutions. Puras (2011) asserts that poverty should also be viewed as a sign that families need support. Thus, in line with this thinking, supporting poor families helps to preserve and enable them to meet basic needs and also look after their children well. Unlike institutionalisation, family preservation is necessary because it indirectly ensures that the child remains in a family environment with biological parents or relatives where the child develops and maintains identity (Hegar, 1999; Kang, 2007; Mushunje & Mafico, 2010; Williamson & Greenberg, 2010).

Family preservation interventions tend to be based on contextual set-ups. In western countries, the interventions are formal, and family members looking after the child receive support from the state (Carpenter & Clyman, 2004; Strozier & Krisman, 2007; Winokur, Crawfod, Longobandi & Valentine, 2008). In sub-Saharan Africa, family preservation is either done formally or informally. Traditionally, the extended family is regarded as the duty bearer of children and families in need of support; however, its effort is restricted by poverty which makes it difficult for family members to meet the basic needs of children (Ayala, 2007; Deininger, Gracia & Subbarao, 2003; Mutangadura, 2003). In South Africa, at-risk families receive counselling and educational skills to keep the family going (Strydom, 2012). In Zimbabwe, the government, non-governmental organisations (NGOs), and multilateral and bilateral organisations engage in various social protection programmes (Masuka et al., 2012; Mushunje & Mafico, 2010). For example, private contributory schemes such as employee benefits and state-funded non-contributory social security schemes, and public assistance also help families boosting household incomes. On the other hand, UNICEF in partnership with the Department of Social Services (DSS) runs cash transfer programmes for orphans and vulnerable children and their households to alleviate poverty (Barca et al., 2014; Roman, 2010). In these programmes, the guardians of vulnerable children receive money to start a project which will increase the household economy.

3.5 ALTERNATIVE CARE STRATEGIES IN CHILD PROTECTION

Apart from family preservation as the preferred child protection strategy, there are alternative care strategies in child protection. These are used to provide the child with a substitute family

environment that promotes proper child development. Alternative care strategies can be subdivided into two categories namely, statutory and non-statutory.

3.5.1 Non-statutory alternative care

The non- statutory strategies do not involve paperwork from the courts and professionals. One of the non- statutory strategies is kinship care where a child is looked after by family members/ relatives other than biological parents (Bromfield & Orsborn, 2007; Green & Berrick, 2004). Kinship care is regarded as non-statutory because it is organised through informal arrangements without the involvement of the state.

Kinship care

As highlighted earlier on, kinship care is a strategy where children are looked after by their relatives. It is defined as a child protection strategy where children are looked after by relatives with whom they have had previous contact (Hega & Scannapieco, 1995; Pretorius & Ross, 2010). In this vein, the family members' carers use their own resources to provide children with proper shelter, food, clothes, education and other needs which may arise (Harden, Clyman, Kriebel & Lyons, 2004; Mutangadura, 2003). However, in some cases, the state or non-governmental organisations provide assistance if assessments recommend the need for assistance (Masuka et al., 2012; Masuka et al., 2012; Mushunje & Mafico, 2010). In Zimbabwe, a non-governmental organisation known as the SOS Children's Villages, engaged family strengthening programmes for orphaned and vulnerable children, and provides support to families of vulnerable children, in the form of school fees, uniforms and food packs for children being looked after by their relatives who were residing in Glen Norah and Glen View Suburbs in Harare (SOS Children's Villages Pamphlet, n.d).

The history of kinship care

Kinship care is the oldest child protection strategy. It has been operating for ages informally (Hega, 1999; Hega & Scannapieco 1995). Kinship care is the traditional form of providing care to children in Medieval Europe and Africa. This means that kinship care originated as an informal non- statutory type of care. In spite of it being the oldest form of care, very little literature on the historical development is available. The literature on kinship care that is available notes that kinship care was used during the slavery period in America, when children of deceased slaves were cared for by other slave relatives; and in England, during the

period of poor laws era, grandparents also looked after their grandchildren (Hegar, 1999; Hegar, & Scannapieco, 1995; Scannapieco, & Jackson 1996).

Kinship care was restructured from kinship care to kinship foster care following the US Supreme Court verdict on the case of Miller vs Youakim in 1979 which granted relative foster carers eligibility for state assistance (Berrick, Barth & Needell, 1994; Hegar & Scannapieco 1995). This resulted in a new version of kinship care referred to as kinship foster care. Thus presently, there are two forms of kinship care, which are kinship care (relative care) and kinship foster care (relative care that is supported) (Bromfield & Osborne, 2007; Carpernter & Clyman, 2004; Strozier & Krisman, 2007).

The prevalence of kinship care

The prevalence of kinship care varies from country to country. According to Connolly and Morris (2012), proponents of child protection in developed countries prefer this type of care, hence it is common in the United Kingdom and United States of America. Munro and Gillian (2013) note that in the United Kingdom, kinship care statistics rose in 2001 with many children staying with grandparents. In most developing countries, kinship care is the traditional form of care for children who need protection. Previous research studies revealed that kinship care is very common in sub- Saharan Africa where relations are still valued, and children in need are looked after by the extended family (Deininger, Gracia & Subbarao, 2003; Green & Berrick, 2004; Gwenzi, 2018; Mutangadura, 2003; Pretorius & Ross, 2010;).

Advantages and disadvantages of kinship care

There are advantages to kinship care. As highlighted earlier on, it is regarded as a better option for childcare and protection in the absence of parents. The main advantage of kinship care is that the child maintains his or her family identity and culture (Aldgate, 2009; Doolan & Nixon, 2003, Farmer, 2009; Green & Berrick, 2004), meaning that a child will continue to identify with the biological family name and way of life. Thus through kinship care, a child will have frequent contact with relatives, and this creates multiple opportunities for children for the child to maintain biological links, acquire knowledge on genealogy and form strong emotional bonds with relatives (Broad, 2006; Cole, 2006; Farmer, 2009). Such knowledge is valuable and is used frequently in explaining one's origins and identity (Bourdillon, 1976; Gelfand, 1979; Makamure & Chimininge, 2015). Kinshp care also makes the children feel

stable and to know that they are loved by their relatives (Cole, 2006; Farmer, 2009; Shaerin, 2007). For childcare practitioners, kinship care is preferred because it warrants stable, unrestrictive and cheaper environments, characterised by less stigma on children (Messing, 2006; Scannapieco & Hegar, 2002; Winokur et al., 2008).

Disadvantages of kinship care

There are several disadvantages to kinship care. Against this backdrop, children could potentially be at risk of significant harm at the hands of their immediate relatives possibly not suitable to look after them due to lack of financial resources and in their personal capacity (Broad, 2006; Cross & Day, 2008). Such caregivers may end up doing more harm than good on children. Furthermore, since it is non-statutory, kinship care is less monitored and supervised, and thus some caregivers may endure challenges in childcare support with minimal support from professionals, and may therefore not comply with court orders (Cuddenback, 2004; Green & Goodman 2010; Warren – Adamson, 2009).

3.5.2 Statutory alternative care

Statutory care is a form of care that involves contributions from child protection practitioners and other practitioners in the justice system. It is normally processed and maintained by state authorities. With reference to child protection, statutory care has three different forms of intervention namely foster care, adoption and institutionalisation.

3.5.2.1 Foster care

Foster care follows a statutory process and there are specific conditions and requirements that should be met by all parties involved. Foster care is defined as a state-funded child protection strategy that is guided by statutory decisions in which children are removed from their natural families on a temporary basis and are cared for in alternative families, whether or not related (Adams, 2012; Connolly & Morris, 2012; Convention on the Rights of the Child, 1989). As explained by Strijker, Knorth, Knot and Dickscheit (2008), foster care is provided on a long-term basis until the child reaches the age of 18, and on a short-term basis where the child can be removed from foster parents after staying for a short period. This means that in foster care, the child maintains ties with the biological parents and may at a later stage be reunified with the family. There are two types of foster care namely, formal and informal foster care.

The latter as non-statutory, and the former involving input from childcare specialists and the courts (Delap, 2011; Johnson, 2005).

There is very little in literature on the history of foster care. This study will explore the historical development of foster care in America as noted by Simms, Dubowitz and Szilagyi (2000). These authors highlight that before the advent of foster care, the extended family looked after children in need. Foster care commenced in the 19th century. It came as a package of social welfare programmes for children who were migrating from urban areas to farms. As time progressed, foster care changed from non- relative care only to kinship foster care. In America, foster care is currently a popular child protection strategy (Delap, 2011).

As far as the researcher knows, in Africa, the practice of informal kinship foster care has been in Africa for ages. Families used to take care of their child relatives in the absence of parents. Formal foster care is a borrowed child protection strategy. It was introduced by the colonialists as part of the package of the social welfare system. To this end, for example in Zimbabwe, the provisions for formal fostering are documented in the Children Act (2001).

Foster care ensures that a child is placed in a real family environment which promotes growth. Before placing a child, childcare practitioners assess, train and match the children with the foster care parents (Delap, 2011; Hunt, 2009). The assessment, training and matching processes are done so as to place children in suitable family settings. This is followed by the placement of the child in the foster home, where the child is looked after for a specified period. Foster care children keep their original identity and can have contact with their biological parents. The role of childcare practitioners in foster care includes, working with children's biological parents, the monitoring and supervision of foster care programmes, and processing child support grants (Delap, 2011; Zastrow, 2010). As highlighted earlier on, foster care is therefore a temporary strategy and children can be withdrawn from the foster families at any time. Present day foster care is processed within the parameters of the UN guidelines for Alternative Care discussed earlier on in this chapter (Johnson, 2005; UNCRC, 1989)

The prevalence of foster care is varied, depending on the location. To this end, it is common in the United States, United Kingdom, Australia and Western Europe (Cuddenback, 2004; Delap 2011; Thorburn, 2010; Williamson & Greenberg, 2010). Foster care is also widely used in sub-Saharan Africa, and most children are cared for by relatives rather than non-

relatives so that they remain in the family and therefore maintain their family identity and tradition (Pretorius & Ross, 2010; Williamson & Greenberg, 2010).

As highlighted earlier on, foster care provides a normal family environment that is conducive for proper child development. Children get an exposure to and become part of real family life and challenges. In the case of kinship foster care, there is continuity of care, and children find it easy to adjust to being looked after by familiar people (Green & Berrick, 2004; Messing, 2006). Furthermore, as explained, the family environment gives the child some form of identity since the child may adapt to the foster family's culture and values. In addition, as revealed by some research studies, foster care helps to preserve families, especially when it is used in situations where a child in placed for a short period during which practitioners will be dealing with the child's biological family to resolve issues and at the same time awaiting the return of the child (Fulford & Delap, 2011; Gauteng Task Team on Foster Care Procedures, 2006; Pretorius & Ross, 2010). Furthermore, research reveals better results in child development among children in foster care than those in institutional care. A study done by Goldfarb in the 1940s as cited in Carter (2005), revealed that children who had gone through foster care performed better in intelligence tests than those raised through institutionalisation. Goldfarb (1943) attributed the poor performance of institutionalised children to absence of parents during their early childhood years.

There are also disadvantages to foster care. It is worthy to note that foster care as a strategy incurs financial costs from the government. The initial costs which tend to be high are incurred during processes of assessment, training and matching as mentioned earlier. To add on, child welfare departments also incur costs on the child support grants given to foster parents. For example, in South Africa, foster parents receive grants from the government (Access, 2003; Patel, 2005). Additional costs are also incurred when practitioners do home visits to monitor and evaluate foster care programmes. Furthermore, the provision of foster care on a temporary basis disrupts the developmental processes of children, as children are then faced with multiple adjustments socially and emotionally each time they join new foster parents (English, 1984).

Foster care has its challenges. It is limited in some societies due to cultural beliefs. Thus, in African and Middle East countries, the prevalence of foster care is low as mentioned earlier, due to the beliefs that a child in foster care may bring in foreign ancestral spirits that can

potentially curse the foster family (Nyandiya-Bundy & Bundy, 2002). Furthermore, low educational attainment has been linked to children who had gone through foster care (Jackson, 1994).

3.5.2.2 Adoption

Adoption is a permanent form of care for children. It involves a process where the biological parents (birth parents) give over their child (adoptee) to other adults (adoptive parents) to permanently look after the child from the date of adoption (Rosenberg, 1992; Silin, 1996; Smith & Howard, 1999; Zamostny, O'Brien, Baden & Wiley, 2003a).

Adoption started long ago (Brodzinsky, Smith & Brodinsky, 1998). Some authors trace its history to the Bible when Moses was picked up in the River Nile and looked after by Pharaoh's daughter (Ferreira, 2007). As observed by Silverman (2001), adoption started in the Roman Empire and later spread to England, America and other countries. In the early years, the process of adoption was very informal; the procedures did not involve the courts and there were no legal instruments. However, as time progressed, an appreciation to the relevance of legislation and practitioners' input grew (Brodzsky, et al, 1998; Sass and Henderson, 2000). In America, statutory adoption started in the late 1800 and in England in 1926 (Silverman, 2001). In sub–Saharan African countries, the colonialists brought in adoption. As noted by Ferreira (2007), in South Africa, formal adoption commenced in 1923 when the Adoption of Children Act was put in place.

Initially, the reasons behind adoption were two-fold. Firstly, it was a strategy to relieve unmarried mothers who could not care for children, and secondly, adoption was used as a means of providing care to homeless children (Zamostny, O'Brien, Baden & Wiley, 2003a). During that time, the adoptive parents usually comprised of rich people but with time, people who could not bear children used adoption as a means of having children. In South Africa, adoption was introduced as part of the Roman Dutch law. In Zimbabwe where social welfare was introduced by the colonialists (Mupedziswa, 1995), adoption came as part of the social welfare package.

As time moved on, trends in adoption brought in new ideas and forms. At inception, adoption was processed in such a way that the adoptee would never see the birth parents again (Grotevant, 2003). However, this has changed, and the current adoption process has an option

that allows openness between the adoptive parents and the natural parents. This option allows communication between the birth parents, child and adoptive parents. There are also various forms of adoption which have emerged. There are *private adoption*, *transnational adoption*, and *transracial adoption*. In this regard, *private adoption* entails the processing of adoption by voluntary agencies together with birth and adoptive parents (Barth & Berry, 1988). *Transnational adoption* involves intercountry adoption where the adoptive parents and the child are from different countries (Friedlander et al., 2000; Stolley, 1993). *Transracial adoption* involves cases where the adoptive parents and the child are of a different race (Rosenthal, Groze, Curiel & Westcott, 1991; Rosenthal, Groze & Curiel, 1990; Stolley, 1993). This means the choice is wide for people who have interest in adopting children. Noteworthy, is the fact that the present-day process of adoption is guided by statutory instruments, and is processed by probation officers (Children's Act, 2001, Children's Act, 1989).

Unlike other child protection strategies, adoption is designed as a lifelong strategy. It is processed by professionals in the field of childcare who include social workers, psychologists and lawyers (Baran & Pannor, 1993; Brodzinsky, et al., 1998). The Probation Officers through the courts issue an adoption order (Ball, 2012; Children's Act, 2001). As a result, parental legal rights are transferred from birth parents to adoptive parents and therefore, there are permanent changes which happen soon after the adoption process. After adoption, the child's ties with the biological parents are severed (Brodzinsky et al., 1998; Connolly & Morris 2012; Smith & Howard, 1999). This means that the child will then legally belong to the adoptive family. The adopted child gets the surname of the adoptive parents and has rights similar to those of the biological children of the adoptive parents (Adams, 2012; Children's Act, 2001).

The prevalence of adoption as alternative care varies regionally due to cultural norms and values. Adoption is common in western countries where it originated. In America, research studies revealed that there were five million adoptees, and six in ten Americans had come across cases of people who had practical contact with adoption in various ways like at work, or friends who adopted a child (Freundlich, 2002; Zamostny et al., 2003b). This shows that the prevalence of adoption is very high in America. In sub-Saharan Africa, adoption is not popular, especially among black people who tend to value their identity using totems (Nyandiya-Bundy & Bundy, 2002). They believe that if people stay with a child whose totem

is unknown, the ancestral spirits of the child's original family can haunt them to the extent of experiencing social problems and bad luck. With an exception of the westernised affluent black people, and white people in particular, adoption cases are rare in Africa.

There are advantages associated with adoption. As highlighted earlier on in the history of adoption, adoption provides a safe environment to children who are homeless or when parents are unable to provide care (Bohman & Sigvardsson, 1990, Triesliotis & Hill, 1990). Linked to this point, is the fact that adoption provides a stable environment that is run by adults (Cole & Donley, 1990; Groze, 1996). Such an environment is conducive for child development as children are exposed to real family life. In this vein, children are also assured of support from foster family members even in adulthood (Bohman & Sigvardsson, 1990, Triesliotis & Hill, 1990). This is due to the fact that the adoptive parents play the role of the biological parents, which includes acting as a support system to the child even in adulthood years. The other advantage of adoption is that, financially, this strategy is less costly for the governments since the adoptive parents bear all the costs incurred in looking after the child (Brodzinsky, 2011; Delap, 2011).

The disadvantages of adoption are varied. The members of the triad (birth parents, adoptee and adoptive parents) sometimes suffer from the stigma associated with adoption (Anderson, 1991; Leon, 2002; Wegar, 2000; Zamonstny et al., 2003). This usually happens where people hold beliefs that childcare is the responsibility of the biological parents. Another disadvantage is that although adoption is done to protect children, some adoptees present with feelings of rejection (Keating, 2009; Triesliotis, 1990). This means that some adoptees feel that their natural parents rejected them and chose to give them over to other people. As a result, adoptees sometimes grapple with psychosocial issues to do with loss, rejection, guilt, shame and identity confusion (Friedlander, 2003; Silverstein & Kaplan, 1988; Zamonstny & O'Brien, 2003). In the researcher's point of view, these feelings can then interfere with child developmental processes resulting in poor social emotional development. In addition, such feelings can affect the social functioning of an adoptee later in adulthood. Furthermore, the feelings of rejection can also be a source of pain for the future generations of the adoptee. On the other hand, after giving over the child, some birth parents experience hard feelings resulting in their being prone to psychosocial problems like depression, anger and guilt (Leon, 2002; Rosenberg, 1992; Silverman, 2001).

3.5.2.3 Challenges with adoption

The main challenges of adoption are multifaceted. To this end, adopted children often struggle with issues related to their biological links. As explained by Baden and Wiley (2007), some adoptees present with anxiety and depression caused by their search for genealogy, to no avail. Consequently, the adoptive parents can in turn feel guilty and experience emotional pain. In the same vein, in some cases, mature adoptees may desire to be reunited with their biological families in search of identity and closure (March, 1995; Pacheco & Eme, 1993; Schechter & Bertocci, 1990; Zamonstny & O'Brien, 2003).

The other challenge is linked to the handling of the adopted child's background information. In cases where soon after the adoption process, the natural parents' information is sealed forever and no one will have access to it, the issue of the best interests of the child becomes questionable (Silverman, 2001). In other words, sealing of information denies the child access to the information, thereby violating the child's rights.

3.5.2.4 Institutional care

Institutional care or residential care is another child protection strategy which entails children living in residences designed to provide them with shelter and care. This study will use the terms residential and institutional care interchangeably. Residential or institutional care is defined as a child protection strategy where a group of children in need of care are housed at one place and looked after by paid caregivers and professionals (Barth, 2002; Browne, et al., 2006; Powell et al., 2004). Residential care is therefore a type of statutory care guided by legislation, policies and standards.

Institutional care originated from efforts by concerned groups to help children who were in need of care as a result of abandonment or orphan hood. It is believed that the first homes were started in Italy during the 14th and 15th century as highlighted by Hardy in Dozier et al. (2012). During that time, the institutions accommodated abandoned babies with one or both parents alive. In Britain and America, the history of institutional care is linked to activities by philanthropists, religious groups and the state. Against this background, before the professional provision of childcare services, the state had no role until the 17th century; religious groups and philanthropists played a pivotal role in caring for children in need; by giving food, shelter and aid to their parents (Friedlander & Apte, 1980).

Upon recognition, the state designed a strategy to deal with children in need. In this vein, children who were categorised as needy or orphaned, as highlighted by Friedlander and Apte (1980), were placed in alms-houses to get help in the form of shelter, food and other things regarded as necessary for child growth. This prompted the idea of providing residences and services to children in need of care similar to present day children's homes. The same authors also observed that, around the 20th century, the alms-houses were criticised as not being conducive for childcare because they were chaotic and characterised by poor sanitary conditions. This led to the establishment of orphanages by private charities and religious groups. At conception, institutionalisation started with no legislation but with time and continuous evaluation, statutory measures were put in place (Smith, Fulcher, & Doran, 2013). As a concept, missionaries, colonialists and philanthropists spread institutionalisation of children to other countries and to date, children are still being placed in homes of safety.

However, through the passage of time, recommendations were passed to remove children from institutions. As noted by Dozier et al. (2012), the recommendations from the White House Conference held in 1909 in the United States of America resulted in a sharp turn in institutional care. The event which was organised by President Roosevelt and attended by childcare workers from all over the world, recommended that "(1) children should be raised by their own families; (2) when it was necessary to remove children from their families, the settings in which they were cared for should be other families' homes or resemble families as much as possible; and (3) no child should be removed from parental care because of poverty alone" (Dozier et al., 2012, p. 3). As the years unfolded, negative factors about institutional care were continually raised in America and the governments preferred to fund foster care as compared to institutional care. With time, the number of institutions declined and institutional care is not popular in western countries but still prevalent in Africa, Asia, Central and Southern America, Eastern Europe and the Middle East (Correll, Dana & Correll, 2009; Dozier et al., 2012).

Children placed in institutional care are looked after by childcare practitioners and caregivers (Browne et al., 2006; Powell et al., 2004; Zeanah et al., 2005). In this vein, childcare practitioners who work in institutional care set-ups have expertise in child welfare, social work, psychology, administration and sociology. They provide psychosocial support in the form of counselling, life skills training and also have to deal with the administrative work

thereof. The caregivers act as the direct providers of care to children; working with them round the clock and assuming the role usually fulfilled by parents in a normal family set-up.

As noted earlier on, institutional care emerged as an option for providing care to children in need. However, with time, it was criticised as not suitable for child development. Due to this, it lost popularity especially in western countries like Spain and Italy (Correll, Dana & Correll, 2009; Mulugeta & Atnafou, 2000; UNICEF, 2003). Institutionalisation is not encouraged, but factors like poverty and high mortality rates due to HIV and AIDS have forced countries to continue with the strategy (Bilson & Cox, 2006; Davis, 2006; Gwenzi, 2018; Milligan, Withington, Connelly & Gale, 2017; Powell et al., 2004). Thus, in spite of criticism, institutional care is still in existence in many countries.

The overall advantage of institutional care is that it allows children to have access to basic needs like food, shelter and clothing in a safe, secure and non-discriminatory environment that is controlled by childcare experts (Children's Act 2001; Powell et al., 2004; UNCRC, 1989).

There are several disadvantages to institutional care. Institutional care is costly as compared to other childcare strategies as revealed by research done in some countries. In this vein, research studies revealed that in Romania, institutional care exceeded foster care cost with US$80; in Tanzania the annual costs of institutional care were pegged at US$1 000 as compared to around US&160 needed for foster care, and in South Africa residential care costs were found as six times more than those of foster care (Desmond & Jeff, 2001; Tobis, 2000; World Bank, 1997). In the researcher's view, institutional care costs are incurred in maintaining the physical structures, administration and staff salaries. The other disadvantage of institutional care is that children in institutional care have limited relationships and experience care disruptions from caregivers' multiple shifts and staff changes (St Peterburg-USA Orphanage Team, 2008; Van IJzendoorn et al., 2011; Zeanah et al., 2005). This affects the socio-emotional developmental processes in children, and thefore culminates into disturbances in attachment (Chisholm, 1998; Smyke, Dumitrescu & Zeanah, 2002; Zeanah, 2000; Zeanah et al., 2002). Lastly, although institutions are designed to provide a near family environment, provisions are short-term as children are expected to leave the institution when they reach the age of 18 (Children's Act, 2001; Mhongera, 2017; Powell et al., 2004; UNCRC, 1989). This may result in attachment disturbances highlighted earlier on, and

produce a wide range of negative emotions experienced when severing ties with the institutional community like anger, fear and loneliness.

There are mainly two models of institutional care. The Zimbabwean National Residential Childcare Standards (NRCCS) (2010) outlines the Dormitory and the Family-Based Models as the two main models of institutional care. Initially, children stayed in dormitory model accommodation and employees performed most of the house chores. The advantage of the dormitory model is that the dorms can house many children who are then looked after by a small number of caregivers. However, the disadvantage is that it does not foster a family environment, hence being unsuitable for the growth of children, as subsequently, children leave the institution into the community without independent living skills.

The Family-Based Model is another model is a set-up in an institution where children stay in homes or houses similar to a family set-up. This model is used in Zimbabwe, where Powell et al. (2004) observed that some institutions were still looking after children using the Dormitory Model, despite criticism. Other institutions used the Family-Based Model where children stay in houses with a surrogate mother and are expected to participate in household chores. This is presently the preferred model, because it provides children with a near-family environment consisting of a parent and siblings.

Specific factors contributing to institutionalisation vary from country to country, and are related to the prevailing socio-economic and political factors such as poverty, natural disasters, wars and pandemics such as HIV and AIDS in both developed and developing countries (Bilson & Cox, 2006; Morantz & Heyman, 2010; Powell et al., 2004). In this vein, some parents cannot afford basic needs because of poverty, poor health, armed conflicts and other factors resulting in children ending up in institutions. In Southern African countries that have been affected by HIV and AIDS, the number of orphaned children overwhelms financial capacities of extended families (Deininger, Gracia & Subbarao, 2003; Mutangadura, 2003). Institutional care then emerged as a solution to help them out.

Thus, a closer look at the reasons behind institutional care shows child abandonment, neglect, abuse or the absence of a parent or caregiver (Dozier et al., 2012; Morantz et al., 2013) forced children into institutional care. In sub-Saharan Africa (for example in Botswana), Morantz and Heyman (2010, p.12) explain that the reasons include “orphan hood, neglect, sick parents, destitution, abandonment and abuse” and this is also reflected in most developing

countries, including Zimbabwe. In addition, the HIV and AIDS pandemic in some instances wipe away all parents, as well as immediate family members, making it difficult for practitioners to recommend kinship care. Against this background, institutional care then emerges as the last resort.

Moreover, some children are placed in institutional care as the result of unconducive environmental conditions in their homes like domestic violence. As observed by Better Care Network (2009), violence at home also contributes to institutional care and in a study done at SOS Children's Villages in Venezuela, it was discovered that 73% of the resident children had history linked to violence at home.

The placement of children in institutional care may also be linked to the disability in children. As explained in the Better Care Network (2009), in Central and Eastern Europe and Jamaica, the likelihood of placing children with disabilities in institutional care is very high.

Children are also placed in institutions when parents and guardians fail to provide adequate childcare, as in the case of Ghana, Zimbabwe and South Africa (Children's Act, 1998; Children's Act. 2001; Children's Act, 2003). These Acts state the conditions upon which the state intervenes for the sake of the child. Thus, in the case of Zimbabwe, among other reasons, children can be institutionalised when parents are deemed as "unfit" as outlined in the Children's Act 2003. In Ghana, as stated in the Children's Act (1998), the protection system attaches value to parental and family care, but children can be removed from parents if there is evidence that the living conditions are not suitable for the child.

Despite efforts to care for children, institutional care has received criticism from different angles as highlighted earlier on. Some European countries like Spain and Italy are pro-deinstitutionalisation due to the negative effects associated with institutionalisation (Correll, Dana & Correll, 2009; Mulugeta & Atnafou, 2000; UNICEF, 2003).

Institutional care environment is regarded as unsuitable for child development. There are sentiments that institutionalisation is not suitable for a child's emotional, social and psychological developmental needs and the growth of a child is stunted and children who have been raised in institutions often present with backwardness, and score low on their IQ (Cskay, 2009; Dozier et al., 2012).

A study carried out by Kang'ethe and Makuyana (2014) on orphaned and vulnerable children using the desk-review methodology, revealed that institutional care affects children emotionally, psychologically and socially. In this vein, some of the emotional effects experienced by children who have gone thorough institutional care, are developmental delays, attachment disorders, depression, poor social adjustments and discriminatory behaviour to strangers (Browne et al., 2006; Riley, 2012; Zeanah, 2002), These psychosocial effects impact the social functioning of a child and may become sources for psychosocial issues later in adulthood. In a research carried out in Russia, it was discovered that some of the children who leave institutional care end up with a criminal record, become homeless, or commit suicide (Puras, 2011).

Institutionalisation has also been criticised for not providing an environment conducive for the personality development of a child. As noted by Gordon (1972, pp 18, 19), studies done by John Bowlby on institutionalised children revealed that the children displayed "severe conduct problems and developmental backwardness". He also highlighted that such characteristics are not as a result of life experiences in institutions, but rather "the result of providing an inappropriate human environment for a child who is convalescing from a particularly traumatic separation".

Child protection specialists argue that there is a correlation between the age at which the child was placed in an institution and the magnitude of the effects. In this vein, the age at which the child was placed in an institution and the period of stay determine the level of damage, thus the ages three years and under are critical for brain development and all children who are exposed to institutional care at that age, are likely to be more vulnerable to the detrimental effects of institutional care (Better Care Network, 2009; Puras, 2011). A study conducted in Romania aimed at comparing institutionalised children and those who had gone through foster care, revealed that children who had gone into institutions at a tender age had more pronounced effects of institutionalisation such as social and emotional issues (Kangéthe & Makuyana, 2014; Zeanah et al., 2005).

As highlighted earlier on, institutional care is also regarded as a costly strategy of child protection since a lot of money is needed to pay the staff involved, maintain physical structures and also meet the needs of children. Statistics provided by the Better Network Care (2009) revealed that it is cheaper to raise a child through foster care than institutionalisation

in Eastern Europe, the former Soviet Union, South Africa and Tanzania, to mention but a few.

The caregiver to child ratio is sometimes very high and compromises the quality of childcare. Thus, the high numbers of children sometimes allocated to a caregiver makes it difficult for the caregiver to develop strong and meaningful continuous bonds that are critical in child development (Better Care Network, 2009; Browne et al., 2006; Zeanah et al., 2005). This directly affects the development in children.

Although institutional care is designed to protect children from potential harm, research has shown that some children are physically or sexually abused by the staff members (Browne et al., 2006; Csaky, 2009).

3.6 THE ROLE OF SOCIAL PROTECTION IN CHILD PROTECTION

Social protection plays a critical role in child protection. It is a programme that is linked the World Bank (Heitzmann, Canagarajah & Siegel, 2002; Holzmann and Jorgensen, 1999). This means that the World Bank controls its initiatives at large.

Social protection has been defined (Blank & Handa, 2008, p2) as "a set of transfers and services that help individuals and households confront risk adversity and ensure a minimum standard of dignity and well-being throughout the lifecycle". This means that social protection provisions are meant to help people to manage their lives and meet the basic needs. As explained by Kamerman and Gatenio-Gaabel (2007), social protection schemes fall into two categories, the contributory and non-contributory. Thus, members deposit money over a period before accessing the service e.g. in pension, disability allowance. On another hand, the non-contributory schemes are not funded by members, but focus on the vulnerable people. Thus, people who benefit from social protection schemes run by governments and non-governmental organisations include the poor and marginalised.

Social protection plays the pivotal role in child protection of ensuring that children access basic needs. As highlighted earlier on in the definition, social protection plays a critical role in child protection and thus, programmes are inclusive of child benefits like childcare grants, free treatment orders and foster care (Kamerman & Gatenio-Gaabel, 2007; Mushunje & Mafico, 2010). The mentioned benefits protect children from the harmful effects of poverty. As a result, member states have an obligation of ensuring that social protection is guaranteed

to groups in need, which include children (Blank & Handa, 2008; Taylor, 2008). Thus, each country has specific social protection interventions suitable for its context. To this end, cash transfers and child grants have been implemented to prevent poverty (Masuka et al., 2012; Mushunje & Mafico, 2010; Taylor, 2008). Literature on social protection reveals that cash transfers and child grants entail the disbursement of money to the recipients. These include cash transfers received by guardians of vulnerable children, foster care services, adoption services and institutional care grants (Kamerman & Gatenio-Gaabel, 2007; Masuka et al., 2012). In Zimbabwe, the government in partnership with UNICEF implemented cash transfer programmes where households of orphaned and vulnerable children receive cash which they in turn use to run small projects to supplement household incomes (Mushunje & Mafico, 2010). The child grants are a form of cash assistance provided by the government to support children. In the context of institutional care, the Zimbabwean government assists childcare institutions with grants worth US$15 per child per month (Masuka et al., 2012). Therefore, all in all, social protection plays an essential role in assisting parents and guardians to provide good care for children.

