



**UNIVERSITY OF
CAMBRIDGE**

This dissertation is submitted for the degree of Doctor of Philosophy

**A Case Study: The Impact of HIV/AIDS on Infected and
Affected Rural Primary School Children in Zimbabwe
– Children’s Perspectives -**

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Abstract

A Case Study: The Impact of HIV/AIDS on Infected and Affected Rural Primary School Children in Zimbabwe – Children's Perspectives

Although there has been increasing research on HIV/AIDS and children, albeit mostly outside the school environment, most research in the area has tends to view 'children as objects' (Christensen and James, 1999) in the research process whereby the change in the child is what is being observed. This view lessens the role of the child and as such means that the results are inadequate – mostly the researcher's perspective is represented. In Zimbabwe, with an estimated 1.1 million AIDS orphans and 115,000 children under 14 living with HIV/AIDS, not much empirical research has been conducted in school settings where they spend most of their time; the complexities of infected and affected students' experiences within the school-home-community spheres are mostly inferred due to lack of empirical research.

Using Bronfenbrenner's Ecological System's Theory and the Capability Approach to adopt a holistic psychosocio-cultural lens, the research aims to understand the experiences of infected and affected students from their perspectives within their school, home and community environments. Added to observations, in-depth interviews based on data collected using photography, drawings, timelines, sociograms and student diaries were conducted with 65 boys and 27 girls aged 10 -13 years from a rural primary school during the months of August to December 2011. In-depth interviews were also conducted with 161 parents and caregivers. Also interviewed were 13 stakeholders comprising of a Senior Research Officer within the Ministry of Education, District Education Officer, 5 Teachers and their Principal, a District Councilor, the Chief, a village head, a local Baptist Minister and a research staff person from, FACT, a local NGO that works with AIDS orphans. Among children findings point to dilapidating issues of stigma, abandonment, unaddressed emotional and physical needs; children relied on each other's advice more than that of teachers and caregivers.

Among the adult community, the education authorities and community leaders who are custodians of their education, ignorance about infected and affected children is astounding. An ageing population of caregivers is barely able to deal with the complexities of infected children. Religion has a powerful negative influence on addressing HIV/AIDS issues. Teachers, citing taboo issues about sex and the fact that HIV/AIDS is not an exam at the school, refused to broach the subject. Education Officials clearly pointed out that there has been no research nor any plans yet to address this population and their needs. Further research will need to be conducted for educational planning that will be most effective in implementing meaningful changes for this group and other rural primary school children.

Declaration

This dissertation is the result of my work and includes nothing which is the outcome of work done in collaboration with others, except where specifically indicated in the text. The length does not exceed the word limit as given by the Degree Committee of the Faculty of Education.

Siza Mtimbiri

July 2013

Dedication

To my wife Laura and my children Raymond, Verity and Alex who supported me relentlessly

To my late brothers, their wives and children who succumbed to HIV/AIDS largely due to silence

To my remaining siblings -Mathew, Linda and Farai – for standing strong in the face of calamity

To Samuel and Dinah Mtimbiri, my parents, for all your love and support always

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ABBREVIATIONS AND ACRONYMS

ABC	Abstain, Be faithful or Condomise
ARVs	Antiretrovirals
BERA	British Educational Research Association
CRDLA	Chimanimani Rural District Local Authority
ECD	Early Childhood Development
EPP	Estimation and Projection Package
FACT	Family AIDS Caring Trust
FOCUS	Families, Orphans and Children Under Stress
HAART	Highly Active Antiretroviral Therapies
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
MOE	Ministry of Education
MOH	Ministry of Health and Social Welfare
NAC	National AIDS Council
NBTS	National Blood Transfusion Services
OVCs	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for HIV/AIDS RELIEF
PICU	Paediatric Intensive Care Unit
PSG	Peer Support Group
SADC	Southern Africa Development Community
SWAA	Society and Women of AIDS in Africa
TASO	The AIDS Support Organization
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children's Fund
ZMPSLSW	Zimbabwe Ministry of Public Service, Labour and Social Welfare
SWAA	Society and Women of AIDS in Africa
WHO	World Health Organization

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The Personal Context

‘Good research questions spring from [a researcher’s] ...values, passions, and preoccupations’
(Russell & Kelly, 2002:5)

The above quote from Russell and Kelly guides me to reflect on events in my own family which have prompted my current interest in the experiences of HIV/AIDS-infected and -affected school children in school, at home and in their communities. Here, a good research question will be taken to mean ‘fitting research question,’ since ‘good’ can be a relative term depending on what the reader thinks. The first part of the introduction relates the HIV/AIDS-related deaths we experienced as a family in Zimbabwe, with the resultant orphans, some of whom were also infected and later succumbed to the disease themselves. Some of the fear, the silence and confusion that my family experienced, as we tried to understand the relentless trauma, could have been averted through knowledge of infected and affected students’ experiences in school, at home and in the community. Additionally, it might have aided the teachers and the community leaders to have dealt with the situation better. The dearth of empirical studies in the Zimbabwean context that address these issues compelled me to research the topic, as it has a direct bearing on affected families and also, the future of education in Zimbabwe. Knowledge about the adults who were passing away, too, would have proven vital. My work as succinctly noted below by Malterud (2001, p. 483-484) is coloured by my past

A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions

Before embarking on the brief historical background that led to the selection of my work, it is worth problematizing the definition infected and affected, terms that are used all throughout the work to identify HIV infected students and those who are not infected with the virus but are, nevertheless, affected.

Problematizing the definition of HIV Infected and Affected

The work that I intend to theorize upon requires that I problematize what I regard to be the infected and the affected in the HIV/AIDS topic on children that I intend to address at length. In Zimbabwe, where my research is located, the sustained scourge of HIV/AIDS has left the entire countrymen, women and children, affected in some form or another. Therefore, the terms that I intend to use to pinpoint the different groups pertinent yet superficial. Whilst everybody in the village is affected in some way or another, in this work when I refer to ‘affected children I will use Tarantola and Gruskin’s (1998:63) description as those

children whose immediate family environment and support system are challenged by the sickness, disability, and premature death from AIDS of one or both of their parents...creating serious stress and emotional trauma including living through the deprivation of parental support and loss of childhood, creating serious obstacles to the child's development’ without being actually infected by the HIV/AIDS virus

Affected children in this work, therefore, will ‘refer to children and young people who have a caregiver who is HIV-positive but who are not infected with HIV themselves’ (Cree and Sidhva, 2011:2. Infected children will be a subset of the affected but in particular, those who are actually infected with the HIV virus and as such will have ‘extra health effects specific to malfunction of their immune system’ (Cooper et. al, 2007) amongst other things shared by affected students like stigma and discrimination – all of which may be experienced differently because of the different conditions of the two. Once again, Tarantola and Gruskin’s (1998:62) provide a succinct description of what would necessitate looking at infected children as a subset

Children infected with HIV/AIDS...suffer the physical consequences of infection through increased morbidity, stunted growth, disability, and premature death...furthermore, their condition creates psychological stress and may expose them to stigma and discrimination, including loss of entitlements to educational, health, and social services

These challenges are also noted by Walters and Kelsvig (2008)¹, adding that they cause either delay to starting school and/or on ongoing complications with re-infection, concentration, language

¹Walters and Kelsvig (2009:14) write about a host of challenges on infected children – ‘biological effects of HIV include malnutrition, anemia, recurrent and chronic illness, and specific neuro-developmental effects. Children with symptomatic HIV disease may suffer from disease-associated morbidities such as respiratory infections, malnutrition

development and absenteeism. As early as 1992, Siedel noted that HIV was the ‘greatest infectious cause of paediatric mental retardation in the United States’ (1992:39). On the challenges of infected children, Siedel (1992:39-40) also noted ‘gross and fine motor skills ...including inappropriate muscle tone (hypertonicity/hypotonicity), reduced flexibility and muscle strength, spasticity and poor control, disability in expressive and receptive language’. I find that these are sufficient differences to research about the experiences of HIV infected and affected children with an awareness that each subgroup will have challenges that might be specific to each, albeit with a lot shared.

The brief history of my family experience with HIV/AIDS

I grew up in a family of nine children – a decent size family in rural Pumula² where parents aimed to get as many children as possible to help with agricultural tasks. Two of the eldest boys in my family, however, were in reality cousins who had been ‘adopted’ by my parents at the age of two. I was later told by my parents that they were *nherera* (orphans) and that the family of 14 next door actually only birthed eight; the rest came from late relatives. Fostering orphaned children is part of the Zimbabwean culture which is now under duress from the increased number of HIV/AIDS orphans. Having known our neighbours since birth, they became like family to us and we have kept in touch for the 40 years that my parents have known them. The two families shared the joys and jubilations of celebrating birthdays, traditional holidays, marriages, births and the long intimate history of each other’s lives – a very reputable aspect in the Zimbabwean rural communal life. Those joys and jubilations, however, have since been replaced by sorrows and tribulations as each family watched, painfully and slowly, as their respective kin and relatives were ravaged by the scourge of HIV/AIDS. My family has been almost halved: there are only four of us remaining with one brother, together with his wife and children, recently infected. Our friends lost eight of their children.

Even though Zimbabwe had adopted a policy of silence during the 1980s about HIV/AIDS (Ray & Madzimbamuto, 2006), many families were confronted with the epidemic loud and clear as they watched their relatives dying in their midst. Watching such tragedies unfold, I was therefore forced

and diarrhea disease. Like other children with chronic diseases and disabilities, their health problems can affect school entry and progress’

² Pumula is a rural town on the outskirts of Bulawayo, the second largest City in Zimbabwe.

to confront my own fears and myths³ very quickly. When I finished sixth form, my first cousin and his wife become extremely weak due to infection. The sickly couple moved back with my family so that we could take care of them, together with their two children. They eventually passed away and my mother thus adopted the two children, who lived to be nine and eleven, respectively, before they too died. The parents' death certificates listed pneumonia as the cause of death and not a word was mentioned about HIV/AIDS. The fear and silence that surrounded issues of HIV/AIDS at that time were deafening. I quickly banished the idea of going to university; being one of the able-bodied children in the family, I had to work to provide for the extra demands that emerged. At that time my parents still had three children in high school and this expense meant that we had to sell a lot of assets to make ends meet. The physical and emotional expense of burying an entire family took a toll on my parents in particular who needed counselling, though this was not available at the time and is still only available to a few families - 20 years later after we suffered our casualties. Both parents stopped working due to stress, which meant there was only one income coming in, a reality that strained resources further. The family was living below the poverty line and we were experiencing what Amoateng *et al.* (2004: 47 quoted in Richter & Sherr, 2008:21) have observed: 'that the illness of the prime-aged individuals can affect the health state of and wellbeing of the elderly as a result of depletion of household resources, additional physical work and the stress of coping with bereavement and the care of young children.'

The silence in my own family was interrupted by the memories that we all had – watching my cousin and his wife slowly pass away while showing all the signs of infection. Due to their own silence and that of the family – very much related to the fear of discrimination from others - testing, which could have led to seeking antiretroviral drugs, was never mentioned. Silence, in a manner of speaking, killed them. We were forced, however, to confront these issues as the two remaining children, before they passed, were constantly sick and complained about being in pain or not being able to stay awake in school. They seemed confused at times and referred to their grandmother, their main caregiver at that time, as their mother. They became increasingly detached from other members of the immediate and extended family. They were afraid to be left by the grandmother for long periods of time and seemed anxious at most times. We were never quite sure how they dealt with a loss since there was not much discussion about how they felt or thought about their deceased

³ The myth that HIV/AIDS is white gay man's diseases was widely propagated in Zimbabwe at the onset of the epidemic and even long after. There were also suspicions of witchcraft – still problematic in the village where I come from and in other parts of the country in Zimbabwe

parents. Teachers in their school reported that the children were becoming increasingly aloof. There were thus issues about loss, identity, attachment and relations with family and peers that needed to be addressed. The family finally got the courage to take the children for testing and unsurprisingly they were both found to be HIV positive, only a year before they succumbed.

It was within a year of the children passing that a second cousin and his wife started getting ill with no respite from pain medication and other drugs which were being prescribed for symptoms. They were eventually bedridden, moved in with my parents and followed the same fate as the first cousin: they left behind 2 children, one of whom was infected and died a year later. The other child was not infected and lives to this day. These children had been about the same age as their cousins and they had just survived the trauma of watching their cousins die when the whole process was repeated with their parents. The costs of medication at this stage led to the family selling even more land⁴ and borrowing heavily from the extended family⁵.

After the first cousin and his wife passed, news travelled rapidly and most people in the village suspected or knew that it was HIV/AIDS. We felt shunned as a family. When a family is suspected to have lost someone through HIV/AIDS people express their condolences but don't usually ask about the cause of death. Our orphaned children complained that other children did not want to play with them in the community, but they played with them at school. Whether this discrimination was imagined or real was unclear. Another child complained that one of his friends was happily playing with him at home but didn't want to play with him at school. There were confusing messages, but one thing was clear: the children were struggling with their friendships. Some of the teachers already knew about the conditions of our children – we had to let them know so that we could take the children out for medication and also to explain the increasing absences during times when their health was at its worst. This was new territory for most teachers and they were simply not sure what to do with the children. Our community – at least the few individuals who knew - was also very unsure what to do to support us. As a family, we struggled to cope with the multifaceted nature of HIV/AIDS.

⁴ Repeated deaths were exacerbating our poverty situation as researchers like Richter (2004) point out

⁵ This pattern was repeated with 3 biological siblings, two of whom left children to be taken care of by my parents and by myself. Even though my family had gotten to a place where we were more comfortable discussing the issues around HIV/AIDS and getting our children tested soon to get them medication, very few medications at that time had been known to be regulated enough to be effective with children and as such, out of the 8 orphans over time we only have 2 remaining, with one who is infected

As I was privy to the information from our longtime neighbours, I knew that their situation was not dissimilar to ours: the family counted eight deceased children who had been married and left orphans, some of whom were infected. After a while, my family and our neighbours came across other families in similar circumstances. In our case, fortunately, since I could work two jobs and the family managed to sell a number of its assets, we managed to keep our orphaned children so they could stay in the same school. Our neighbours, on the other hand, had to send some of their children to far away relatives who could provide care and share the burden. This, of course, meant moving schools for the children. Indeed, we witnessed children moving back and forth so many times that some ended up giving up school altogether since they did not know when they would be moved again. This was especially true with our neighbours: they had lost all of their older children who would have been able to help financially and thus they had to work longer hours to provide for the increasing needs of their families. By the time we had to sell more of our land, they had to sell their home to meet expenses.

It is not clear to what extent the above scenario might be playing out in various parts of Zimbabwe since we now have an estimated 115,000 children who are infected and more than a million HIV/AIDS orphans (Central Statistical Office, 2005). I had read various articles in Zimbabwe during the late 90s to find out what other parents/ caregivers thought and how they dealt with this new orphan population and their various needs. Also, I wanted to find out what the community leaders knew and how they planned to tackle some of the issues. But nothing was forthcoming. Most importantly, information from children regarding their school, home and community experiences - areas that formed their environment – was, and still is, scarce. An understanding of these issues would greatly contribute to the knowledge base about the relationship between HIV/AIDS and schooling, and also the relationships between HIV/AIDS affected families, the school and the communities in terms of knowing how to deal with the epidemic. Even though there is a sizeable literature about AIDS orphans, most of it is on orphans *outside* the school system and I have not yet come across studies that tackle the school, home and community connections while emphasising the child's perspective. The health approach, bent heavily towards the sexually active adult population, dominates the discourse in Zimbabwe. During my pilot study, lack of information and planning in this area was succinctly summarized by the quotes below:

Director of the National AIDS Council (Mr. Mupa): *Our focus is on prevention and care...we work with adults only for now. We do not have any information about young school going children even though we are aware, however, that there is a growing orphan problem (Mtimbiri, 2008)*

These sentiments and the lack of information and desire to start working on the issue were further confirmed by the Education Department -

District Education Officer (Mr. Gwenya): *We don't have any information about students who are either infected or affected. The Ministry does not deal with that – at least in this Province, there is nothing in our 5-year plan to touch on that. We've only just introduced HIV/AIDS education, but no thought as yet has been put towards what you're talking about (Mtimbiri, 2008).*

The above comments show that the government is not aware of any research in this area, neither are there plans to conduct any in the near future – 20 years after my family experienced their first HIV/AIDS-related casualties, including issues with the remaining infected and affected children. There were also familiar issues that seemed to emerge in the pilot study: infected and affected children were clearly moved from one place to another depending on who could care for them at that time, raising issues of school, community and environmental displacement. Abandonment also came to the fore as children were left alone for many hours by caregivers who needed to work to cater for their increased needs. There was evidence of children counselling each other due to either the extended absence of caregivers or lack of confidence in teachers as to whether they would take them seriously. Caregivers complained of not having enough knowledge about these children and not enough time because they had to be away longer to provide for them (Mtimbiri, 2008). It is clear that the lived experiences of infected and affected children are not well understood by the parents and caregivers, the teaching faculty at the schools or the various authorities (the Chief, the Education Officer, the Priest and even the National AIDS Council Officials who have the mandate to work on these issues). I had met with the Minister of Education, David Coltart twice, in October 2008 and in August 2009 and he confirmed the need for research with this group. Doing research with children poses many ethical issues and a well thought out research design and relevant experience in knowing how to deal with various issues becomes pertinent. Below I will give an overview of my work experience with children and how I think it aided me in my research. I will relate how my professional and academic training prepared me to engage with young children. Included will be the training that I undertook in Zimbabwe as part of the preparation for my fieldwork.

Training relevant to the age group and targeted population of vulnerable children

Amongst other things, my degree in Education at the University of South Africa, which I did in conjunction with my diploma in Education in Zimbabwe, and my subsequent 14 years of teaching⁶ equipped me with the knowledge of the development of the self-realization of the pre-school and the primary school child through education. Reading through various theories of education challenged ways that I previously thought about education, how I had experienced it as a student and prepared me to think about practice in different ways. Growing up the system was akin to what Paulo Freire refers to as the ‘Pedagogy of the oppressed’ (Freire, 1970). The teacher was the unquestionable authority who deposited oft irrelevant curriculum content to passive students who acted as receptacles for the information; students patiently ‘received, memorized and repeated’ the information when called upon (Freire, 1970 in Cahn, 1997: 460). This banking concept of education purposefully ‘projected an absolute ignorance onto the students, a characteristic of the ideology of oppression, which negates education and knowledge as a process of inquiry’ (*ibid*). This way of teaching, which unfortunately is still very evident in Zimbabwe, reduces or eliminates the participation of students within the learning community. The ‘process of inquiry’ being negated, teaching and learning lack the reflection that makes it meaningful. As shall be seen later, it also means that HIV/AIDS intervention programs that aim to educate children differently by encouraging them to reflect upon their circumstances, ‘critical consciousness’ as suggested by Freire, might be ineffective in a culture of learning that uses didactic methods of learning that rely on the banking method. The challenge this method readily posed to my study is that it would have been difficult for students who are used to regurgitating information to suddenly start sharing their own perspectives about their experiences in the school, the home and the community; to enable a sudden switch from the passive to the active mode relationally becomes a task that needed an experienced researcher. John Dewey’s influences on my teaching perspectives added to my subsequent work with vulnerable children.

As an educator, I strived to practice my teaching differently, to ‘become a student of education who sees theories and ideas demonstrated, tested, criticized and the evolution of new truth’ emerging (Dewey, 1900:93). I wanted to make sure that children got opportunities to express themselves, to reflect upon their own learning, to have a voice and to participate in the community of learners

⁶ I taught in Zimbabwe, South Africa (informally), Morocco and the United States (Boston and New Hampshire)

even before they left primary school or high school. Dewey idea of ‘shared interest’ between the teacher and the student framed my teaching experiences.

Because I was very interested in students’ participation, I was inspired by Dewey’s interest of community which translated itself into his vision of classrooms in action where learning takes place through group activities. – the running of shops, the cultivation of gardens, the staging of plays – occupations that meant that children were truly engaged in learning and reflection - not merely busy work. Children sharing their experiences from their own perspectives thus are central to my study. A strong influence that Dewey presents in his works, albeit known within the African Cultures for a long time⁷, is how the child learns through interacting with the social environment – either informally through the family or through an institution like a school. The link therefore of the community, the home and the school are inseparable in the learning of the child; those links form the world in which they inhabit; this understanding allows me to adopt a holistic look at the children’s experiences from their own perspective within those spheres.

My teacher training in Zimbabwe and the subsequent teaching for more than 14 years, has been augmented by further training in Special Needs which aided me in working with vulnerable children during my research. To teach Special Needs in New Hampshire, I took relevant psychology courses at Harvard University as part of my second undergraduate degree and was mentored by Dr. Stephen Cohen⁸ to be certified in both areas of General Special Education and for students who are Emotionally Handicapped. My 3 years of working with this vulnerable population of students who had emotional handicaps due to either long-term illness or unstable home environments gave me the experience to know how to listen and help them cope with their required duties in school. Prior I had opportunities to work with vulnerable children in South Africa, Morocco and Boston (USA). In South Africa, I worked with poor children in a squatter camp. The squalid conditions of the slums presented children with all sorts of problems – unpredictable movements from one area to another, lack of food security, sanitary facilities and frequent fights that broke out in the slums made it very difficult for any of the children to cope. In Morocco, I volunteered at a Catholic Orphanage which looked after street children who had been abused by

⁷ The Zimbabwean (African) culture is very community oriented and the proverb, ‘it takes a village to raise a child’ comes from the notion of the community working together in the education of the child in becoming part of the community

⁸ Dr. Cohen is a District Psychologist responsible for training and supervising Special Needs Teachers in the District of New Hampshire, USA

paedophiles. This experience equipped me, once again, to work with children under extreme duress. Teaching homeless children in Boston afforded me further work experience with vulnerable children. This experience, coupled with my recent work with infected and affected children during my pilot in Matabeleland in Zimbabwe, prepared me to work with vulnerable children in my study. In addition to these, I had further training with two Non-Governmental Organizations in the Manicaland District, HOPE and FACT.

Training with HOPE and FACT – training specific to the study

HOPE, an organisation that works in partnership with the United Baptist Church in Zimbabwe and a UK based religious organisation called Serving in Mission (SIM), aims to ‘keep orphans and vulnerable children (OVCs) in school, maximising their potential of becoming fully contributing citizens in society’ (SIM, 2008)⁹. They have been working with OVCs consistently in Manicaland for more than 10 years.

Due to difficulties of gaining access to work with children within schools, HOPE does not work directly in school but supports OVCs in school by paying for their school fees and then does a range of activities – counselling, camps, support with meal packs and relocations where needed from outside the school environments. Basically, they aim to:

- Respond to situations through resources that best meet the problem encountered with orphans and OVCs, referring cases to appropriate service providers – those cases which they might find to be beyond their expertise
- Initiating and encouraging sustainable income-generating initiatives and projects for orphans and vulnerable children
- Networking and looking at an integrated approach on issues related to Children’s Welfare with other appropriate stakeholders.
- Empowering communities to take a leading role in the care of orphans and vulnerable children. (Mishake, 2010).