Social protection programmes are run worldwide. However, its prevalence is high in Southern Africa, East Africa, Asia and Latin America (Adato & Basset, 2009; Devereux & Vincent, 2010). This can be attributed to the fact that most of the countries located in the mentioned continents are still developing, and therefore have high numbers of poor people.

The main advantage of social protection is that its inclusiveness in structure ensures that everyone across the board is protected from various risks. Thus, social protection provides assistance to poor people who cannot afford contributory social protection schemes like maternity, medical aid and pension (Kamerman & Gatenio-Gaabel, 2007; Taylor, 2008). There is a potential high risk of loss of cash during transfers as noted by Devereux and Vincent (2010). It is assumed that losses are likely to happen due to robbery or even when handling cash.

3.7 SUMMARY

Child protection is designed to offer protection services to children in need. It seeks to and provides children an environment that is proper for their full development. This is achieved through the use of relevant theories, international and regional instruments, pieces of legislation, various child protection strategies and social protection schemes. It should be

noted that children end up in institutions mainly when families fail to look after them, or when other alternative options for child protection are not suitable for the child's circumstances (African Charter, 1999; Gwenzi, 2018; Kaime, 2009; Milligan, et al., 2017; UNCRC, 1989).

The environment in institutions should be conducive for the physical, cognitive and social emotional growth of children. It should meet the needs of children and groom them into responsible future citizens. Institutional care has been criticised as not being conducive to childcare. In spite of criticism, institutional care, is still in existence in several countries including Zimbabwe, and is likely to be there in the foreseeable future due to poverty and other attendant evils.

As depicted in some parts of this chapter, Member States take part in dealing with child protection issues, and specifically institutional care. It is against this background that the next chapter will focus on child protection and institutional care, specifically in Zimbabwe.

CHAPTER FOUR:
CHILD PROTECTION AND INSTITUTIONAL CARE IN ZIMBABWE

4.1 INTRODUCTION

This chapter seeks to review literature on child protection and institutional care in Zimbabwe. Various authors observed that child protection services in Zimbabwe are provided both informally and formally (Chibwana & Gumbo, 2014; Parry, n.d; Powell et al., 2004). As highlighted in the previous chapter, informal child protection services comprise non-statutory protection services provided by the family and community; and on the other hand, formal child protection services are statutory and guided by national policies and legislation (Masuka et al., 2012; Mushunje & Mafico, 2010; Mutangadura, 2003; Roby, 2011; UN, 2011). Against this background, this chapter will explore literature on contemporary child protection practices in Zimbabwe. Furthermore, this chapter will explore the historical development of institutional care in Zimbabwe, its prevalence, legislation, and models of institutional care, roles played by the duty bearers, and the challenges faced in institutional care.

4.2 CHILD PROTECTION PRACTICE IN ZIMBABWE

Child Protection issues in Zimbabwe are multifaceted. Psychosocial issues often presented by Zimbabwean children include among others, depression, loneliness, fear, grief, bereavement, instability, anxiety, homelessness, inferiority issues and stigma (Chibwana & Gumbo, 2014; National Plan of Action For Orphaned and Vulnerable Children (NAP), 2004; REPSSI, 2007; UNICEF, 1992; Zimbabwe Country Strategy, 2014-2016). This section will focus on child protection issues and strategies used in Zimbabwe, inclusive of the international instruments, local pieces of legislation and policies, practitioners involved in childcare work and structures put in place by the government to deal with child protection issues.

Child protection practices in Zimbabwe are aimed at mitigating the HIV/AIDS and socio-economic effects on children. For instance, child protection deals with Orphaned and Vulnerable Children's (OVCs) issues in Zimbabwe which are varied, and have been largely attributed to the HIV and AIDS pandemic, and prevailing socio-economic conditions (Ministry of Health and Child Welfare, 2011; Mupedziswa, 2006; Mushunje & Mafico, 2010). Zimbabwe is one of the countries that has been affected by the HIV and AIDS

pandemic; therefore, it has a large number of orphaned children who need care and support (NAP for OVCs, 2004; NAP I for OVCs, 2004-2010; NAP II for OVCs, 2011-2015). It is estimated that the HIV and AIDS pandemic and socio-economic factors have resulted in 1.6 million vulnerable children, and 5 000 children who are living in institutions (Powell et al., 2004; NAP II for OVCs 2011-2015; National AIDS Council, 2011). From the aforementioned figures, it is clear that the number of vulnerable children exceeds the number of those in institutional care, hence most of the orphaned and vulnerable children are in custody of the extended family, foster family and very few with adoptive parents (Mushunje & Mafico, 2010; NAP II, 2010-2015). In addition to the pandemic, the macro-economic situation in Zimbabwe due to inflation, unemployment and national economic constraints resulted in poor households which are not able to provide for children's basic needs; culminating in 66% of all children living below the poverty line (National Action Plan For Orphaned and Vulnerable Children, 2011-15; National AIDS Council, 2011; Poverty Assessment Survey, 2003; ZIMVAC, 2010). It is estimated that about 1.5 million households, inclusive of 3.5 million children in Zimbabwe, are poor (NAP for OVCs 2011-2015; Zimbabwe Demographic and Health Survey, 2006; ZimVAC, 2010) and therefore need assistance. This magnitude of poverty has in some cases resulted in child abuse and child labour and affected the wellbeing of children (REPSSI - Zimbabwe Country Strategy, 2014-16; Zimbabwe Child Labour Report, 2004). In order to deal with this crisis, the Government of Zimbabwe is using various child protection strategies which are implemented by public and private agencies and guided by international and regional instruments, local pieces of legislation, policies and programmes (Chandiwana; 2009; Gurupira & Chikutuma, 2017; Kavishe, 2007; Masuka et al., 2012; Mushunje, 2006;). These child protection strategies are formal because they involve statutory procedures.

Based on the information above, the practice of formal child protection in Zimbabwe is modelled along foreign concepts that are linked to activities by the colonial British government that include the establishment of the Department of Social Welfare in 1948 (Mupedziswa, 1995; Wyatt, Mupedziswa & Rayment, 2010). This development resulted in the introduction of British child protection strategies in Zimbabwe, which was then Rhodesia (Bundy & Bundy, 2001; Kaseke; 1991). Notably, child protection practice has also been among other factors, influenced by the significant increase in the number of children who were made vulnerable due to effects of the HIV and AIDS pandemic, poverty and drought

(Chibwana & Gumbo, 2014; Kaseke, 1991; Powell et al., 2004; Wyatt, Mupedziswa & Rayment, 2010). Therefore, to minimise the impact of these problems on children, various childcare strategies have been implemented both formally and informally; and these were either inherited from the colonial system or formulated during the post-independence era. These strategies include foster care, kinship care, adoption and institutional care for children (Child Rights and Childcare for Caregivers in Zimbabwe, 2011; Chatiza, Marongwe, Dhlembeu, Mushamba, & Motsi, 2014; Powell et al., 2004) are implemented by various child welfare related organisations and coordinated by the Department of Social Services (DSS) (Powell et al., 2004; Wyatt, Mupedziswa & Rayment, 2010).

Zimbabwe has a childcare system that has similarities with those of other countries in sub-Saharan Africa. In precolonial Zimbabwe, the traditional childcare system placed the role of childcare on the family (nuclear and or extended) and the local community (Chibwana & Gumbo, 2014; Parry, n.d; Powell et al., 2004). As highlighted earlier on, formal childcare strategies were introduced by the colonialists, resulting in the existence of both traditional and statutory systems of care. Against this background, the Zimbabwe National Orphan Care Policy (1999) presents childcare strategies using a six-tier safety net system designed in order of preference as indicated next:

(i) Biological Nuclear Family
(ii) Extended Family
(iii) Community Care
(iv) Formal Foster Care
(v) Adoption
(vi) Institutional Care.

As indicated in this policy, it is clear that the Zimbabwean childcare system attaches value to the *biological nuclear family.* Therefore, all childcare practitioners in Zimbabwe arguably concur that children are better looked after in their families, and thus should remain in their families (Chibwana & Gumbo, 2014; Powell et al., 2004). Against this backdrop, the nuclear family is the most preferred form of care for all children in Zimbabwe. However, in spite of this strong preference, other children are being looked after by members of the *extended family* largely because the biological parents are deceased, have migrated to other countries in search of greener pastures (employment), or are not capable of looking after their children

(Chibwana & Gumbo, 2014). As a result, the extended family is regarded as a second option of care in cases where parents are not available (Ministry of Labour and Social Services, 2010; National Orphan Care Policy, 1999). This is due to fact that this form of care is less costly, children maintain their identity and caregivers fulfil the sociocultural obligation of social responsibility as highlighted earlier on in Chapter 3.

It is worthy to note that although the Zimbabwean childcare system was westernised by the colonialists as explained earlier on, community care is still existent in some parts of Zimbabwe. This type of care typically entails the community, comprising of non-relatives, looking after children who are not cared for by their nuclear and extended families (National Orphan Care Policy, 1999; Tolfree, 1995; National Plan of Action for Orphaned and Vulnerable Children, 2004). Some communities still use the 'Zunde raMambo' concept to store food for future use by families that would be deemed in need (Mushunje, 2006; Mushunje & Mafico, 2010). As observed by some scholars, in Zimbabwe, *community care* is prevalent in commercial farms, rural villages and peri-urban communities (Chibwana & Gumbo, 2014; NAP II for OVCs, 2010-2015; Parry, n.d).

The fourth safety net of child protection strategy in Zimbabwe is *formal foster care* as highlighted earlier on. This care entails non-relative care and is usually processed by DSS staff who assess the carers, monitor care, and disburse foster care grants to foster parents (Chibwana & Gumbo, 2014; Masuka et al., 2012). This form of care is regarded as the fourth option after nuclear family, extended family and community-based care, and is better preferred compared to adoption (Child Rights and Childcare for Caregivers Handbook, 2011; National Orphan Care Policy, 1999). Reasons for the preference are largely because it is temporary arrangement, state funded, and the child would not adopt the foster's family totem and identity as highlighted earlier on in Chapter 3.

The fifth safety net for vulnerable children in Zimbabwe is called *adoption*. This form of care is statutory and processed by probation officers in conjunction with the magistrate's courts. The probation officers assess cases, write reports and work with the magistrate's courts to process adoption orders (Ministry of Labour and Social Services 2010; Wyatt et al., 2014). As explained in Chapter 3, adoption is permanent; and thus, in spite of it being regarded as a safety net for children in need of care, adoption is not popular in Zimbabwe, specifically because of cultural implications associated with it (Chibwana & Gumbo, 2014; Parry, n.d;

Powell et al., 2004; Powell, 2006). In this regard, people are not comfortable with taking a child into the family with an unknown background due to fear of inheriting bad spirits which they believe, may be superstitiously residing in the unfortunate child (Howard et al., 2006; Roby, 2011).

The last safety net and least favoured option in childcare strategies is *institutional care*. This option is deemed as the last resort because of the detrimental effects it has on child development, growth and socialisation (National Orphan Care Policy, 1999; National Plan of Action for Orphaned and Vulnerable Children, 2004-2010; Powell et al., 2004). This concurs, with sentiments highlighted in the Attachment Theory in Chapter two, which contend that institutional care forces children to break bonds/attachments with biological relatives resulting in a wide range of emotional issues (Ainsworth & Bowlby, 1991; Bolwby, 1977, 1989; Dobrova-Krol et al., 2009; Zeanah et al., 2005). To this end, again as indicated in the Psychocoscial Theory, children with emotional issues find it difficult to overcome challenges they may experience at each stage of psychosocial development (Erikson, 1968; Berk, 2004; Hoare, 2002). Institutional care will be discussed in detail in the upcoming section.

4.3 INTERNATIONAL AND REGIONAL INSTRUMENTS AND LOCAL LEGISLATION ON CHILD PROTECTION IN ZIMBABWE

International instruments, local pieces of legislation and various policies as discussed, guide Child protection strategies. Zimbabwe is a signatory to international instruments namely the United Nations Convention of the Rights of the Child (UNCRC) (1989), the International Protocol for Alternative Care (Child Rights and Childcare for Caregivers in Zimbabwe, 2010; Masuka et al., 2012; NAP 1 2004-2010; NAP II 2011-2015). In this regard, Zimbabwe adheres to the requirements of the UNCRC and thus child protection practice mainstreams the four fundamental principles namely, *non-discrimination*, *best interests of the child, rights to life,* and the *survival and development and respect for the view of the child* (UNCRC, 1989). To explain in detail, in Zimbabwean child protection systems ensure that children are protected from all forms of discrimination and the best interest of the child is considered in all activities that involve children. Furthermore, it is clear that children in Zimbabwe's right to life, survival and development is adhered to, based on the contents of the constitution which stipulates that no-one is allowed to end another person's life; and also, the various Acts that make it an offence to kill a child (National Action Plan for Orphaned and Vulnerable Children Phase I, 2004-2010; Zimbabwe Constitution, 2013). Lastly, in line with UNCRC

fourth principle, the Zimbabwean Child Protection System respects children's views; and therefore, takes cognisance of children's participation and views (Chibwana & Gumbo, 2014; NAP II, 2011-2015).

The other child rights stated in the UNCRC (1989) that are upheld in Zimbabwe are summarised and indicated in the following Table.

Table 4.1: Children's Rights upheld in Zimbabwe

Children's Rights	Legislation available and/or activities done to uphold the rights
Right to protection against abduction and illicit transfer	*Child Abduction Act* (1996) to protect children against abduction and trafficking.
Protection from violence, abuse and neglect	*Sexual Offences Act* (2004) to protect girls and women against sexual abuse. In addition, *The Domestic Violence Act (*2006) that protects children from abuse and being forced to engage in harmful cultural practices like forced early child marriages, virginity testing and pledging girls.
Right to identity	*Birth and Death Registrations Act (1996)* that enforces the registration of all births and deaths of Zimbabwean nationals. In this regard, it is an offence not to process a birth certificate for a child.
Right to life and survival	The Zimbabwean Constitution that make is an offence to kill a person deliberately and also the *Criminal Procedure and Evidence Act (1996), Infanticide Act (1996), Concealment of Birth Act (1996)* that stipulate that it is an offence to kill a child.
Rights to health and education	Provision of free medical assistance for all children under 5 years. Provision of free medical treatment orders for orphaned and vulnerable children (Masuka et al., 2012; Mushunje & Mafico, 2010). All children are expected to go to school as stipulated in the Education Act, (2006).
Freedom from economic exploitation	The Zimbabwe Labour Regulations Act (1996) which restricts people from employing children.
Protection from illicit use of drugs	Children should not be allowed to use drugs including alcohol.
Right to express views and be heard, and freedom of thought, conscience and religion	Children are given an opportunity to express their views at home or in meetings, and are encouraged to participate in child-led committees which will be discussed later in this section (NAP for OVC, 2004). Children should be given

	freedom to join religions that they want to, and they should not be forced to be involved in religions in which they are not interested.
Right to be raised by a parent	The National Orphan Care Policy which prefers care by biological family to other childcare strategies.
Right to family reunification	Children, especially in institutional care or other forms of alternative care, have the right to reunite with biological family members.
Protection of children without families	As Indicated in the Children's Act (2001) and Children's Protection and Adoption Act (1996). All children in need of care should be protected and placed in a safe environment that is conducive for their development.
Rights of children with disability	Children with disabilities should be cared for without discrimination. To this end the country has institutions for children with disabilities. There is also a piece of legislation called the Disabled Persons Act (1996).
Right to protection of the Rule of Law	This entails respecting children and not assigning guilt on them pending criminal/conflict investigations. Children in conflict with the law should be rehabilitated and the country has institutions for children in conflict with the law.
Social integration of victims	Not isolating children or confining them to one place. Thus, those who reside in institutions should be given the opportunity to integrate with the society through holiday visits or other social activities.

Furthermore, the Zimbabwean Government is a signatory to the United Nations General Assembly Special Session*s (UNGASS) Declaration of Commitment on HIV* (2001) in which plans were made to request international donors to support Zimbabwean programmes that intended to benefit vulnerable and pro- social inclusion (NAP for OVC, 2004). The Government of Zimbabwe participated in the World Summit for Children in 1990 and 2002 and is a signatory to the Declaration on *A World Fit for Children* in which it set goals that were aimed at creating a child-friendly environment for children from 2002-2010 (NAP for OVC, 2004).

At regional level, Zimbabwe is a signatory to the African Charter, meaning that it adheres to the stipulations of the charter. Notably, as highlighted earlier on in Chapter 3, the charter calls

member states to uphold African values and restrict them from participating in cultural practices that are harmful to children and recognise the responsibility of the family and parents in childcare (African Charter, 1999; NAP for OVC, 2004). In this regard, Zimbabwe still attaches value to traditional models of care and contributions from traditional leaders (Mushunje & Mafico, 2010; NAP, 2004). In addition, the country discourages child marriages (Chibwana & Gumbo, 2014; Zimbabwean Constitution, 2013). More so, Zimbabwe also made significant commitments at a Regional Workshop on Children Affected by HIV and AIDS in Namibia in 2002 for the betterment of orphaned and vulnerable children by increasing political will, assessing OVCs issues, consulting stakeholders and developing a national plan of action for assisting OVCs (NAP, 2004).

At country level, Zimbabwe has enacted various pieces of legislation and formulated policies to ensure that childcare issues are handled effectively and efficiently. As depicted in Table 4.1, Child Rights and sections of relevant Legislation and/or actions done to uphold the rights of children, child protection services in Zimbabwe are guided by specific pieces of legislation namely, Child Protection and Adoption Act (1996), Guardianship of Minors Act (1996), Maintenance Act (1996), Child Abduction Act (1996), Birth Death and Registration Act (1996), Marriages and Divorce Act (1996), Children Act (2001), Sexual Offences Act (2004). However, some scholars argue that although some of these Acts and guidelines are well drafted, they are not being used or enforced because of resource constraints (National Action Plan for Orphaned and Vulnerable Children, 2004; Williamson & Greenberg, 2010).

Furthermore, there are a number of policies that have been formulated in a bid to meet the needs of orphaned and vulnerable children in Zimbabwe. Against this background, The National Orphan Care Policy discussed was formulated inclusive of Government ministries, non- governmental organisations, faith-based organisations, and the public (Masuka et al., 2012; NAP for OVC, 2004) to deal with issues of care provision for orphaned and vulnerable children. As highlighted earlier on, this policy highlights the safety nets for vulnerable children. The other policies existent in Zimbabwe include the National AIDS Policy (1999), The National Plan of Action (2004), The National Action Plan I (NAP II) 2004-2010 and National Action Plan 2011-2015, all focused on the protection of vulnerable children. Notably the National Action Plan 2011-2015 rests on four pillars namely strengthening the household economy, child protection, access to basic services, and programme coordination and management.

The Government of Zimbabwe also runs social protection programmes aimed at supporting orphaned and vulnerable children. These include the *Basic Assistance Education Module (BEAM*) that provides school fees to orphaned and vulnerable children, the *Public Assistance Programme* that provides support to needy families and children in the form of cash transfers, free medical treatment orders and drought relief, and the *National Strategy on Children in Difficult* C*ircumstances* that supports local authorities to collaboratively work with stakeholders dealing with children who need care; *OVC programmes* that are run inclusive of input from non-governmental organisations, faith-based organisations and community-based organisations (Kaseke, 2004; Masuka et al., 2012; Mushunje & Mafico, 2010; NAP, 2004). In addition, the Government of Zimbabwe developed a *National Case Management System* on how to assist OVCs, and there is also a tool kit known as the *Zvandiri tool kit* designed to guide practitioners on how to handle issues presented by children who are living with HIV (AfricAid Pamphlet, n.d; National Action Plan for Orphaned and Vulnerable Children 2011-2001; REPSSI Zimbabwe Country Strategy, 2014-2016).

In particular, various stakeholders are involved in implementing child protection strategies, among them, the Department of Social Services, social workers, magistrates, paraprofessionals, traditional leaders, non-government organisations, bilateral and multilateral organisations, faith-based organisations and community-based organisations (Dziro & Rufurwokuda, 2013; Kavishe, 2007; Masuka et al., 2012; Mushunje & Mafico, 2010; Powell et al., 2004). In connection with the point previously mentioned, the Zimbabwean Child Protection System uses the following structures to achieve its intended goals: District AIDS Action Committees, Victim Friendly Court Sub-Committees, Child Protection Committees, Child-Led Protection Committees and various Outreach/Family Strengthening Child Welfare Programmes run by NGOs who complement government efforts (Mushunje & Mafico, 2010; National Action Plan For orphans and Vulnerable Children, 2011-2015). It is worthy to note that the Zimbabwean system recognises the importance of child participation and therefore acknowledges contributions from child-led protection committees (Chibwana & Gumbo, 2014; National Plan of Action for Orphaned and Vulnerable Children, 2004-2010).

4.4 INSTITUTIONAL CARE IN ZIMBABWE

This section seeks to discuss institutional care in detail. As defined earlier on in Chapter 1, institutional care refers to a childcare practice where children reside at a place built for them

and receive care conducive for their physical, emotional and psychological growth provided by trained and salaried caregivers and practitioners (Chibwana & Gumbo, 2014; National Residential Care Standards, 2010; Powell et al., 2004). As indicated in the National Orphan Care Policy (1999), institutional care is regarded as the last resort among all childcare strategies. This is, as already stated earlier, due to the fact that institutions are not ideal environments suited for proper child development and the psychosocial care of children, and the environment influences and effects on the growth and development of children (Brown et al., 2006; Chibwana & Gumbo, 2014; Masuka et al., 2010). In light of this observation, a study carried out in Zimbabwe on institutionalised children from 10 children's homes revealed that institutionalised children presented concerns associated with, among other things, lack of opportunities to develop lasting bonds with caregivers (Powell et al., 2004; UNICEF, 1992). Bonding is a critical aspect of human development and as explained by Bowlby (1969), attachments that are secure and build foundations for good relationships in future. In view of this and for other psychosocial reasons, institutions are expected to provide an environment similar to the environment in an ideal family that is conducive for proper child development (Chibwana & Gumbo, 2014; Dziro & Rufurwokuda, 2013).

4.4.1 The history and prevalence of institutional care in Zimbabwe

As highlighted earlier on, institutional care is a foreign strategy for protecting children. This is due to the fact that its systems are different from the African culture which emphasises that all children in need of care should be looked after by their relatives (Dziro & Rufurwokuda, 2013; Mushunje & Mafico, 2010). In this line of thinking, the Zimbabwean traditional system places the role of childcare in the hands of the biological family (Muguwe, Taruvinga, Manyumwa & Shoko, 2011; Mushunje & Mafico, 2010). For these reasons, parents are expected to provide the basic needs of their children and in the absence of the nuclear family, the extended family takes over. The community of the child also plays a role by giving support to the child's family of origin. Long ago, traditional communities had strategies that were put in place to protect children who were vulnerable. These, as mentioned earlier on, included the *Zunde raMamambo* projects where communities had communal granaries which stored food for the orphaned and vulnerable children (Mhongera & Lombard, 2017; Mushunje, 2006; Mushunje & Mafico, 2010). These projects are still operational and effective in some rural areas, but not customary in towns. However, due to urbanisation, rising levels of poverty and HIV and AIDS pandemics, the placement of children in

institutional care appears to be one of the main options when children need protection and care. Although children are still being placed in institutional care, childcare practitioners still recognise the role of the family in childcare as most important, and therefore consider institutional care as the last resort (Masuka et al., 2012; National Orphan Care Policy, 1999; National Plan of Action For Orphaned and Vulnerable Children, 2004-2010).

The Ministry of Labour and Social Services (MoLSS), and the Department of Social Services (DSS) have the mandate to oversee all childcare institutions and, are also the custodians of all children in Zimbabwe. The state plays a critical role in protecting children and its efforts are complemented by international, local and voluntary organisations that are registered with the DSS (Kaseke, 1991; Mupedziswa, 1995; Wyatt et al., 2010). In addition, the government or the church or international non-government organisations and local non-government organisations run each of these institutions.

As highlighted earlier on, in the traditional Zimbabwean context, their family members looked after children and the British Colonialist Government introduced institutionalisation as part of the social welfare services in 1948 (Mupedziswa, 1995). Although institutional care has been in existence since then, Zimbabwean literature available is scanty and does not reveal the date of establishment of the first childcare institution. However, it is clear that the provision of childcare by family members was overtaken by institutional care due to a sharp increase in the number of children who needed care (Chibwana & Gumbo, 2014; Child Rights and Childcare for Caregivers Handbook, 2011; Powell et al., 2004; Williamson & Greenberg, 2010). It is evident that institutionalisation became prevalent when the number of orphaned and vulnerable children increased to the extent of exceeding the capacity of the communities and families to provide care. It is against this background that institutional care is still being considered as another key strategy of child protection and provided by both registered and unregistered institutions or children's homes (Muguwe, 2011; Powell et al., 2004). The registered institutions comprise childcare homes that are recognised by the DSS and have been awarded welfare registration numbers. They operationally abide within the existing childcare guidelines and regulations and are monitored by staff from the DSS. On the other hand, the unregistered institutions comprise childcare institutions that operate illegally as they are not recognised by the DSS. The total number of registered institutions varies from one year to another, and the number of children in institutions also differs from one institution to another. In 2004, all registered institutions were looking after 3 279 children,

while the unregistered ones had only 67 (Powell et al., 2004). In Zimbabwe, the number of registered institutions has increased over time. As explained earlier, statistics reveal that in Zimbabwe a total of 5 000 children are receiving care in various children's homes around the country (Chinake & Passaportis, 2012; REPSSI Zimbabwe Country Strategy, 2014-2016). In 2002, there were 45 children's homes and the number of registered institutions rose to 56 in 2003, owing to efforts by many faith-based organisations which continued to register more institutions (Matshalaga & Powell, 2002; Powell et al., 2004). By the year 2011, Zimbabwe had 72 children's homes on its registers (Muguwe et al., 2011) and in 2014, the number of registered institutions had risen to 90 (Chatiza et al., 2014) and in 2017, the number of institutions in Zimbabwe was not known (Gwenzi, 2018; Mhongera & Lombard, 2017).

Although it is not the preferred option in childcare, institutional care is still, and remains an important component of childcare services in Zimbabwe. As highlighted in the Child Rights and Childcaregivers Handbook for Caregivers in Zimbabwe (2011, p. 21), childcare institutions are regarded as "an indispensable element of child protection systems in Zimbabwe as there will always be children who are in need of places of safety temporarily". The Child Rights and Childcaregivers Handbook for Caregivers in Zimbabwe (2011) also highlights that the weakening of the extended family system resulted in poor kinship care or abuse of children, thereby paving the way for institutionalisation. This has in turn led to an increase in the number of children who may be considered for institutional care.

In a bid to reduce the number of children in institutions, as well as ensure that children grow up in their families of origin or family environment, institutions in Zimbabwe make tremendous efforts to reintegrate children back into the community. As noted by the Child Protection Society in Muguwe, Taruvinga, Manyumwa and Shoko (2011), a total of 801 children were reunited with their biological or extended family members. The reintegration process involves tracing the relatives of children in residential care and reuniting the children with their relatives. Another version of reintegration entails the provision of foster care by community well-wishers, and this happens during school holidays only or upon request (Rusike Children's Home, n.d). Although the aforementioned type of care is short and temporary, one of its advantages is that it exposes children to everyday family life and community life. Reintegration and reunification programmes are meant to reduce the number of children in institutional care and also to create an environment where children grow and develop in a society which nurtures their culture and beliefs (Matshalaga & Powell, 2002).

4.4.2 Legislation relevant to institutional care in Zimbabwe

The Zimbabwean Government is a signatory to the following international instruments: the United Nations Convention on the Rights of the Child (1989) which was ratified in Zimbabwe in 1992, the National Action Plan for Orphaned and Vulnerable Children (2004-2010, modified in 2008), the African Charter on the Rights and Welfare of the Child (1990) which was ratified in Zimbabwe in 1995, the Child Rights and Childcare for Caregivers Handbook (2011), the Guidelines For Alternative Care For Children (2010). This means that Zimbabwean legislation on child protection takes into cognisance some of the provisions recorded in the aforementioned international instruments. It can be argued that the Zimbabwean child protection systems, in particular institutional care, meet international standards.

Furthermore, Zimbabwe is also a signatory to the Southern Africa Development Community Regional Instruments. This means that institutional care in Zimbabwe also meets regional standards. Moreover, at national level, institutional care is guided by a number of policies and pieces of legislations. As observed in the National Residential Childcare Standards (2010), child protection operations inclusive of institutional care, are centrally administered by the Ministry of Labour and Social Services using guidelines and stipulations outlined in the Zimbabwean Children's Act (2001). This Act stipulates that children recognised as in need of care, are those whose parents are deceased, unknown, do not have the capacity to look after the child, or in cases where parents cannot control their children. This act is the major piece of legislation that guides the provision of institutional care services in Zimbabwe.

Other pieces of legislation which have been put in place to address children's issues are as follows: the *Education Act (2006)* which has stipulations on the administration of education in Zimbabwe and also addresses access to education for young children by specifying that all young children who are supposed to be in school should have access to primary education; the *Child Abduction Act (1995)* with provisions regarding the removal of children and procedures in the event of abduction; the *Customary Marriages Act (Chapter 5:07) (1997);* the *Marriage Act (Chapter 5 - 11 (1989);* the *Matrimonial Cause Act Chapter 5:13 (1996),* with stipulations on conduct of marriages and expectations in the event of irretrievable breakdown of marriages in Zimbabwe; the *Guardianship of Minors Act (Chapter 5 08 (1996),* which outlines the courses of action and the provisions for guardians; The *Maintenance Act*

(Chapter 5: 09) (1971 and amended in 1997) that covers stipulations regarding the upkeep of children whose parents are not living together; the *Domestic Violence Act Chapter 5:16*; (2006) which emphasises that it is illegal to pledge children in marriages, force them to marry early or participate in cultural practices that are harmful (Child Rights and Childcare for Caregivers Handbook, 2011); the *Deceased Estates Succession Act Chapter 6:02 (1996)* the *Customary Law and Courts Act Chapter 7:05 (1997)*; the *Magistrate Courts Act Chapter 7:10 (1996)*; the *Criminal Law Codification(1996)* and the *Reform Act Chapter 9:2*3 (1996). All these pieces of legislation seek to ensure that children are safe and secure, whatever their circumstances.

On the other hand, several policies have been put in place to protect children. These include, the National Programme of Action for Children 1992; the National Orphan Care Policy 1999; the National AIDS Strategic Policy 1999; the National Gender Policy; the National Action Plan for Orphaned and Vulnerable Children 2004 that was implemented from 2004 to 2010 (Ministry of Labour and Social Services, 2010; Masuka et., al, 2012). It was designed to meet the needs of orphaned and vulnerable children in Zimbabwe which includes psychosocial support and also facilitates access to basic necessities for all children. One of its key objectives then was decreasing the number of children not living with their family members by December 2005 (National Plan of Action, 2004). The other policy is the National Action Plan for Orphaned and Vulnerable Children Phase II 2011- 2015, which was formulated to deal with children's issues and follows on the National Plan of Action for Orphaned and Vulnerable Children of 2004-2010. The Policy assigns the Zimbabwean Government the responsibility of providing resources to children in institutions and is run by the government and UNICEF.

The pieces of legislation and policy explored above are critical in this study as they are designed and implemented to ensure that children in institutional care are provided with better services. As the study unfolds, the researcher will compare the stipulations in the pieces of legislation and the services offered in institutions so as to determine and describe the relevance of the existing services.

4.4.3 The models of institutional care in Zimbabwe

Different models of institutional care are provided depending on policies, frameworks and funding. According to Powell et al. (2004), there are two models of institutional care in

Zimbabwe, namely the dormitory style and family-based units, and these will be explained in detail

4.4.3.1 The dormitory style model

Initially, the dormitory model was used and it entailed children staying in dormitories based on sex and age, with facilities shared communally. Proponents for this model regard it as less costly, because children are housed in large complexes and looked after by a small number of caregivers and staff. However, although this model is cost effective, it has been criticised for not allowing children to experience an ideal family life and is scoring low on psychosocial support and care (Powell, 2004), mainly because the model does not provide a near family environment. Thus, children are housed in dormitories where they have minimal opportunities to do house chores, since caregivers do most of the work. As a result, this model makes it difficult for children to acquire life skills like cooking, housekeeping, communication with parents, how to deal with siblings and neighbours, and many other skills that are critical later in adulthood. Against this background, an undated document from the Chinyaradzo Children's Home revealed that the dormitory style is not good for children because it does not give them a full sense of belonging to a home. Furthermore, the same document highlights that the dormitory style hampers social development critical in child growth, and more specifically, the set-up of the dormitory style does not give children opportunities to manage siblings/family relationships and challenges that potentially arise in an ideal family set-up. The dormitory style of accommodation for children's homes is therefore associated with a number of negative factors. Hence in Zimbabwe, all the children's homes that had adopted the dormitory style at inception, were or are bound to convert their physical structures to family-based units (Powell et al., 2004).

4.4.3.2 The Family-based Model

The Family-based Model asserts that children stay in houses located at one communal place and are subsequently looked after by a caregiver whom they refer to as "mother''. They stay with other children whom they regard as siblings, and also interact with children from other houses located locally. Children do house chores and live in an environment almost similar to the one in an ideal family and villages (Chibwana & Gumbo, 2014; Powell et al., 2004). The Family-based Model is believed to be a more suitable model that can provide a family environment to children in need in institutions.

The advantages of this model are that unlike the dormitory style, children get exposed to what happens in an ideal family. As a result, this model provides a near family environment for children where they learn critical skills they would use after leaving the children's home. It seems the Family-based Model provides an environment that is more conducive for children to bond with caregivers and acquire age-related psychosocial skills. This is largely due to the fact that children stay in a family environment that is controlled by a mother figure who assumes motherly roles.

However, as noted by Powell et al., (2004), one of the shortcomings of the Family-based Model is that the family-based units/houses, are not located in communities where there are real families. This may result in the discrimination and prejudice of these children to an extent that at times they are attached 'labels' linked to the name of the children's home, for example a child is addressed to as *Mwana wekuNherera*, meaning child from an orphanage (UNICEF, 1992).

4.4.4 The role players in institutional care in Zimbabwe

Institutionalisation of children is done using multi-sectorial and multidisciplinary approaches and spearheaded by the DSS. The role players in institutional care are the Government, various childcare practitioners like social workers, caregivers and the community (Chibwana & Gumbo, 2014; Powell et al., 2004). A detailed explanation of the ways in which each of the role players contributes to institutional care is provided next.

The Government plays a major and leading role in institutional care for children in need through services provided by the DSS and the Ministry of Justice. The placement of children and the registration and supervision of the children's institutions lie in the offices of the DSS (Mupedziswa, 1995; Wyatt et al., 2010). Furthermore, children's homes are run by either the Government or faith-based organisations and private voluntary organisations as highlighted earlier on. These parties are expected to register with the DSS before commencement of service provision and in this vein, placement of children in institutions is processed by probation officers employed by the DSS. These officers have additional roles of monitoring the quality of services provided in institutions and on the impact on the children. The DSS on behalf of the state also disburses grants to institutions worth US$15 per child per month (Masuka et al., 2012). Again, the Government plays a major role through the Ministry of Justice which superintends operational legislation that promotes and ensures that all

institutional support and activities are the best interest of the children. In this vein, placement of children in the institutions is done with authority from the courts, following stipulations from the Children's Act (2001) section 14, 15 and 16 (Chatiza et al., 2014; Chibwana & Gumbo, 2014).

Other role players are institution-based social workers, who play a significant role of helping children to deal with social problems. From a generalised point of view, the mission of social work as observed by Nicholas, Rautenbach and Maistry (2009, p.5) is "to enable people to develop their full potential, enrich their lives and prevent dysfunction". This is achieved through the provision of effective and relevant services. This implies that the responsibilities of social workers employed in the child protection field, entail the creation of a safe environment for children and the provision of good care.

As highlighted earlier on, institutional care proceedings or probation work is handled by social workers. Most of the caregiving work outlines are assessed and recommended by social work experts. The DSS employs social workers to help people deal with social issues, including the welfare of children (Mupedziswa, 1995; Powell et al., 2004; Wyatt et al., 2010). Its framework is designed for probation officers, who are mainly social workers, to take care of the placement of children into institutions, supervision and monitoring whilst they are institutionalised and managing the discharging once they leave the institution.

Some children's homes also employ residential social workers to provide services to children placed at the homes. These residential social workers are, among other services, involved in the re-unification procedures aimed at reuniting children with their families (Chibwana & Gumbo, 2014; Wyatt et al., 2010). At times, social workers at the DSS liaise with residential social workers in institutions in order to effectively help children. In spite of the fact that the role of the social worker is critical in child protection, it is worthy to note that the same role is not being performed effectively. This has been attributed to low numbers of social workers available in Child Protection Teams, largely due to financial constraints which deter recruitment (Chibwana & Gumbo, 2014; Masuka et al., 2012; Wyatt et al., 2010). As a result, the number of social workers available on duty is limited to cope with the high caseloads. The ratio of children to social worker in Zimbabwe is pegged at 49, 587:1 (Chatiza et al., 2014; Wyatt et al., 2010). This shows that social workers deal with huge caseloads, which therefore affect their level of performance, competence and effectiveness. To confirm this,

some children's homes, were actually operating without social workers, meaning the professional social work input was not part of the service delivery in those homes, thereby putting children's needs at risk (Masuka et al., 2012).

The relatives or parents of children placed in homes play a pivotal role in the care provided to the child. Morally, they are expected to visit the child and at times spend the school holidays with the child (Chibwana & Gumbo, 2014). In some cases, the social workers recommend temporary placement of the child, which will be superseded by total care from parents or relatives.

Furthermore, the community also makes significant contributions in childcare in institutions. In this regard, concerned people from the community provide foster care services to children from children's homes. Well-wishers from the community thus take children from institutions to stay with them during school holidays, and return them when schools open (Chibwana & Gumbo, 2014; Matthew Rusike Children's Home Pamphlet, n.d).

4.4.5 The role of caregivers in institutional care

Institutionalised children are looked after by caregivers. Powell et al. (2004) note that institutions train caregivers on how to provide care for children. They add that a number of caregivers receive training from the Red Cross Society and the Zimbabwe Council for the Welfare of Children. There is a paucity of literature on training and required qualifications of caregivers in institutional care. The content of the training is also not well documented. However, as explained in the National Residential Childcare Standards (NRCCS) (2010), training is provided before caregivers are in contact with children. But as observed by the Child Rights and Childcare Handbook in Zimbabwe (2011), caregivers should have background that displays acceptable moral behaviour sound health and be literate, supportive of family set ups, act as good role models for the children, and be able to provide first aid and social emotional support to children. In addition, it also highlights that children's homes should recruit caregivers who are mature thinkers and maybe aged 25 years and older. This is due to the fact that caring for children is complex and should be done by someone who is mature and able to multitask.

The responsibilities of caregivers resemble those of a parent in an ideal family set-up. Caregivers look after children as well as supervise them while performing household chores;

they also carry out the responsibilities like teaching good manners, helpfulness, integrity, honesty, tidiness and respect for others, usually taken by a mother in a family set-up (Powell et al., 2004; Child Rights and Childcare for Caregivers in Zimbabwe, 2011; Chatiza et al., 2014). The quality of care given to the child is also a major component of institutional care. The NRCCS recommends a caregiver ratio of one caregiver to 10 children. It is believed that at this ratio, the caregiver would be able to provide good care to resident children.

4.4.6 Factors contributing to the institutional care of children in Zimbabwe

There are several factors behind the existence of institutional care as is revealed by literature. The major contributing factor causing children to be placed in institutional care is poverty (Gwenzi, 2018; Milligan et al., 2017). This is linked to the macro-economic situation in Zimbabwe which has seen parents and other extended family caregivers lose their means of survival, therefore making it difficult, and in many instances impossible for them to provide proper childcare (Chibwana & Gumbo, 2014; Powell et al., 2004; Williamson & Greenberg, 2010). Research reveals that Zimbabwe has experienced economic decline from the late 1990s and this has increased the rate of inflation and unemployment (Chibwana & Gumbo, 2014; USAID, 2007). As a result, some families found it hard to fend for their children, and either neglected or abandoned them, thereby increasing the number of children who needed care (Mupedziswa, 2006; Mushunje, 2006; Mushunje & Mafico, 2010; Powell et al., 2004; Williamson & Greenberg, 2010). Some studies have indicated that in Zimbabwe there were 200 000 to 250 000 poor families and more than 3 000 children living in poverty (Children's Fund, 2010; Wyatt et al., 2010). Research also reveals that poverty increased at national level during the period 1995 to 2003, and this in turn increased the number of children who need care and support (Mushunje & Mafico, 2010; Poverty Assessment Study Survey, 2003). Presumably, a number of such children are absorbed by other child protection strategies, but institutional care remains the only option for those who become homeless or are ill-treated as a result of failure to meet their basic needs.

Lack of family strengthening and support policies and programmes in Zimbabwe also contributed to the disintegration mentioned. Family strengthening programmes help to ensure that the family remains intact (Chibwana & Gumbo, 2014; Williamson & Greenberg, 2010). Poverty and the lack of family strengthening programmes often result in family disintegration which in turn increases the vulnerability of children, as in the case of Zimbabwe. Limited

resource constraints at national level resulted in limited progress made to prevent family disintegration. As a result, there are many children from broken families who need care and institutionalisation emerged as the key option.

4.4.7 The challenges experienced in institutional care in Zimbabwe

Children residing in institutions are vulnerable and experience a number of challenges. UNICEF (1992) notes that in Zimbabwe, institutionalised children presented the following challenges, namely: lack of opportunities to develop continuous bonds with loving caregivers, identity problems with some labelled "Chiraswa" (vernacular word meaning those who have been thrown away); limited socialisation with and exposure to adult role model because the legislation compels children to leave the institution at the age of 18 years and start fending for themselves, despite the fact that this is not always practical (Mhongera, 2017; Powell, 2006). Furthermore, children from institutions tend to present with behaviour linked to high levels of stress as a result of their circumstances (Browne, 2009; Muguwe, 2012), which might manifest in stealing, bullying, displaying selfish and withdrawn behaviour.

Furthermore, institutional care presents an artificial environment for children which affect children's social life and personal management skills. Such an environment is controlled by schedules, policies and acts, and limits children to exercise their independence, and decision-making skills (Mhongera, 2017; Rakodi & Lloyd-Jones, 2002; Shanahan, 2000). As a result, some children find it difficult to take responsibility and live meaningful lives after leaving the institution.

Moreover, lack of resources and shortage of staff (Probation Officers) at the DSS also affect the period that children stay in the institutions. The minimal resources make it difficult for probation officers to process and trace relatives of children within appropriate time frames and also to prepare children for post-institutional care life (Gurupira & Chikutuma, 2017; Mhongera, 2017; Powell et al., 2004; Williamson & Greenberg, 2010). Research studies revealed that in Zimbabwe, the ratio of children to social workers was estimated at 49, 587:1; implying that social workers deal with huge caseloads and the chances are that they may not carry out their duties timeously (Chibwana & Gumbo, 2014; Wyatt et al., 2010). This might also lead to compromising the quality of their work, and consequently, sometimes children stay in the childcare institutions/ children's homes for longer periods, pending the reviewing

of court orders (Chatiza et al., 2014; Wyatt et al., 2010). In addition, lack of resources also affects the administrative process of childcare. It is not surprising that some of the planned work is not completely carried out and sometimes not carried out at all, due to the shortage of probation officers and/or lack of transport to carry out home visits.

Some of the challenges are linked to staff employed at institutions. The high turnover of social work practitioners experienced at the DSS, also spilled over to the field of childcare and resulting in a shortage of social workers (Masuka et al., 2012; Powell et al., 2004). Therefore, ill-equipped personnel who find it difficult to cope with high caseloads, having to work in an under-resourced environment, and cannot perform duties manage the DSS efficiently (Masuka et al., 2012; Mhongera & Lombard, 2017; Wyatt et al., 2010). In addition, there are no social workers employed by or rendering services in some children's homes, implicating that at times the psychosocial issues presented by children may not be addressed (Masuka et al., 2012).

Some of the challenges in institutional care are linked to costs. Some authors argue that raising a child in an institution is more expensive as compared to other forms of alternative care (UNICEF, 2010; Williamson & Greenberg, 2010). This in turn affects the quality of services rendered to children in the institutions. As stated previously, the Government, churches and private voluntary organisations with unique structures and different financial support run institutions. As a result, some institutions use the dormitory model, while others adopted the Family-based Model (Powell et al., 2004). The meagre resources have forced some homes to continue with the dormitory model which is deemed not to be conducive to child development.

The structures developed at some of the children's homes in Zimbabwe resemble foreign cultures and social contexts. As such, Powell et al. (2004) highlight that most institutions were built using guidelines written in the colonial era and as a result they followed the western models. It is also worthwhile to note that institutions that are supported by international donors, adopt models that resemble those of their foreign funders, and have thus been criticised for a lack of cultural sensitivity as children in these settings are subjected to a culture with no bearing to their own (Masuka et al., 2012; Tolfree, 1995; UNICEF, CASS & GoZ, 2010).

4.5 SUMMARY

Institutional care has always been one of the strategies in childcare. Although it is not the preferred strategy of care in Zimbabwe, it is still prevalent in Zimbabwe. Although it is guided by formal legislation and standards of care, this chapter explains that institutionalisation in Zimbabwe is practised and operationalised within specific models and it does play an important role, despite the valid challenges depicted in the literature. Having explored institutional care and the relevant international and local legislations frameworks and standards in terms of childcare, the next chapter presents the research methodology that was used to explore the experiences of the direct providers of the services, namely the directors of childcare institutions, the caregivers and the children residing in the institutions.

CHAPTER FIVE:
RESEARCH METHODOLOGY

5.1 INTRODUCTION

This chapter explores the research methodology in detail and its suitability for the study of childcare in institutions in Harare, Zimbabwe. This study was based on a qualitative approach and it used a multiple case study design. The participants comprised of key informants from the Department of Social Services in Harare, Zimbabwe, caregivers and children from four children's homes in Harare. The researcher collected data through interviews and focus group discussions. The raw data was analysed from the point of view of the participants. The following questions guided the research study:

1. What are the views of management and caregivers in childcare institutions in Harare about the appropriateness of services provided in relation to the developmental needs of children?
2. What are the experiences of caregivers in childcare institutions in Harare about the appropriateness of services provided in relation to the developmental needs of children?
3. In what ways do the childcare services in childcare institutions equip children with life skills critical for their development?
4. How do children experience the psychosocial support services provided in childcare institutions in Harare, Zimbabwe?

The research was aimed at exploring and analysing the views of management, experiences of caregivers and children about the appropriateness psychosocial-centred childcare services in childcare institutions in Harare. The secondary objectives for the study were to:

1. Establish the views of management on the nature of childcare services at different childcare institutions in Harare, Zimbabwe.
2. Investigate the experiences of caregivers as direct providers of psychosocial support services in childcare institutions in Harare, Zimbabwe.
3. Explore the experiences of children in institutional care as recipients of services provided in institutions.
4. Make recommendations regarding improving childcare services in institutions.

This chapter starts by describing the qualitative research methodology used in this study, followed by detailed descriptions of the research approach, design, sampling, data collection methods and data analysis. In addition, this chapter includes a discussion of the trustworthiness of data, ethical considerations and limitations of the study.

5.2 RESEARCH STRATEGY

As highlighted earlier on in the introduction of this chapter, this study was aimed at exploring and analysing the views of management, and the experiences of caregivers and children about the appropriateness of psychosocial-centred childcare services in childcare institutions in Harare. This involved the researcher collecting information from childcare institutions' directors, caregivers and children to find out whether the services provided in institutions met the children's needs and enhanced their psychosocial functioning. Against this backdrop, the study used the qualitative approach and specifically the interpretivism paradigm to explore the experiences of childcare institutions' managers, caregivers and children. In this regard, interpretivism or the phenomenology in which the qualitative approach is embedded is a paradigm that focuses on the significance of people's actions and participation in social and cultural life, and seeks to understand the social and psychological issues from the perspective of people involved (Chowdhury, 2014; Elster, 2007; Vos, Strydom, Schulze & Patel, 2011; Walsham, 1995). In the context of this study, the paradigm was used to understand reality in childcare institutions, based on subjective experiences of directors, caregivers and children involved.

Furthermore, the procedures undertaken in this study had a bearing on interpretivism rather than the natural sciences. In this vein, interpretivism differs from the natural sciences approach because it acknowledges that human beings are different, provide different responses to phenomena, and reality is obtained from collecting data from people involved in a situation (Bryman & Bell, 2011; Grint, 2000). Therefore, the relationship between the researcher and the participants is critical in interpretivism. This is largely due to the fact that the researcher should collect data that is based on the subjective meaning of participants and emphatically understands their views (Bryman, 2012; Chowdhury; 2014; Elster, 2007). Against this backdrop, in this study, the researcher was the primary instrument of data collection and played a big role in creating an environment that allowed participants to express their thoughts and feelings about childcare services provided in institutional care settings. This was achieved through taking into cognisance the principles of communication

and social work like acceptance, confidentiality, non-judgement, the purposeful expression of feelings and a controlled emotional involvement (Biestek, 1957; Zastrow, 1995).

Linked to the above, is the methodology used in the study. Thus, the study used data collection methods that suit interpretivism, such as interviews and focus group discussions to collect information on participants' meanings, thoughts and feelings (Creswell, 2014; Silverman, 2010). These methods were useful as they allowed participants to express their experiences from a subjective point of view. Furthermore, the study used a thematic analysis of data, which involved sorting data into themes that emerged from the study and then analysing the subthemes (Braun & Clarke, 2006; Bryman, 2011; Silverman, 2010), and integrating them with direct quotations from participants and relevant literature to support or contradict the findings.

5.2.1 Approach

The research used a *qualitative approach* which is descriptive and exploratory in nature. As explained by Creswell (2008, p. 46), qualitative research is "a type of educational research in which the researcher relies on the views of participants; asks broad questions; collects data consisting largely of words(text) from participants; describes and analyses these words for themes; and conducts the inquiry in a subjective biased manner". This means that a qualitative research entails the collection of data from people in the form of what they say, think or describe. In the same vein, Babbie and Mouton (2001) define a qualitative approach as the one to "study human action from the insider perspective" (p.53). This means that a qualitative approach relies on the actions and input from people under study (Bryman & Bell, 2011; Durrheim, 1999). Therefore, this approach suits this study in exploring the experiences of the participants, which can only be explained from a subjective point of view. Thus, a qualitative approach was found suitable for this study due to two reasons. Firstly, the approach allowed caregivers and children to explore and describe their feelings, perceptions, meanings and experiences in institutional care. Secondly, it gave management the opportunity to reflect on, and articulate their views with regard to the practice of institutional care in Zimbabwe.

Applying a qualitative approach in the study had two advantages namely, creating an opportunity to ask open-ended questions, and allowing the researcher to probe. Firstly, the open-ended questions allowed for in-depth exploration of issues as participants are given the

opportunity and freedom to answer the open-ended questions in detail (Creswell, 2009; Folkestad, 2008). This happens when participants talk about issues and even raise matters in areas that are unknown to the researcher. The other advantage is the continuous opportunity to probe for more detailed input, and allowing flexibility in the research process (Chalhoub-Deville & Deville, 2008; Denzin & Lincolin, 2002). This absence of rigidity allowed the researcher to get more information even on additional subjects and issues that are raised by participants during the research process (Corbin & Strauss, 2008; Flick, 2011).

The disadvantages of the qualitative approach are that it relies on what people say, some responses tend to be very subjective and because the responses might be true for the context, they cannot be generalised to a larger population (Harry & Lipsky, 2014; Flick, 2011; Thompson, 2011). In addition, the researcher has to guard against and be aware of the fact that participants might give socially desirable answers during the research process.

5.2.2 Research design

A case study design, described as a plan that is followed by the researcher when conducting research (Creswell, 2007; Leedy & Ormrod, 2015; Mouton, 2001), was employed in this research study. Creswell (2009, p. 13) defines a case study design as "a strategy of inquiry in which the researcher explores in depth a program, event, activity, process or one or more individuals". There are different types of case study designs, and this study used a multiple case study design to explore the views of management on the childcare services offered in childcare institutions in detail, and to establish the experiences of caregivers and children in four selected institutions of childcare in Harare. The multiple case study research design suited this study as it allowed participants to reflect on and give an insider view of their experiences (Gillham, 2000; Sarantakos, 2013; Stake, 1995).

The main advantage of a multiple case study design is that the researcher can explore the occurrence of the same matter in different settings and reflect on the effect thereof (Yin, 1994; Zaidah, 2003; Zaidah, 2007). The researcher collected data on views of directors about childcare services and the experiences of children and caregivers about the childcare services from four different childcare institutions, managed by different structures. The church is managing one, the second is managed by the Government of Zimbabwe, the third by an international non-governmental organisation and the fourth by a local non-governmental organisation.

The disadvantage of the multiple case study design is that it is time consuming as the researcher is collecting data from more than one setting (Yin, 1984; Zaidah, 2007). Furthermore, the findings from a multiple case study contextualise the collected data in relation to the specific settings, and it cannot be generalised to the wider population (Gray, 2009; Tellis, 1997; Yin, 2003).

5.2.3 Population and sampling

A population comprises of the total number of people targeted by the study where a sample is collected (Bryman & Bell 2011; Durrheim & Painter, 2008). In this study, the population comprised of 56 caregivers employed by four different childcare institutions, 439 children who were residing in the four different institutions, and five directors of whom four were the directors of the four different childcare institutions and one was the Director of Child Welfare from the Department of Social Services in Zimbabwe.

The study collected samples from caregivers, children and directors using purposive sampling which shall be discussed below. A sample consists of people, systematically selected to participate in a study on behalf of the entire population (Durrheim, 2008; Tailor, 2005; Walliman, 2011). In this study the sample of caregivers and children consisted of the following:

- Five to six caregivers per children's home, who had been employed by the institution for at least a year or more, and who had received formal training in childcare services provided by the institution and were directly taking care of the children.
- Five to seven children per children's home who were residing in the home for a period of at least one year. The researcher selected five to seven children participants who were still in primary school from two of the institutions and five to seven who were in secondary school from the other two institutions. As a result, 10 to 14 primary school participants and 10 to 14 secondary school participants were sampled. The purpose of selecting children from primary and secondary schools was to create opportunities for the voices of children from different developmental stages, to be heard.
- In addition, five key informants, one director per childcare institution and the Director of Child Welfare from the Department of Social Services were

approached to participate in the study due to their expert knowledge in the field of study.

Owing to the qualitative nature of the study, purposive sampling, a type of non-probability sampling, was used to draw samples for caregivers, children and directors who participated in the study. Purposive sampling involves the selection of participants based on the needs of the study and judgement of the researcher (Babbie & Mouton, 2001; Baker, 1994; Creswell & Plano Clark, 2011). Therefore, this study selected participants who had been exposed to services provided in childcare institutions. In this vein, the sample consisted of caregivers and children who had been in the institution for a period of not less than one year, and directors who were managing childcare institutions for an unspecified period.

The advantage of purposive sampling is that since it is based on the judgement of the researcher, there are high chances of getting suitable participants for the research (Bernard, 2002; Denzin & Lincoln, 1994).

There are disadvantages to the use of purposive sampling. In this regard, using purposive sampling can be subjective, resulting in the researcher unintentionally skipping other important participants or getting biased unknowingly when selecting participants (Etikan, Musa & Alkassim, 2016; Gray, 2009; Zhi, 2014). Furthermore, the findings from a sample selected using purposive sampling are limited to the population that was studied only (Baker, 1994; Zhi, 2014).

With regard to recruitment, the researcher sought permission from the Director of Social Services in Zimbabwe to undertake the study in four institutions. Permission was granted and then the researcher presented the permission letters to the institutions and requested to conduct focus group discussions with caregivers and hold interviews with children in the four childcare institutions. All four the institutions granted the researcher permission to collect data from caregivers, children and directors. The researcher held a meeting with caregivers to build rapport and trust with them, explain the purpose of the study, discuss the content of the participant information sheet (Appendix A) and asked them to sign a consent form (Appendix C). The researcher also spent a day with children at each of the four institutions to observe and understand a day in the life of a child in institutional care. This afforded the researcher an opportunity to meet with the children informally and observe them while they were doing their everyday activities. The researcher played games with the children so that the children

would become acquainted with the researcher. On the following day, the researcher held a meeting with the children to further build a good rapport, explain the purpose of the study, discuss the content of the participant information sheet, and asked them to sign consent forms (Appendix D). Furthermore, the researcher held meeting with the directors of the institutions and one director from the DSS. After these introductory meetings, the researcher then conducted focus group discussions with caregivers and interviews with the children and directors.

5.2.4 Research instruments

The study used three different instruments, which are an interview guide for children, another interview guide for directors, and a focus group guide for caregivers.

The two interview guides were semi-structured (Appendices E and F). A semi-structured interview guide comprises questions that are presented flexibly in such way that participants can explore and explain issues in depth (Bryman, 2012; Greeff, 2011; Hesse-Biber & Leavy, 2011; Kvale, 1996; Ritchie & Lewis, 2005). The interview guides were designed using English language, which is the official language in Zimbabwe. The advantage of semi-structured interview guides is that they are not restrictive; rather they allow participants to respond to questions asked and also add additional relevant information (David & Sutton, 2004; Gillman, 2000; Gray, 2004; Gray, 2009; Patton, 2002). On the other side, the disadvantages of interviews are that some participants may not have adequate responses as needed, and interview sessions may be highly subjective since the researcher has more control over the proceedings (Bryman, 2001; Corbett, 2003). As indicated earlier, the study also used a focus group guide which had questions that were administered in focus group discussions. The main advantage of the focus group guide is that it helps the researcher to remain focused, in a group where different views on the same subject are collected (Bryman, 2012; Gray, 2009). In the same vein, focus group discussions provide an environment where participants discuss issues in depth, argue and reach a consensus (Babbie & Mouton, 2001; Munday, 2006; Warr, 2005). This helps the researcher to collect multiple data at the same time. The disadvantages of a focus group guide are that sometimes the questions may influence the magnitude of control the researcher may have on the group, and therefore restrict participants to talk about certain issues and leave some. Focus group discussions also

provide little information about participants' lines of thinking (Babbie & Mouton, 2001; Madriz, 2000; Morgan 2002).

Noteworthy is the fact that interview and focus group guides designed for children and caregivers, respectively, were translated into the local vernacular (Shona), so that participants who found it difficult to express their feelings and experiences in English used their mother tongue.

5.2.5 Pretesting of instruments

Pretesting of the instruments was conducted before the main research so as to identify and address ambiguous items on the research instruments. It served the purpose of ascertaining the relevance of the items on the instruments, as well as determining the amount of time required per session for the interviews (Bowden, Fox-Rushby, Nyandieka & Wanjau, 2002; Bowling, 2009; Brown, Lindenberger & Byrant, 2008; Cohen, Manion & Morrison 2007; Faux, 2010; Sarantakos, 1998).

The researcher was granted permission to pretest research instruments at another childcare institution managed by Shungu Dzevana Children's Home in Harare. Purposive sampling was used to select the participants for the pretest. The researcher conducted interviews with the director of the childcare institution and six children at primary school level and four children at secondary school level. A focus group discussion was held with six caregivers based at the home. This activity then helped the researcher to make the necessary changes to the wording of questions and handling of interviews and focus group discussions. The outcome of the pretest revealed that the instruments were relevant and clear. The researcher made only one adjustment on the translated version on one question in a semi-structured interview guide for children. The data collected during the pretesting of the instrument was not incorporated as part of the data analysed in the research study.

5.2.6 Method of data collection

The collection of data during qualitative research has to be a rigorous process to contribute to the trustworthiness of the study. As explained by Creswell (2009, p. 178), "the process of data collection includes setting the boundaries for the study, collecting information through unstructured or semi-structured observations and interviews, documents and visual materials, as well as establishing protocol for recording information". For purposes of the research

study, in-depth interviews were held with key informants and children and focus groups were held with caregivers in an attempt to collect rich data which can be analysed and interpreted in terms of specific themes and discussed in relation to the objectives of the study. Noteworthy is the fact that before collecting data, the researcher furnished the participants with a participants' information sheet which explained the details of the researcher, the purpose of the study, and other information regarding the study (Appendix B). In addition, the participants who volunteered to participate in the study were given a consent form to read and sign (Appendix C).

The interviews for the directors were mainly conducted in English, and children had an option to use their vernacular. The study used interviews with children and directors because they allowed the expression of subjective meanings and lived experiences by participants, and also contributed to the collection of rich data for the study. According to Kvale (as cited in Greeff, 2011, p. 342), "qualitative interviews are defined as, attempts to understand the world from the participant point of view, to unfold the meaning of people's experiences and to uncover their lived world prior to scientific explanations". The interviews for children lasted not more than thirty minutes and those for managers lasted not more than one hour. They were conducted in a private room located at each of the four childcare institutions. The advantages of an interview are that the researcher has control over the questions and can probe during the interview to ensure the collection of rich data, which the participants can provide about their experiences of past and present events (Bryman, 2012; Kvale 1996). The disadvantage with interviews is that participants from the different institutions might not feel free to share their experiences and instead give socially desirable answers. They might also feel threatened because of face-to-face sessions conducted which may not warrant anonymity to the researcher or scare them (Babbie & Mouton, 2001; Sarantakos, 2013). However, appropriate interviewing skills were used during the individual interviews with the different participants in order to allow them to feel comfortable to share their unique views and experiences.

The study also used focus groups which are defined by Greeff (2011, p. 360) as "group interviews". They are described by Krueger, cited by the same author as, "a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment (p.361)." This means that focus groups use a guide which was described earlier on, in order to collect information. Focus groups allow participants to share

with others what they have gone through in their lives (Bryman, 2012; Greeff, 2011). These focus groups were held with caregivers at their childcare institutions at a venue that warranted privacy and lasted not more than one and a half hours. The researcher played the role of facilitator and the discussions were tape recorded. The advantages of focus groups as explained by Krueger (as cited in Babbie, 2010) are that they are suitable for collecting data on real-life experiences, flexible, quick to produce results, and cheap to run. Focus groups also accommodate participants who are afraid of one-to-one interview sessions with the researcher (Bryman, 2012; Madriz, 2003). The disadvantages, as highlighted by the same author, are that the researcher should possess special skills to moderate the group, analysis of data might be cumbersome, and that the group process may be affected if conflict arises amongst participants (Bryman, 2012; Kitzinger, 1994; Kvale, 1996;). The other disadvantages are that other group members might influence participants and they might not feel free to share their experiences and might also give socially desirable answers (Kamberelis & Dimitriadis, 2005; Morgan, 2002). With regard to logistics, separate focus groups for caregivers per institution were conducted. The initial focus groups were conducted to collect data from caregivers. The second focus groups were conducted to check analysed data and clarify or explore data collected in the first focus groups. In total, the researcher conducted eight focus groups with caregivers in the four different childcare institutions.

As indicated by Babbie and Mouton (2001) and Bryman (2012), an audio tape recorder was used to record all the interview sessions as a way of ensuring that verbatim data was available to be transcribed for purposes of data analysis. As explained earlier on in this chapter, all interviews and focus group discussions were tape recorded with the consent of the participants (Appendices C, D, I, J, K, L, M and N).