The weekly programs involved visitations with 20 primary and high school students who ranged from 10 to 18 years old. My training involved shadowing Mishake, the Director who runs the

⁹ www.sim.org Accessed December 2008

program. During the training, there were 12 primary school children (10 boys and 2 girls) and 8 high school students (7 boys and one girl). Children who were in the HOPE program were identified by volunteer caregivers who work closely with the community and referred to Mishake who then provided the counselling and any other needed provisions. With infected children, disclosure was done either by parents when they introduced the child to the program or children themselves during counselling sessions. There were no group sessions for confidentiality purposes. A counselling session is done using the imagery of a tree. The roots are the background of the child – where they come from. At the root stage, children, usually at the first meeting, talk about their parents and siblings. The trunk, the next topic of discussion, represents a space for them to talk about their support structures - their relatives within the extended family — who they are, how close the child feels to them and how the child feels supported by them. This helps HOPE to find out who else in the extended family can be of help when they (HOPE) cannot be available and also, with whom they can share confidential information that must be communicated to someone in the family if the child is at risk. The bark of the tree is when the student can talk about problems and challenges they might be experiencing. The fruits of the tree give them an opportunity to talk about any of their achievements

The tree idea was mostly used with primary school children, but a more casual, adult approach was adopted for high school students. During the 3-week period that I trained with HOPE, counselling sessions with high school students took place over lunch at a restaurant or during a stroll through the park. What HOPE emphasized about the counselling sessions were active listening skills, follow-ups (where needed within the same week) and remembering – with as much detail as possible - what the students’ issues were about. Sessions had a maximum of 2 hours and all the students almost always exhausted their scheduled time.

The program, I found, had many shortcomings and faced serious challenges – some of which HOPE is acutely aware of. The project remains largely undocumented such that new OVC Directors have to rely on a two-week verbal handover with a few scattered notes on what needs to be done. This reflected a general trend on a few efforts scattered around the country in that a ‘systematic documentation of on-the-ground practices for combating AIDS is...surprisingly scant... much practical experience remains undocumented or, at best, relegated to anecdotal accounts within reports.’ (Nguyen et al, 2004:2). What this meant is that my trainer had to learn a

lot on the job and repeated most of the same mistakes because no information had been documented over time. The HOPE project lacks a theoretical basis on why and how they do what they do. The program is inadequately funded – the reason for the under-staffing that HOPE is currently experiencing. My ‘trainer’ had to do many other things before his counselling sessions in the afternoon¹⁰. In the mornings he sorted out food packages for orphans who live in more remote areas, worked on contacting people who were working with them on short-term projects, tried to work on the paperwork for children supported by HOPE in schools and to liaise with their program in the village, where their colleague had been on sick leave for a month. He seemed exhausted by the end of the day and at times he couldn’t remember what he had last discussed with some of the students. The shortage of staff meant irregular support visits to remote areas leading to inconsistencies of the program as the distance from the centre increased. Depending on public transport meant that we were late (several times) to meetings with students. The program is heavily dependent on external funding which has led to the near suspension of some activities, in particular, the program on creating sustainable income-generating initiatives and projects for orphans and vulnerable children.

After 3 weeks with HOPE, I had been scheduled to work with the Family AIDS Counselling Trust (FACT), the oldest AIDS NGO in Mutare, Zimbabwe¹¹. Within FACT, I was meant to work with their branch that focuses on children –called the Families, Orphans and Children Under Stress (FOCUS)¹². I had initially approached them for the 3-week training as they were previously said to work in eight rural sites in the Manicaland Province where they conducted 60,000 visits in 1999. Just before I was due to arrive I was informed that FOCUS had been disbanded due to financial constraints. I was, however, invited to attend a five-day Behaviour Change Workshop with health workers from the surrounding villages - including Kumakomo¹³, the village where my school of research is located. This workshop was also meant to include methods of counselling children and youth. Chipso, one of the instructors from FACT (together with the counsellor from HOPE when she returns to work) kindly offered to be available to provide counselling services to participants in

¹⁰ Counselling sessions lasted between 4- 6 hours in total for the afternoon sessions

¹¹ FACT was established in 1988 by Dr. Geoff Foster who has written extensively about HIV/AIDS

¹² FOCUS’ mandate was to identify needy children in their home areas, help track the children’s need and provide basic material, practical and psychosocial support (Jackson, 2002).

¹³ Kumakomo is the name I have adopted for the village in which the school of my research is located for anonymity. Similarly, the pseudonym for the school is Kupisa.

my research in the event that they were needed. Chipo is an experienced counsellor who used to run the FOCUS group and comes to the village of my research 3 times a week.

During the workshop not much time was spent discussing children as the health workers had lots of questions about issues of behaviour change that were not working in their villages. The workshop did, however, relate how they rely on Jackson's (2002) 8 stages of mourning that occur when people (adults and children) find out they are infected and that these stages were important to know as they both helped the counsellor to have an idea of where the student (or adult) was in their mourning process and also, to assure the child or adult being counselled that what they were going through was normal within the circumstance. They warned that counsellors needed to be culturally sensitive and not assume that everything on the list would be shown or exhibited by those in mourning. They also needed to alert them that some people may go back and forth between stages and that it was not by any means linear. Matters of confidentiality were addressed, with women in the village telling the instructors that most often confidentiality is difficult to maintain since there are always people close by listening in. The table below shows the different aspects of the mourning process.

Table: 1:1 Stages of Mourning (Kubler-Ross, 1987 quoted in Jackson, 2002:202)

Stages of mourning	
Shock	An intensely emotional and bodily reaction to the devastating news, similar to shock after physical trauma; feelings of hysteria, numbness, inability to think and act clearly or a sense of unreality; inability to take in related information or to respond to counselling
Denial	Linked with shock; a deep-seated inability or refusal to take in the information that may continue after the initial shock has worn off. Temporarily protective, continued denial becomes problematic as it blocks appropriate behaviour change and coping
Anger	Fury at being singled out for such trauma, as the situation begins to seem unreal; anger may be directed at a spouse or parents, God, the opposite sex in general, or be completely generalized
Bargaining	A plea to supernatural or human agents such as healthcare staff to change the diagnosis. This may include pledges for behaviour change
Guilt	Self-blame for the situation, often greatly reducing self-esteem, and concern for all those directly affected; the degree of guilt may bear no relation to the actual blameworthiness.
Depression	Deep sadness, withdrawal and helplessness, with low self-esteem and loss of hope. This may be in recognition to many areas of loss and fear e.g. loss of hope for a long-term future or a job, of loving relationships, of having children, or of losing control, and fear of stigma, rejection, loneliness, blame, suffering and death, or leaving dependants without support
Acceptance	No longer feeling overwhelmed; recognizing that the situation cannot be changed and beginning to come to terms with it
Coping	Adjusting to the new living situation and getting back to normal as far as possible regaining self-esteem, planning effectively and coping with life, and adopting appropriate behaviour change. Regaining hope

Unfortunately, the stages of mourning had not been adapted very much for children during the time that FOCUS was working in the village; they too had not documented much of what they had been doing with children. In discussion with the health workers at the workshop, they complained that

FOCUS, when they were still working in the villages, seemed to be out of touch with children and spent most their time playing games. They also complained that as health workers they neither had enough training to work with children nor the time since there were already too involved with adults in their communities. As far as learning about how to work with children, this workshop was not very useful, but it was greatly informative about why interventions do not work, discussed further in Chapter 2, under *Interventions*.

Chapter 1

The Background, Aims and purpose of the study

'The future of any nation is directly linked to the future of its children and by investing in children and in the families that sustain them, a nation is ultimately investing in its own development.' (Bellamy, 2000).

'AIDS is not only taking away our children's present, but it also has the potential to subtract from their future' (Desmond Tutu, 2005).

The quotes above succinctly capture the reality of most nations: that investment in forthcoming generations is indispensable for their future development, yet both the present and the future are being disrupted by the relentless effects of the epidemic on children. With many developing nations already under severe economic strain, the future prospects of development are being increasingly sabotaged by HIV/AIDS. The statistics are staggering – 40 million people worldwide were expected to be infected by the HIV/AIDS virus by the end of the decade (UNAIDS, 2007). Statistics for 2017, 10 years later, show a high estimate of 42.9 million people living with HIV worldwide (UNAIDS, 2018). The lower average of 36.7 million people living with HIV (*Ibid*) is still as alarming. As will be seen under the HIV/AIDS overview, there has been a significant drop in the numbers of newly infected people all around and hence, a decreased number of deaths. About two-thirds, 21 million, (*Ibid*) reside in Southern Africa. A closer look at individual countries paints an even more sobering scenario. In Zimbabwe, for instance, the deaths of adults and children totalled 170,000 in 2003 (UNAIDS, 2006; Ray and Madzimbamuto, 2006¹⁴) and has left an increasingly fractured society. 15 years later, the number of annual HIV related deaths has dropped to 30,000 (UNAIDS, 2017). Ray and Madzimbamuto (2006) recently estimated that there were 1.8 million HIV infected adults and children in 2003, of whom 120,000 were children under 14 and 980,000 orphans under the age of 19. Once again, the drop from 1.8 million in 2003 to 1.3 million in 2016 (UNAIDS, 2017) is a welcome development, even though the numbers are still alarming.

¹⁴In 2006 Ray and Madzimbamuto, founder members of the Zimbabwe Association of Doctors for Human Rights, published a paper in the Commonwealth Journal of International Affairs that traces the rise of HIV/AIDS in Zimbabwe and the history of official (political) silence that surrounded it and how the medical profession failed to voice its concerns. They argued that women are a particularly vulnerable group but are most often deprived of treatment. They conclude that the effects of HIV/AIDS will be felt for the next 50 years and that unless the response to HIV/AIDS is dramatically strengthened by 2025 that Zimbabwe's population might decrease by more than 14%.

Even though an average prevalence 24.5 percent among adults between 15 and 49 years (UNAIDS 2006; WHO 2006) has since dropped to 16.85 percent (UNAIDS, 2017), it remains that the dependency ratio will increase, straining meagre resources further. At first sight, the most recent statistics, estimated through the UNAIDS Estimation and Projection Package (EPP) and released by Zimbabwe's National AIDS Council (NAC) together with UNAIDS and WHO, show very encouraging progress between 2003 and 2011. Deaths in 2011 were estimated at 63,765, with numbers living with HIV/AIDS down to 1,157,097, of which 138,642 were children (15 years and under), a decreased number of orphans to 946,547 and an impressive national prevalence rate of 13.1 % among adults between 15 - 49 (UNAIDS, Global AIDS Response Progress Report: Zimbabwe Country Report 2012: 2). Except in the case of children where the increase in number is attributed to limited access to antiretroviral medication, all other decreases were 'attributed to successful implementation of prevention strategies especially behaviour change, high condom use and reduction in multiple sexual partners' (*ibid*). These decreases, as shall be seen in the discussion under 'Zimbabwe National HIV/AIDS Response to the Epidemic,' could be flawed because of limitations of the EPP. What remains for now, however, is that Zimbabwe is under serious strain from the epidemic.

Research predicted that between 2000 and 2010 the number of AIDS-related deaths within the teaching community in Zimbabwe alone could be close to 16,200 (Bennell, 2003¹⁵) out of a total teaching force of 150,000. This bleak scenario repeated over time suggests that the Zimbabwean qualified teaching staff has shrunk from '150,000 in 1995 to 70,000 in 2008,' (28,000 of whom only hold temporary posts) including teachers who migrated to neighbouring countries in search of better salaries, leading to the closure of two fifths of schools halfway through 2008 (Murimba, 2010). This serious depletion of human resources naturally affects the quality of education that will be available for children and hence the future development of the country. Such a high

¹⁵ Bennell (2003), in a background paper for the Biennial Meeting of the Association for the Development of Education in Africa, December 2003, made the prediction that Zimbabwe could lose 16,200 teachers by 2010 based on the assumption that the 1999 adult HIV prevalence rate in each country (Kenya, Nigeria and South Africa were also considered) would not increase, and teachers are unable to access life-prolonging ARVs, which is particularly evident in rural areas. In his review of the available evidence on the impact of the epidemic on teachers, Bennell (2003) points out that there is relatively little empirical research that has been done on teachers and that most of it is based on demographic models – which tends to either over or under inflate the results. He concludes that the AIDS epidemic does pose a serious threat to teachers in high HIV prevalence countries and yet the available evidence does not support the prevailing consensus that this impact is likely to be catastrophic. I would argue that it is already catastrophic for infected and affected students who have very little and at most no support in the school system due to the shortage of qualified (and HIV informed) teachers as shall be seen in the findings chapter of this work

depletion of human resources, teachers and education managers who are custodians of children and the education of a nation, has serious socio-economic and political implications for a country like Zimbabwe. Barnett (2006: 305) succinctly notes that

A widespread epidemic adversely affects the potential and actual capacity for society and economy to reproduce itself in a variety of ways via transmission of knowledge and education, through maintenance of social and cultural patterns or via the peopling of institutions.