The advantage of tape recording is that it is one way of storing actual verbatim messages as they are, for analysis. In this vein through tape recording, the researcher can listen to what participants said over and over again and can analyse the actual participants' messages several times later (Bryman, 2012; Chenail, 2009; Gray, 2009). However, the disadvantages of tape recording are linked to costs incurred, and the fact that some participants may be scared to be recorded and this may compromise their responses (Bryman, 2012; Sarantakos, 2013).

All in all, the interviews and focus group discussions were held on dates and times that suited the participants. The process of data collection lasted two and a half months.

5.2.7 Method of data analysis

The analysis of qualitative data is a continuous, involving and a complex process. It involves perusing the collected data and coming up with meaningful interpretations. According to Creswell (2009, p. 184), "data analysis is an on-going process involving continual reflection about the data, asking analytic questions and writing memos throughout the study". It should be noted that the method of data analysis depends on the type and design of the research. In this vein, a qualitative dimension was embedded on interpretive analysis or phenomenology discussed earlier on in this chapter, meaning the data was analysed from the lived experiences of participants (Bryman & Bell, 2011; Creswell, 2012). The study used qualitative data analysis, in particular thematic analysis, which is defined by Braun and Clarke (2006) as "a method for identifying, analysing and reporting patterns (themes) within data and minimally organises and describes data set in detail" (p.79). Against this backdrop, the process of data analysis entailed putting together all data *item* or pieces of data collected in order to get the data *corpus* or all data that was collected (Bernard, 2000; Braun & Clarke, 2006; Terre Blanche, Durrheim & Kelly, 2006), followed by the identification, sorting and coding to get the data *extract* which was used during analysis (Braun & Clarke, 2006; LeCompte & Schensual, 1999; Patton, 1990) This was followed by a thematic content analysis of subthemes that were drawn from information gathered from the participants which entailed analysis, interpretation and integration with literature review and theory (Boyatzis, 1998; Braun & Clarke, 2006; Braun & Wilkinson, 2003; Tuckett, 2005). A more detailed explanation is in the following paragraph.

This paragraph seeks to explain the phases of data analysis that were adopted in this study as outlined by Braun and Clarke (2006).

Phase 1: Familiarising with raw data

The analysis process started during collection when the researcher took down important notes and attached meaning to them. During this phase, the researcher repeatedly read and reread the data corpus or all the data collected which comprised field notes and voice recordings from interviews and focus group discussions held. The mentioned data was transcribed

meaning all the tape-recorded data was put into words or texts (Lapad & Lindsay, 1999; Riessman, 1993).

Phase 2: Generation of codes

This phase involved the generation of codes which, as explained by Boyatzis (1998), "identify a feature of data that appears interesting to the analysts, and refer to the most basic segment, or element, of raw data that can be assessed in a meaningful way regarding the phenomenon" (p.63). This process was done manually and codes were set depending on the data that was collected (Braun & Clarke, 2006; Kelle, 2004).

Phase 3: Generation of themes

This involved the generation of themes from the coded data. These are conceptualised with responses that are recurring (Babbie & Mouton, 2004; Patton 2002). These themes were generated from the various responses in the form of words, explanations and experiences on one question that was given by participants.

Phase 4: Reviewing the themes

As the name sounds, this phase involved refining the themes by rereading the themes, dropping other themes that did not have enough data to support them, separating other themes that sounded complex, and remaining with themes deemed valid for the study (Braun & Clarke, 2006; Patton, 1990).

Phase 5: Conceptualising and attaching names to the themes

This involved the further refinement of themes. In this regard, the study defined themes by attaching names and explored the subthemes (Braun & Clarke, 2006). Thus, for each group of participants, the study came up with two categories of themes and subthemes that were linked to each category.

Phase 6: Report writing

This final phase involved the writing of a thematic analysis report using the themes. These themes were supported by evidence from participants in the form of quoted responses on participants' lived experiences (Braun & Clarke, 2006; Creswell, 2012; Flick, 2009; Merriam, 1998). In addition, the themes were integrated with theory and arguments from literature reviews (LeCompte & Schensual, 1999; Miles & Huberman, 1994; Wolcott, 1994).

At this point, the researcher was then able to make arguments, deduce the gaps, pose questions and suggest recommendations.

5.3 TRUSTWORTHINESS OF THE STUDY

The following four aspects contributed to the trustworthiness of the study namely, credibility, dependability, transferability and confirmability (Babbie & Mouton 2001; Bryman, 2012; Williams & Morrow, 2009). These aspects were incorporated in this study as explained next.

Credibility entails the degree to which the study measurements used in the study are accurate. In this context it is the level to which the real experiences of the participants match with what people say about them (Babbie & Mouton, 2001; Shenton, 2004). This study ensures credibility as:

- The researcher conducted fieldwork for a longer period until she had reached a point where she felt that she had reached saturation point (Lincoln & Guba, 1985; Shenton, 2004).
- The researcher used triangulation of data collection methods namely key interviews, interviews and focus discussion. This resulted in the triangulation of data from the director of child welfare, directors of institutions, caregivers and children, and was done as a way of checking on the qualitative validity of the findings (Babbie & Mouton, 2001, Bryman, 2012; Silva & Wright, 2008).
- Relevant documentation, e.g. annual reports, training manuals, policies and procedures, guidelines and pamphlets with detailed information about the institutions were perused. These documents provided information which might have been left out by the participants and is likely to provide an overview and full record in writing about the history and future plans of the institutions (Shenton, 2004). This contributed towards the trustworthiness of the study by ensuring that the information collected from the participants concurred with the written documents.
- The researcher recorded all interviews and kept a record (field notes) of all observations during the interviews.
- In addition, data collection procedures were clearly outlined to ensure that participants provided relevant data and that there was no loss of meaning when transcribing data from participants' vernacular to English.

Transferability is defined by Babbie and Mouton (2001, p.277) as "the extent to which the findings can be applied in other contexts or with other respondents". Transferability was achieved through:

- The use of one data gathering method for each category of participants (Babbie & Mouton 2001; Guba and Lincoln, 1994; Shenton, 2004). In this regard one key informant interview, interviews and focus group discussions were held with directors of institutions, children and caregivers respectively.
- The study taking cognisance of boundaries in light of the participants and the lengths of period for data collection (Babbie & Mouton 2001; Shenton, 2004). Against this backdrop, the study collected data from a selected number of participants; held interviews which lasted not more than thirty minutes for children, not more than one hour for managers and caregivers, and focus group discussions in not less than one and a half hours. In this vein, as explained earlier on, the researcher used purposive sampling to select participants based on the needs of the study. Thus, in the study, children aged 9-12 years and those aged 13-18 years were interviewed to get the voices of children at different ages. The researcher also selected caregivers who had been with the institutions for at least one year, based on the assumption that they are familiar with operations in the institutions. In addition, the study interviewed five key informants.

Confirmability is conceptualised as the extent to which the research findings' participants' information was devoid of biases from the researcher (Babbie & Mouton, 2001; Pratt, 2008; Shenton, 2004; Spencer, Ritchie, Lewis & Dillon, 2003). To guard against the researcher's bias, the study used the triangulation of multiple methods of data collection described earlier on namely key informant interview, interviews and focus group discussions (Shenton, 2004). Moreover, the research has evidence needed for an audit trail that was based on a data oriented approach (Guba and Lincoln, 1994; Shenton, 2004), which is available in the form of recorded audio tapes, field notes, and the actual findings from the study.

Lastly, *dependability* is the extent to which the same results can be obtained from the same participants following a repeat of the study (Babbie & Mouton, 2001; Bryman, 2012; Lincoln & Guba, 1986, Shenton, 2004). This was achieved through that triangulation of data from directors, caregivers, children and documents with information on the institutions.

Furthermore, a data audit was conducted and this entailed the review of information gathered in the field or from the various documents that the researcher came across.

5.4 ETHICAL CONSIDERATIONS

Ethical considerations entail the use of principles which will guide the research process and the conduct of the researcher (Bless, Higson-Smith & Kagee, 2006; Bryman, 2012; Silverman, 2010). The research took cognisance of the following ethical principles:

Social work Code of Ethics

The study observed professional ethics (Creswell, 2014; Punch, 2005). It was conducted in the field of Social Work and therefore was guided by the Social Work profession's code of ethics. This is a document that guides the social work practice worldwide, and outlines social work principles and values. As explained, the National Association of Social Workers Code of Ethics (2008) prescribes that social workers should evaluate programmes and policies. In addition, with regard to research, the document affirms that research should be carried out in a professional manner observing ethical principles discussed, like confidentiality, avoidance of harm, informed consent and voluntary participation. Furthermore, the code of ethics also highlights that the researcher should report findings accurately and avoid conflict of interest when undertaking research. In line with the aforementioned explanations, the study was carried out in line with Social Work profession requirements. It took cognisance of Social Work ethics namely confidentiality, avoidance of harm, informed consent and voluntary participation. These ethics will be explained as this section unfolds.

Submission of the proposal to the university's Research Ethics Committee

This Ethics Committee requires students to submit their research proposal to the academic institution's Ethics Committee. In this vein, the research proposal was submitted to the University of Witwatersrand Research Ethics Committee for perusal. The Committee assessed whether the study was academically well designed, professionally organised, and did not cause harm to the participants (Babbie & Mouton, 2001; Creswell, 2003; Creswell, 2014; Terre Blanche et al., 2006). Thus, assessments of this nature are done to ensure that students stick to the ethical procedures and everything is carried out in a professional manner. To this end, after assessing the research proposal for this study, the University of

Witwatersrand Ethics Committee granted the researcher permission and issued her a certificate with a Protocol number (H14/10/24).

Permission from institutions to do the research

Gatekeepers are people who control activities in the institutions as well as granting authority to outside interested parties wishing to gain insight into their activities (Creswell, 2003; Creswell, 2009; Heath, Brooks, Cleaver & Ireland, 2009). To this end, the researcher applied and was granted permission to carry out the study in four institutions by the Director of Child Welfare and Probation Services, which falls under the DSS. Directors of participating institutions also gave the researcher permission to conduct the study. The researcher was also granted permission to pretest research instruments at another children's home by the Director of Child Welfare and a Children's Home that did not participate in the study. (Appendices I, J, K, L, M and N).

Informed consent and assent

In observance of research ethics, the researcher sought consent from participants and assent before interviewing them. The British Education Research Association (as cited in Heath et al., 2009, p. 23) defines informed consent as "the condition in which participants understand and agree to their participation without any duress, prior to the research getting underway". This means participants were furnished with full information about the research, and they chose to participate knowing very well what the research was about (Ryen, 2004; Silverman, 2010). Such information included the name of the person doing the research, the aims, time required, and voluntary participation, maintenance of confidentiality and anonymity, and the use of help from professionals in case of triggers (Creswell, 2009; Gray, 2009). In this vein, after understanding the aforementioned, the caregivers and key informants signed a consent form, while children signed an assent form before participating in the research process (Appendices C and D).

Voluntary participation

Data was obtained using the principle of voluntary participation as opposed to forced participation of respondents (Creswell, 2014; Punch, 2005; Silverman, 2010). Thus, in the study, participants were not forced to take part. Those who participated did so on a purely voluntary basis.

Anonymity

The would-be participants were furnished with a participant information sheet which informed them among other things, that their identity and information would not be divulged (Creswell, 2014; Blanche, Durrheim & Painter, 1999). Anonymity means that the researcher will not use or reveal the real names of participants. In light of the aforementioned, the researcher did not write personal details of caregivers and children on the response sheet in the data presentation and analysis so that they would remain anonymous. The quotations cited on a section on the data presentation and analyses, do not bear the names of participants.

Confidentiality

This researcher took cognisance of the principle of confidentiality throughout the research. Confidentiality means that the researcher will not share information gathered from the participants without their consent (Babbie & Mouton, 2001; Punch, 1994; Westmarland, 2001). In this vein, the researcher treated details and information gathered from the directors with secrecy. The interviews were conducted at a venue which warranted privacy to the participants (Bryman, 2012; Greeff, 2011). In addition, the researcher recognised that confidentiality cannot be guaranteed in focus groups and therefore instructed participants to maintain confidentiality by not disclosing to other people, information discussed in focus groups. Raw data was also locked up in a safe place to ensure that data remained confidential and inaccessible (Silverman, 2010). Furthermore, written reports and recorded voice audios were put in a secure place and will be destroyed after six years.

Avoidance of harm

The researcher ensured that no harm was done to the participants. Before interviewing them, the researcher advised participants that the research might trigger emotions and as such participants had the right to withdraw or refrain from participation (Creswell, 2014; Silverman, 2010; Strydom, 2011). Interviews can trigger emotions in children; hence the researcher observed sensitivity and had made arrangements such that those who were affected would be provided with supportive counselling from a qualified counsellor (see Participant information sheet for Caregiver and Key Informants & Children Participant Information Sheet, Appendices A and B respectively.). As highlighted earlier on, the research proposal was submitted to the University's Research Ethics Committee that checked among other

things, that the participants were not going to be harmed. As mentioned earlier on, the University granted the researcher permission to do the study and issued her with an Ethics Certificate with a Protocol number (H14/10/24).

Analysis and publication of findings

Data was analysed and a complete research report was published in accordance with research ethics. The researcher analysed data as it is, and included both positive and negative aspects without exaggerating or minimising facts (Babbie & Mouton, 2001; Neuman, 2009). Participants got feedback on the findings and the participating institutions were given a copy of the research report. All effort was made to avoid plagiarism and this research will be published in reputable journals bearing the names of all people who made significant contributions (Babbie & Mouton, 2001; Creswell, 2014; Strydom, 2011).

5.5 LIMITATIONS

As highlighted earlier on, the study was based on a qualitative approach which relies heavily on messages and opinions from people and documentation (Bryman & Bell, 2011; Durrheim, 1999). As a consequent, chances are that some participants might have exaggerated or underrated their experiences in institutions for one reason or another.

The use of purposive sampling might have resulted in selecting a limited number of personalities and referained from consulting more children (Gray, 2009; Silverman, 2010; Zhi, 2014). As a result, the findings may not be representative of the views of all institutionalised children.

The educational levels of some participants could have restricted them in articulating views and some aspects regarding psychosocial issues that are probed during interviews. This means that despite efforts by the researcher to explain the concept of psychosocial issues, some participants who did not have a background in psychology or social sciences, might not have understood the conceptualisation, possibly affecting their responses, and subsequently the data collected.

Lastly, some participants might have provided socially desirable answers in interviews and focus group discussions held, due to fear of breaching the institutions' code of conduct with respect to confidentiality (Kamberelis & Dimitriadis, 2005; Morgan, 2002). As a result, the

researcher might have collected data comprising acceptable issues, and leaving those existing issues that are viewed as unacceptable.

Finally, the abovementioned factors might have compromised the data that was analysed, as well as the findings drawn and recommendations passed.

5.6 SUMMARY

This chapter explored the methodology that was used in the study from approach, sampling, collection of data and analysis. The next chapter will focus on the findings that were drawn from participants from the four institutions in Harare. It is noteworthy to read the institutional care experiences based on information collected from the children, caregivers, directors of institutions and the Director of Child Welfare. Such information provides a glimpse of the reality of what is transpiring in the four childcare institutions in Harare.

CHAPTER SIX:
PRESENTATION OF AND DISCUSSION ON MANAGEMENT VIEWS ON INSTITUTIONAL CHILDCARE SERVICES IN HARARE, ZIMBABWE

6.1 INTRODUCTION

This is the first of three chapters in which the findings of this study are discussed. This chapter will explore the views of management on institutional childcare services in Harare, Zimbabwe. These views are based on the data collected from the five key informants who were purposefully selected to participate in this study. The key informants were directors, one from the DSS, and one director from each of the four childcare institutions that participated in this study. In this chapter, the words manager and director will be used interchangeably to refer to a person with a top position of overseeing all the activities done and services provided in a childcare institution (Bloom, 1991a; Kagan & Bowman, 1997; Nupponen, 2006).This chapter will therefore focus on the first objective of the study namely to establish the views of management on the nature of childcare services at the different childcare institutions in Harare, Zimbabwe.To this end, the above-mentioned objective sought to establish the intrinsic appropriateness of services provided to children in institutional care. In light of the objective, this chapter answers the following research question:

- What are the views of management in childcare institutions about the appropriateness of services provided in relation to the developmental needs of children?

Furthermore, this chapter will also dwell on managers' views regarding childcare services that are aimed at equipping children with life skills critical in child development. So, this chapter will also focus on the study's fourth objective stated below.

- To determine how childcare institutions, provide services that equip children with life skills critical in child development.

It is vital to note that, managers' actions play a pivotal role in services provided in institutions, hence it was crucial to include them as participants in this study. The views of managers in childcare institutions on childcare services are critical because their thinking, knowledge and skills influence the strategic plans in terms of service delivery in childcare institutions (Kagan, 1994; Kagan & Bowman, 1997; Robert, Woodrow & Moreton, 1998). In

light of this, different themes were identified during the analysis of the data collected from managers. Two main themes were identified, namely appropriate services provided in childcare institutions and challenges with which institutional care services are confronted in their bid to provide this much-needed service. These themes will be presented and integrated with direct quotations from participants and relevant literature to support or contradict the findings. The themes and subthemes are presented in the following Table.

Table 6.1: Themes and subthemes on data collected from managers

Theme	Subthemes
1. Appripriate services in childcare institutions	a. Efficient management and leadership. b. The creation of a supportive family environment. c. Support from government through the DSS. d. Provision of relevant psychosocial support services to children. e. The provision of services that equip children to become well adjusted citizens in the society.
2. Challenges experienced in childcare services provided in snstitutions	a. Unrealistic or distorded expectations from children in alternative care. b. Financial challenges, dealing with staff members who do not care. c. Lack of adequate support from the government. d. Legislative procedures that are not practical.

6.2 PROFILE OF PARTICIPANTS

The five participants in the study comprised one director from the Department of Social Services and a director from four childcare institutions and Table 6.2 presents a profile of the four institutions that participated in the study and qualifications held by the directors.

Table 6.2: Profile of Childcare Institutions

Institution	Profile of the Childcare Institutions	Managers Professional Qualification
Department of Social Services (DSS)	This is the Government institution that is responsible for providing social services and social welfare services to child and adults in need of care. It was established in 1948 by the Colonial British Government and is regarded as the custodian of all children in Zimbabwe (Masuka et al., 2012; Mupedziswa, 1995) and therefore controls and regulates childcare work in Zimbabwe. Its efforts are complemented by Faith based Organisations, Local Private Voluntary Organisations and International Organisations.	Bachelor of Social Work Degree
A	Children's Home A is Faith Based Children's Home that is affiliated to a Christian Church. It was founded by Minister of Religion in the 1950s, to provide assistance to orphaned children. It has been operational since then and currently provides childcare services to children who are placed by the DSS.	Bachelor of Social Sciences Degree
B	Children home B is run by the Government of Zimbabwe, Ministry of Labour and Social Services – (DSS). The home was established in 1951 to accommodate boys aged 12 years only. In 1980, when the country gained independence, the home was granted authority to accommodate an additional number of girls. In 1997, the home adopted a new name, Children's Home B and its enrolment figure increased. Since then the home provides services to children in need of care	Bachelor of Social Work Degree
C	Children's Home C is local private organisation that was established in 1962 to provide places of safety for children. At inception the home used buildings that were designed to provide a dormitory style of accommodation to children. However, after taking cognisance of the negative effects associated with the dormitory style, the home adopted the family-based unit style and in 2003 all the dormitories were converted into family- based units. To date the home houses 58 children who stay in family units.	Bachelor of Social Sciences degree
D	Children's Home D is funded by International donors and affiliated to an international body that is active in many countries. It was founded	Bachelor of Social Work

	in Austria by a man who felt that every child needed a home to grow in. In Zimbabwe, Children's Home D has 2 other home located out of Harare but its first children's home was built in 1989. It also provides childcare services to children in need of care.	Degree.

In line with the research ethics particularly, anonymity and confidentiality, the study used pseudonyms in Table 1 to protect the identity of the institutions and participants and also to maintain confidentiality (Babbie & Mouton, 2001; Blanche, Durrheim & Painter, 1999; Creswell, 2014). A closer look at the table shows that the institutions that participated in the study have been providing childcare services for decades. This might mean that their systems have been tried and tested over the years and therefore are experienced in providing childcare services. Furthermore, as shall be discussed later on in this chapter, it is clear that the managers who participated in this study possessed qualifications in social sciences, meaning they had a very good understanding of children's psychosocial issues, relevant services provided by their institutions and the gaps that needed to be addressed.

6.3 APPROPRIATE SERVICES PROVIDED IN CHILDCARE INSTITUTIONS

This section will explore the first main theme that focused on services that are deemed as appropriate in institutional care. It will discuss the subthemes that emerged which are efficient management and leadership, the creation of a supportive family environment, support from government through the DSS, provision of relevant psychosocial support services to children, and the provision of services that equip children to become well - adjusted citizen in the society. These subthemes will be explained and supported by direct quotations and discussed in view of relevant literature and theoretical frameworks.

6.3.1 Efficient management and leadership

It emerged from the study that one of the key strengths of childcare institutions was the inclusion of a directorship/ manager position on their organograms. As portrayed in the study, each of the four institutions were manned by a director whose responsibilities included the day-to-day running of activities in the institution and the supervision of staff, as well as acting as the link between the institution and the outside community. In this vein, the study discovered that despite the complexity of the directorship role, all the institutions recognised

its importance in enhancing the quality of services provided. This was evident from the following responsibilities of the manager as explained by participants:

> *Responsible for caring, safekeeping and growth of all children, looking after properties, management of staff and fundraising.* (Participant 1).
>
> *To develop and coordinate activities at the institutions based on childcare programmes, supervise caregivers, recruitment, coordination, networking and implementation of policies from the board and the nation.* (Participant 2).
>
> *Focal person who links with the outside community, giving caregivers tasks and supervising them, accountable for all assets and to give care and support to children's homes.* (Participant 3).

As explained by Participant 1 above, the director's role entails ensuring that children are safe and growing well, looking after properties, supervising staff and looking for and managing financial resources. This role is complex as it is intertwined with expectations from the owners of the institutions, the beneficiaries, members of staff and the nation at large (Burton, 1999; Nupponen, 2005; Seplocha, 1998). Furthermore, the directorship responsibilities call for one to be very knowledgeable on childcare, as well as to possess good leadership and communication skills. It can be argued that managers who are knowledgeable are likely to be more familiar with their area of operation and competent enough to provide effective and efficient services that result in high quality management that enhances children's development (Adams & Phillips, 2001; Shim, Hestenes & Cassidy, 2004, Vandell, 2004). Notably, out of the five managers who participated in this study, three had qualifications in social work and two in social sciences disciplines. These two disciplines (social work and social sciences) are relevant in jobs that involve interactions with people and dealing with psychosocial issues (DuBois & Miley, 2010; Horner, 2007; Zastrow, 2010). Therefore, it can be argued that the childcare institutions that participated in the study are managed by persons who are qualified, knowledgeable. This is consistent with sentiments that place emphasis on why it is critical for managers in childcare institutions to have relevant knowledge, especially on child development, children's needs, legislative, and social contexts (Bergin-Seers & Breen, 2002; Nupponen, 2005). Furthermore, a detailed exploration of Participant 2's explanation shows that managers in childcare institutions are also responsible for coordination, recruiting of staff and communicating with the outside world. This means these

managers have huge responsibility in childcare institutions, of hiring the right staff members who will provide good quality services. Against this background it is vital for managers to have good skills in leadership, communication and supervision. Furthermore, Participant 3's contributions highlight the fact that managers have a responsibility of communicating with the outside world. In the context of childcare, the outside world comprises the community, the state, NGOs and other organisations, to mention but a few. Against this backdrop, when managers communicate with the aforementioned stakeholders, they link the institution with other service providers and the society at large. This is consistent with Bronfenbrenner's Ecological Theory (1979) that takes cognisance of the contribution of environmental factors in child development. Seeing that development is affected by changes in the environment, there is need for institutions to move with times and embrace contemporary societal aspects and relevant policies and guidelines to plan and render home childcare services in line with the 21st century life styles (Bronfenbrenner, 1999; Nupponen, 2005). In this regard, managerial services are appropriate and very important in childcare institution.

It emerged from the study that the other resultant factor linked to the knowledge of managers was the recognition of the multifaceted nature of children's needs. All participants concurred that child development is multifaceted and encompasses various aspects that contribute to the complexity of caring for children in institutions. This was evident from the following explanations from participants:

> *Children need food, shelter, love attention and to be heard*. (Participant 1).
>
> *Our children extremely need love. Because they lost it when they were young*. (Participant 2).
>
> *Children need recognition and to have positive bonds with caregivers.* (Participant 3).
>
> *Development is a wide word. Keeping children in the house is development, feeding them is development, teaching them gardening is development, sending them to school is development, monitoring their performance and behaviour is development, training them in various skills is development.* (Participant 4).
>
> *Children need birth certificates and identity cards*. (Participant 5).

The above-mentioned quotes highlight the needs of children and show that children have basic psychological, emotional and social needs. As highlighted by some scholars, children in institutional care carry with them the burden of difficult backgrounds that they experienced before admission. In this vein, some children present with issues that emanate from effects associated with separation from their primary caregivers, lack of early parental love and guidance, resulting in trauma, which in turn affected their development and social functioning, (Ainsworth & Bowlby, 1991; Bowlby 1969; Gurupira & Chikutuma, 2017; Jarolmen, 2014; Morantz & Heyman, 2010). In this regard, provision that meets children's needs becomes very critical in childcare institutions as these cater for curative and preventative aspects in child development. The curative aspect might be seen when institutions provide shelter, food, home, a caring caregiver to a child whose background had comprised none of these. This corroborates the arguments that meeting children's needs enhances development and psychosocial functioning (Hoare, 2002; Hook, 2002; Maslow, 1970).

Furthermore, participants reflected on how successful the different institutions were in meeting the needs of children as evidenced by the following responses:

> *We are meeting children's basic needs as we are providing them with shelter, food and access to education.* (Participant 2).

> *There are different psychosocial programmes at this institution that are provided to help children to deal with past or present painful experiences.* (Participant 3).

> *We teach our children various projects like poultry and gardening.* (Participant 4).

The above-mentioned responses show that institutions recognise that children's needs are multifaceted and inclusive of both basic and psychosocial needs, and that the provision of basic needs is fundamental during child development. As explained earlier on, meeting children's needs enhances the total development of children (Hook, 2002; Levine & Munsch, 2014; Pringle, 1985). When institutions meet children's needs, they raise children who will be able to live their lives in adulthood in spite of difficult circumstances encountered during childhood years.

The above-mentioned response by Participant 3 highlights that institutions have different psychosocial support programmes, implying that institutions go beyond providing material

needs to children in institutional care. With respect to this, the provision of psychosocial programmes gives children opportunities and coping mechanisms to deal with personal issues that may hamper growth, and also equip them with the required social skills.

Moreover, it is worthy to note that the managers recognised that children's needs can also be met by involving them in income-generating activities, as indicated in a response by Participant 4 who mentioned that institutions teach children income-generating projects like poultry and gardening. These projects equip children with skills that they may need in adulthood, such as to run their gardens or poultry enterprises and either use the produce for domestic consumption, or selling them, thus increasing household incomes, and contributing to the national economy. This is consistent with sentiments that emphasise that income-generating activities help to reduce poverty, eliminate hunger and encourage self- sufficiency (Khandker, 2003; Stewart et al., 2010; Weiss, 2003). Therefore, by encouraging children's involvement in income-generating projects, childcare institutions help prepare children to survive in the face of adverse economic conditions in the community after institutional care.

However, it was highlighted in the responses by managers that although institutions endeavoured to meet all children' needs and rights, they were experiencing challenges, particularly in the provision of birth certificates and identity cards which largely needs government intervention or input. This was evident in the following observations from participants:

> *The Government through the (DSS) takes too long to process birth certificates for children in institutional care; as a result, these children are sadly not allowed to participate in school coordinated sporting activities*. (Participant 1).

> *The delays in processing of birth certificates results in some children being discharged from institutions at 18 years of age without birth certificates or identity card, and therefore they experience problems in furthering their education, getting employment and accessing services that demand proof of identity.* (Participant 2).

As indicated from the response by Participant 1, the processing of birth certificates was taking too long, resulting in exemption of some children from sporting activities and others being discharged from institutions without any form of identification. This is contrary to legal and societal expectations that recognise that all children should have birth certificates

(Caplan, 2001; Scott, 1998; United Nations Convention on the Rights of the Child, 1989). Sadly, non-possession of documents that provide legal identity has a negative impact on children's social lives as they may find it difficult to identify themselves to responsible authorities, and more so, to social institutions like employment agencies, work places, tertiary education institutions or intercountry entry points. It is without doubt that in some cases, these children may experience embarrassment and hurt when having to involuntarily share their difficult backgrounds which caused them to stay in childcare institutions and then get discharged without legal identity documents. Again, this is likely to prolong Erik Erikson's fifth stage of identity crisis versus role confusion, as children will be finding it hard to identify themselves in the society (Berk 2007; Hoare, 2002; Hook, 2002).

6.3.2 Provision of noble services to children

This subtheme emerged as managers highlighted that the services provided in institutions were relevant and noble as evidenced by the following responses:

> *We are providing all the basic needs for children. In this case, children are going to school, have shelter, food and care. We also endeavour to trace children's relatives and reunite them with their biological families.* (Participant 5*).*

> *We prefer family-based care hence we are also involved in facilitating fostering and adoption and refer interested parties to the DSS.* (Participant 3*).*

> *We are finding it easy to empower children through the provision of life skills and access to education. This is being achieved by involving children in cooking, running poultry projects, sport and interaction with children from other homes.* (Participant 2).

> *Most of the training for caregivers is done well and we involve our partners to provide training in various aspects of childcare.* (Participant 1).

A closer look at the quotations above, shows that managers of childcare institutions recognise that provision of basic needs is vital in child development, as highlighted by Participant 1. Children in institutional care are provided with basic services like food, shelter and clothing. These services are critical in child development as they have an effect on the wellbeing of children during childhood and later in adulthood. For example, as explained by theorists,

persons with childhood experiences of going without food, ill-treatment and living in harsh environments, present various psychosocial issues like mistrust, insecurity, fear, anger and lack of confidence (Bowlby, 1969; Bronfenbrenner, 1979; Hoare, 2002; Maslow; 1970). It is therefore worthy to note that institutions in Harare are indirectly guarding against the development of the aforementioned negative psychosocial issues by meeting the basic needs of children under their care. The other highlights on the preference of family-based care and the provision of psychosocial support will be discussed in detail in other subthemes.

As highlighted by Participant 1, the caregivers who look after children are trained. This shows that caregivers provide professionalised services to children, which are likely to be guided by ethics, principles and a sound knowledge base. This corroborates sentiments from various authors who view training as a critical component in caregiving work (Child Rights and Childcare for Caregivers in Zimbabwe Handbook, 2011; Powell et al., 2004) because it equips the caregivers with relevant skills and also assists in standardising the quality of care given to children.

6.3.3 Creation of a supportive family environment

The other appropriate service that emerged from the study is linked to institutions' endeavours to create a supportive family conducive for producing a responsible child. Against this backdrop, all participants concurred that the biological family is the best institution where a child's developmental milestones can be fully met and realised. In this regard, participants concurred that although institutional care did not resemble the features of a real family, the existing services are designed to provide children with a near-family environment, as evidenced by institutions' objectives that were explained by participants.

> *To provide support to children who come from extremely difficult circumstances.* (Participant 1).
>
> *To build and strengthen families for children in need.* (Participant 3).
>
> *To provide psychosocial support to vulnerable children and empower children by providing life skills and education to these disadvantaged children.* (Participant 4).