The reduction of educational opportunities for children through the depletion of necessary human resources has coincided with Zimbabwe's worst economic crisis. Trying to suppress the world's highest run-away inflation of 2.2 million percent¹⁶ (see trillion and billion-dollar notes in Appendix C on page 308), Zimbabwe has been struggling to feed its own people, let alone focus on development matters or the impact of HIV/AIDS on the education of children. A weak and dwindling economy such as Zimbabwe is experiencing 'aggravates the transmission, spread and control of HIV infection...by increasing the population at risk through increased urban migration, poverty, women's powerlessness, prostitution and indirectly through a decrease in healthcare provision' (Sanders and Sambo, 1992:32 in Shaeffer, 1994:1¹⁷). This domino effect of one crisis on another leads to an increasingly fractured society with a bleak future since the next generation is adversely affected just as much, if not more so. Within the 'multi-sectoral' impact of HIV/AIDS on affected countries, UNICEF reported that 'its profound effects are concentrated in the education sector' (2000:10 quoted in Bennell et al, 2002).

Despite the realisation of the impact of HIV/AIDS on children's education, which is indispensable for the future development of countries like Zimbabwe, there is a relative dearth of empirical research about the plight of more than 1 million infected and affected children (UNICEF, 2003) and how it impacts their education, particularly in traditionally neglected rural primary schools. The continuing onslaught of the epidemic on children, amongst other various sectors as already pointed out, prompted UNICEF and UNAIDS to initiate the 'Unite for Children, Unite against AIDS' global campaign in 2005, with the aim of closely looking at the impacts on children. While

¹⁶Mpofu, 2008 - <http://allafrica.com/stories/200807180661.html> (accessed 18 July, 2009)

¹⁷ Shaefer, in a literature review conceptualising the possible impact of HIV/AIDS on education – matters which I will touch on later in this work - concludes that research must be done both on what this impact actually looks like – what actually happens in schools, communities, and families affected by HIV and AIDS in terms of educational demand, supply, processes, and quality - and on the ways in which affected parties react to, and cope with, such impact. This lack of empirical research is also evident in the work of infected and affected children

a report by UNICEF in 2009 noted some progress, recent statistics show that the world is not yet on track in meeting the needs of this vulnerable population – hence the need for ongoing research.

Although ample research shows that 75 percent of children in Sub-Saharan Africa are enrolled in primary education and of that 67 percent stay until 6th grade (Bennell *et. al* 2002¹⁸), the literature about infected and affected children's educational experiences in school, at home and in the community is growing but still lagging in parts of Africa, particularly in rural Zimbabwe. This pertinent information could help educators to maximise the education needed for students to be self-sufficient before most of them drop out of school; there is a known number of 115,000 children under 14 living with HIV/AIDS in Zimbabwe (National AIDS Council of Zimbabwe (NAC) (2006). The complexities of their experiences – without which we cannot know how to educate them effectively - are yet to be researched. In the Zimbabwean context, research in rural areas is particularly important because this is where two-thirds of the population resides and 40 percent of rural households, compared to 25 percent in urban areas, have either infected or affected children (*Ibid*).

The Purpose of the Research

The purpose of my research, therefore, is to understand the impact of HIV/AIDS on rural primary school children in Zimbabwe. I seek to understand the experiences of infected and affected students (invariably compared to their 'normal'¹⁹ counterparts) from their perspective – how they are affected within the school, at home and their immediate community. Most research in the area of HIV/AIDS has tended to view 'children as objects' (Christensen and James, 1999) in the research process whereby the change in the child is what was being observed. This view lessens the role of the child and as such means that the findings are partial at best - mostly the perspective of the researcher is what is presented. Education planning based on such research is likely to create intervention programmes that do not meet the needs of infected and affected children. There is a

¹⁸ Bennell, Hyde and Swainson, in study conducted in 2002 on the impact of HIV/AIDS on the education sector in sub-Saharan Africa, synthesised the main findings and recommendations of a three country study (Zambia, Malawi and Botswana). They used demographic models for the 3 countries to arrive at the possible 67% that stay until 6th grade. They also found that knowledge about HIV/AIDS transmitted to young people did not translate to behaviour change – calling for multifaceted approaches to the dilemma

¹⁹ 'Normal' when referring to students who are neither infected nor affected will be used to represent children currently living with both parents and without immediate relatives affected by HIV/AIDS i.e. no sick relatives living with them in their home

need, therefore, to give children a voice, to treat them as participants (*ibid*) in the research process thereby increasing the probability of conclusions that could lead to the creation of intervention programmes and policies that are cognizant of those for whom they are being created. The research question, therefore, that I seek to answer from the broad question of the impact of HIV/AIDS on rural primary schools is as follows: How do rural primary school children experience education at school, at home and in the community in the midst of the HIV epidemic in Zimbabwe? I will address this question by subdividing it into the following questions:

1. *How do infected, affected and normal rural primary students experience education in school, at home and in the community?*
2. *Similarly, what are parents' or caregiver's perceptions of infected, affected and normal students' schooling?*
3. *What are the community leader's perceptions of the education of infected, affected and normal student's schooling?*

As pointed out earlier in the Epilogue, my 14 years of teaching experience and work in village communities, amongst other things, have brought me to the realisation of how the home, school and community lives of a child are inseparable; thus, a holistic understanding of these will provide a better understanding of students' experiences.

The aforementioned questions are discussed in further detail below.

The first question (*How do infected, affected and normal rural primary students experience education in school, at home and in the community?*) is intended to gather information on how infected, affected and uninfected students experience schooling by relating their own narratives. I was interested in researching about how these three groups relate to each other as peers, their overall experiences in school and their experiences at home and in the community, as these necessarily impact on their experiences at school. By 'community' I mean their immediate environment outside their home – their neighbours and their friends within their immediate locale²⁰.

²⁰ Cohen (1985:15) has a more apt description for a community that encapsulates that of the rural village in which I undertook my work – 'Community is that entity to which one belongs, greater than kinship but more immediate than the abstraction we call society. It is the arena in which people acquire their most fundamental and most substantial experience of social life outside the confines of the home...where one learns and continues to practice how to be social.'

The second research question (*Similarly, what are parents' or caregivers' perceptions of infected and affected students' schooling?*) aims to find out the thoughts of the parents or caregivers about the students' education; how they perceive education will have a bearing on the student's learning and their experiences of looking after such a group of children. Our understanding of how these parents and caregivers think will give us a fuller picture of the world that these students inhabit – either the support or lack thereof will be important factors in aiding our knowledge and thinking. It might also help educators plan for appropriate intervention and support systems.

The third research question (*What are the community's perceptions of the education of infected and affected student's schooling?*) aims to find out what the community leaders (i.e. the Chief, City Councillor, the teachers, the Education Officers, the Baptist Minister) think about this situation. Since community leaders are in charge of allocating resources for education and other purposes, their understanding of the epidemic and its impact on the primary school children have direct implications for future planning.

The Significance of the Research

The significance of conducting research on the impact of HIV/AIDS on primary schools in rural areas is that it will bring a clearer understanding of how children and their education are being affected by the epidemic, which is prerequisite to meaningful and effective educational planning and implementation. Upon surveying the literature regarding the impact of HIV/AIDS on primary education, I contend that not enough empirical research has been done in actual school settings (Bennell *et al*, 2002; Kelly 2000) with children as actors in the Zimbabwean rural context, even though there is a growing literature beyond. Research is also lacking on actual programs that have attempted to meet their needs. Further and equally important, the significance of doing research that takes into consideration the psychosocial and cultural contexts is likely to maintain relevance. This lack of empirical research means that effective planning for those schools could, in essence, be based on projected data leading to wide generalizations and hence, less focused planning. Unfocused planning will, in turn, lead to a waste of resources which a country like Zimbabwe can ill afford. Beyond making attempts to provide for children as a right, I believe that the education of the most populated rural areas of Zimbabwe will have direct effects on its socio-economic and political development. Having been an educator in Zimbabwe, I was and am interested in

researching ways Zimbabwe can address the problems of HIV/AIDS within the education system because I believe the education of Zimbabweans will be paramount in solving the problems which are presently suppressing the country. In the absence of a vaccine for HIV/AIDS, education has the potential to become the ‘social vaccine’ (Vandemoortele and Delamonica, 2000) that can keep the epidemic at bay.

Literature Review and Justification for the Study

To see what has been covered related to HIV/AIDS and Education and hence justify exploring the experiences of students in the midst of the HIV epidemic, I will first take a closer look at the severity of the global situation followed by a survey of selected research on and with children. The section closes with a focus on the Zimbabwean situation and the direct impact on education. Altogether, it will show the severity of the impact of HIV/AIDS on education, interwoven with growing but still scant research on infected and affected children’s experiences in school, at home and in the community, despite their increasing numbers.

HIV/AIDS Overview and Its Impact on Education

The staggering number of people living with HIV/AIDS globally, 35.9 million in 2006 (UNAIDS, 2006) with a slight increase to 36.7 million in 2017 (UNAIDS, 2017), coupled with the estimated total deaths of 10.6 million between the years 2000 and 2017 (ibid), is cause for concern. The summary of global figures below shows a decrease in the numbers of the newly infected and also, a decrease in the number of deaths.

Global HIV data

	2000	2005	2010	2012	2013	2014	2015	2016/* June 2017
People living with HIV	27.7 million [23.2 million– 32.3 million]	31.0 million [26.0 million– 36.3 million]	33.2 million [27.6 million– 39.2 million]	34.3 million [28.5 million– 40.3 million]	34.9 million [29.0 million– 40.9 million]	35.5 million [29.5 million– 41.6 million]	36.1 million [30.2 million– 42.2 million]	36.7 million [30.8 million– 42.9 million]
New HIV Infections (total)	3.0 million [2.6million– 3.4 million]	2.5 million [2.2 million– 2.8 million]	2.2 million [1.9 million– 2.4 million]	2.1 million [1.8 million– 2.3 million]	2.0 million [1.7 million– 2.3 million]	2.1 million [1.9 million– 2.4 million]	1.9 million [1.6 million– 2.2 million]	1.8 million [1.6 million– 2.1 million]
New HIV infections (aged 15+)	2.5 million [2.2 million– 2.9 million]	2.1 million [1.8 million– 2.3 million]	1.9 million [1.6 million– 2.1 million]	1.8 million [1.6million– 2.0 million]	1.8 million [1.5 million– 2.0 million]	1.7 million [1.5 million– 2.20million]	1.7 million [1.5 million– 2.0 million]	1.7 million [1.4 million– 1.9 million]
New HIV infections (aged 0–14)	460 000 [370 000– 540 000]	430 000 [340 000– 510 000]	300 000 [230 000– 370 000]	270 000 [250 000– 190 000]	220 000 [160 000– 280 000]	190 000 [130 000– 260 000]	170 000 [110 000– 240 000]	160 000 [100 000– 220 000]
AIDS-related deaths	1.5 million [1.2 million– 1.8 million]	1.9 million [1.7 million– 2.2 million]	1.5 million [1.3 million– 1.7 million]	1.3 million [1.1 million– 1.5 million]	1.2 million [1.0 million– 1.4 million]	1.1 million [940 000– 1.3 million]	1.1 million [880 000– 1.3 million]	1.0 million [830 000– 1.2 million]
People accessing antiretroviral therapy	685 000 [600 000– 710 000]	2.056 million [1.8 million– 2.1 million]	7.7 million [6.8 million– 8.0 million]	11.2 million [9.8 million– 11.6 million]	13.1 million [11.6 million– 13.7 million]	15.1 million [13.3 million– 15.7 million]	17.1 million [15.1 million– 17.8 million]	19.5 million [17.2 million– 20.3 million] / *20.9 million [18.4 million– 21.7 million]
Resources available for HIV (low- and middle-income countries)	US\$ 4.8 billion*	US\$ 9.4 billion*	US\$ 15.9 billion*	US\$ 18.8 billion*	US\$ 19.5 billion**	US\$ 19.2 billion**	US\$ 19.0 billion**	US\$ 19.1 billion**

* Includes countries classified as low- and middle-income level per the World Bank 2012 classification.