Using the above information from participants, it emerged that childcare institutions recognise that they have a critical role to play in raising children. Against this backdrop, it

can be argued that contrary to the thinking that institutional care has detrimental effects on child development (Browne et al., 2006; Morantz & Heyman, 2010; Powell et al., 2004; Zeanah, 2002), managers felt that institutions were endeavouring to build or strengthen families for children in need and provide them with psychosocial support. This concurs with observations by some scholars that most children in institutional care have a history of vulnerability which affected their psychosocial functioning, and therefore they need a family environment and appropriate services to mend their situations (Modi, Nayar-Akhtar, Ariely & Gupta, 2016). As a result, managers believed that institutions had a vital role to play in society of providing appropriate services to vulnerable children. This is consistent with Bronfenbrenner's Ecological Theory that postulates that the environment inclusive of physical and social settings, affects children's development (Bronfenbrenner, 1977; Bronfenbrenner & Morris, 2006). As a consequence, it can be argued that it is fundamental for institutions to create a suitable environment where vulnerable children can deal with issues related to the difficult circumstances they experienced, and at the same time go through and experience normal stages of child development.

The above sentiment was also cemented by participants as indicated:

> *We emulate the interactions that occur in biological families as they are conducive for child development*. (Participant 2).

> *I strongly believe that the biological family provides the best environment for the child*. (Participant 3).

The sentiments from Participants 2 and 3 showed that managers attach value to real family life because they provide the best environment for child development and growth (Elliot, 1991; National Orphan Care Policy, 1999; Shung-King & Smith, 2005). It is rightly believed that a biological family has natural components that assist in child development and growth. As highlighted earlier on, institutional care activities are designed to create a near-family environment so as to try and enhance proper child development (Gumbo, 2014; Powell et al., 2004). To this end, the study discovered that the idea of the "family concept" is embraced in the binding statements on some participating childcare institutions. This was evident from participants from childcare institutions binding statements that read:

Every child belongs to a family and grows with love, respect and security. (Institution 1).

A child-friendly environment that achieves full potential for every child. (Institution 2).

We build families for children in need, we help them shape their own futures, and we share in the development of their communities. (Institution 1).

Therefore, this indicates that the family is an important institution in every child's life, therefore children should ideally be cared for in a family environment. This is corroborated in various policies and agreed on by experts in childcare work (Chibwana & Gumbo, 2014; National Orphan Care Policy, 1999, National Action Plan for Orphaned and Vulnerable Children, 2004; National Action Plan for Orphaned and Vulnerable Children Phase II 2011-2015; Powell et al., 2004). As highlighted by Institution 1, all children belong to a family and the expectation is that they should grow with love and security. These components are critical in child development; as they influence children's psychosocial well-being and have an effect on their future lives (Bowlby, 1969; Hook 2002; Levine & Munsch, 2014; Pringle, 1985).

Furthermore, the study also gathered that childcare institutions recognise the role of the community families in childcare work. This was evident in one institution's mission statement, which read:

To protect, care and provide for the well-being of children and mobilise community capacity to help them realise their full potential. (Institution 2).

The notion of community inclusion was also evident in highlights from another participant who said:

We involve the community in our childcare services. During school holidays, our children are taken by willing families so that they are exposed to real family life. (Participant 2).

We are running community outreach programmes to provide assistance to vulnerable children who will be staying with their extended family members. (Participant 3).

> *Institutional care is not very good for children, so we involve families from nearby communities to take children in to be with them during school holidays*. (Participant 4).

The responses above show that institutional care providers regard the community as a partner and duty-bearer in childcare. It can also be argued that community participation helps to dilute the artificial environment that is provided by institutional care systems. So, mingling of children with other children and families in the community exposes children to real family life, cultural expectations, values and national identity (Bourdillon, 1976; Chibwana & Gumbo, 2014; Matthew Rusike Pamphlet, n.d). Furthermore, as explained by Participants 3 and 4, institutional care is not the best option for children, and therefore strengthening strategies should be provided to struggling families on the verge of breaking down to curtail total breakdown. This concurs with sentiments from several authors who highlight that institutional care does not provide an environment conducive for child development, and as such family preservation should take precedence in cases of vulnerability (Muguwe et al., 2011; Mushunje & Mafico, 2010; Powell et al., 2004). Interestingly, the study revealed that institutional care providers are aware of the effects of institutionalisation, hence they run proactive programmes like the above-mentioned in order to preserve families, and create a supportive environment for vulnerable children in communities.

The study also revealed that institutions were making strides to create a good environment as depicted by participants' comments:

> *We are focused but challenges keep mounting. The number of children is increasing due to poverty*. (Participant 1).

> *We are trying our best because we receive training on real issues in homes.* (Participant 2).

> *We believe children must be told the truth so that they are aware of their background.* (Participant 3).

Taking the above-mentioned into cognisance, managers felt that childcare institutions were achieving their goals due to focus, staff training and communication with children. In this regard, training in childcare work is critical as it equips the role players with adequate skills that results in the provision of high quality services (Elliot, 2006; Litjens & Taguma, 2010;

Sherridan, Pramling, Samuelson & Johansson, 2009), which are likely to include among others the creation of a family-like and supportive environment for children.

Therefore, since childcare work involves interaction with children and helping them to deal with psychosocial issues that may present, social sciences including social work knowledge are critical for staff members. As highlighted earlier on, it emerged that three out of the five managers who participated in this study had qualifications in the field of social work and two in social sciences, meaning they possessed professionalised, social scientific knowledge on how to deal with social issues (Friedlander & Apte, 1980; Skidmore, Thackery & Farley, 1994; Zastrow, 1995). It can therefore be argued that these managers were either providing services that are adequate, or had the ability to observe with a professional view and address the gaps in childcare work in Harare, Zimbabwe.

6.3.4 Support from Government through the DSS

The study revealed that the other key strength in childcare services is the active role played by the Government of Zimbabwe to support and complement the efforts of private voluntary and faith-based organisations. Thus, like other countries, the Zimbabwean Government is playing an active role through the formulation, implementation and evaluation of various policies, frameworks and procedures (Chibwana & Gumbo, 2014; Powell et al., 2004; Williamson & Greenberg, 2010) discussed earlier on in the Literature Review, Chapter Four. The DSS is the custodian of all children in Zimbabwe and the childcare institutions take care of children through an official order from the DSS (Masuka et al., 2012; Mupedziswa, 1995). Therefore, childcare institutions are expected to operate within, and meet guidelines and policies approved and prescribed by the Government. Childcare institutions play certain roles and make particular decisions, while the DSS acts as the mother body and has an overall say on all decisions regarding children in institutional care. In commenting the role of the DSS, participants asserted that:

> *Social welfare makes all the decisions for children. This arrangement is good in that it brings institutions together and also embraces the African notion which regards a child as belonging to everyone in the community*. (Participant 1).

> *Our national childcare policies are well outlined.* (Participant 2).

We have various programmes like cash transfers, Beam and public assistance which are designed to assist vulnerable children and their families. (Participant 3*).*

The responses by Participants 1, 2 and 3 show that the Government of Zimbabwe attaches a strong level of commitment to child protection issues. This is consistent with sentiments from various authors who have written extensively on child protection in Zimbabwe and echoed that the Government of Zimbabwe plays an active role in addressing child protection issues (Masuka et al., 2012; Mushunje, 2006; Mushunje & Mafico, 2010). However, there was a general feeling from the participants that, although childcare institutions are doing their part, the government takes too long to make certain decisions resulting in inefficiency and poor service delivery to children. In support of this, special mention was made to the fact that the probation officer from the DSS who has the mandate to come up with action plans for the children on placement, is usually not in contact with caregivers, staff and children. As a result, managers felt that the responsibility of coming up with action plans for childcare in institutions should be given to directors at institutions, because they are in contact with both the caregivers and the child on a full-time basis.

With regard to national legislation in Zimbabwe, participants highlighted that the Children's Act is easy to implement as it clearly defines children in need of care and the procedures for assisting them, but a shortcoming is on the legal age of discharge from the institution. Participants felt that although the Children's Act articulated children in need of care, their issues and procedures to put them in a place of safety, and the legal age of the discharge of children from institutions, lacked practicality. This was evident from the following participants' comments:

I believe at 18 years children still need support from caregivers and should therefore not be discharged. (Participant 1).

The stipulation is inappropriate because children will not be fully mature to run their lives and act responsibly. (Participant 2).

Children will be going through a transitional phase and will therefore be in need of guidance from adults. (Participant 3).

> *I think there is need to come up with half-way (transitional) homes that will provide post-institutional care and adulthood guidance till the children reach the age of twenty-five.* (Participant 5).

To this end, it was suggested that there was need for the Government to come up with half-way homes that will provide post-institutional care and adulthood guidance up to the age of twenty-five. It can be argued that these half-way homes will provide children with transition services that will help them to fit into the society (Mhongera, 2017; Mhongera & Lombard, 2017).

Furthermore, with regard to policies and guidelines, the study noted that participants viewed some parts of the existing operational guidelines as too restrictive and negatively affecting children's autonomy. This was evident in the following comments by participants:

> *Existing operational guidelines stipulate that a caregiver should accompany children wherever they go. This is viewed as too restrictive as children are not given opportunities to make decisions or explore their immediate environments on their own. For example, we are not allowed to give children simple tasks that are found in a real family, like asking children to go the shops and buy vegetables*. (Participant 1).

As explained by Participant 1, some guidelines restrict children from doing things on their own. From a theoretical point of view, this guideline contradicts with propositions by Erik Erikson in his Theory of Psychosocial Development that contends that children should be given room to experiment and explore on their own and initiate things (Hook, 2002; Levine & Munsch, 2014). Therefore, it can be argued that as a result of this guideline, some children are being deprived of opportunities to make autonomous decisions and this negatively affects their level of confidence in future.

Participants also shared their views on the National Action Plan I and National Action Plan II whose guidelines institutions have to follow and shared the following sentiments:

> *Childcare policies in this country are drafted in favour of donors because usually it is the stakeholders that participate in policy formulation, implementation and evaluation, who use a lot of money on staff training instead of giving these resources to the children. Moreover, these trainings are held excluding people who have direct contact with children in institutional care, and even the children placed under*

institutional care. The NAP II should target people on the ground, hear their voices and then come up with programmes that are relevant to the intended beneficiaries. (Participant 1).

There is non-involvement of institutional care staff in policy matters. As a result, it is challenging to meet some of the things stated in the National Residential Care Standards as the guide is Eurocentric and was documented by people who did not have direct contact with African children in care institutions. (Participant 2).

Currently in Zimbabwe, there are no policies for adults who grew up in a children's home in spite of the fact that they may have needs that require specialist attention. (Participant 3).

Policy formulation, implementation and evaluation are done exclusive of the appropriate and positive input from institutional care managers, caregivers and children themselves. As a result, policy makers formulate policies that are too theoretical with some aspects of the policies being out of context. (Participant 4).

6.3.4.1 Models of Institutional Care

The study also solicited for participants' views on the models used in institutional care. As a result, the study gathered mixed views from participants:

Family units are noble in that institutions create a family environment that is conducive for child development. (Participant 1).

In my view, family units and dormitories produce the same results, so there was no need to convert dormitories into units because the environment created by family units and dormitories is artificial as caregivers from the two set-ups also take days off work or would eventually also go into retirement. (Participant 2).

Our institution has shifted from dormitories to using family units as is required by the National Residential Care Standards. (Participant 3).

The sentiments from Participants 1, 2 and 3 were consistent with literature which observes that in Zimbabwe there are two main models of institutional care namely, family-based units and the dormitory style of which the preffered model is the family-based model (National

Residential Care Standards, 2010; Powell et al., 2004). Therefore, in light of this, it can be argued that literature contracdicts with participant 2's views that dormitories and familybased models produce same results. This is largely due to the fact that the family- based model provides a family set up for children where they acquire social skills through oberversation and practice. In contrary, the dormitory set up provides shelter and not a family unit environment. Thus, the two models are likely to produce different results.

The study also collected information with regard to discipline in childcare institutions. Below are responses that came out

> *Current regulations in institutional care stipulate that discipline is not enforced by people who are in contact with children, but the Director of Social Services. For instance, when a child breaks institutional rules the caregiver is required to write a report to the superintendent who then writes to the district, then in turn to the province until the issue reaches the national supervisors who then write back following the aforementioned channels till the child is disciplined and this takes about three months.* (Participant 4).

> *The national approach on disciplining children is much steeped in bureaucracy, thus not reflective of what happens in an ideal family setting, but presents an artificial form of discipline which does not agree with the indigenous African culture that institutions endeavour to cultivate in children.* (Participant 2).

Therefore, with regards to discipline, managers felt that the beareauratic approach distorts the family aspect in institutional care, largely due to the fact that in real families, disciplne is not bearercatic. As a result, impacts negatively on children's understanding of discipline in families.

Furthermore, in rounding up on the role of the DSS, participants shared that the government department oversees all childcare activities and meetings in Zimbabwe, so the DSS acting as the arm of the government of Zimbabwe coordinates meetings that are held on a quarterly and annual basis. This provision was evident from the following responses from participants:

> *I think they have brought in a reporting system where we meet quarterly at district level where we share statistics in terms of children we have in the home. They have designed a good form which I am sure is very easy to work with.* (Participant 1).

We attend yearly meetings coordinated by the District AIDS Action Committee and Case Management staff from the DSS. These meetings are very important because they give institutions in the district a forum to meet and share current statistics. (Participant 2).

Although these meetings are informative, the period between them is too long resulting in some issues not being tackled timeously and effectively. For example, issues to do with the placement of children in institutions that are also discussed at these meetings take too long to be solved since the next meeting will be held the following year. Thus, there is need for the DSS to set up more regular meetings to discuss pressing issues regarding childcare in institutions. (Participant 3).

The above-mentioned responses show that the DSS appreciates the contributions from childcare institutions and also influences order in childcare work. This is consistent with literature that emphasises that in Zimbabwe, childcare work activities are controlled by the DSS and faith-based and private voluntary organisations provide services to vulnerable children (Chibwana & Gumbo, 2014; Masuka et al., 2012; Powell et al., 2004; Wyatt et al., 2010).

6.3.5 Provision of relevant psychosocial support services to children

The other subtheme that emerged from the study is the provision of relevant psychosocial support services to children in institutional care. All the managers who participated in this study agreed that most children present with psychosocial challenges that may affect their social functioning. This was evident from the following comments from participants:

They extremely need love because they lost love. (Participant 1).

There were children aged around 7 to 8 years who presented with early interest in sex, stealing, aggression, bullying, not doing homework for no reason, self-neglect, losing clothes deliberately, and resorting to begging, ungratefulness and being clingy. (Participant 2).

They feel you (staff) are workers, you are not our mothers, and …. if our mothers were around, things would be better. (Participant 3).

Children experience rejection where they reject the society and the society in turn also rejects them, resulting in suicidal tendencies. (Participant 4).

The response by Participant 1 shows that children in institutional care need love and therefore care in homes should demonstrate the essence of love and warmth towards the resident children so that they learn to receive love and to show it to others. Demonstration of love towards children was seen as critical, because love impacts on children's future lives especially with regard to intimacy and relationships with other people in the community and subsequently, in society as a whole. Giving children love is critical in child development as it influences the psychosocial functioning and development of children (Gurupira & Chikutuma, 2017; Mosina, 2012). This is consistent with contributions from the John Bowlby Attachment Theory, Erik Erikson's Psychosocial Theory and Abraham Maslow's Personality Theory which contend that showing love to children is a critical aspect in child development which can result in secure, trustful and autonomous relationships (Berk 2004; Bretherton, 1992; Eccles, 1999; Jarolmen, 2014; Neher, 1991).

In light of the above, the study revealed that caregivers and other staff members play a big role of showing love to children in need of love, providing counselling to children with various interpersonal and intrapsychic issues, encouraging children to seek support from significant persons or children's committee members and also addressing spiritual issues through religion that one prefers.

Moreover, as explained by Participant 3, some children in institutional care do not respect staff members because they think that they are employed to work for them. This disrespectful attitude contradicts local African cultural expectations and views and may breed tension between caregivers and children. Gleaning at this uncouth behavioural aspect from another angle, Abraham Maslow's Personality Theory contends that children with unmet needs often present with psychosocial needs that may manifest as delinquency, disrespect and poor performance (Caspi, Henry, McGee, Moffit, & Silva, 1995; White et al., 1990). Therefore, it is critical for institutional care practitioners to have programmes that fill the gaps that were created before institutionalisation, and which at the same time, deprived children of their critical needs. This sounds complex and cumbersome if comprehensive packages are provided. Maybe what would be ideal is for practitioners to address the issues on an individual basis and use a flexible approach to come up with useful coping strategies.

The issue of rejection as mentioned by Participant 4 is a bone of contention among children in institutional care. As indicated by the same participant, children feel rejected and in turn reject the society. However, the reality is that although children reject the society, they have no option but to live in the society they have rejected. They are expected to display acceptable personalities, which may not be possible as a result of feelings of rejection that developed after separation from primary caregivers. This corroborates with Bowlby's Attachment Theory, that when children are separated from their caregivers, they experience negative feeling which may affect their relationship with others (Bowlby, 1989; Laurent & Parent, 1999; Malekpour, 2007). In light of this, participants mentioned that the trauma that children experienced caused them to display the following behaviours:

> *Lack of confidence, hatred, and when offended, some children become upset to the extent of destroying property, for instance cutting settees, towels, blankets, burning …… and use of vulgar words, moody, bullying, fighting and disrespectful behaviour.* (Participant 1).

> *We have children who are ungrateful, bully others and are very aggressive.* (Participant 2).

> *Some of our children are very careless, they do not take care of their belongings like clothes, they easily lose their clothes and quickly start to beg or steal.* (Participant 3).

The feelings that children experience as explained by Participants 1 and 2 are likely to be the effects of separation and insecure relationships as explained in Bowlby's Attachment Theory. Furthermore, the observation by Participant 3 where children fail to take care of their belonging is corroborant with sentiment linked to the disorganised attachment pattern that is characterised by disruptive behaviour and confusion, among others (Malekpour, 2007; Moss, Laurent & Parent, 1999; Pappalia, Odds & Feldman, 1999). Therefore, institutions should also come up with programmes that help to eliminate the effects of the disorder and confusion that children might have experienced before institutionalisation.

In addition, participants mentioned stigma by the community as another psychosocial issue that affects children when they mingle with other children or adults in the community. This was evident in the following responses from participants:

The community is not supportive of institutional life as people tend to stigmatise the child. Any child who goes to a children's home is either pitied or reviled, they think the child is naughty because within our culture all children have an extended family to live with. (Participant 1).

Institutionalised children are labelled orphans from "that institution" and reminded that they had been thrown away. (Participant 2).

The above-mentioned comments are consistent with findings from a study carried out in Zimbabwe that revealed that children from childcare institutions are given names that imply that they are outcasts or had been thrown out of society (UNICEF, 1992). In the end, this stigma sometimes results in low self-esteem and withdrawnness as children end up isolating themselves, lose opportunities of developing social skills, and may face problems in fitting into the society.

Some of our children lack social skills and do not know how to handle social problems; and because of that, they find it difficult to distinguish true and fake love, and at times strangers take advantage of this and abuse them. (Participant 1).

We have come across cases of discharged children who find it difficult to settle down as they face a number of issues cascading from their circumstances, such as lack of proper accommodation and unemployment. Haanapekurara, haanazvekudya, course yaaniayohaishande, akashandaanodzingwa. So vanenge vachingodzungaira. (Loosely translated this means that such children will be unsettled with no place to sleep, no food, in possession of training that is not marketable and in the event of getting a job, they get sacked easily. (Participant 2).

As explained by both participants, social skills are critical in child development. This was also explained earlier on in the theoretical framework. These skills such as engaging in a trustful relationship, the ability to make sound decisions and self-control are acquired in early years during child development (Berk, 2004; Bowlby, 1989; Hook, 2002; Shore, 2003).

Based on the detailed discussion of psychosocial issues presented by children in childcare institutions, it emerged from the study that children in institutions face multiple psychosocial challenges that require adequate psychosocial support. With respect to this, the study

explored the psychosocial interventions used by childcare institutions to help children to cope. Participants highlighted the following psychosocial support interventions:

> *Our caregivers are equipped with skills needed to deal with institutionalised children who often present with psychosocial problems*. (Participant 1).

> *Caregivers receive training on various childcare programmes. They are encouraged to tell children the truth about their backgrounds as this helps children to understand issues about their life. Our caregivers familiarise children with the consequences of breaking the rules or doing bad things in life.* (Participant 2).

> *We provide life skills training for children in order to train them discipline and prepare them to deal with any situation that they may encounter during adulthood.* (Participant 3)

> *Holiday programmes where children stay with real families in the communities during school holidays helps to dilute the effects of institutionalisation.* (Participant 4).

Psychosocial support is regarded as an important component in childcare work. To this end, the researcher discovered that each of the four institutions has unique psychosocial programmes designed to assist children. The study also explored the psychosocial programmes that are provided by institutions to help children to cope. A detailed discussion on the psychosocial programmes available in institutions is provided next. Participants highlighted that psychosocial programmes encompass life skills, spiritual programmes and self- help projects. This was evident from the following responses from participants:

> *Our life skills programmes are varied and include building confidence, conflict resolution and management, how to deal with peer pressure, anger management and many others. They are designed to help children to cope with life issues, live independently and fit in the society later in adulthood. Some homes provide counselling and assess children's behaviour periodically. Counselling is provided to children who will be in need of on-site staff with expertise or external staff upon referral*. (Participant 1).

We run spiritual programmes aimed to help children to deal with spiritually related issues. As such, the environment created when discussing spiritual issues, helps children to form meaningful relationships with other children who may be sources of support later in life. We run a weekly programme known as Devotion, where children meet, discuss, share knowledge on spiritual issues, pray and teach each other to depend on God and His word in the Bible. Children learn that there is one God for all people who loves them and made it possible for them to be placed in an institution to get good care, in spite of rejection from their parents or relatives. (Participant 2).

Periodic assessments are conducted in order to check on the development of the child. Caregivers identify children's talents during play time for further development of that talent. We also conduct assessments in order to rate children's behaviour. (Participant 3).

Self-help projects expose children to skills that may be useful in future, especially for some who are not gifted academically, and likely to depend on self-help projects. We grow vegetables and rear poultry to increase household income and to expose children to the skills needed in home project management. Income-generating projects help children to deal with stress and increase their self-esteem, as they are likely to feel that although they were rejected by their parents, they are capable of doing something meaningful in their lives. (Participant 4).

Our children are sometimes fostered by willing families from communities during school holidays. We run these programmes with the hope that children would acquire knowledge on the cultural norms and values which they will need later in adulthood, and these foster families may be sources of support and identity formation to the child. In some cases, some children may end up using the totems of foster families in order to blend in with the society. If there is a sound relationship between the child and the community caregiver, arrangements are done to discharge the child and organise foster care placement with the same caregiver. (Participant 5).

A closer look at the above responses shows that institutions recognise the relevance of psychosocial intervention for children. As explained by Participant 1, the life skills programmes are designed to help children to deal with both intrapsychic and interpersonal issues and also assist them to function well in the society. It is without doubt, that childcare

institutions make great attempts to meet children's psychosocial needs when they provide multiple interventions to help them deal with aspects such as anger, insecurity, fear, rejection, stigma, spirituality, identity crisis and many other related issues. This is consistent with contributions from childcare experts who contend that children who have gone through difficult circumstances should be given relevant psychosocial support so that they will address the negative effects that have counter effects on development (Gurupira & Chikutuma, 2017; REPSSI, 2007; Richter et al., 2006). In light of this, the study revealed that the childcare institutions are aware of the impact of unresolved psychosocial issues on children and thus engage in the aforementioned interventions to assist children.

6.3.6 Provision of services that prepare and equip children to become well-adjusted citizens in the society

It emerged from the study that childcare institutions provide services that prepare children to become well-adjusted citizens in the society. These services are critical as legal requirements stipulate that children should be discharged at 18 years of age (Children's Act, 2001; Powell et al., 2004), and also bearing in mind that although childcare institutions provide near family services, their systems have been critiqued as artificial and Eurocentric and were viewed as hubs for developmental delays, poor social adjustments and attachment disorders (Brown et al., 2006; Masuka et al., 2012; Zeanah, 2002). Consequently, it turned out that the psychosocial programmes discussed, the provision of a family environment, and all children's needs discussed above are all provided to raise children who will fit into the society in spite of difficult experiences encountered before institutionalisation. In addition, participants highlighted that childcare institutions run programmes that are designed to produce a responsible adult/citizen who is self-sufficient. This was evident from the following comments made by participants:

> *We have care plans to guide caregivers at each stage of child development. We also encourage caregivers to assist and encourage children to do things that are age appropriate.* (Participant 1).

> *We provide life skills training so as to equip them with various social skills so that they are able to manage their lives and handle challenges they will come across during adulthood.* (Participant 2.

We are running a foster-care programme where families from the communities take children who stay with them during school holidays. This is very helpful to our children as they get an exposure to real family life. Those who are discharged from our institution are given support in the form of rent for six months. Thereafter they are weaned and expected to fend for themselves. (Participant 3).

We teach our children income-generating activities like piggery, poultry and growing mushrooms. We also teach those who are not gifted academically, sport with the hope that some may excel and use proceeds from sport as means of survival. (Participant 4).

Our diet which comes from the Ministry of Health emphasises that children should eat indigenous foods that are readily available in this country such as beans, vegetables and other foods. It is not about liking the food, but training them to appreciate the food, so that when they get into the society then can adjust. (Participant 5).

In light of the above-mentioned responses, the study also discovered that institutions endeavour to groom children so that after institutional care, they will fit into the society. This is contrary to arguments in literature that institutional care life does not expose children to indigenous culture, but to the European way of life.

6.4 CHALLENGES IN CHILDCARE SERVICES PROVIDED IN INSTITUTIONS

This section will present the challenges experienced in institutional care. Notably, these challenges are also drawbacks and gaps in the provision of institutional care services. The following subthemes linked challenges in childcare services provided in institutions which emerged from the study, unrealistic or distorted expectations from children in alternative care, financial challenges, dealing with staff members who do not care, lack of adequate support from the government, and the doing away with legislative procedures that are not practical. These subthemes are going to be discussed and integrated with theory.

6.4.1 Unrealistic or distorted expectations from children in alternative care

The participants felt that at times children in alternative care present with unrealistic or distorted expectations. In this vein, it was highlighted that some children overemphasised their rights, resulting in them living in a self-designed and distorted environment which is not

conducive for child development. This was evident from the following comments made by participants.

> *Institutionalised children fail to draw the line between training and abuse and therefore report that they are being abused when they are asked to perform house chores or are reprimanded*. (Participant 1).

> *The donations that children see also distort their minds to a certain extent. For instance, in the event of lacking anything materially, they do not readily fend for themselves but think of donors for support. If children are told that there is no sadza (staple food), they will say let's go to the storeroom and see whether we cannot get anything to eat because we know there is something in the storeroom.* (Participant 2).

The above-mentioned responses show that at times children in institutional care live away from reality. This is corroborant with arguments that institutional care negatively affects children in the sense that it provides them with an artificial environment that deprives them of the capacity to adjust to real life, and therefore delays their development (Browne et al., 2006; Masuka et al., 2012). It can therefore be argued that this distortion is a function of the systems inherent in institutional childcare practices and may cause imbalances on a child soon after discharge from an institution.

6.4.2 Financial challenges

Participants cited financial challenges as another drawback in institutional childcare work. It was highlighted that finances are needed to fund all the activities in and services provided in institutions. In most cases, the money that is usually available in institutions, does not match with the ever-increasing number of children who are placed in institutions. This was evident from the following comments from participants:

> *We are still focused, though challenges keep on coming because the number of children in need of care is rising in our society. We used to have children at three or four years of age, but now we see baby-dumping after birth.* (Participant 1).

> *The high poverty levels in Zimbabwe are making it difficult for parents to look after their children. As a result, stranded parents dump children, resulting in the increasing number of children in institutions*. (Participant 2).

Most institutions have high numbers of children because meagre resources at the DSS result in delays in processing discharge order and family reunification procedures. (Participant 3).

Institutionalisation is regarded as the last resort on paper, but practically it is emerging as the first resort in probation work which is under resourced and in most cases, whenever a vulnerable child knocks at the door of the Probation Officer towards the end of the day, the easiest and quickest option is institutional care as it does not call for thorough assessments, home visits and follow-ups. (Participant 4).

People (the general public) support childcare institutions with material things but what is not there, is money. Ten years ago, we used to 'swim in money' so to speak, but right now we are in dire need. This is indirectly forcing managers to approach local donors who still perceive that the childcare institution is fully resourced and therefore offer minimal support. (Participant 5).

From the responses above it is clear that institutions experience financial challenges as a result of the ever-increasing number of children who are placed in institutional care. The DSS delays in discharging children and the macro economic situation in Zimbabwe has dire consequences. This is consistent with literature that contends that institutional care services are affected by meagre resources, inefficient services provided by probation officers and the economic problems that Zimbabwe is experiencing (Chibwana & Gumbo, 2014; Gurupira & Chikutuma; 2017; Masuka et al., 2012; Powell et al., 2004). It turns out finances are needed to run critical aspects of institutional care. This was evident from the following comments by participants.

The free medical treatment orders provided by the Government do not cover urgent treatments at private medical centres. Facilities for urgent medical attention are generally not available at government hospitals, so we need money to cover urgent treatments for children, especially those who require attention from private doctors or need private surgeries. (Participant 1).

We use money to pay for caregivers' medical check-ups for communicable diseases and fingerprints at police stations to fulfil Government requirements for all caregivers who work in residential care settings for children. This is very costly for

us, and there is no waiver on the medical bills, we have no option but to follow the guidelines. (Participant 2).

The Government takes too long to disburse grants for children in institutions, forcing institutions to use their own resources to meet children's needs. (Participant 3).

From the above-mentioned comments it can be argued that financial challenges force some institutions to struggle to meet the caregivers' requirements and the children's needs. It is not surprising that in some cases, some childcare centres which may not be well funded end up omitting some of the institutional childcare requirements. There is need for the Government to consider waiving the costs for the medical check-up for the caregivers and disburse grants on time. This will help to fuel efficiency and increase the quality of care given to children.

6.4.3 Inadequate number of Probation Officers

The study revealed that the number of Probation Officers available at the DSS to oversee and process institutional care services is very low. As a result, some of the issues may be left unattended and this compromises childcare work and all the effort made by institutional care staff. This was evident from the following responses from participants:

The Probation Officers at the DSS are not fulfilling their duties and as a result, children remain in institutions for periods longer than the stipulated 3 years. Probation Officers do not avail institutions with feasible work plans, they also do not visit children as stipulated in the guidelines and in some cases, one Probation Officer is expected to work with all children in a district. This is too much and affecting the quality of services that children receive. (Participant 1).

We know that here in Zimbabwe the ratio of social worker to children is 1:49 000. The low numbers at the DSS are largely due to low salaries and poor working conditions. (Participant 2).

From the comments above, it is clear that the DSS has inadequate staff and as a result childcare services are not being adequately provided as expected. This is consistent with literature that observes that institutional childcare work in Zimbabwe has been compromised by high staff turn-over, low numbers of probation officers and meagre resources at the DSS (Chibwana & Gumbo, 2014; Masuka et al., 2012; Mupedziswa, 1995; Wyatt et al., 2010). To

this end, the Government employs few probation officers who work with huge caseloads. Linked to the aforementioned was the fact that the few workers who are employed do not exert their duties as expected, or are not interested in childcare work but working for the remuneration. This was evident from the following comments made by participants:

> *Some of the practitioners are not caring, but are interested in getting their salaries only. They don't care about what the child has eaten, or where the child is going after being discharged from the institution.* (Participant 1).

> *We have many cases of incomplete assessment because Probation Officers do not conduct long detailed interviews with the child and family, the institution and family visits and follow-ups. Because of this, some assessments have gaps as some children lie about their backgrounds and usually reveal the truth later during discussions with caregivers at the institutions*. (Participant 2).

> *We are experiencing serious delays in the acquisition of birth certificates owing to huge caseloads that probation officers are working on.* (Participant 3).

> *The officers at the DSS are not coping with huge caseloads, and yet continue to place children in institutional care. We have turned to foster care and adoption in order to reduce the ever-increasing numbers of children in institutions*. (Participant 4).

Based on the above-mentioned comments, it can be argued that due to low numbers, Probation Officers are not doing enough in terms of services delivery in childcare work. This has counter effects on the quality of services provided to children in institutional care and this is likely to increase the harmful effects of the system on children and society at large. With respect to the ecological theory, the presence of probation officers shapes the physical and social setting of the child's environment. Therefore, lack or absence of probation officers' results in an environment that is not conducive for child development. It is therefore critical for the Government of Zimbabwe to employ more probation workers so as to enhance the quality of services provided to children.

6.4.4 Lack of practical transition services for children discharged from childcare institutions

This subtheme is linked to the legal action that requires children to be discharged from childcare institutions when they reach 18 years of age, because they would have entered into adulthood (Children's Act, 2001; Powell et al., 2004). Participants lamented the fact that children will still be immature and needing caregivers' guidance. These factors are further exacerbated by that fact that the DSS does not have transition services for children discharged from institutions (Mhongera, 2017; Mhongera & Lombard, 2016). As a result, discharged children faced insurmountable challenges that erode all the efforts made by institutional care practitioners to raise a child who would fit into the society as an adult. This was evident from the following comments made by participants:

> *Discharging children at 18 years of age does more harm than good, as children will not be mature enough to be on their own. There is need to review the age group for these children to be released at least at the age of 21 or 25 years.* (Participant 1).

> *When children reach 18 years we refer them back to the DSS. In my view the process of severing ties between the caregiver and child is not well handled enough to cater for the emotional needs of the child. I believe this affects the emotional status of most discharged children and caregivers as well.* (Participant 2).

> *In my view, discharging children at the age of 18 years is probing as a huge drawback on us. We feel we have wasted resources because some of our children end up living on the streets because they have nowhere to go*. (Participant 3).

> *When we discharge children, we refer them back to the DSS, and provide them with an exit package that will last for six months; thereafter they have to fend for themselves.* (Participant 4.)

Using the information from the above-mentioned comments, it can be argued that the timing of discharging children is not appropriate. As explained by Participant 1, discharging children at the age of 18 years may not be appropriate as it may end up doing more harm than good. Chances are it leaves some children in the deep end and brews more psychosocial problems due to the fact that at 18 years, children would be too young to run their lives and would still be in need of guidance from adults.

The matter of discharge issues was asked to determine managers' views on the appropriateness of the discharge plans/court orders and procedures for children who turn 18 years of age and who are expected to be discharged in line with the legislative requirements. In this vein, various responses came out that are linked to legislation, child-caregiver relationships, and post institutional care life.

It was highlighted that the child belongs to the state and therefore upon reaching 18 years, the child goes back to the state. In this vein, one participant highlighted that the discharged children are referred back to the custodian of all children, the DSS, but commented that the movement is usually not handled well to cater for the emotional care needed when the child severs ties with staff at the institution.

The study also gathered that some institutions have a budget for children who have just been discharged. Thus, as explained by another participant, all children who are discharged are given an exit package in the form of money for groceries and rentals for a few months and thereafter they are expected to take care of themselves.

6.5 SUMMARY

To conclude, management views on the appropriateness of childcare services produced different responses culminating into interesting discussions on services that are appropriate and the challenges experienced by managers in institutional care. In this vein, the findings from participants revealed similarities and differences on the services provided by the four institutions that participated in the study. All in all, managers revealed that some of the existing childcare services are appropriate and therefore promote proper child development. However, there were other aspects that were identified as needing further attention such as the low numbers of Probation Officers, delays in the processing of legal identity documents, and the lack of practical transition services for children discharged from childcare institutions. On another note, it appeared as if managers focus more on their administrative roles as compared to caregivers who work with children round the clock. This means that there is likely to be a notable difference between the managers and caregivers' experiences. Therefore, it is interesting to capture caregivers' experiences based on their round-the-clock work with children. It is against this background that the following chapter will focus on the experiences of caregivers.

CHAPTER SEVEN:
PRESENTATION AND DISCUSSION ON CAREGIVERS' EXPERIENCES ON INSTITUTIONAL CHILDCARE SERVICES

7.1 INTRODUCTION

This chapter seeks to present and discuss the caregivers' experiences on institutional childcare services that were explored in eight focus group discussions with six participants each conducted at four institutions during this study. These caregivers' job description in short, entails looking after children on a full-time basis (Child Rights and Childcare for Caregivers in Zimbabwe Handbook, 2011; Powell et al., 2004). This implies that caregivers act as the direct service providers of institutional childcare services. Against this background, it was fundamental to gather data from caregivers due to the likelihood that their experiences were most likely to be different from those of managers who engage mostly in administrative work. This chapter will focus on objective number two which was aimed at investigating the experiences of caregivers as direct providers of psychosocial support services in childcare institutions in Harare, Zimbabwe. Therefore, the detailed information in this chapter seeks to answer the research question two stated next:

What are the experiences of caregivers in childcare institutions in Harare about the appropriateness of services provided in relation to the developmental needs of children?

In addition, this chapter will also highlight caregivers' experiences on strategies that are being used by the institutions to equip children with life skills critical for their development in order to address objective 4 stated below:

- To determine how childcare institutions, provide services that equip children with life skills critical in child development.

In this study, the word "experience" is used to refer to the aspects that caregivers came across when providing care to children, and their perceptions on specific areas in childcare work in institutions.

It is worthy to note that various themes emerged from data collected from caregivers. This study has divided these themes into two groups, namely appropriate services in childcare institutions and challenges experienced by caregivers. The themes will be presented,

integrated with direct quotations from participants and relevant literature to support or contradict the findings.

Table 7.1: Themes and subthemes on data collected from caregivers

Theme	Subthemes
1. Appropriate Institutional Care services	2. Provision of family-like services in institutions
	3. Use of caregivers who are role conscious,
	4. xistence of well trained caregivers who recognise children's needs
	5. Provision of relevant psychosocial support to children
	6. Provision of services that prepare and equip children to be well adjusted citizens of the country
2. Challenges experienced by caregivers	a. Existence of a multiple reporting system for children
	b. High caseload and lack of resources
	c. Regulations which do not promote proper child development
	d. Inadequate training for caregivers
	e. The non-existence of a body for caregivers

7.2 PROFILE OF PARTICIPANTS

A profile of participants is shown in Table 7.2.

Table 7.2: Profile of caregivers who participated in the study

Institution	Female participants	Male Participants	Total Number of Participants
A	6	0	6
B	5	1	6
C	6	0	6
D	6	0	6

As explained earlier on in chapter six, the study used pseudo names to protect the names of participants and also to maintain confidentiality. As indicated in the table above, there was only one man from the four groups of caregivers who participated in the study. This could be an indication that caregiving in Zimbabwe work in childcare institutions is dominated by females.

7.3 APPROPRIATE INSTITUTIONAL SERVICES

This section will discuss subthemes that focused on the appropriate services in childcare institutions, namely the provision of family-like services in institutions, the use of caregivers who are role conscious, well trained and recognise children's needs, the provision of relevant psychosocial support to children, and the provision of services that prepare and equip children to be well adjusted citizens of the country.

7.3.1 Provision of a family-like environment

It emerged that caregivers felt that institutions have a crucial role in providing a family-like environment to children in institutions. Such an environment is designed to meet the basic needs of children like shelter, food, clothing, love and many others (Chibwana & Gumbo, 2014; Powell, 2004). In addition, the family-like environment provides children with a near

family set-up in which they grow up and pass all the milestones of growth. In other words, in institutions children get brothers, a mother and a family. It is worthy to note that the primary duty bearers of this family-like environment are the caregivers who assume the critical role of heading the family and providing emotional and social support around the clock. This was evident from the following responses from participants:

> *Children at this institution live in a family set-up, they have a mother, brothers and sisters.* (Focus Group 2 Participant 1).
>
> *Children do house chores and we involve them in buying groceries and coming up with family budgets.* (Focus Group 3 Participant 2).
>
> *We buy the clothes that they like and give them motherly support when they are ill.* (Focus Group 4 Participant 3).

As indicated by the quotations above, caregivers make significant contributions towards the creating of a family-like environment in institutions. This is consistent with literature on institutional care that recognises the input of caregivers in raising children in childcare work (Chibwana & Gumbo, 2014; Powell, 2004; Wyatt et al., 2010). It can be argued that since caregivers play the role of a mother, there is a strong likelihood that they have great influence on child development. It is therefore critical for institutions to employ caregivers who are knowledgeable. In addition, the creation of a near-family environment by caregivers is debatable, largely due to the absence of a male figure who also works with children around the clock. As a result, caregivers provide children with services found in a female-headed household. This type of family has its pros and cons and it is the cons that are likely to result in harmful effects on children. Against this backdrop, the study found that some institutions were planning to employ couples to work as caregivers in a bid to provide children with a real family environment.

However, on the other side, caregivers aired sentiments linked to the fact that institutionalisation is not good for children, due to lasting detrimental effects it has on child development. In light of the psychosocial theory, institutional care services may hinder the proper pyschosocial development as highlighted in Erik Erikson's Psychosocial Theory; especially when caregivers fail to meet children's needs at each stage of psychosocial

development (Erikson, 1968; Berk, 2004; Hoare, 2002). This was evident from the following comments from participants:

> *Children should grow up in the custody of biological relatives so as to strengthen bonds and build a good relationship with them.* (Focus Group 4 Participant 1).

> *Institutional care environment fosters 'group thinking' amongst children, which is not conducive for nurturing independent life among children in that the child tends to rely on what the group says, instead of having personal thoughts.* (Focus Group 5 Participant 2).

> *Institutional care is not good for children because the artificial set-up that exists has gaps which cause disobedience that the children may later take with them into the society, like the multiple reporting system.* (Focus Group 6 Participant 3).

> *Institutional care is not conducive for child development and I give it 1-4 out of 10 rating, whereas family life is rated 9 out of 10*. (Focus Group 7 Participant 4).

As indicated, although caregivers are working in institutions, they recognise the detrimental effects of institutional care. This view is supported in some publications on institutional care that argue that institutional care negatively affects children. Hence it is fundamental that children should stay with their family members (Browne et al., 2006; Deininger et al., 2003; Green & Berrick, 2004). These authors maintain that positive changes are seen in child development among children who leave institutional care and join their real families.

Caregivers also mentioned that there is need to revisit the age for discharging children. Caregivers felt that at 18 children are too young to look after themselves or cope with adulthood issues.

7.3.2 Use of caregivers who are role conscious, well trained and recognise children's needs

It emerged from the study that institutions were employing caregivers who are self-driven and role conscious. In exploring the aforementioned, the study solicited for information regarding the caregivers' reasons to uptake employment at childcare institutions. It turned out that most of the caregivers were self-driven as evidenced by their responses:

I am into childcare work to fulfil a calling of God. I am doing this work as a service to God. I believe when I die I will be given a crown. (Focus Group 1 Participant 1).

I am a Christian and base my work on Luke 14 verse 12 from the Bible which reads, "When you give a feast, invite the poor, the crippled, the lame and the blind, and you will be blessed because they are not able to pay you back." I believe by doing this work I am fulfilling the verse. I chose to work in childcare institutions in order to fulfil my desire to work with children, personal commitment to work with children, and responding to a call from the heart and in order to earn money. (Focus Group 2 Participant 2).

After going through a frustrating and painful marriage and later divorce, looking after orphaned children emerged as a source of comfort. (Focus Group 3 Participant 3).

I view my childcare work as part of my community service contribution to the Zimbabwean nation. (Focus Group 4 Participant 4).

I applied for this job because I have relevant qualifications- i.e. a certificate in social work. (Focus Group 5 Participant 5).

After completing a pre-school course, I felt that I needed to work with children. I joined the organisation because I wanted to do a job with a better grade. (Focus Group 6 Participant 6).

I joined the organisation after I heard that the organisation was employing mature women. (Focus Group 7 Participant 2).

Using the above-mentioned responses, it can be argued that caregivers are into childcare work for various reasons that range from their belief system, niches, skills and competency. It is therefore critical for managers in institutions to take cognisance of reasons and give caregivers tasks that may be aligned to their reasons. Perhaps, defining their individual caregivers' niches, skills and competencies they bring into childcare work.

Furthermore, the study explored the roles of caregivers in institutions. The study discovered that the caring input from caregivers from the four institutions had both similarities and differences. The similar tasks came out from the following responses:

We provide care that is similar to care that is given to a child in an ideal family, give children the same kind of love that we give to our children, and groom them to ensure that the they will fit when they mix with children from real families. (Focus Group 3 Participant 1).

We teach children age-appropriate house chores and instil acceptable social values and norms so that when they leave the institution, they will fit in the society. We teach a three-year-old toileting, we teach children aged 5 and older to wash their hands after visiting the bathroom. Children who are aged 10 years and older are taught to remove and clean plates soon after eating, and those who are 10-12 years old are taught to prepare food for the family. (Focus Group 4 Participant 2).

Our work involves imparting life skills like cooking and tailoring, dressing appropriately, ironing and organising. A child should know that when visitors come, they should be greeted. (Focus Group 5 Participant 3).

From these responses, it can be argued that caregivers value the family concept and therefore play the role carried out by parents in a normal family. This means they perform tasks done by real parents. In addition, as observed in the study, it turned out that caregivers go a step further than real parents because they handle children's emotional issues linked to their past painful backgrounds. This was evident form the following comments by participants:

Our role includes unbundling the difficult background that a child went through. (Focus Group 2 Participant 1).

We provide counselling and support to children. In some cases, when a child misbehaves or when we feel that the child is mature enough, we pull out the child's file and give it to him/her to read the details, and this will be followed by a discussion of the contents. (Focus Group 3 Participant 2).

We try as much as possible to remove "institutionalisation" from children. (Focus Group 4 Participant 3).

As indicated above, caregivers also highlighted that their role involves helping children to deal with their past painful issues related to their background. For instance, as explained by Participant 1, their role includes *"unbundling the difficult background that the child went*

through" To achieve this, caregivers use various skills to communicate with the child and help the child to deal with the difficult issues emanating from the circumstances that led to their institutionalisation. It emerged that at one of the institutions, the unbundling of the background is done by caregivers who are expected to show children love and acceptance, resulting in a good caregiver-to-child relationship where they feel free to disclose and discuss their background. Therefore, using the Attachment Theory, in so doing caregivers fill in the gaps that were created when children broke bonds with their biological relatives after separation (Ainsworth & Bowlby, 1991; Bolwby, 1977, 1989; Chibwana & Gumbo, 2014; Powel, 2004). Thus, the caregivers mend broken relationships and form attchments or bond with children who will then feel free to talk to and see them as a source of comfort. To this end, in commending this role, caregivers reported that children tell probation officers incomplete stories about their circumstances but reveal correct details to caregivers later. This was attributed to the fact that caregivers have more time to build trust and form bonds with children that will eventually result in children disclosing their secret information. On the contrary, the probation officers do not form bonds with children due to limited contact time they have with children (Chibwana & Gumbo, 2014; Wyatt et al., 2010). As a result, it appears there is need for caregivers to work together with Probation officers in order to help children effectively.

Linked to this is the role of disclosing to the children correct details recorded on their backgrounds by either probation officers or other childcare practitioners. During data collection, it turned out that at one of the institutions, this task is undertaken by professionals employed by the institutions, while at another home this responsibility lies in the hands of the caregivers and school teachers. In this vein, some participants mentioned that they tell children information about their background and the timing for the disclosure is usually based on the caregiver's judgement that the child is mature enough to understand issues. As explained by Participant 2 in Focus Group 3:

> *When a child misbehaves or when we feel that the child is mature enough, we pull out the child's file and give it to him/her to read the details, and this will be followed by a discussion of the contents.*

By so doing, children will then get to know their circumstances in an environment that is supportive. In this regard, telling children the truth about their lives helps them to accept their

circumstances and also work hard to prepare their future life after leaving the institution. In a nutshell, caregivers provide supportive counselling to children who present with various psychosocial issues, in most cases linked to self-perception, interpersonal issues and reproductive health.

Caregivers also mentioned that their role includes removing "the mind of institutionalisation" from children. This was evident from the following comments from participants:

> *Institutional environment is not good for children and it should therefore be eroded from children's minds so as to increase their self-esteem and self-perception*. (Focus Group 3 Participant 1).

> *We try to remove their institutional care life from children's minds by engaging children in activities similar to those in normal families like sweeping, laundry, cooking and gardening and other house chores mentioned earlier on.* (Focus Group 4 Participant 2).

All this showed that caregivers were aware of the fact that institutionalisation is not good for children. The negative associations with institutionalisation have been lamented by several childcare practitioners who contend that institutionalisation is harmful to children (Browne et al., 2006; Zeanah et al., 2005). Therefore, it can be argued that since caregivers are aware of the effects of institutional care, they minimise the system's influence on children and try to raise children in such a way that they will fit in the society.

It emerged from the study that institutions use caregivers who are trained so that they provide services that are professional and controlled by childcare ethics. Some of the topics covered in caregivers training include, counselling, being a mother, child rights, childcare, cooking, hygiene, first aid and home management. This was evident from the following comments by participants:

> *Our trainers were from the University of Zimbabwe, School of Social Work. They trained us on how to give proper care to children in institutional care*. (Focus Group 6 Participant 1).

We received training in many areas including cooking, first aid, psychology, health issues, bereavement issues, counselling and psychosocial support and how to handle children's problems. (Focus Group 7 Participant 2).

We have different skills that we acquired from the different training backgrounds that we have …. some are trained in catering, sewing, carpentry and building, and we impart these skills to children in institutional care. (Focus Group 8 Participant 3).

Based on the above information, the study revealed that institutions value training highly, and therefore employ caregivers who are trained. Therefore, these findings on the training of caregivers contradict the assertion by Heron and Chakbrati (2002) that institutions employ caregivers who are not qualified. However, the study discovered that the caregivers from the four institutions did not go through similar training. In this regard, caregivers at one of the institutions held a certificate in social work and could therefore comprehend children's issues from a social work perspective. On the other hand, another institution did their own training of caregivers, including hiring experts to train a specific concept excluding social work content. Similarly, another institution provided a comprehensive course for caregivers called Mother Training with content on childcare, child abuse, bereavement, counselling and child rights, to mention just a few. In a nutshell, training in social work-related skills, practical skills and motherhood is very important in childcare work. Therefore, it can be argued that training is a critical component in childcare work that enriches caregivers' skills in childcare work (Child Rights and Childcare for Caregivers in Zimbabwe Handbook, 2011).

On the other hand, some caregivers felt that they were inadequately trained in some areas of childcare and therefore vouched for retraining. This was evident from the following comments:

We come across complex cases during counselling. A refresher course in counselling will help us to deal with cases that are complicated, like those on abuse or trauma. (Focus Group 3 Participant 5).

The current setup is designed in such a way that the Probation Officer liaises with the foster parent who then takes the child for a vacation, thus excluding input from caregivers. These foster parents are not trained and as such, they spoil children when they take them. I think foster parents should receive training before they are given

children, as they will then provide proper care to children. (Focus Group 3 Participant 6).

It is important for institutions to train foster parents on childcare as this result in caregivers and foster parents having common goals. (Focus Group 4 Participant 6).

Using above information, the study discovered that there was need to train caregivers on issues of child development and discipline. In addition, the study gathered from the above comments that there was need to equip caregivers with counselling skills and also to train foster care parents on childcare. Counselling skills are very critical when dealing with children who have gone through difficult circumstances. In the context of institutional care, most children placed in institutions will have had pre-histories of difficult experiences as result of abuse, abandonment and separation with primary caregivers, which result in many social and emotional issues (Bowlby, 1969; Hunt, 2016; Zeanah et al., 2005). Against this background it is fundamental to equip caregivers with the necessary counselling skills so that they can provide services to children around the clock. On another note, it emerged that one of the institutions facilitated caregivers and foster parent caregivers' meetings to discuss childcare issues. Caregivers felt that in the absence of training, there was need for institutions to facilitate caregivers and foster caregivers' meetings to discuss issues pertaining to children under their care. This was evident from the following comments by participants:

Some foster caregivers are too nice to children and in most cases, spoil them to the extent that when school holiday ends the children will be reluctant to return to their institutions. I think there is need to train all foster parents before giving them children. (Focus Group 2 Participant 7).

We find caregivers and foster parent meetings to be very helpful. Before these meetings it was common for caregivers to start preparing a child upon return from foster care. (Focus Group 3 Participant 5).

The caregivers and foster carers meetings are very helpful as they deal with strange behaviour that children tend to display to foster carers where they would tell them that "I don't eat this and that", or refuse to work. (Focus Group 5 Participant 2).

The issues that caregivers and foster carers discuss are aimed at standardising the quality of care given to the child in order to produce a responsible person who is self-

reliant. Using the words of another participant "we tell foster carers that hapana zai apa munhu semunhu." Loosely translated, this means that foster caregivers should not treat children as eggs, that is, treating them delicately as this spoils them. Rather children should be trained to work and adapt to reality. (Focus Group 8 Participant 6)

Using the above-mentioned information, it can be argued that training is fundamental when dealing with institutionalised children. Furthermore, as explained by Participant 2, caregivers and foster care parent meetings are very important, as they help to set a common ground for both of them and also give the trained caregivers an opportunity to impart to foster parents' knowledge and skills gained from previous training sessions. Against this backdrop, the study revealed that literature alludes to the training of caregivers (Chibwana & Gumbo, 2014; Child Rights and Childcare for Caregivers in Zimbabwe Handbook, 2011; Powell et al., 2004), but there is not much emphasis on the training of foster parents. It is therefore critical to address this gap so that when children are taken in by foster parents, they get an exposure of real life which is devoid of being spoilt.

It emerged from the study that caregivers recognised that the children that they were caring for had needs. This was evident from the following comments:

Children need love, care, clothes, going to watch a movie, sheltered play, a good diet, attention, praise, protection, a sense of belonging, education, to mix with others in the society, going on holidays to places like Victoria Falls, and providing pocket money. (Focus Group 5 Participant 4).

Children also need to know their relatives and also their background. In addition, they need to have information on physical structures like buildings in town. Children enjoy a visit to the city centre where they familiarise themselves with the physical structures such as streets/ roads, buildings and reputable shops. (Focus Group 6 Participant 5).

*Children yearn to know more about their family history and whereabouts of their relatives as this helps them to describe and define their identity. It should be a must for children to see their relatives because they need those relatives when they leave the institutio*n. (Focus Group 7 Participant 6).

> *Children need to be in possession of identity documents. However, the DSS takes too long to process the documents. Right now, we have a child who is sitting for O-level exams but does not have a birth certificate.* (Focus Group 8 Participant 1).

It can be concluded that caregivers were aware of children's needs. As explained by Participant 4, children need love, care, clothing and many other basic things. This provision of basic needs is critical in child development as if affects the socio-emotional functioning of children during their development and later on in adulthood. This is consistent with literature and assertions from child development theoreticians who contend that the provision of basic things and emotional support are important, as it enhances proper child development (Bowlby, 1969; Bronfenbrenner, 1979; Maslow, 1970; Pringle, 1985). The other needs like exposure to the external environment help the child to be familiar with surroundings and to fit in the society. Thus, confining children to the walls of the institutions deprives children of knowing their surroundings, and therefore reduces their confidence when they mingle with other children and people in the society. The same applies to information regarding family history and identity. This is consistent with Erik Erikson's Psychosocial Theory that affirms that lack of identity in children can produce confusion; which can later on affect their functioning in adulthood (Hook, 2002; Levine & Munch, 2014). This again includes the possession of legalised national identity documents. However, it is very disturbing to note that the DSS takes too long to process the documents and this affects children's socio-emotional status.

The study solicited for information regarding the things that are done by caregivers in order to address the needs of children. To this end, caregivers mentioned various things as is indicated by the following quotations:

> *We work with children on a daily basis and see to it that they have food, clothing, blankets, uniforms and many other basic items.* (Focus Group 4 Participant 1).

> *We do many things to show children that we love them like, carrying toddlers on our backs, hugging, giving children equal portions of food, giving children time to talk in private, and giving children presents when they go for foster care during school holidays*. (Focus Group 6 Participant 2).

We give support to children in many other ways such as cheering children when they are participating in sport, attending school consultative visits, and allowing children to share with us their painful psychosocial issues. (Focus Group 7 Participant 3).

The above-mentioned quotations show that caregivers are actively involved in meeting children's needs. This is consistent with literature and contributions made by child development theoreticians that emphasise the importance of providing material and immaterial needs in order to enhance proper child development and social functioning later on in adulthood (Mhongera, 2017; Powell et al., 2004, Powell et al., 2005; Powell et al., 2006; Shanahan, 2000). Therefore, caregivers play a critical role in shaping children's lives for the future.

7.3.3 Provision of relevant psychosocial support

The caregivers who participated in the study indicated that some children in institutions present with a number of psychosocial issues and therefore need relevant psychosocial support. The caregivers cited a number of psychosocial issues as evidenced by the following quotations:

Children desire to know more about their background and therefore ask us questions like, "How did I come here? What is my home area like?" (Focus Group 4 Participant 1).

We have children who steal, make false statements and present with extreme loneliness. (Focus Group 5 Participant 2).

Some children display bitterness, are not keen to be reunified with their family members as they accuse them of serious neglect and abuse. (Focus Group 6 Participant 3).

We have children who are very slow. We sometimes push them to cook or wash clothes and actually supervise them to organise their shelves. (Focus Group 6 Participant 4).

Some children in this institution are HIV positive and need information on the disease and self-care. (Focus Group 7 Participant 5).

> *We have children who cling to institutional life. Such children fail their grades deliberately so that they will repeat classes and remain in institutional care*. (Focus Group 8 Participant 6).

These quotations present the issues that caregivers felt needed intervention. In explaining psychosocial issues, this section adopts a definition on psychosocial psychology by Hook et al. (2002, p.6) that explains that psychosocial psychology refers to "a person's sense of identity and self, and to their sexual, moral, and psychological growth within a particular socio-cultural context". It is worthy to note that some issues presented by children were similar among the institutions under study, thereby confirming the similarity and nature of the issues that institutionalised children grapple with. The issues are consistent with literature on institutional care and contributions from theoreticians who focused on child development (Browne et al., 2006; Chibwana & Gumbo, 2014; Zeanah et al., 2003). In this vein, the desire to know more about oneself can be linked to Erik Eriksons' Psychosocial Support Theory stage called Identity vs Confusion. Using Erikson's ideas, it can be argued that it is important to equip children with information regarding their background and in cases where the circumstances trigger emotions, as in cases where the whereabouts of relatives are unknown, it is important for caregivers to use a sensitive approach. The slowness of children in undertaking simple household duties is consistent with observations made by various authors who felt that this was a result of the difficult experiences encountered by institutionalised children (Browne et al., 2006; Powell et al., 2004; Zeanah et al., 2005). The clingy behaviour explained by Participant 6 could be a sign of children resenting separation again and facing the consequences. In linking this finding to the Attachment Theory, children repeat classes so that they remain in the same environment which they deem might be better that post-institutional care life. On the other hand, using Bowlby's Theory, this reluctance can be attributed to the bonds that children build with caregivers, and thus find it hard to sever them as a result of discharge. Against this explanation, this also shows institutions' lack of discharge plans that are clearly outlined. It can therefore be argued that if institutions had plans that are clear, children would work hard in order to reach towards another stage where they will be fending for themselves. Against this backdrop it is fundamental for institutions and all childcare practitioners to have clear discharge plans.

The other psychosocial issue discussed centred on children who are HIV positive. Caregivers observed that such children know that the disease is incurable and are obliged to take

medication for the rest of their life. As a result, as noted by caregivers, children ask caregivers questions about the disease and their care when they leave the institution.

It is clear that the psychosocial issues presented by children were either observed by caregivers or verbally presented by children. In this vein, the study gathered that currently the institutions do not have a checklist for psychosocial issues, or if the checklist is there it is not in use, since there was no reference of the checklist in all the discussions.

The study solicited for information regarding the interventions used by caregivers to help children to deal with psychosocial issues affecting them. As mentioned earlier on in this chapter, caregivers are the direct service providers in childcare institutions. As such, they are the first port of call in terms of psychosocial support to children. In exploring the psychosocial interventions, this section adopts a definition by Richter et al. (2006, p.16) where the term psychosocial is seen as referring to "a range of intervention tools, processes and programmes delivered to children in difficult circumstances to address non-material needs. Participants discussed various interventions which are in use as indicated in the following quotations:

> *We sit down and talk to children in a free environment*. (Focus Group 4 Participant 1).
>
> *We provide counselling and show them love*. (Focus Group 7 Participant 2).
>
> *Whenever we want children to know about their background, we pull out their files from the offices and then sit down with them and discuss the contents of the file.* (Focus Group 8 Participant 3).

Caregivers thus make strides to deal with the children's issues. However, the study gathered that all four institutions did not have programmes that are tailormade for the newly-placed children. Using Bowlby's Attachment Theory, the process of placing children in institutional care separates them from the figures to whom they are attached. As a result, children may experience negative feelings highlighted by Bowlby (1969) like anxiety and sorrow, fear, resulting in regression. Bowlby (1977) maintains that if these issues are not resolved, the likelihood is that they may generate more psychosocial issues both in childhood and adulthood. Furthermore, as explained by Richman in Muguwe (2012), it is practical and conducive for newly-placed children to present past sadness and loneliness from past experiences before institutionalisation. It is against this background that the researcher felt

that there is need for institutions to avail psychosocial programmes that cater for the socio-emotional needs of children soon after their placement in childcare institutions. Presumably, these programmes will help children to deal with the psychosocial issues that they may bring along upon placement, and may include programmes like informative and supportive counselling, how to deal with loss, and how to adapt to new life and memory work. On the other hand, using Bronfenbrenner's Ecological Theory it is important for institutions to create an environment that nurtures healing of children who have been separated from their parents, guardians, or primary caregivers. In support of this, Steckley and Smith (2011) suggest that institutions for children should have environments or "healing spaces" where children deal with past painful experiences. To this end, such environments should take into account the children's interactions with other people, and childcare institutions' relationship with other stakeholders like the school, the clinic, the input that children give in committees and other bodies, and the culture that exists in the environment in which children will be growing up. Hopefully, all this can help children to deal with past painful issues and move on with life.

7.3.4 Provision of services that prepare and equip children to be well adjusted citizens of the country

During focus group discussions, participants highlighted the services available in institutions that are provided to prepare and equip children to become well-adjusted citizens in Zimbabwe. This was evident from caregivers' responses:

> *We teach children self-help projects like gardening, poultry and sewing, access to education from primary to tertiary level, house chores like cooking, baking and cutting firewood, hygiene and cultural norms.* (Focus Group 3 Participant 4).

> *We teach them manners so that when they go out there, they will be able to relate with their future bosses at work and future neighbours.* (Focus Group 4 Participant 6).

From these responses, it can be highlighted that caregiving work in childcare institutions in Zimbabwe also entails equipping children with skills and information that will help them to adjust well in the society such as personal hygiene, communication, confict management, sex and sexuality information. These skills and information are critical and will be useful to them later during adulthood years (Mhongera, 2017; Shanahan, 2000).

7.4 CHALLENGES EXPERIENCED BY CAREGIVERS

This section will discuss the challenges that are experienced by caregivers which include the existence of a multiple reporting system for children, high caseload and lack of resources, regulations which do not promote proper child development, inadequate training for caregivers, and the non-existence of a body for caregivers. Noteworthy is the fact that these challenges result in the rendering of inappropriate services to children in institutions and also negatively affects the efforts made by caregivers in raising these children.

7.4.1 Existence of a multiple reporting system for children

Caregivers pinpointed the existence of a multiple reporting system as one of the challenges that caregivers were facing. This multiple reporting system was defined by caregivers as a situation where a child who has problems has the mandate to talk to anyone in the institution, right from mothers, directors or to the country directors of the institutions. Caregivers described this as a source of confusion and conflict for all the children with whom care workers are involved in the case of the children who would have reported. This was evident from the following comments made by participants:

> *We have a multiple reporting system which allows children with grievances to report their matters to anyone in the institution including other employees who do not have direct contact with the children*. (Focus Group 4 Participant 1).

> *The multiple reporting system that exists in this institution creates an open-door policy for children, but deprives them of the opportunity to use the correct channels of communication and maintain confidentiality. As result, children who are discharged from the institution portray a disrespectful attitude towards authorities such as at work or in the community*. (Focus Group 5 Participant 2).