** Includes countries classified as low- and middle-income level per the World Bank 2013 classification.

Table 1:1 UNAIDS Global HIV Data (2017)

Saharan Africa is the most affected region counting an estimated average of 19.4 million adults and children living with the virus (UNAIDS, 2017). The long incubation nature of the disease means that these statistics are the results of infections that took place a decade ago (Barnett & Blaikie, 1992, quoted in Shaeffer 1994:28²¹; Iliffe, 2006). Thus, the estimated number for the newly infected, now 3 million (UNAIDS, 2017) from 2.8 million in 2006 (UNAIDS, 2006) in Sub-Saharan Africa has yet to take its toll in the next 10 years if this situation continues unabated. The table below summarises the statistics of the unrelenting epidemic, despite modest improvements.

Region	People living with HIV (total) 2016	New HIV infections 2016			AIDS-related deaths (total) 2016	Total number accessing antiretroviral therapy 2016	Total number accessing antiretroviral therapy June 2017
		Total	Aged 15+	Aged 0–14			
Eastern and southern Africa	19.4 million [17.8 million–21.1 million]	790 000 [710 000–870 000]	710 000 [630 000–790 000]	77 000 [52 000–110 000]	420 000 [350 000–510 000]	11.7 million [10.3 million–12.1 million]	12.5 million [11.0 million–13.0 million]

Table 1:2 Regional HIV/AIDS Data (2016)

The high number of HIV/AIDS deaths has left an estimated 10.9 million orphans in Sub-Saharan Africa (UNICEF, 2015). The difference between orphans whose parents have died from HIV/AIDS and those orphaned by other causes is a matter of stigma: the former are shunned (Duffy, 2005²²; Holzemer, et al, 2007²³) and most families are reluctant to take them as foster children (Foster et al,

²¹ In a review of literature about the impact of HIV/AIDS on Education, Shaeffer (1994) suggests more anticipatory planning - the ability to look in data not only for the likely but also for the merely possible and even the unexpected - in order to see what is in the process of happening or what might happen - since there are a lot of infections still occurring but not yet recognized

²² Duffy (2005), during 2001 and 2002, also conducted an ethnographic study in rural Zimbabwe to examine factors that facilitate or hinder women's ability to prevent HIV (Duffy, 2003). Key participants included a core group of 11 women recruited through purposive sampling, 17 key informants and four focus groups. Although gender inequality emerged through the narratives as the main influencing factor for women's inability to protect themselves, serious issues around the stigmatization of the disease were revealed and significantly added to the complexity surrounding HIV transmission and AIDS care. Through the focus groups she also found that Zimbabweans would not mention the reason for death for fear that those remaining, the spouse and children will be shunned. What could have strengthened this study, in particular about children, would have been to include them in the sampling and interview them directly.

²³ Holzemer et al (2007) conducted a study to develop a conceptual model delineating contexts and processes of HIV/AIDS stigma as reported by persons living with HIV/ AIDS and nurses from African countries as part of a larger study to increase understanding of HIV/AIDS stigma. Forty-three focus groups were held with persons living with HIV/AIDS and with nurses in five African countries. They identified 2 components: contextual factors - environment, health care systems and agents) and the process of stigma in which children who had lost a parent through HIV/AIDS

2000²⁴). In Southern Africa where the epidemic is most visible, Zimbabwe is one of the worst affected nations as shall be seen below. The neighbouring countries which border Zimbabwe are all part of the Southern Africa Development Community (SADC), an organisation whose mission is to foster economic and political development among member states²⁵. Migration within SADC is very common, which implies a higher likelihood of HIV/AIDS infections increasing from member states who are already struggling with high prevalence rates (WHO, 2006). The already alarming estimated figures above are underestimated by 25-35 percent (Foster & Williamson, 2000²⁶) in many instances since extremely few studies look at children as potential victims infected with the virus. The chart above highlights the intensity of HIV/AIDS in the region and hence the urgency to deal with the epidemic as it is further disrupting the regional socio-economic and political well-being. The high prevalence rates imply that education planning will need to be dynamic in nature and make intelligent estimates and forecasts – guided by empirical research wherever possible - to deal with a disease that has already staked its claim on millions.

were reported to be shunned, as other children did not want to play or even walk with them and how they ended up keeping to themselves

²⁴ Foster et al (2000), in a study conducted in 2000 to examine the condition of orphans, held focus group discussions and interviews with 40 orphans, 25 caretakers and 33 other community workers from a rural area near Mutare, Zimbabwe. Their findings reflect that orphan concerns included feeling different from other children, stress, stigmatization, exploitation, lack of schooling, lack of visits and neglect by relatives.

²⁵ Zimbabwe used to be a formidable leader within SADC as far as HIV/AIDS legislation was concerned - they were the first to introduce non-discrimination laws against people with HIV/AIDS in the work place and elsewhere - but due to the impact of HIV/AIDS compounding the worsening economy and vice-versa, Zimbabwe is no longer capable of being a leader in the struggle against the epidemic (Ray and Madzimbamuto, 2006).

²⁶ In a review of literature of the impact of HIV/AIDS on children in sub-Saharan Africa conducted in 2000 Foster and Williamson argue, amongst other things, that Orphan studies are likely to assume greater prominence when the number of children affected by HIV/AIDS is accurately and consistently quantified and lament the lack of data and limited studies on orphans and also, how agencies involved in research frequently fail to conduct studies in partnership with (instead of 'on') children and affected communities

The HIV/AIDS Situation in Zimbabwe

Zimbabwe is one of the countries worst affected by HIV/AIDS, with at least 3000 deaths every week (Ray & Madzimbamuto, 2006; UNAIDS, 2006). The table below gives a quick overview of current statistics:

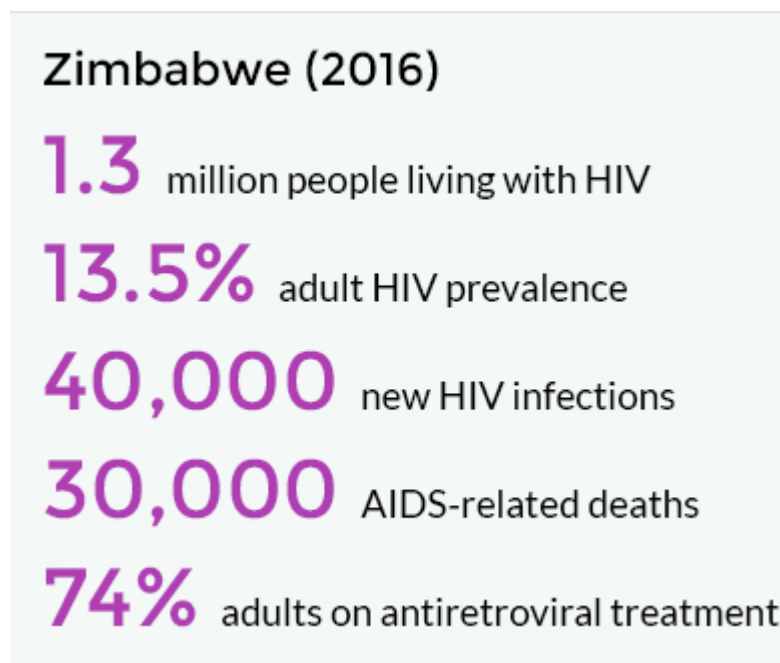


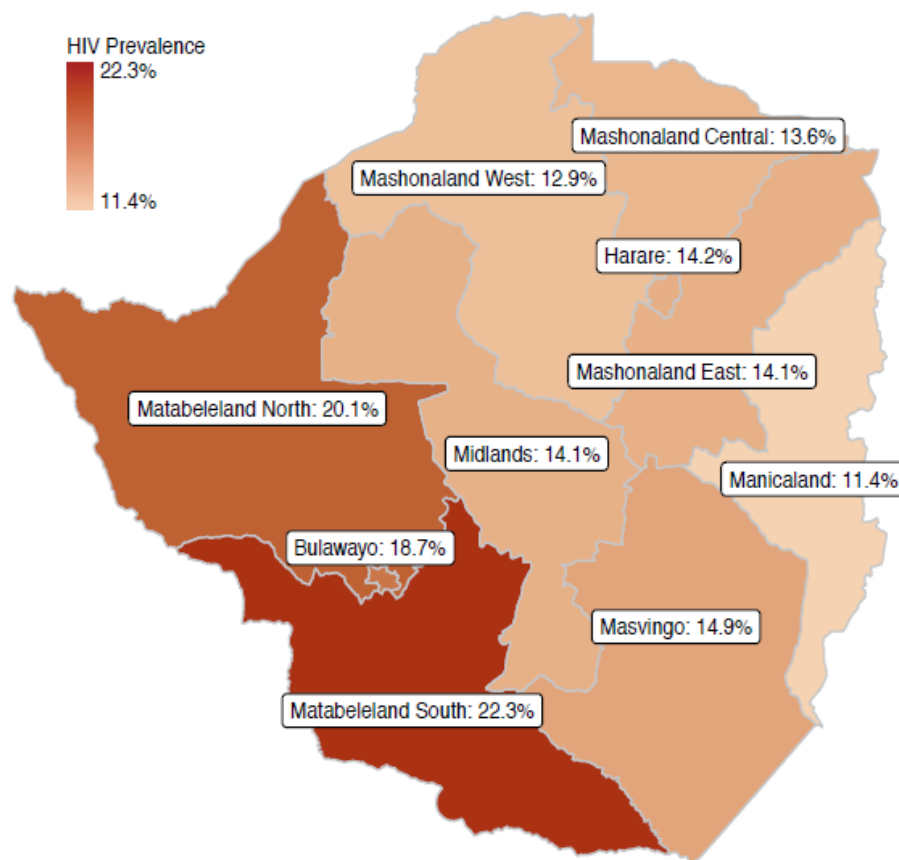
Table 1:3 Zimbabwe HIV/AIDS statics (UNAIDS, 2017)

In total, an estimated 180,000 people died in 2005 (NAC, 2006). A bigger reduction through various initiatives was noted 2013 when the numbers dipped to 61,000 and again in 2016 when they were halved to 30,000 (UNAIDS, 2017). Despite these welcome statistics, the death toll is still a troubling number for a population of 11.6 million. An estimated 780,000²⁷ women aged between 15 and 49 are living with HIV (Ministry of Health and Social Welfare, 2005). Coupled with 115,00 children living with HIV/AIDS (UNICEF, 2012), the dependency ratio is magnified.

²⁷ WHO (2005) estimates that the number of women living with HIV/AIDS is about 890,000 – a rather large discrepancy compared to the 780,000 quoted by the Ministry of Health in Zimbabwe. As shall be seen later, Zimbabwe had adopted a policy of silence about HIV/AIDS at its advent and deflated figures of those who were infected (Ray and Madzimbamuto, 2006) - it could explain the discrepancy

The high number of deaths in child-bearing women has serious implications for population growth and the survival of the family since 89 percent of women are breadwinners in Zimbabwe (Foster, 2000). 50 percent of women who reside in the rural areas are responsible for 70 percent of the agricultural produce (Quisumbing, 1994; Mutangadura, 2000) and they tend to spend the greater part of their income on their families as compared to men who spend mostly on themselves. The stresses due to HIV/AIDS suffered by this important productive group - emotional distress, depression, hopelessness, suicidal ideation (WHO, 2003) – are passed down to their children, creating psychological and other traumas, which Zimbabwe will have to find ways to deal with. This rather high number of deaths in women at the height of their productivity is exacerbated by some cultural norms that create power inequalities between man-women relationships, making the latter vulnerable to sexual abuse and increasing chances of infection (Cohen, 1997; Kelly, 2000).

Whilst children under the age of 14 who are living with HIV number close to 115,000, children who are orphans due to HIV/AIDS are estimated to be over 1.1 million (Central Statistical Office, 2005). UNICEF (2013) estimates a slightly higher figure: 1.2 million orphans due to HIV/AIDS (which is 30 percent of the child population in rural and high-density urban suburbs) and that child mortality has increased from 80 to 129 per 1000 births since 1990. The average high prevalence rate of 18.2 percent (*ibid*) means that the country will experience even more deaths in 10 years' time, further straining the economy which already suffers due to political instability and an economy struggling to recover from hyperinflation (Mpofu, 2008). The figure below shows the prevalence rates in different provinces around the country.



Map 1:1 Zimbabwe Prevalence Rates by Province (ZIMPHIA, 2016)²⁸

Province	HIV Prevalence
Manicaland	11.4
Mashonaland Central	13.6
Mashonaland East	14.1
Mashonaland West	12.9
Matabeleland North	20.1
Matabeleland South	22.3
Midlands	14.1
Masvingo	14.9
Harare	14.2
Bulawayo	18.7

Table 1:4 Zimbabwe Prevalence Rates by Province (ZIMPHIA, 2016)

²⁸ ZIMPHIA Zimbabwean Population Based HIV Impact assessment

The epidemic is more prevalent in the rural areas, with some places like Buhera²⁹ showing a prevalence rate of 50 percent. Other border towns also have high prevalence rates: Beitbridge, 46 percent; Mutare, 37.7 percent and Victoria Falls, 42.6 percent (National AIDS Coordinating Program, 1998). Research shows that there is a significant correlation between low education and high infection and vice-versa (Machelo *et al*, 2006; Hargreaves and Boler, 2006) most people reside in rural areas and most border towns tend to be less educated – hence the high infection rates noted above. An increasing orphan population means tougher competition from all sectors for scant resources. In the prevailing situation, Zimbabwean education is under severe threat. A clearer understanding of the epidemic in Zimbabwe, to be able to create useful intervention programs, requires more than just statistics: information that reveals the prevalence rates of entire cities and demographics to enable educators to implement focused planning directed to classrooms will be necessary. Other types of information that enable a clear understanding of the processes of education will also be needed.

The statistics noted above are all for adults and research is silent about HIV/AIDS prevalence and its impact on children in rural primary schools, hence the need to explore how infected and affected children experience education in the midst of the epidemic. The lack of child-specific statistics gives a false impression that perhaps they are not affected. My pilot study (Mtimbiri, 2008) revealed a total absence of national planning for infected and affected children. As noted earlier, I was informed by the NAC (2008) that there were no specific demographic statistics for groups below the age of 15 and that they did not have any plans to start collecting any soon.

NAC HIV/AIDS campaigns were clearly focused on prevention and therefore they concentrated on collecting information on those whom NAC regarded as sexually active (i.e. those who are 18 and over). HIV/AIDS is seen mostly as an adult problem with children seen as asexual (Pattman and Chege, 2003) - the country is still far away from researching this important group – children on whom its future depends.

There is a need, also, even when in the possession of statistics, to provide narratives that expose the constant breakdown of families due to HIV/AIDS. The literature points to discrimination and stigma as issues that exacerbate the HIV/AIDS epidemic. These issues will be discussed next.

²⁹ Buhera is a rural district in the province of Manicaland

One of the multi-faceted components of the HIV/AIDS epidemic in Zimbabwe is the stigma associated with the disease. Stigma, however, is a complicated issue that should not simply be assumed but investigated. The studies discussed below imply that the stigma of HIV/AIDS has created attitudes which make those affected and infected resist confronting the disease, disclosing their status or figuring out ways for treatment (Duffy, 2005; Gilborn et al, 2001). This results in increasing fatal consequences for both individuals and the nation (Chesney & Smith, 1999; Parker and Aggleton, 2002). Unfortunately, there is a shortage of literature on how stigma is experienced among children in the home-school-community environments.

Stigma and Silence as Factors Exacerbating the Epidemic

Goffman (1963:3) describes stigma as ‘an attribute that is significantly discrediting ... used to set the affected person or groups apart from the normalised social order, and this separation implies devaluation.’ Brimlow, Cook, and Seaton (2003 quoted from Kiragu, 2009: 22) say that HIV-related stigma refers to all unfavourable attitudes, beliefs, and policies directed towards people perceived to have HIV/AIDS as well as toward their significant others and loved ones, close associates, social groups, and communities. In Zimbabwe, even though the word ‘stigma’ is used, there is no Shona³⁰ equivalent; what is commonly meant are ‘reactions and fears towards people suspected to have HIV/AIDS (Bond et al, 2002). It is used in terms of discrimination towards people suspected of having HIV/AIDS or those who have it, a sense of ‘othering.’ DFID (2006) notes that

In Zimbabwe, although the majority of people know about HIV and AIDS, there is still a widespread belief that being HIV-positive is shameful, even a punishment from God...that the stigma that surrounds infection prevents people from getting tested, seeking treatment and admitting their HIV-positive status to others (www.DFID.org)³¹.

As part of their Anti-Stigma campaign in Zimbabwe, DFID (2006) conducted a survey of 2,201 adults in 2006. Results show that the fear of casual transmission and a lack of empathy are major reasons for the high levels of stigma and discrimination in Zimbabwe. They discovered that 82 percent of people surveyed noted that they would be ashamed if a member of their family had

³⁰ Shona is one of the languages spoken in Zimbabwe, particularly by the dominant Shona tribe mostly located in the northern parts of the country

³¹ www.dfid.org/Zimbabwe/stigma (accessed 25 November, 2010)

HIV/AIDS and 82 percent claimed that they would feel ashamed if they were infected (*ibid*). Whilst the DFID reports that their 5-year anti-stigma campaign was successful³³, the survey, unfortunately, did not include children, a burgeoning population who are affected. In a study referred to earlier, Foster *et al.* (1997), in discussions with orphans, caregivers and community workers, found that children reported anxiety, fear, stigmatisation from friends and community, depression and stress. More research still needs to be conducted within the school, where children spend most of their time, to see if stigma is not only prevalent in that setting but how it plays out.

Bond et al (2002:353), in a study conducted in 2001 to research the extent of perceived and enacted HIV/AIDS-related stigma in a rural setting in Zambia, discovered that stigma was ‘manifested in the forms of verbal abuse, rejection, eviction and imposed restrictions on the person...people with HIV/AIDS were subjected to blame, bitterness, anger, denial and the withdrawal of treatment and care, sometimes leading to blatant neglect.’

Within the community, Bond et al (2002) noted that people frequently reported putting physical distance between themselves and persons suspected of having HIV/AIDS exemplified by not shaking hands or sitting next to such people on buses, not sharing food and drinking utensils, were all signals of rejection. In one of the few studies that report on how stigma affects children in school, Bond *et al* (2002:355) report on the impact on teachers and children

In school HIV/AIDS-related stigma manifested itself in the forms of rejection, gossip and taunts. HIV positive teachers suffered from self-stigma, withdrawing themselves from the public eye. Leave was sometimes imposed upon them, making their sickness invisible. Other children sometimes taunted children whose parents had died as a result of HIV/AIDS

This study is helpful in conceptualising the impacts of stigma in a rural setting as it looks at the impacts on the family, the community and the school. Since its focus was mother-to-child transmission and largely used interviews from service providers within the medical domain, it

³³ The first campaign, launched in May 2005, has been successful in addressing stigma as a barrier to accessing HIV services. Those exposed to the campaign were more likely to know their HIV status (31 percent) than those not exposed (16 percent), and were less likely to see HIV as a punishment from God and more open to touching an HIV positive person or playing with an HIV positive child (DFID, 2006).

suffers from over-reliance on one approach. The key informants from other fields³⁴ were interviewed based on their observations but it does not show if they actually conducted any research to report confidently on matters of observed stigma. Thus, the methodology is weak in that it does not explain the grounds on which the key informants can be considered well-informed and children's perspectives were not directly sourced. Nevertheless, aspects of stigma noted by Bond *et al* (2002) are reflected in infected and affected students' experiences in my study albeit in different ways as will be shown in the analysis chapter.

Another study by Gilborn *et al* (2001:1) to assess the impact of an orphan support program on the physical, educational, and emotional wellbeing of children concluded that

children with HIV/AIDS or associated with HIV through infected family members have been stigmatised and discriminated against in educational settings in many countries. Stigma has led to teasing by classmates of HIV-positive school children or children associated with HIV

They state, however, that 'parents and guardians supplied the data for younger children (age 5-12), while older children (age 13-17) *were* interviewed directly' (2001:7); children as young as 6 (Pattman and Chege, 2003) have been shown to be able to communicate their opinions and certainly children as old as 12 can be interviewed effectively using appropriate methods. The voice of the child, therefore, could have been employed more in this research for a fuller perspective. The work nevertheless alerts about the existence of stigma in school contexts which need investigation, particularly from the children's perspectives.

Other studies, however, also show that stigma associated with HIV/AIDS is likely to compound the epidemic's destructiveness. In Zimbabwe and Kenya, families who are infected and affected by AIDS struggle to communicate their status because of 'a fear of anticipated consequences, including disruption, separation or abandonment, which in turn may lead to a loss of economic and social support' (Bor *et al*, 1993: 9). A slight indication of this is reflected in a 1992 study in Zimbabwe conducted by Meursing and Sibindi (1992) to examine how families cope with HIV, stigma and disclosure matters. They found that out of 31 HIV-infected patients who were told of their HIV-positive status, 50 percent (15) refused to communicate their status to their partner. The

³⁴ Local representatives of political parties, churches, schools, traditional healing and HIV education, representatives from the media, health policy, law, people living with HIV/AIDS and a HIV/AIDS counselling organisations (Bond *et al*, 2002:350)

reasons for not disclosing were related to fear of break-up, guilt or fear of rejection (Bor *et al*, 1993). The remaining participants who did disclose to their partners ended up in broken relationships (Meursing & Sibindi, 1992). I stated that this is a slight *indication* above because the authors caution that they are not certain if the break-ups were solely through the disclosure or if it merely exacerbated an existing problem.

Guest (2005:2) has noted that the stigma surrounding HIV/AIDS is so strong that it has created silence among infected and affected families. This leads to skewed reporting of deaths associated with HIV/AIDS as doctors ‘rarely put AIDS as the cause of death on a patient’s certificate.’ Beyond studies conducted by Guest, I witnessed the same in my family where successive deaths that we knew were due to AIDS were recorded, on request from my family, as any one of the major symptoms at the time of death. In addition, the Zimbabwean government had an implicit policy of silence and denial at the beginning of the epidemic which unfortunately caused many people to die when potentially life-saving information was withheld (Ray & Madzimbamuto, 2006; Makami, 2009). The created silence in turn cements stigma which propagates the epidemic: ‘any epidemic sustains itself largely because of the social organization that supports its propagation, not simply because of the biological characteristics of the causative agent’ (Basset and Mhloyi, 1991: 144). Stigma has simply become one of the main barriers to effective implementation of strategies against the epidemic (Bell, 1997; Mahajan et al, 2008; Boler, 2003).