> *This has a negative effect on the caregiver-to-child relationship in that caregivers do not feel comfortable to reprimand children or correct their mistakes as children have the mandate to report anything.* (Focus Group 6 Participant 3).

> *In my view staff members who do not have direct contact with children should not deal with children's issues because their involvement culminates in discords due to the lack of experience in direct childcare work*. (Focus Group 7 Participant 4).

It is clear from these quotations that caregivers were not happy with the multiple reporting system, as it results in children disrespecting other members of staff. Such an attitude deprives children of the opportunity to building trustful relationships with caregivers, and since such a system does not exist in normal families, it fosters an artificial environment which culminates into many negative effects on children later in life (Hook et al., 2002; Masuka et al., 2012). Therefore, there is need for institutions to address this reporting system and put mechanisms in place that will be child friendly as well as user friendly by childcare staff.

7.4.2 High caseloads and lack of resources

It emerged from the study that caregivers were attending to high caseloads. This meant that they were handling more cases than the stipulated manageable number of cases. This was evident from the following comments from participants:

> *The caseload is too high, we are looking after too many children although we prefer a ratio of 8-10 children per caregiver.* (Focus Group 5 Participant 1).

> *My observation is that the number of children is increasing and now we are caring for too many children.* (Focus Group 6 Participant 2).

It is clear that caregivers recognised that the number of children they were looking after was too high for them to manage efficiently. As highlighted in Better Care Network (2009), the high numbers of children sometimes allocated to a caregiver makes it difficult for the caregiver to develop strong and meaningful continuous bonds that are critical in child development. Again, as explained by Participant 3, although the numbers of children were increasing, some institutions were operating with meagre resources and as such, there was a lack of space and few members of staff which resulted in compromised childcare service delivery. Presumably, organisations would find it difficult to meet the basic needs of children. There is need therefore for institutions to adhere to the recommended number of children per caregiver.

7.4.3 Regulations which do not promote child development

It emerged from the study that some of the regulations in institutions deprive children of opportunities to exercise their initiative and autonomy. This was evident from the following comments made by participants:

> *We are expected to accompany children every time they leave the institution. As a result, most of our children are not confident to move on their own*. (Focus Group 3 Participant 1).

> *We are not allowed to send children to go and buy groceries or even vegetables on their own. I think this regulation negatively affects children*. (Focus Group 4 Participant 2).

> *We find it difficult to look after children with difficulty to identify their strengths and interests or have mental problems. Such children do not perform well in gardening, school and house chores as it is very difficult to know their niche and further develop it*. (Focus Group 5 Participant 3).

As indicated, it can be highlighted that caregivers felt that there was need for policy makers to review childcare regulation to ensure that they promote child development for example, by instilling confidence in children. This is consistent with views from Erik Erikson's Theory of Psychosocial Development, on a stage on Autonomy vs Guilt, which contend that denying children opportunity to do some things on their own results in negative feelings associated with guilt, incapability and inferiority (Hook, 2002; Hook et al., 2002; Levine & Munsch, 2014). Similarly, Pringle (1985) concurs with Erikson and observes the non-existence of confidence in children who are not given room to explore new things. Therefore, as unanimously observed by participants, policy makers possibly need to redraft policies which leave room for children to use their own initiatives and give them more autonomy so that they get used to doing things on their own.

Furthermore, the other challenge that emerged centred on birth registration and identity documents. This was evident from the following comments by participants:

Parting with an 18-year-old child who will be discharged without a birth certificate is very painful, especially when you know that they do not have national identity documents. (Focus Group 6 Participant 1).

To me, parting with a child who has no identity documents makes me feel as if I wasted my energy because it deprives children from proceeding with education or to get a formal job. In some cases, we end up meeting such children in the street living street life and displaying a bleak future. (Focus Group 8 Participant 2).

Again, as explained earlier on by managers, the issue of late and non-processing of birth certificates was a bone of contention for caregivers. It appears the DSS is not performing the task as expected and as a result, children are discharged from the institutions without national identity documents. This is contrary to expectations stipulated in childcare institutions and literature, which highlight the importance of national identity documents for children (African Charter on the Rights and Welfare of the Child, 1990; Powell et al., 2004; United Convention of the Rights of Children, 1989). In particular the UNCRC stipulates that all children have a right to a birth certificate meaning all children should possess birth certificates. There is need for the DSS to address this issue to ensure that all children possess identity documents.

Another challenge that exists, as explained by Participant 3, is linked to dealing with children who are mentally challenged and wrongly placed at childcare institution instead of a special home. There is need for probation officers to address this by conducting full assessments before placing children in institutional care, to avoid placement of children who do not qualify. Again, this is another issue that should be addressed by policy makers, to ensure that children who are mentally challenged and **need special attention, are attended to.**

7.4.4 Inadequate training for caregivers and non-existence of a managing body for caregivers

Caregivers expressed the view that there is no body which represents the needs of caregivers. This was evident from the following comments of participants:

There is no body for caregivers in Zimbabwe and we have never heard of such a body in Zimbabwe because authorities believe that caregivers are abusers. (Focus Group 4 Participant 1).

> *My feeling is that if we had a body for caregivers, it would cater for caregivers' issues like work-related disputes, working conditions and caregiver assistance programmes while at work. Right now, if a caregiver is dismissed from work, she just goes home*. (Focus Group 6 Participant 2).

In the same vein, the non-existence of a caregivers' body displays child practitioners' lack of concern for the rights of the caregivers whom they expect to provide quality care to children. There is need to put in place a body for caregivers which will be responsible for hearing the voices of caregivers and running their affairs.

On a similar note, caregivers felt that although they are providing a noble service in the society, the general public does not award them the respect which they deserve. This was evident from the following comments made by participants:

> *People look down upon us, see us as "the uneducated".* (Focus Group 3 Participant 1).

> *People who bring donations do not treat us with respect in that at times they are overly concerned in wanting to know where the donated things will go and how it will be shared. This is done in a way that sounds as if they are strongly suspecting that caregivers will misappropriate the donations.* (Focus Group 4 Participant 2).

It is clear from the comments that caregivers feel that although they are providing services to children, the society at large lacks respect towards them. This is concurred by Heron and Chakrabarti (2002) who confirmed that childcare institution employees are inadequately qualified, poorly paid and lowly ranked.

7.5 SUMMARY

This chapter has covered the experiences of the caregivers based on their hands-on interaction with children. The coverage which was comprehensive, explored issues regarding both caregivers and children. These issues were analysed using existing literature and theories adopted in this study. It is worthy to note that caregivers attach a lot of value to their job, but at the same time feel that institutional care does not provide the best environment for children in need of care as it impacts negatively on child development. A closer look at the issues raised by caregivers, reveals that the institutions endeavour to meet children's needs in line with developmental domains which are physical, cognitive and social-emotional. It was

clear that all four the institutions are meeting the needs of the physical domain in child development because participants never mentioned cases of children who were malnourished, obese or had other physical developmental challenges. However, as revealed in contributions from caregivers, childcare institutions need to address loopholes identified with regard to the cognitive and social-emotional needs of children as is explained in the section that covered information on the psychosocial issues presented by children and the intervention strategies used by caregivers.

The next chapter will look at the experiences from children as the direct recipients of the services provided in institutions. In this vein, it is worthwhile to find out whether the children's experiences and perceptions match with the views from the directors of institutions discussed in the previous chapter, as well as the caregivers' experiences explored in this chapter.

CHAPTER EIGHT:
PRESENTATION AND DISCUSSION OF FINDINGS ON CHILDREN'S EXPERIENCES ON INSTITUTIONAL CARE

8.1 INTRODUCTION

In this chapter data collected via individual interviews with children on their experiences in institutional care will be presented and discussed. In addition, the presentation and discussion of these findings will be based on objective number three which sought to explore the experiences of children in institutional care as recipients of services provided in institutions. Therefore, this chapter sought to answer research question number three:

How do children experience the psychosocial support services provided in childcare institutions in Harare, Zimbabwe?

Therefore, based on the above-mentioned research question, this chapter will discuss experiences on psychosocial support services are conceptualised as services that are aimed to help children deal with social, psychological and emotional issues in order to enhance their well- being. These services include interventions that focus on a person's sense of identity, psychological growth and other social issues (Hook et al., 2002). In this regard, children's experiences centred on psychosocial services which constitute part of the package of services provided in institutions to cater for the total person components which are emotional, physical, spiritual and social.

Furthermore, this chapter will look at children's experiences with regard to services that are provided in institutions in order to equip children with life skills critical for development as explained in objective 4 of the study.

Various themes emerged from the data collected from these children, and this study has divided the themes into two groups namely; the desirable aspects and undesirable aspects in childcare institutions. The table below shows themes and subthemes that emerged from the study.

Table 8.1: Themes and sub-themes on data collected from children

Theme	Subthemes
1. Desirable aspects in childcare institutions	a. Provision of a family environment
	b. Provision of basic needs
	c. Availability of a child-friendly environment
	d. Relevant psychosocial and spiritual support
	e. Existence of services that equip children with skills critical in adulthood
2. Undesirable aspects in institutional care	a. Lack of exposure to the external environment
	b. Dealing with caregivers who are uncaring
	c. Stigma from members of the general public
	d. Fears about post-institutional care life

As indicated in Table 8.1, the study identified sub-themes from the two aforementioned groups. Thus, on the desirable aspects, the following themes emerged: the provision of a family environment, the provision of basic needs, the availability of a child-friendly environment, relevant psychosocial and spiritual support, and the existence of services that equip children with skills critical in adulthood. On the other hand, the undesirable aspects category comprised lack of exposure to the external environment, dealing with caregivers who are uncaring, stigma from members of the general public, and fears about post-institutional care life. These subthemes will be presented in this chapter, integrated with direct quotations from children and relevant literature to support or contradict findings.

8.2 PROFILE OF PARTICIPANTS

Table 8.2: Profile of children who participated in the study

Institution	Age range of participants	Female	Male	Total
A	9- 12 years	3	3	**6**
B	9-12 years	3	3	**6**
C	13-18 years	3	3	**6**
D	13- 18 years	3	3	**6**

As shown by Table 8.1, the study engaged a total of 24 children from four institutions to collect data on children's experiences in institutional care. These participants were split into two groups which were those aged 9 - 12 years and those aged 13 - 18 years. This shows that childcare institutions provide care to children who are at different developmental stages. Against this background it is critical for institutions to give children opportunities to express their views (Hammaberg, 2008; Mushongera, 2015) in order to render services that are relevant their developmental stages.

8.3 DESIRABLE ASPECTS IN CHILDCARE INSTITUTIONS

This section will discuss the desirable aspects in childcare institutions. It will present and discuss the following subthemes mentioned earlier on: the provision of a family environment, access to basic needs, the provision of appropriate psychosocial support services, and existence of services that equip children with skills critical in adulthood.

8.3.1 Provision of a family environment

It emerged from the study that children felt that institutions were providing them with a family environment which has shelter, a parent and siblings. This was evident from the following comments from the children participants:

> *I came here as a baby. I am grateful that I found a family here and I have a mother, brothers and sisters.* (Participant 1).

This place is a very nice place, from the time I came here, I have experienced many new things that that I find useful in my life. Initially, I used to think that living in a home was disgusting as one will be experiencing bad things about life. Instead I found that it was a very good place because our mothers are very caring. (Participant 2).

We are taught good manners and rules, like don't steal, don't lie, greeting people in the morning, praying and to do house chores before taking a bath. (Participant 3).

We needed a home and we got it! (Participant 4).

I like the type of care that we get here. I understand that it is not easy to look after other people's children, but our mothers are doing their best. (Participant 5).

We live like a family, we do house chores that are similar to the ones done in a family. (Participant 6).

This institution is s a nice place, a nice home, a caring and loving one because they say every child belongs to a family so I just feel at home. (Participant 7).

Based on the above-mentioned quotations, it can be highlighted that children felt that that the institutions were providing them with a family environment. This is consistent with literature that contends that institutions should provide a safe and caring family environment to children under their care (African Charter, 1990; SOS Pamphlet, n.d; United Nations Conventions on the Rights of Children, 1989). Furthermore, it can be argued that it seems as if the provision of a family environment is the main objective of many childcare centres. However, on the other hand, the study revealed that the existence of the family environment that should prevail in childcare institutions is not felt by all children as indicated by a child who could not comment on what could be done to improve the family environment and therefore said:

I don't know what to say because I don't know how it feels for one to have parents or be in a home other than this one. (Participant 5).

In this regard, there is need to consider other alternatives for such children like putting them in foster care so that they experience real family life (Delap, 2011; Hunt, 2009).

8.3.2 Access to basic needs

Having access to basic needs emerged as another theme from the study. In this vein, children appreciated efforts that are made by institutions to meet their basic needs. This was evident from the following comments:

> *The staff here is very caring they give us everything we need like books, textbooks, money and food*. (Participant 1).

> *I am well cared for, and not being abused. I love my mother and she loves me as well.* (Participant 2).

> *We are given, food, clothes and school fees and uniforms*. (Participant 4).

These findings tally with the findings from Chapter 6 that explained the recognition of children's needs by managers. From the above-mentioned quotations, it can be highlighted that children felt that institutions recognised their needs and thus made endeavours to ensure that those needs are met. This is consistent with views that childcarers should provide children with basic needs so as to enhance proper child development (Pringle, 1985; Ruppel, 2009; Simons, Irwin & Drinnien, 1987; UNCRC, 1989).

Linked to the above-mentioned subtheme, is the provision of a child-friendly environment by institutions. The study revealed that childcare institutions provide children with an environment that allows children to be themselves and to be proactive. This was evident from the following comments:

> *We receive presents like toys, clothes and shoes on Christmas day and birthdays*. (Participant 1).

> *We play games of our choice and I enjoy football and cricket*. (Participant 2).

> *During our spare time we watch TV, go to swings and play with our friends.* (Participant 3).

Using the information from the above-mentioned quotations, it is clear that institutions recognised children's need and right to play. In this regard, institutions avail children various ways of play and understand that play is a critical component in child development. This is consistent with literature that contends that it is through play that children gain confidence,

learn to make decisions, release stress, as well as manage emotions. All these aspects contribute towards children's well-being (Chudakoff, 2007; Schaefer & Reid, 2001; Whitebread, Basilio, Kuvalja & Verma, 2012).

8.3.3 Provision of appropriate psychosocial support services

The other subtheme that emerged focused on the provision of appropriate psychosocial services. This came out when children explained that the mothers/caregivers always help them to deal with pressing issues. This was evident from the following comments from participants:

> *It is not easy to look after someone else's child but our mothers are doing the best*. (Participant 1).
>
> *When I have a problem, sometimes I feel better after discussing the issue with my mother (caregiver).* (Participant 2).
>
> *We have a committee for children which is responsible for attending to issues raised by children. I am the chairperson of that committee. We meet three times a term, discuss problems and submit them to the Director of the institution*. (Participant 3).

It can thus be highlighted that children gave general comments on psychosocial support services. As explained by Participant 1, the caregivers were doing their best to care for children, implicating that some of the caregivers were providing quality care which is critical for the psychosocial functioning of children. The other two comments allude to that fact that children are free to approach caregivers for emotional support and also that the children's committee provides peer support mechanisms which may be non-threatening to children. This shows that children do not only expect basic things in institutions, but also desire psychosocial care. This is consistent with ideas by Erikson, propounded in his Psychosocial Theory and John Bowlby in his Attachment Theory, that when caregivers develop trustful relationships and strong attachment with children, children in turn feel free to interact with them and presumably share past painful experiences (Bowlby, 1969; Hook, 2002). In this regard, it is very critical for caregivers to have sound relationships with their children as they promote good environments for provision of psychosocial support.

8.3.4 Existence of services that equip children with skills critical in adulthood

The other subtheme that emerged from the study is the existence of services that equip children with skills critical in adulthood. Children appreciated the services that they get from the institution as they prepare them for future life. This was evident from the following comments by participants:

> *I attend life coaching sessions on Saturdays. These self-grooming sessions have changed me, now I know how to present myself to people and also manage time.* (Participant 1).

> *I have learnt a lot here because when I came here I was just someone who could just sit and sleep the whole day and wait for someone to do things for me, but since I came here I have learnt that yeah, you have to be a hard worker and when our supervisor finds our place dirty, she will be upset and you feel like 'no', I have to do something. So like comparing my background and the way I have been here it totally different and I have experienced many things here at this children's home. Back at home we used to have maids and the only thing that I could do was the dishes, but here I learnt how to cook and wash my clothes.* (Participant 2).

> *I am in a boarding school and the institution provides me with everything that I need.* (Participant 3).

> *I am a footballer, the institution is helping me a lot to nurture my talent, I intend to make a living out of football*. (Participant 4).

> *We have time to go to school and to church. As you know our economy is not good, it is like down. It is going down so we need to go to school so that we can find a better job. It is not like when we are just here and wait for 18 years and we're discharged and so much good. I like going to school so that I can socialise and mingle with my friends.* (Participant 5).

From the above-mentioned comments, it is clear that institutions groom and prepare children so that they will be able to run their lives after institutional care. In this vein, the self-grooming sessions, house chores, access to education and playing sport assist children to prepare for future life. This is critical taking into cognisance the fact that after institutional

care, children join the society at large and are expected to fit in and make significant contributions. This is corroborated by Mhongera (2016) who affirms that it is very important to prepare children for post-institutional care life. However, it is sad to note that although the children alluded to this, reporting on organisations that provide post-institutional care services is very little, meaning most children are absorbed in the society with little preparation.

8.4 UNDESIRABLE ASPECTS OF INSTITUTIONAL CARE

This section presents subthemes linked to undesirable aspects existent in childcare institutions. These subthemes include strained relationships with other children and caregivers, lack of exposure to the outside world, stigma from members of the general public, fears about post-institutional care life, and lack of knowledge on how to handle unresolved issues.

8.4.1 Strained relationships with other children and caregivers

It emerged in the study that children were experiencing strained relationships with other children and caregivers. These relationships affect the way they relate with others as well as children's emotional well-being. This was evident from the following comments by participants:

> *There is a lot of bullying here and this makes me sick*. (Participant 1).
>
> *Some mothers scold children and quote the difficult circumstances that resulted in institutionalisations. We do not take action because there is nowhere for us to report. This is very painful, and forces us to wish we were living with our real parents*. (Participant 2).
>
> *Sometimes, children scold each other using hard words like "you are a prostitute".* (Participant 3).
>
> *At times, young children are beaten up for minor mistakes and this is not fair. Caregivers should bear in mind that children are still learning a lot about life unlike them, hence they should talk to children with respect and not just beat and scold them all the time*. (Participant 4).

The above-mentioned quotations revealed that at times children experience strained relationships with other children and caregivers and in particular as mentioned by Participant 1, bullying that may exist in some homes makes life unbearable for other children. This is consistent with arguments by Gibbs and Sinclair (2000) that children residing in childcare institutions are sometime vulnerable to bullying and this affects their self-confidence and sense of security.

8.4.2 Lack of exposure to the environment outside the Institution

Another theme that came out from the study was linked to a lack of exposure to the outside world. In this vein, children highlighted that some of the institutions' rules and regulations restricted them from getting exposed to things that happen outside the institution. As a result, they end up lacking confidence in themselves and when mingling with other children. This was evident from the following comments:

> *We lack exposure to what is happening outside this institution. We just hear, but we do not know how it is like out there. Although our mothers tell us that out there, life is very tough, we somehow think that everything is soft because here we get everything, If I ask for a book, I get it and sometimes I find it difficult to understand that another child will be struggling to get a cover for books.* (Participant 1).

> *I think there is need for someone to come and stay with us and tell us about how life is like out there. For example, if a person can start by telling us his/her background and then share their life story. It is very important for us to know what is happening outside so that we will be familiar with many things by the time we get discharged from this institution.* (Participant 2).

> *We are not allowed to go out of this place, yet we really want to go out to buy clothes and shoes.* (Participant 3).

> *I don't enjoy kuvharirwa mugedhi (being in the institutions all the time), I wish I could go to hotels or other places that I have never been to.* (Participant 4).

> *We are not allowed to possess cell phones but some children have cell phone which they bought using their pocket money and savings from free taxi rides.* (Participant 5).

You feel out of place when you go outside, especially when you do not have a birth certificate because every child needs a birth certificate. So at school they will tell you to come with your birth certificate and when you tell them that you don't have one, they will start to ask you questions about where you live. What is the problem for me not to get a birth certificate, they will then ask you to go home and get a birth certificate and here they will say the birth certificate is not yet out and a child without a birth certificate will not participate in sports. My age estimation was done when I was in grade 7 and now I am in Form Two and it is not yet out. It is embarrassing to be in secondary school without a birth certificate as people will laugh at you because they do not understand why I do not have a birth certificate. (Participant 6).

At one moment, I was not allowed to go for a trip for no apparent reason. I was also not allowed to go to boarding school although I had passed the entrance test at two boarding schools. I think my mother did not allow me to go because she wants me to work in the garden. Right now, I still feel pain about the trip. (Participant 7).

The above-mentioned quotations show that children are not comfortable with the restrictive life that is offered by institutional care. These sentiments were also echoed by caregivers as highlighted in Chapter 7, that such restrictions limit children's chances for exposure to the outside world. Again, the issue of birth certificates that was also raised by managers and caregivers, emerged in this chapter. Children emphasise the fact that it is embarrassing for one not to possess a birth certificate. In linking the findings to literature, children's wishes of going out the gate can be equated with their need to experience new things. Against this backdrop, Pringle (1985) notes that children enjoy experiencing new things, and he even cites the exploration of new things as another psychosocial need for children that cultivate confidence and independence. This means that when institutions deny children the opportunity to go out of the gate, they also deprive them of chances of exploring new things and gaining confidence. As a result, upon discharge children make wrong decision and choices as evidenced by the following comments by caregivers:

Most of the girls who got the chance of leaving the gate were impregnated within a short space of time.

Therefore, restricting children too much from interacting with their environment outside the institution, results in their lack of social skills to deal with people who live in the community.

This is due to the lack of continuous exposure to them. In support of the above-mentioned, participants who had had a chance to stay out of the institution shared positive comments and therefore indicated that exposure to the external environment is one of the components that is available in normal families with whom they stay. This was evident from the following comments:

> *I like staying with my foster family in Glen Norah because we are allowed to go out and meet friends, as long as we come back well on time.* (Participant 1).
>
> *I enjoy staying in Glen Norah because we are free to go anywhere as long as it is during the day*. (Participant 2).

The two quotations show that children enjoy freedom to move around and explore new things. This is consistent with Erikson's Psychosocial Theory that affirms that children should be given opportunities to explore new things (Hook, 2002; Levine & Munch, 2014). In this regard, there is need to revisit the restrictions in order to meet children's needs for the exploration of new things.

8.4.4 Stigma from members of the public

The other theme that emerged from the study is linked to stigma from members of the public. Children highlighted that people who live outside the institution label them and this affects them emotionally. This was evident from the following comments:

> *When people refer to me as that child from an institution (Mwana wepahome), it makes me wish I was staying with my mother*. (Participant 1).
>
> *I find it difficult to tell other children that I stay at a children's home, so I always lie that my mother works there because people view us as people who are struggling and I don't like the pity that people show us.* (Participant 2).
>
> *I don't feel comfortable to tell other people that I stay at a children's home so I just tell people the location of the street, not the actual address of the children's home.* (Participant 3).

The above-mentioned quotations are consistent with findings from the research conducted by UNICEF in 1992 which revealed that children in institutional care are called names that

stigmatise them. Again, this finding is consistent with sentiments from childcare directors highlighted in Chapter 6, that children from childcare institutions are reviled and pitied by the society at large. Against this background, it can be argued that there is need to educate and sensitise the community on how external people interact and communicate with children in institutional care without discriminating against them.

8.4.5 Fears of leaving the institution

The other undesirable aspect is connected to fears of leaving the institution. Against this backdrop, the study revealed that some children were too scared to sever ties with in the institution. This was evident from the following comments made by participants:

> *I am scared of staying on my own after leaving the institution.* (Participant 1).
>
> *I think when I leave this institution I am likely to face the challenges outside unlike other children with relatives who have the option of staying with their relatives. As for me, I should look for a place to stay so that the institution will pay rent for three months only, and thereafter I start to run my own life.* (Participant 2).
>
> *I think leaving the institution will be a challenge, because as soon as I get out of the institution and I may not have a place to go to. I always think about where will I go, stay and eat.* (Participant 3).

As indicated by the quotations, it can be highlighted that children ponder about post-institutional care life and sometimes see a bleak future. This is consistent with findings from directors of institutions and caregivers who pinpointed that the institutional care system has no proper discharge plans for children who reach 18 years of age and who are due to be discharged. Furthermore, it can be argued that this lack of discharge plans affects the children's psychosocial functioning as they struggle to think about their future. This concurs with literature that highlights that the Zimbabwean childcare system does not have childcare trategies for children who are discharged from institutions (Mhongera, 2017; Wyatt et al, 2010). Against this backdrop, there is need for institutions to designs proper discharge plans for children and also to familiarise children with such plans well before they are discharged from the institutions.

8.5 SUMMARY

This chapter has discussed the experiences of children who are placed in institutional care. In this regard, the study revealed both positive and negative experiences and their impact on child development. It is worthy to note that children in institutions appreciated the services in institutions and also highlighted some of the gaps that needed to be filled, like the timeous processing of birth certificates, their relations with caregivers, the nature of the institutional environment, and post-institutional care life, to mention but a few.

Children highlighted the psychosocial issues that they were experiencing in the institutions and their coping styles. In this context, it appears most of the interventions used to help children lie in the hands of caregivers and the directors of institutions, excluding input from the DSS. Therefore, although the Zimbabwean Children's Act gives more power to the Probation Officers, there is not much that is being done by the officers concerned towards children's psychosocial well-being, except placing them in institutional care. As a result, psychosocial interventions existing in institutions are run, excluding the Probation Officer. This exclusion has been attributed to meagre resources allocated to social services departments. These resources are insufficient to finance childcare programmes (Chibwana & Gumbo, 2014; Wyatt et al., 2010). Against this backdrop, if the issue of finances remains unaddressed, the quality of services will continue to be compromised, and in turn institutions will rear children who will end up as social misfits. In this vein, there is need to revamp the office of the Probation Officers in order to bring about change in the processing of birth certificates mentioned repeatedly, and the provision of relevant psychosocial interventions for children in need of care.

The above issues are critical in institutional care and should be addressed in order to enhance the quality of services provided in institutions. It is against this background that the following chapter will focus on the main findings, conclusions and recommendations based on information gathered from the directors of childcare institutions, caregivers and children.

CHAPTER NINE:
MAIN FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

9.1 INTRODUCTION

As highlighted in the literature review (Chapters 2 and 3), institutional care for children has been operational globally and in Zimbabwe for many years. The primary aim of this study was to explore the views of management, childcare workers and children about psychosocial-centred childcare services in childcare institutions in Harare, Zimbabwe. In this regard, this study collected information from managers, caregivers and children at four institutions in Harare, Zimbabwe. The main findings of the study, conclusions reached and recommendations derived from the study, are presented in the final chapter.

9.2 SUMMARY OF THE MAIN FINDINGS

This section will present the summary of the main findings based on the objectives of this study.

9.2.1 Objective 1: To establish the views of management on the nature of childcare services at the different institutions in Harare, Zimbabwe

This objective was achieved by the literature review and conducting in-depth interviews with childcare managers on their views on the nature of childcare services. The analysis of the data revealed that childcare institutions were providing services, which they deemed appropriate to children placed in their institutions. In addition, the study also discovered that, the efforts of the institutions to provide childcare services were hampered by various socio-economic challenges. The following summarises the appropriate services provided by institutions and the challenges experienced.

- **Provision of efficient management and leadership**

The study revealed that a director who was responsible for executing management and leadership roles manned all the institutions. As discussed earlier on in Chapter 6 (Section 6.2), the directors of these institutions possessed a degree in either social work or social sciences, which means they have extensive and comprehensive understanding of social issues and how to deal with people in needy circumstances. The study also revealed that these managers were knowledgeable about children's needs as well as how to run the institutions.

- **Provision of noble services to children**

Linked to the above-mentioned point, is the finding that managers felt childcare institutions were providing a noble service to the society at large, despite the fact that institutional care is regarded as a last resort and detrimental to child development (Browne et al., 2006; Mulugeta & Anatofu, 2000; National Orphan Care Policy, 1999; Zeanah, 2002). As concurred by one of the managers during interviews in Chapter 6 (Section 6.4.2), on paper, institutional care is the last resort, but in practice it is the first resort for Probation Officers. As a result, managers and childcare workers have no option except to provide care to institutionalised children, and provide for the needs of these children, deemed critical in child development. As indicated by participants and concurred by literature, it is however sad to note that these efforts are hindered by lack of support from the Government, which is visible when the Probation Officers do not fulfil some of their roles effectively such as visiting children to make assessments and develop care plans, and not processing national identity documents on time (Chibwana & Gumbo, 2014; Powell et al., 2004; Wyatt & Mupedziswa, 2010).

- **Creation of a family environment**

The participants revealed that institutions endeavour to create a family environment for children. This is endeavoured because the family is regarded as the basic institution for socialisation and provides an environment conducive for child development (Browne et al., 2006; Deininger et al., 2003; Ross, 2011). In the context of institutional care, institutions admitted that they mainly care for children who have been forced by circumstances beyond their control to sever ties with their families. As highlighted earlier on in Chapter 2, separation from family members results in children experiencing various psychosocial issues, which may affect them later on in adulthood (Ainsworth & Bowlby, 1991; Bowlby, 1977; Gurupira & Chikutuma, 2017; Morantz & Heyman, 2010). Against this background, participants revealed that childcare institutions create a family environment so as to provide children with mothers, fathers, siblings and an ecological set-up where they acquire social skills that are critical in adulthood like cooking, washing, proper communication with siblings, and personal management.

- **Administrative support from the government through the DSS**

The findings from the study showed that institutions were receiving administrative support from the government and managers highlighted that the Government is proactive in the formulation of childcare policies and frameworks. This concurs with literature which reiterates that Zimbabwe has well documented childcare policies and frameworks designed to address child protection issues (Chibwana & Gumbo, 2010; Masuka et al., 2012; Mushunje, 2006). This shows that the government provides clear guidelines needed when dealing with childcare issues and in this context, institutional childcare services. However, as explained by another participant, these well-documented programmes are designed to please donors and do not involve input from the people on the ground like the childcare institution managers, the caregivers and children in institutional care (Chapter 6, Section 6.3.4). As a result, some of the points stated in these policies and frameworks are not applicable to institutional childcare centres. There is need therefore, to include the voices of people on the ground as already stated, the childcare institutions' managers, the caregivers and children in institutional care when developing and implementing policies and frameworks that are relevant to their needs (Mushongera, 2015; Viviers & Lombard, 2012). On the other hand, participants felt that there was need for the Government to support the childcare centres to lessen costs by waving medical services costs for caregivers who are required to go on routine medical check-ups, and also to disburse institutional grants well on time.

- **Provision of relevant psychosocial support to children**

It was revealed that children who are placed in institutional care bring along with them various psychosocial issues. As a result, childcare institutions provide psychosocial support interventions in the form of counselling, life skills programmes, spiritual care programmes, and self-help projects, to mention a few. Participants felt that these interventions help children to deal with past painful experiences, cope and come to terms with their difficult backgrounds. Noteworthy is the fact that although psychosocial support is deemed as very critical in childcare institutions, Zimbabwe does not have a standardised framework for psychosocial support in childcare institutions. As a result, each institution offers children what they deem as relevant to children.