There is, however, very little explicit research done on the experiences of social interactions between children who are infected or affected and other uninfected children – particularly in primary schools. Further research needed to be conducted in schools to ascertain, first, the presence of stigma and, second, the extent to which it creates further problems, psychological or otherwise, for infected and affected students and thus creates and implement appropriate programs (Wallman, 1988; Kelly 2000, World Bank 2000). My study, therefore, through researching their experiences, amongst other things, sought to find out how infected and affected children negotiated and made sense of possible stigma and discrimination issues³⁵ and how stigma actually plays out in their relations with others.

³⁵ My pilot revealed severe stigma (discrimination) issues experienced differently by infected students compared to the simply affected. The former were shunned much more publicly which affected their relationships with other students. The latter, if they were not discovered to be HIV/AIDS orphans did not suffer much stigma at all, they were in fact

Beyond the lack of specific statistics - albeit underestimated - and the scant research in children experiences of education within the epidemic, a further look at the possible resulting changes and conceptualisations in demand, supply and process in education highlight the seriousness and agency for the research for infected and affected children as it further underlines how they are affected. I revisit Kelly's (2000) framework again in the conclusion to see how it either fits or is contradicted by the findings. His broad framework allows us to think through what I consider to be the most important areas to be given serious consideration in education systems affected by the HIV/AIDS epidemic.

HIV/AIDS potential impact on the demand for education

Due to the high death rate both within the adult cohort (15 – 49) and infant mortality rate, there will be reduced numbers of children to educate (Kelly, 2000, World Bank 2000). The increased deaths of parents and caregivers will likely cause already high school fees to be unaffordable because of reduced family incomes (Ainsworth *et al*, 2005). Some children, mostly girls, might have to stay home to nurse their infected parents (Katahoire *et al*, 2004)³⁶. Studies also show that girls in poverty-stricken rural areas are the most affected (Rispel *et al*, 2006; Lewin, 2009 quoted in Unterhalter, 2009). Infected students sometimes might need to stay home because of health challenges leading to 'erratic attendance patterns' (Aikman *et al*, 2008). According to government estimates, primary school attendance in Zimbabwe is expected to drop by 71,000 students in 2010 because of HIV/AIDS (MOE, 2002). Most of the infected and affected students who will not be able to attend school would be the very ones who need to since school is one place where they could be counselled and have some normalcy of being with other students. The weakness in this part of Kelly's framework is that it overlooks the many other children who are already out of school who might simply fill the spaces; these numbers are up to 5000 children who never attend first grade in some rural areas (MOE, 2005). Demand might indeed drop but that would be in the very long term.

embraced; they, however, together with unaffected students made sure not to associate with infected students for fear of being shunned or branded 'ill' by association (Mtimbiri, 2008).

³⁶ The lower demand might also be due to the fact that some children will become heads of households and therefore might not be able to have the time or the money to attend school.

Yet another reason for the possible drop in demand for school might be due to the traumatic experiences of children who have to care for their dying parents with HIV/AIDS (Schaeffer, 1994; Bennell et al 2002; Germann, 2004). This points to the effects of HIV/AIDS on the clientele for education; the emerging 1.1 million orphan population in Zimbabwe (UNAIDS, 2006) presents the education system with students who might need to be educated differently because of the situations they have endured. The material, emotional and physical vulnerabilities that orphans endure are well documented in research (Young and Ansell, 2003; Madhavan, 2004; Townsend and Dawes, 2004; Ray and Madzimbamuto, 2006). Double orphans and children who become heads of households suffer the most anxiety about the future and wonder if they themselves are infected (Donald and Clacherty, 2005; Foster 2000). How these anxieties play out in the school environment and how teachers and the children's peers deal with them is yet to be fully researched. The introduction of infected and affected students readily presents challenges that affect the process of education.

HIV/AIDS potential impact on the process of education

Due to the absenteeism of teachers because of illness associated with HIV/AIDS, education is likely to become erratic in crowded classes (Kelly, 2000). The possibility of children having to watch their fellow students or teachers slowly deteriorate from the disease is traumatic, severely affecting their emotional stability (Siamwiza & Chiwela, 1999; Kelly 2000; Howard *et al*, 2006). As already noted, students and teachers who are infected with HIV/AIDS are likely to face stigmatisation and discrimination, which affects the teacher-learning environment (Shaeffer, 1994; Zierler and Krieger, 1997; Duffy, 2005). The cultural powerlessness of girls (Mutangadura, 2000, Leach and Machakanja, 2000) might lead to some being sexually abused. In Zimbabwe, cases of sexual abuse of students by teachers have been documented (Tichatonga *et al*, 2001; Foster, 2000) mostly for adults but not much has been written about sexual abuse among children.

The examples from the research noted above show and describe the disturbances to the process of education and the myriad of psychological problems for both teachers and students. The role of education in alleviating these problems, however, has not been adequately addressed; efforts need to be employed to understand the effect on the process from the students' perspectives. A matter that is closely linked to the process of education is how HIV/AIDS has the potential to affect the

content of education. Education content will have to evolve to include HIV/AIDS education that will enable students to discuss their feelings and recover from some of their traumatic experiences (Richter *et al*, 2004). HIV/AIDS education has been in place in Zimbabwe since 1991 (O'Donoghue, 1995; MOE, 2002), though it remains to be seen whether it has made a difference in the behaviour of students, preventing the spread of HIV/AIDS, or considering the needs of children in a more holistic manner. The successful integration of HIV/AIDS education into the curriculum is likely to be one of the best investments in keeping the epidemic at bay (World Bank, 2002, MOE, 2002).

HIV/AIDS potential effect on the supply of education

The reduction in the supply of teachers and managers of education will 'erode the system's capacity to plan and implement educational policies and programs' (Shaeffer, 1994: 21). Thus, the idea alluded to at the beginning of this work (i.e. education potentially becoming a 'social vaccine'), becomes seriously compromised by this situation. This reduction in supply will invariably affect schooling for all children, but particularly those who are infected and affected. The World Bank projection that 2.1 percent (12,400) of teachers in Zimbabwe would have died by 2010 means that there will be a difficulty of matching the supply of teachers with the already uncertain demand from pupils (World Bank, 2000; Kelly, 2000). A drop in the supply of teachers and a drop-in demand for school would seem to imply that it might even out yet there are large numbers of out of school children already in Zimbabwe (MOE, 2002) – which might keep demand constant, depending on many other variables like school fees. Teacher supply will also be lost even with some teachers still teaching due to the prolonged nature of the disease – absenteeism of teachers as they seek medical help will result in sporadic teaching that leads to non-attendance and pupil dropout (Shaeffer, 1994; Baxen and Breidlid, 2004; Castro et al, 2007). The supply of teachers is further exacerbated by the estimated 15,000 annual migration of teachers to neighbouring countries (Robertson, 2008). In a recent interview the Zimbabwean Minister of Education, David Coltart, confirmed that they lost 20,000 teachers between 2007-8.³⁷ In Zimbabwean rural schools with traditionally scant resources (Mutangadura, 2000; MOE, 2002), increased overcrowding of classes means that teachers will not have time to attend to the needs of

³⁷ <http://www.swradioafrica.com/pages/qt-coltart310511.htm> (assessed on January 17, 2012).

infected and affected pupils as will be shown in the discussions and findings chapter. What then could be done? Some literature points to attempted community efforts, such as after-school programs (Mutangadura, 2000), but for the most part, the situation remains dire. There has not been substantial research that indicates how communities are dealing with the challenges of these students (Howard *et al*, 2006). The students' experiences, particularly in school settings, are still vaguely understood. But this engenders a question: what has been the Zimbabwean response to date?

Zimbabwe National HIV/AIDS Response to the Epidemic

To contextualise the Zimbabwean government's response to the HIV/AIDS epidemic, I must briefly trace a history of how it reacted to various events in the life of the epidemic so far. This section will show how the government's muted policy of silence exacerbated the HIV/AIDS infection amongst the adults and almost ignored its effects on children. I will also discuss how the implemented efforts by the government remain ineffective and how this further justifies the work at hand, as children have only just started being considered seriously relative to when the first case in the country was publicly acknowledged in 1985 (Avert, 2010a).

In medical wards in Zimbabwean hospitals, more than 70 percent of admissions are HIV-related opportunistic infections (Johnson and Fleming, 2004; MOH, 2005). These numbers had been growing since the first case of HIV/AIDS was reported in Zimbabwe in 1985 through blood screening by the National Blood Transfusion Services (NBTS). When the NBTS started screening blood products more intensively in 1985, they did not have the legal authority to notify those who were affected (National AIDS Council of Zimbabwe, 2006:7). Moreover, their focus was market-driven to sell blood to Europe (Garfield, 1994 quoted in Ray and Madzimbamuto, 2006). This meant that people who were infected were left to get worse and also, to infect others unknowingly. At the advent of the epidemic in 1982, Ray and Madzimbamuto (2006: 220), medical professionals who lived and worked within the Ministry of Health, claim that the government adopted a policy of silence and 'many people died in the 1990s and more were later infected between 1985-90 while accurate information on the existence of HIV and how to protect oneself was actively suppressed

by politicians and the medical profession.’ Ray and Madzimbamuto (2006) implicate the medical profession for their failure to raise their voices about what they knew to be an epidemic waiting to happen. A series of newspaper articles in the Herald, the government mouthpiece, gave the impression that there was nothing much to worry about since an HIV test could be false, one of the headings announced that ‘Positive AIDS results may prove false’ (Herald, 1988, quoted in Ray and Madzimbamuto, 2006:221). The story described the complications of population-based screening tests that may give false results. A few days earlier, another headline from the same newspaper carried the story headlined ‘Blood tests for AIDS not conclusive, says city Ministry of Health’, concluding that ‘our present impression is that the test done indiscriminately, is more dangerous than the infection itself, as it leads to suicides, ostracizations and loss of jobs’ (*ibid*). Ray and Madzimbamuto (2006) reason that this gave the impression that the testing process was unreliable and unbelievable, as well as that the doctors who gave the results were unprofessional and therefore not to be believed. Although it seems that there was a campaign of silence by the government partly through the Herald, it should be noted that the newspaper articles mentioned cannot be accessed in order to see the full context within which the pieces were extracted.

Uganda, on the other hand, acted swiftly once they discovered the ‘slim’ disease in 1982 (Ray and Madzimbamuto, 2006). Uganda had been sending their troops for training to Cuba. Cuba, however, had a strict HIV/AIDS testing regime and sent half the troops back to Uganda because they were HIV positive. The Ugandan president, Yoweri Museveni, on realising the threat to his power base, acted swiftly to enlist help from the international community. He supported initiatives publicly, working together with research bodies and non-governmental organisations. By the time the Ugandan AIDS control program was established in 1987, they had already been publicly collaborating with other organisations³⁸ formed with the support of the President for more than five years (*Ibid*). The Zimbabwean government, despite having had teachers, doctors and soldiers returned from Cuba for the same reasons, maintained their policy of silence. Those returned were given minimal counselling and generally left to die (Ray and Madzimbamuto, 2006). The silence was perpetuated by doctors who decided not to inform pregnant women of their status since there was a 50 percent chance that their children would be born negative with no thought for the health of the mothers (*ibid*).