- **Provision of services that prepare and equip children to become well-adjusted citizens in the society**

The study revealed that institutions provide services designed to prepare and equip children to become well-adjusted citizens in the society. In this regard, participants highlighted that they were aware that institutionalised children are placed in care institution for a limited period, and in the context of Zimbabwe, until children are 18 years of age (Children's Act, 2001; Mhongera, 2017; Powell et al., 2004), and when they join the society they are expected to fend for themselves. Participants highlighted that institutions assist children with educational needs until they obtain a tertiary qualification and get employed or start their own business. In addition, institutions teach children self-help projects/income-generating projects so that they will use such projects later in adulthood to sustain themselves. Furthermore, institutions endeavour to expose children to real family life through foster care programmes where children get to live with real families in nearby communities during school holidays. This also helps children to deal with the unrealistic and distorted expectations that they will be having about life post institutional care. Lastly, the life skills programmes mentioned earlier on, help children to cope and acquire skills that will be useful in future when they face challenging psychosocial issues. However, in spite of these preparations, participants lamented the fact that institutional childcare framework and the policy exit strategy erode all the efforts made by institutional care staff, and possibly what the DSS seeks to achieve as a whole as there is no proper discharge plan for children in institutional care. Thus, as highlighted by another participant, some children end up on the streets begging and living as vagrants (Chapter 6, Section 6.3.4). To curtail this unintended consequence, possibly borne out of both poor planning and underresources, there is need for the Government of Zimbabwe as the sole custodian of child protection and Childcare Institutions to come up with a comprehensive preparation for and post institutional care discharge plan for children when they get to 18 years of age.

Conclusion

The conclusions drawn from the first objective are that in Zimbabwe, although institutional care is regarded as the last resort, the childcare institutions are operational and looking after children who need proper care and support. In this regard, institutions are run by qualified managers who oversee the day-to-day running of activities in the institutions, and also

interact with the outside communities which include the government and families near the childcare institutions. Furthermore, institutions endeavour to provide proper childcare services critical in child development, relevant to their psychosocial needs and prepare and equip children with skills that will help them to adjust in the society. It was highlighted that although the Government of Zimbabwe is supportive in terms of frameworks and policies, there were gaps on institutional childcare services that needed serious attention.

9.2.2 Objective 2: To investigate the perceptions of caregivers as direct providers of psychosocial support services in childcare institutions in Harare, Zimbabwe

To achieve this objective, as highlighted earlier on in Chapter 5, the researcher conducted focus group discussion with caregivers from the four childcare institutions in Harare. In these discussions, caregivers shared their perceptions as direct providers of psychosocial support services in childcare institutions. Findings showed the following:

- **Provision of a family-like environment**

As is implicated by the second objective, the caregivers are the direct service providers of childcare services in childcare institutions. As highlighted by managers earlier on, participants also highlighted that they provide children with a family environment through playing the parental role that entails looking after them round the clock, and also grooming and preparing them to become good citizens in future. Findings revealed that caregivers achieve this through the use of the relevant training that they received upon commencement of duty, and their personal wish to care for vulnerable children. Participants felt that they were doing their best to provide a family environment, but there were other factors which were impeding their efforts, which included a high caseload, regulations that are not pro-child development, and the multiple reporting system which is non-existent in any family set-up (Chapter 7, Sections 7.3.1, 7.3.2 & 7.4.3). In addition, caregivers felt that the childcare system in Zimbabwe does not appreciate their services and coupled with that, there is not a body in place to attend to caregivers' issues. As a result, institutional childcare services are pro-children's needs and ignore the needs of the caregivers. It was highlighted that there is need for childcare systems to attend to caregivers' needs so that they will in turn execute their duties efficiently.

- **Provision of relevant psychosocial support services**

This aspect was also highlighted by managers, and findings from the study revealed that caregivers who work with children and observed them round the clock, provide the bulk of these psychosocial services. As indicated in Chapter 7 (Section 7.3.3), caregivers provide psychosocial services to help children to cope and enhance their social functioning. Again, as explained earlier on in objective number one, childcare institutions do not have documented standardised guidelines on the provision of psychosocial support by caregivers. Notably, caregivers who have basic training in dealing with children, provide these services. It would be ideal if institutions engage qualified professionals like social workers, psychologists and other clinicians to assist children to deal with insurmountable psychosocial issues.

- **Provision of services that equip children to be well adjusted citizens of the country**

As alluded to by managers, childcare institutions provide services that equip children to be well adjusted citizens. The findings from the study showed that caregivers play an active role in providing children with the mentioned services. These included self-help projects, good manners, personal management and other various social skills. Participants highlighted that their efforts were sometimes quashed by regulations that do not promote proper child development (Chapter 7 Section 7.3.4), and lack of training on how to deal with children who are very slow.

Conclusion

The conclusions drawn from the discussions with caregivers are that caregivers are duty-conscious and provide services in line with expectations from childcare institutions as well as childcare policies and guidelines. However, as highlighted earlier on, they felt that some policies were not applicable and guidelines were not practical and therefore should be revisited. Moreover, that the childcare services are designed in such ways that they display a positive slant towards children and at the same time are silent on the caregivers' welfare.

9.2.3 Objective 3: To explore experiences of children in institutional care as recipients of services provided in institutions

In order to achieve this objective, the study conducted in-depth interviews with children to hear their voices regarding institutional childcare services. The findings from the study revealed the following:

- **Provision of a family environment**

As highlighted earlier on by caregivers and children, findings from this study showed that children appreciate the family environment that prevails in childcare institutions. This environment gave them a sense of belonging and provided them with parents, siblings and a home (Chapter 8, Section 8.3.1). This corroborates literature that advocates that the main goal of a childcare institution should be to avail a family to those children without one (African Charter, 1990; SOS Pamphlet, n.d; United Nations Convention on the Rights of the Child, 1989). On the other hand, as indicated earlier on by caregivers, children also concurred that the home environment provided in children's home has limitations and therefore does not foster exposure to the external environment at times (Chapter 8, Section 8.4.2).

- **Access to basic needs**

The findings revealed that children have access to basic needs owing to the services provided in institutions. In this regard, children shared that the institutions provided them with basic needs like food, shelter, a home and education. On the other hand, children highlighted that the Government takes long to process their birth certificates making it difficult for them to access services that require a birth certificate like participating in interschool sporting competitions, and other post-institutional care engagements (Chapter 6, Section 6.3.1; Chapter 7, Section 7.4.3 and Chapter 8, Section 8.3.2).

- **Provision of appropriate psychosocial services**

The findings concurred with sentiments shared by managers and caregivers that alluded to the fact that psychosocial services are provided in institutions, and children also expressed that they get psychosocial support services from the caregivers. The study also showed that in some cases, children support each other through child-led programmes and committees and it

is difficult to tell whether children give each other support that is relevant, as some children cited in interviews that they had strained relationships with each other and the caregivers.

- **Existence of services that equip children with skills critical in adulthood**

The participants declared the existence of services that equip children with critical skills in adulthood such as life coaching sessions and self-help projects. In addition, children highlighted that they were taught house chores and social skills. However, children raised the same issue that was raised by caregivers, that although they access basic needs, institutionalisation deprives them of exposure to the outside world (Chapter 8, Section 8. 4.2). As a result, they were not confident enough to engage with children and adults from ideal families, and alongside this, children also expressed fears of leaving institutions (Chapter 8 Section, 8.4.5). This finding concurred with findings from managers and caregivers that emphasised the lack of a proper preparation and discharge plan for children who turn 18 years of age. Consequently, this lack of clear discharge plans creates instability in children and may result in more psychosocial issues even before they are discharged.

Conclusion

The study concluded that children acknowledged the services in childcare institutions, and felt that as a result of those services, had found a home and a family. However, they felt that there was need for the government to address some of their needs like birth certificates and free access to the external environment, especially while still in care.

9.2.4 Objective 4: To determine how childcare institutions provide services that equip children with life skills critical in child development

To achieve this, the researcher asked managers, caregivers and children their views on the psychosocial services provided in childcare institutions. Hence responses to that objective have already been discussed in this chapter. What is notable is the fact that there is no standardised document or framework for psychosocial support provisioning in childcare institutions. In this regard, the researcher felt that there is need for childcare institution and the government to develop a psychosocial framework for children in institutions.

Conclusion

Psychosocial support services are existent in childcare institutions, but there is no framework to standardise the services and guide the caregivers and other related professionals involved in the care of the children.

9.2.5 Objective 5: To propose recommendations regarding improving childcare services in institutions in Harare, Zimbabwe

These are discussed in 9.3.

9.3 RECOMMENDATIONS

This section will present the recommendations which are based on the findings and conclusions from the study.

- There is need to increase the number of Probation Officers

The findings from the study revealed that Probation Officers were not executing some of their duties efficiently, effectively and timely, owing to low numbers. To this end, participants highlighted that there was need to increase the number of probation officers so as process children's birth certificates, care plans and discharge plans well on time.

- There is need for the Government of Zimbabwe to involve members of staff who have direct contact with children and the institutionalised children in trainings and policy formulation, implementation and evaluation

As highlighted earlier on in Chapters 6 and 9, participants felt that policies and frameworks were designed excluding input from people who have direct contact with children like managers and caregivers; resulting in the production of policies that are good on paper but not applicable in real-life situations. In this regard, this study recommends the engagement of managers, caregivers and institutionalised children in policy making and training on childcare issues.

- There is need to come up with a body for caregivers

The findings also revealed that caregivers do not have a body that attends to their issues. This study recommends the formation of a body for caregivers which will address their needs and possibly regulate their activities in childcare institutions.

- Need to standardise and develop a framework for psychosocial support interventions for children in institutional care

The findings showed that there is no framework for psychosocial interventions provided in childcare institutions. In this vein this study recommends the development of a framework for psychosocial interventions. That framework would then serve as a guide for all childcare institutions.

- There is need to revisit the discharge age for children and discharge plans also include support services for adults who were raised in childcare institutions

The findings revealed that managers, caregivers and children were not happy with the legal age of discharge of institutionalised children for childcare institutions. In this regard, this study recommends revisiting either the age at which children are discharged from institutions, or a redress of the discharge plans to make them practical and applicable to real-life situations that children will experience after leaving the institutions.

9.4 RECOMMENDATIONS FOR FUTURE RESEARCH

Based on the findings from the study and the limitations highlighted in Chapter 5 Section 5.5, the following areas for future research are recommended:

- Research needs to be undertaken on adjustment into the society by adults who were raised in institutions with the aim of determining their evaluation of the services that they had received while in institutional care.

- Research is recommended on theoretical frameworks that are applicable to childcare in African institutional set-ups. This is due the fact that, as indicated earlier on in Chapter 3, institutional care is not an African Strategy of looking after children in need of care. To this end, this study recommends a research to ascertain the theoretical frameworks that may be deemed suitable to childcare institutions existent in the African context.

- Research is required on the efficacy of psychosocial support interventions available in childcare institutions.

9.5 CONCLUDING COMMENT

The prevalence of institutional care is high in Zimbabwe because of tough or difficult socio-economic conditions. The sentiments that it is the last resort are on paper, but not in practice as highlighted by managers. More and more children are being placed in institutional care (Chapter 6, Section 6.4.2). As result, there is need to improve on the quality of care in order to guard against the detrimental effects of institutionalisation on children (Browne et al., 2006; Mhongera, 2017; Zeanah, 2002). Furthermore, the conclusions drawn from focus group discussions and interviews held with caregivers and children, respectively, revealed that institutions should address existing gaps like non- availablility of national identity documents and lack of exposure to the external environment and non- existence of a body for caregivers. Lastly, the in-depth interviews held with managers produced information which concurred with experiences from caregivers and children. In this vein, managers emphasised that there was need for the parcatictioners to involve people on the ground as well as children in childcare institutions when drafting and evaluating institutional childcare frameworks and policies. It was hoped that this would result in the formulation of frameworks, guidelines and policies that are appropriate for services offered in childcare institutions (Gwenzi, 2018; Mhongera & Lombard, 2017; Zeanah, 2002).

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APPENDIX A:
PARTICIPANT INFORMATION SHEET FOR KEY INFORMANTS AND CAREGIVERS

Institutional Childcare Services in Harare, Zimbabwe: Exploring Experiences of Caregivers and Children.

Good day

My name is Patience Chinyenze, and I am a postgraduate student registered for a PhD at the University of the Witwatersrand Johannesburg. I am doing a research study aimed at exploring and analysing the views of management and children about psychosocial centred childcare services in childcare institutions in Harare, Zimbabwe. It is hoped that the findings of the study will influence policy, enhance interventions, and contribute to the knowledge base on appropriate best practices in childcare services.

I am kindly inviting you to participate in this study. Participation in the research study is entirely voluntary and should you decline to participate, you will not be disadvantaged in any way. If you agree to participate in the study, no compensation will be given. Your agreement to partake in the study entails an individual interview guided by a semi-structured interview guide. The interview will be arranged at a place and time that is suitable for you and it will last approximately one hour. You may refuse to answer questions that you find discomforting and you may also withdraw from the study at any time without any consequences.

With your permission, the interview will be tape-recorded. Only my supervisor and I will have access to the tapes. Please be assured that your name and personal details will be kept confidential and no identifying information will be included in the final research report. The interviews will be conducted professionally, however, in the event of participants feeling emotionally upset during or after the interview, arrangements have been made with a social worker, Mr. Noel Muridzo and/ or a psychologist, Ms. Nancy Ruhode, contact numbers 0772 346 507 and 0772 572 532 respectively to support you. You can make an appointment to see them free of charge for professional assistance.

Should you have any questions about the study, please do not hesitate to contact me on 00 263 772 395 622 or + 27 60 336 7335 or my supervisor, Dr Edmarié Pretorius on + 27 11 7174476. Your questions will be answered to the best of our ability. Should you wish to receive information about the research outcomes, a summary of the findings will be provided to you on request.

Your consideration to participate in the study is greatly appreciated.

Yours sincerely

Patience Chinyenze

APPENDIX B:
PARTICIPANT INFORMATION SHEET FOR CHILDREN

Institutional Childcare Services in Harare, Zimbabwe: Exploring Experiences of Caregivers and Children.

Good day

My name is Patience Chinyenze, and I am a student studying for a PhD in Social work at the University of the Witwatersrand in South Africa. I am doing a study to understand how you are experiencing being one of the children living in a childcare facility. It is hoped that after the study, there might be changes to make a living in children's' homes a more positive experience.

I am kindly inviting you to take part in this study where we will have a one- on- one conversation and talk about some questions that I will ask. Please note that you are not forced to take part in the study, but if you do, your name and shared views will not be made public, and you are also free to only answer questions that you feel happy to answer. This will only take about 30 minutes of your time. If you do not wish to continue to take part in the study, you can say so without fear of punishment. Please also note that you will not be rewarded or paid for taking part in the study and you will not get into trouble if you choose not to take part in the study.

With your permission, our conversation will be tape-recorded. Only my supervisor and I will listen to the tapes. Please understand that your name and personal details will not be disclosed in the report after the study. If after the conversation you are feeling upset, feel free to inform me, and I will make arrangements so that you can get help from a social worker, Mr. Noel Muridzo and/ or a psychologist, Ms. Nancy Ruhode.

Should you have any questions about the study, please contact me on 00 263 772 395 622 or + 27 60 336 7335 or my supervisor, Dr Edmarié Pretorius on + 27 11 7174476. We shall try to answer your questions to your satisfaction. If you want a copy of the summary of the study you can ask and it will be given to you.

Thank you for considering participating in the study.

Yours sincerely

Patience Chinyenze

APPENDIX C:
CONSENT FORM FOR PARTICIPATING IN THE RESEARCH STUDY AND AUDIO-TAPING THE INTERVIEW FOR KEY INFORMANTS AND CAREGIVERS

Institutional Childcare Services in Harare, Zimbabwe: Exploring Experiences of Caregivers and Children.

I, ..., hereby consent to participate in the study. The purpose and procedures of the study have been explained to me. I understand that my participation is voluntary and that I may withdraw from the study at any time or refuse to answer some questions without any negative consequences. I understand that confidentiality will be maintained and that I will remain anonymous when the findings of the study are presented. I also consent to tape-recording of the interviews. I understand that confidentiality will be maintained at all times and that the recordings will be kept in a locked cabinet and destroyed two years after producing any publication arising from the study or six years after completion of the study if there are no publications.

Name of participant: _____

Signature: _____

Date: _____

Name of researcher: _____

Signature: _____

Date: _____

APPENDIX D:
ASSENT FORM FOR CHILD PARTICIPANTS

Institutional Childcare Services in Harare, Zimbabwe: Exploring Experiences of Caregivers and Children.

My name is ....., and I have agreed to share information about my experiences relevant to being a resident in a childcare facility. The researcher did explain to me why the study is being carried out and I understand that when I share my views, my name will not be made public, so I will not be identified. I also understand that I am free to only answer the questions I feel comfortable about and if I do not want to continue to participate in the study, I can say so without fearing any punishment. I also agree that the discussion can be tape-recorded. I understand that my name will not be identified and that the recordings will be kept in a locked cabinet and destroyed two years after any publication arising from the study, or six years after completion of the study if there are no publications.

Name of participant: _____

Signature: _____

Date: _____

Name of researcher: _____

Signature: _____

Date: _____

APPENDIX E:
INTERVIEW GUIDE FOR KEY INFORMANT

(Department of Social Services -Director of Child Welfare and Probation Services)

Institutional Childcare Services in Harare, Zimbabwe: Exploring Experiences of Caregivers and Children.

Mr/ Ms..... Thank you for accepting my invitation to participate in this interview.

Identifying Particulars

Designation	
Period of time in this position	
Gender	
Date of Interview	

1. You are the Director of Child Welfare and Probation Services; a very challenging position. Please share with me what your position entails.
2. In your view, what are the general needs of children?
3. Given your perceptions about children's general needs, how do you perceive childcare children's homes meeting these needs?
4. Share with me the policies and procedures underpinning the provision of childcare services in general in Zimbabwe.
5. Please tell me what the role and responsibilities of the DSS is in relation to the care of children in children's homes in Zimbabwe.
6. Given the existing policies, procedures and guidelines regarding childcare services in Zimbabwe, what areas do you think can be improved on?

7. What are the challenges that the DSS is experiencing with regard to caring for children in children's homes?

8. How does the DSS handle challenging situations regarding the care of children in children's homes?

9. What are the preferred theoretical frameworks and/or methods of intervention in children's homes in Zimbabwe that are helping children to deal with psychosocial issues?

10. In your view, what are the shortcomings in the guidelines and/or methods of intervention used in children's homes in Zimbabwe?

11. In addition to what is already offered in children's homes, what else do you think can be provided in order to prepare and equip children to become well-adjusted citizens of this country and society?

12. Is there anything else that you would like to share with me regarding care of children in children's homes in Zimbabwe?

Thank you very much for sharing your time and wisdom regarding children in children's homes!

APPENDIX F:
INTERVIEW GUIDE FOR KEY INFORMANTS (Directors of Institutions)

Institutional Childcare Services in Harare, Zimbabwe: Exploring Experiences of Caregivers and Children.

Identifying Particulars

Name of Children's home	
Designation	
Period of time in this position	
Gender	
Date of Interview	

1. You are the Director of this children's home; a very challenging position. Please share with me what your position entails.
2. Please explain the purpose and mission of this children's home to me.
3. What are the main objectives of these children's homes?
4. In your view, which of these objectives do you think your children's home meet, and why?
5. Share with me which of the objectives are challenging to meet, and why?
6. When reflecting, how would you describe childcare services provided by this children's home?
7. What are your views about policies, procedures and guidelines underpinning childcare services in Zimbabwe?
8. Given the policies, procedures and guidelines regarding childcare services in this country, which areas do you find relatively easy to implement and which areas do you find challenging, and why?
9. In your view, what are the general needs of children?

10. Explain the main psychosocial challenges presented by children in this children home?

11. What are the preferred guidelines and/or methods of intervention that are implemented by your children's home to assist children to deal with psychosocial issues?

12. In your opinion, what kinds of services does this children's home provide in order to prepare and equip children to become well-adjusted citizens of this country and society?

13. Is there anything else that you would like to share with me regarding care provided for children in this children's home?

Thank you very much for sharing your time and wisdom regarding children in children's homes!

APPENDIX G:
FOCUS GROUP GUIDE FOR CAREGIVERS

Institutional Childcare Services in Harare, Zimbabwe: Exploring Experiences of Caregivers and Children.

Demographic information

Name of Children's home	
Number of participants	
Gender Male Female	
Age Ranges 20 -29 30-39 40-49 50-59 60+	
Date of Focus Group	

1. As a group, can you briefly tell me why you became caregivers in a children's home?/*Ndinokumbirawo kuziva kuti chii chakaita kuti mude basa rekuchengeta vana panzvimbo inochengeterwa vana?*
2. Caregivers have important roles to play in the childcare in children's homes. Can you please share with me what your roles and responsibilities are?/*Ndinodaira kuti vanochengeta vana vane basa rakakosha zvikuru, ndinokumbirawo kuziva kuti zvii zvamunotarisirwa kuita mubasa renyu*?
3. The roles played by caregivers require appropriate training. Can you tell me about the training you have attended or are attending in order to prepare you to fulfil these roles?/*Basa rekuchengeta vana rinoda ruzivo.Makapuwarudzidziso kana kuti muri kupiwa rudzidziso rwakadini kuti muzochengeta vana nemazvo?*
4. When you reflect on what is expected of you as caregivers, are there areas that you think you need additional training on?/*Kana mukatarisa basa rinotarisirwa*

kuti vanochengeta vana kuti vaite., pane here zvimwe zvamunofunga kuti mungada kudzidziswa zvakare?

5. In your view as caregivers, what are the general needs of children?/ *Semaonero enyu, ndezvipi zvinhu zvinodiwa nevana?*

6. In your experience as caregivers, what are the primary needs of the children in this institution?/*Semaziiro enyu nenguva yamagara mubasa rekuchengeta vana, ndezvipi zvinhu zvakakosha zvinodiwa nevana panzvimbo ino?*

7. As caregivers please explain how you contribute towards addressing the needs of the children in this children's home./*Munganditsananguriraw*o *here zvinhu zvamunoita sevachengeti wevana mukuedza kuzadzisa zvinodiwa nevana?*

8. What are the psychosocial issues that are presented by children in this children's home?/*Ndezvipi zvinhu zvinotaurwa nevana zvinovanetsa maererano nemagariro avo uye zvavanofunga mupfungwa.*

9. As caregivers how do you deal with these psychosocial issues?/*Zvii zvamunoita mukuedza kugadzirisa zvinhu zvinotaurwa nevana zvinovanetsa pamagariro uye zvavanofunga mupfungwa dzavo?*

10. In your view as caregivers, in what way is your children's home providing services similar to those found in a family environment?/*Semaonero enyu, zvii zvinoitwa pano kuvana kuitira kuti vagarese magariro anoita vanhu mumhuri?*

11. What kind of services does this children's home provide in order to prepare and equip children to become well-adjusted citizens of this country and society?/*Sekufunga kwenyu, ndezvipi zvinhu zvinoitirwa vana kuitira kuti mune ramangwana vave vanhu vanogara nevamwe zvakanaka?*

12. Can you share with me the positive experiences you have encountered in your line of duty as caregivers in this children's home?/*Semuchengeti wevana ndezvipi zvinhu zvakanaka kana zvinofadza zvamakasangana nazvo mubasa renyu?*

13. What are the challenges that you are facing as caregivers in this children's home?/*Zvii zvinhu zviri kukuomerai kana kukunetsai mubasa renyu?*

14. Is there anything else that you would like to share with me regarding your experiences as caregivers at this institution?/*Pane here zvamungada kutaura neni zvakananganana nezvamakasangana nazvo mubasa renyu sevachengeti vevana?*

Thank you very much for sharing your time and wisdom regarding children in children's homes!

Mazvita henyu nekundipa mukana wekutaura nemi uye kundipakurirawo ruzivo rwenyu maererano nemachengeterwo anoitwa vana varimunzvimbo dzakasanagurirwa izvozvo.

APPENDIX H:
SEMI STRUCTURED INTERVIEW GUIDE FOR CHILDREN

Institutional Childcare Services in Harare, Zimbabwe: Exploring Experiences of Caregivers and Children

Demographic information

Name of Children's home	
Gender Male Female	
Age Ranges 9-12 13-18	
Date of interview	

1. Like any other children, I believe you have needs and wishes. When you first came into this children's home can you tell me what these needs and wishes were?/ *Ndinodaira kuti une zvaunoda nekushuwira muupenyu. zvii zvawaitarisira pawakanzi uri kuuya kuzogara pano?*
2. In your view, how does this children's home try to meet your wishes and needs?/*mumaonero ako, zvii zviri kuitwa munzvimbo ino zvinozadzisa zvishuwo zvako uye zvinhu zvaunoda*?
3. Please share with me the things that you really like about this children's home./*Zvii zvaunoda chaizvo zvinoitwa panzvimbo ino?*
4. Please share with me the things that you really dislike about this children's home./*Ndezvipi zvinhu zvausingadi zvinoitwa paunogara?*
5. What do you find most difficult in being in this children's home?/*Zvii zvaunoona zvakaoma mukugara panzvimbo inochengeterwa vana?*
6. In your view, what else would you like this children's home to do to make you feel that this place is like your home/family?/*Semaonero ako, zvii zvaunoda kuti zviitwe panzvimbo inokuitira kuti ifanane nekumba?*

7. What else do you think this children's home should do in order to prepare and help you to achieve your dreams?/*Ndezvipi zvaunofunga kuti zvingaitwa munzvimbo ino kuitira kuti ubatsirikane kuzadzisa zvaunoda kuzoita mune remangwana?*

8. Is there anything else that you would like to share with me regarding your experiences at this children's home?/*Pane here zvimwe zvaungada kutaura neni zvakananganana nezvawakasangana nazvo uchigara panzvimbo ino?*

Thank you very much for having a conversation with me and taking part in the study!

Wazvita hako nekukurukura neni uye kundibatsira muongororo yandanga ndichiita.

APPENDIX I:
LETTER OF APPROVAL: CHILD PROTECTION SOCIETY



CHILD PROTECTION SOCIETY

Incorporating: (Reg No: W.O.7/67)

Community Based Child Care Project
Colin John Campbell Centre
Advocacy project Margaret Campbell Centre
Chinyaradzo Children's Home

27 January 2014

Patience Chinyenze
463 Kambuzuma 2
Harare

Dear Patience

RE: LETTER OF AUTHORISATION TO CARRY OUT RESEARCH

This is to confirm that you have been given authority to undertake research at Chinyaradzo Children's Home.

Yours sincerely

Tomaida Banda
Director

APPENDIX J:
CLEARANCE CERTIFICATE: PROTOCOL NUMBER H14/10/24

Research Office

HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)
R14/49 Chinyenze

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER H14/10/24**
PROJECT TITLE	Institutional childcare services in Harare, Zimbabwe. Exploring experiences by Caregivers and Children
INVESTIGATOR(S)	Ms P Chinyenze
SCHOOL/DEPARTMENT	Human & Community Development/Social Work
DATE CONSIDERED	24 October 2014
DECISION OF THE COMMITTEE	Approved Unconditionally
EXPIRY DATE	03/12/2016

DATE 09/12/2014 **CHAIRPERSON** _____ (Professor T Milani)

cc: Supervisor : Dr E Pretorius

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10000, 10th Floor Senate House, University.

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to completion of a yearly progress report.**

_____ _____/_____/_____
Signature **Date**

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

APPENDIX K:
LETTER OF APPROVAL: DEPARTMENT OF CHILD WELFARE AND PROBATION SERVICES

Official communications should not be addressed to individuals
Telephone: Harare 703711/790721-4
Telegraphic Address: 'WELMIN
Fax:796080/790543/ 703714
SW 12/5

ZIMBABWE

DEPARTMENT OF CHILD WELFARE AND PROBATION SERVICES
P.O. Box CY 429
Causeway
Zimbabwe

29 January 2014

Patience Chinyenze
463 Kambuzuma
Harare

RE: APPLICATION FOR PERMISSION TO CARRY OUT AN ACADEMIC RESEARCH ON CHILDREN AT HUPENYU HUTSVA, MATTHEW RUSIKE, CHINYARADZO AND SOS WATERFALLS CHILDREN'S HOMES

Receipt of your letter dated 18 December 2013 of similar subject as above is acknowledged.

Please be advised that authority is hereby granted for you to carry out a study entitled **"Child Care Institutions. Perceptions of children and caregivers from children's homes in Harare, Zimbabwe."**

The permission is hereby granted **STRICTLY** on condition that the research is for academic purposes only in pursuit of your Doctor of Philosophy Degree in South Africa and not for publicity.

As the study has a bearing on our mandate with regard to children's rights, it would be appreciated if a copy of your research output document could be availed to us.

T.A Chinake
A/**DIRECTOR OF CHILD WELFARE AND PROBATION SERVICES**
c.c A/ Provincial Social Welfare Officer
Harare
The Superintendent/ Manager
Hupenyu Hutsva Children's Home
Matthew Rusike Children's Home
Chinyaradzo Children's Home
SOS Waterfalls Children's Village

APPENDIX L:
SOS CHILDREN'S VILLAGES ZIMBABWE: PERMISSION TO CARRY OUT RESEARCH PROJECT

SOS CHILDREN'S VILLAGES ZIMBABWE

Mon Repos, Newlands
P.O. Box HG 766
Highlands, Harare
Zimbabwe
Tel +263 4 746451-3
Fax +263 4 746454
E-mail soszim@soszim.org.zw

12th December 2013

TO WHOM IT MAY CONCERN

REFERENCE: PERMISSION TO CARRY OUT A RESEARCH PROJECT: MS PATIENCE CHINYENZE

This serves to confirm that Ms Patience Chinyenze has been granted permission to carry out a study on the topic: "Child Care in Institutions, Perceptions of Children and Caregivers from Children's Homes in Harare, Zimbabwe" at our SOS Children's Villages Waterfalls.

Please note that the above permission is granted on condition that:

1) Children's privacy and conditions of admission are protected and considered and treated with confidentiality
2) A copy of the final study is availed to the organisation through the Deputy National Director.

Yours faithfully



L. T Zangunde

DEPUTY NATIONAL DIRECTOR

APPENDIX M:
LETTER OF APPROVAL: MATTHEW RUSIKE CHILDREN'S HOME

HEAD OFFICE
Methodist Church in Zimbabwe
Wesley House, 3 St/Selous Avenue
P .O. Box CY71, Causeway
Harare, Zimbabwe
Telephone: +263 4 724069,721154
Fax: 263 4 723709
Email:

HOME
EPWORTH MISSION
P.O.Box H99, Hatfield
Harare, Zimbabwe
Cell:+263 779 136 053
Cell: +263 772 416 224
Cell: +263 772 416 221
matthew_rusike@yahoo.co.uk

15 January 2014

Dear Mrs P. Chinyenze

RE A LETTER OF ACCEPTANCE

This letter serves to inform you that you have been accepted to conduct your research at Matthew Rusike Children's Home.

You are therefore kindly asked to come and sign our code of conduct form which includes Child Protection Protocols to be followed.

We wish you all the best in your research.

Yours Faithfully

MATTHEW RUSIKE CHILDRENS HOME
P. O. BOX H99, HATFIELD, HARARE
CELL: 0912 416 220-4, 0912 311 529
DATE 15/01/2014
SIGN

Rev M .Mawire
MRCH-National Director

APPENDIX N:
PERMISSION TO PRETEST RESEARCH INSTRUMENTS AT SHUNGUDZEVANA CHILDREN'S HOME

Official communications should
Not be addressed to individuals

Telephone: Harare 790871 6
Telegraphic Address: "WELMIN
Fax:796080/

ZIMBABWE

Department of Child Welfare and
Probation Services
Compensation House
Cnr 4th Street/Central Avenue
P.O. Box CY 429
Causeway
Zimbabwe

SW 12/5

16 March 2015

Patience Chinyenze
Women's University in Africa
P.O Box MP1222
Mount Pleasant
Harare

RE: PERMISSION TO PRE TEST RESEARCH INSTRUMENTS AT SHUNGUDZEVANA CHILDREN'S HOME

Please be advised that permission is hereby granted for you to pre test your research instrument at Shungudzevana Children's Home in Harare before carrying out your research entitled "Child Care Institutions, Perceptions of children and caregivers from children's homes in Harare" at Hupenyu Hutsva, SOS Children's Village, Chinyaradzo and Mathew Rusike Children's Homes.

The permission is granted **STRICTLY** on condition that the research is for academic purposes only in pursuit of your Post Graduate studies and not for publicity and that the identity of participating children will be protected.

May you submit a copy of your final research document to the Department of Child Welfare and Probation Services upon completion.

T. A. Chinake
DIRECTOR OF CHILD WELFARE AND PROBATION SERVICE