³⁸ In Uganda, one of the organisations formed by families and other people with HIV/AIDS was the AIDS Support Organisation (TASO) which had President Museveni’s support

In 1987 the MOH established the National AIDS Council (NAC) to raise HIV/AIDS awareness, promote behaviour change and provide counselling. Progress, already slow, was complicated by the way the government depicted HIV: as a disease ‘associated with having sex with a prostitute’ (Ray and Madzimbamuto, 2006: 224). For women the situation was (and still is) even worse; in Zimbabwe AIDS posters attempting to discourage people from risky sexual behaviour depicted women clad in miniskirts as carriers of the virus – as such, women who became HIV positive were associated with prostitution (Herek et al., 1988; Morrison and Guruge, 1997; Ray and Madzimbamuto, 2006). Women, especially wives who are HIV positive, become ostracized by their in-laws and in some cases, their own families which of course affects their children (Meursing and Sibindi, 1995). Being a patrilineal society, the idea of men having multiple partners was not even addressed (Ray et al, 1998). In 1989 the Society and Women of AIDS in Africa (SWAA) invited Sally Mugabe, then Zimbabwean First Lady, to become their patron and that is suspected to have spurred progress somewhat. It was at the first conference of the SWAA that prevalence statistics first showed that younger women were more vulnerable than their male partners (Willmore and Ray, 1989). From 1989-1994 a Long-Term Plan was devised to promote behaviour change in order to prevent HIV infection and to treat Sexual Transmitted Infections, but infections were already at an all-time high by then. Women who reported STIs were also tested for HIV/AIDS. By 1990 prevalence in Harare was 52 percent, reaching 71 percent (with an average of 65 percent in other testing sites outside Harare) in 1995 (Ray and Madzimbamuto, 2006). The army suffered the worst casualties: with a 55 percent prevalence rate in 1999, 75 percent of soldiers died within a year of leaving the army (UNAIDS, 1999; UNDP, 2003). In Manicaland, the province where I conducted my research, prevalence was 27 percent for men and 46 percent for women between 1998 – 2000 (Nyamukapa and Gregson, 2005). Women were clearly more affected. Ray and Madzimbamuto (2006) note that the entitlement culture in Zimbabwe promoted gender inequality by giving preferential access to men. During their time in the medical profession they found that men in some treatment schemes, through workplace programs, have often received ‘access that is denied their partners and that in more community-based schemes limited resources have ensured that men get first access because of being heads of households’ (Ray and Madzimbamuto, 2006:226)

Almost 10 years after the first case was reported, the government devised a National AIDS Policy in 1999 that paved the way for a 3 percent AIDS levy on taxable income to spur prevention efforts (National AIDS Council of Zimbabwe, 2006). Policy, however, was not formally launched until the year 2000 when the National HIV/AIDS strategic framework was introduced to operationalise the National Policy. NAC's mandate was to coordinate the national HIV/AIDS response through its 13-member board that included people living with HIV/AIDS (NAC, 2006). In 2003, 21 years after the country was first aware of HIV/AIDS, the disease was declared an emergency, by which time average life expectancy had fallen from 60 to 37 years (WHO, 2005).

The Zimbabwe National HIV and AIDS Strategic Plan (ZNASP), implemented from 2004-2010, has significant shortfalls, which means that Zimbabwe's efforts to combat the epidemic are still in need of serious improvements. The ZNASP Review (NAC, 2006) reports that Zimbabwe has made big strides in HIV prevention, which is evidenced by a decline in disease prevalence from 24.6 percent to 20 percent between 2003 and 2005 and 13.7 percent in 2009³⁹. They also quote, as further evidence of the decline in prevalence, the distribution of 85 million condoms in 2004⁴⁰ (*ibid*). These pronouncements are deceptive in that the Ministry of Health (MOH) does not fully explain how it arrived at the latest prevalence rate of 13.7 percent. To recap, at first sight, the most recent statistics, estimated through the UNAIDS Estimation and Projection Package (EPP) and released by Zimbabwe's National AIDS Council (NAC) together with UNAIDS and WHO, show very encouraging progress between 2003 and 2011. Deaths in 2011 were estimated at 63, 765, with numbers living with HIV/AIDS down to 1,157,097, of which 138, 642 were children (15 years and under), a decreased number of orphans to 946,547 and an impressive national prevalence rate of 13.1 % among adults between 15 - 49 (UNAIDS, Global AIDS Response Progress Report: Zimbabwe Country Report 2012: 2). Except in the case of children where the increase in number is attributed to limited access to antiretroviral medication, all other decreases were 'attributed to successful implementation of prevention strategies especially behaviour change, high condom use and reduction in multiple sexual partners' (*ibid*). These decreases could be flawed because of the limitations of the EPP. A major limitation of the EPP is that it relies on data from both the urban and rural areas where 'HIV prevalence in pregnant women attending antenatal clinics (ANCs) is taken to represent prevalence in all adults, male and female, aged 15 – 49' (Ghys et al, 2004: 7).

³⁹ The prevalence rate of 13.7% is from the Ministry of Health estimates from 2010; quoted from the workshop conducted by FACT, 2010.

⁴⁰ 37 million in the public sector and 48 million in the social marketing sector.

Zimbabwe has limited data from ANCs because not all of the pregnant women are tested for HIV, a lot of women, since the breakdown of the health system in Zimbabwe (Avert, 2010b), have home births and there is simply poor coverage in rural areas. Surveillance of HIV/AIDS data is extremely poor in rural areas, as Ghys et al (2004:5) concur ‘... major limitations in the EPP are related to the quality and non-representative nature of data available at present ... for generalized epidemics, rural data are often not very representative of rural populations, and the EPP by itself cannot resolve this problem’. Further, they suggest that ‘generalised epidemics in severely affected countries require considering urban and rural sub-epidemics separately’ (*ibid*). Amongst other issues, the lack of expertise and difficulty of access to rural areas would make this a tough task in Zimbabwe despite its importance in giving us better data.

At the recent workshop organised by FACT (2010), the health workers who provided the MOH with data from the villages seemed confused about the percentages for modes of transmission and prevalence of HIV within the population. When asked about what they knew to be the prevalence in the country, estimates ranged from 60 – 95 percent. When one of the instructors took time to explain the difference between modes of transmission and prevalence, they adjusted their figures which then ranged from 50-75 percent. It was clear that they still didn’t understand. The second presenter then did a brief math lesson about percentages and even then, the Health Workers whom the MOH (2005) relies on to provide some of the statistics failed to come anywhere near the 13.7 percent. These statistics, therefore, would need to be explained in more detail for them to make sense – they remain unreliable given the small sample of Councillors⁴¹ and health workers who are not well acquainted with data collection yet are relied on by the MOH to provide some of the needed statistics. Secondly, there is no evidence of how many of the distributed condoms were actually used. They also state that 750,000 female condoms were distributed from various outlets. Being aware of gender inequalities in Zimbabwe, research would need to be conducted to the usefulness of distributing female condoms and the extent in which they were used bearing in mind the prevailing attitudes of the male-dominated society (Leach and Machakanja, 2000; Bourdillion, 1985).

⁴¹ A Councillor is a traditional leader who is in charge of 5 or more villages, most of which have a minimum population of 3-4000. The largest ward has a population of about 6000. According to FACT estimates at the meeting, their 12 participants came from wards that had a total population of 27,000 villagers (FACT, 2010).

The ZNASP's own review noted challenges that many new infections occurred among married adults in which behaviour change strategies were inadequate. Lack of changes in sexually active young people, sex workers, out of school orphans and mobile workers were also acknowledged (NAC, 2006). In matters of treatment, only 7 percent of eligible people had access to ARVs (25,000 out of 166,000) due to lack of foreign currency to purchase ARVs, lack of trained personnel to administer the drugs and conduct follow-ups and the basically deteriorating infrastructure (*ibid*).

In children, paediatric antiretroviral therapy has been stalled by difficulties in early diagnosis, lack of trained staff, insufficient paediatric formulations and insufficient access to counselling and testing of HIV in rural areas (NAC, 2006). The improvements noted so far, all targeted at adults, were the 27 voluntary counselling and testing centres in urban areas, 389 testing centres in rural areas and mobile units for hard to reach areas. The report further notes that the Prevention of Mother to Child Transmission (PMTCT) sites increased from 205 to 1,369 between 2003 and 2005, covering many parts of the country. Unfortunately, hard to reach rural areas are still rather neglected.

In all this planning and work that ensued through the ZNASP, orphans and vulnerable children had not been part of the plan. This very slow national response that led to many deaths was mostly concerned with the sexually active adult population and children have only just been a relatively recent consideration through the National Action Plan for Orphans & Vulnerable Children by the Zimbabwe Ministry of Public Service, Labour and Social Welfare (ZMPSLSW). As a result of this plan, orphans in Zimbabwe are defined as those aged 0-18 with one or both parents dead.

Vulnerable children include the following:

- Children with one parent deceased
- Children with disabilities
- Children affected and/or infected by HIV and AIDS
- Abused children (sexually, physically, and emotionally)
- Working children
- Destitute children
- Abandoned children
- Children living on the streets

- Married children
- Neglected children
- Children in remote areas
- Children with chronically ill parent(s)
- Child parents
- Children in conflict with the law (ZMPSLSW, 2004:12)⁴²

This National Plan was a response to the increasing number of OVCs due to HIV/AIDS after the estimated 761,000 orphans in 2003 which, at that time, was projected to increase to 1.1. million in 2005 (MOH, 2005)⁴³.

Though it is already 2012, the government has barely been able to identify half the orphans (NAC, Chimanimani 2010) and has chosen to report, instead, increased adverse effects on children. The reason for the lack of progress once again has been attributed to a weak socio-economic climate and thus lack of resources. By their own admission:

National policies and laws establishing the legal infrastructure for the coordination of OVC programmes and services have not been fully implemented for lack of financial, material, and human resources. In the absence of full implementation and enforcement of policies and legislation that protect children's rights, OVC service providers report an alarming increase in cases of child abuse. (ZMPSLSW 2004:14)

This is all despite the fact that ‘as of 2008 around US\$86 million had been mobilised from different donors’ (ZMPSLSW, 2004: 17). Another goal – to ‘increase access to food, health services, and water and sanitation for all OVCs by December 2010’ – might have been too optimistic since the government could not even provide access to people who were prepared to pay for the stated items

⁴² This definition of the OVCs suffers from being too broad without defining some of the areas that it proposes to cover; for example, ‘working children’ in rural areas needs to be defined because children helping in the fields and at home seems to be how people live in Kumakomo. ‘Children in remote areas’ – that is also not defined anywhere in the document of ZMPSLSW – there are 100,000s of children in rural remote areas – do all automatically become OVCs? This broad definition has the potential to make it difficult, if not impossible, for the government to make an assessment of their progress

⁴³ The aim was to ‘to ensure that OVCs are able to access education, food, health services, birth registration, and be protected from abuse and exploitation through coordinated efforts by government and civil society with the full participation of children...to reach out to all orphans and vulnerable children in Zimbabwe with basic services that will positively impact on their lives. By December 2010 the goal was to strengthen national institutional capacity to identify all orphans and vulnerable children and to have reached out with service provision to at least 25 percent of OVC who are considered to be the most vulnerable (ZMPSLSW, 2004: 9)’

they aimed to increase. They also intended to ‘increase school enrolment of OVC by at least 25 percent while ensuring retention of OVC in primary and secondary schools by 2010’ (ZMPSSLW, 2004: 26). In the school where I conducted my research, the two grade 6 classes had seen a 25 percent drop-out of girls. The boys in both classes have maintained their numbers. ZMPSSLW has not only lagged behind in their goals but the situation is getting worse.

The introduction of Zimbabwe Life Skills Programme in 1992 by the Ministry of Education, working hand in hand with ZMPSSLW, seemed to carry a lot of promise. The Program

targets students and teachers from Grades 4-7 in all primary schools and Form 1-6 in all secondary schools ... to effect attitudinal and behaviour change amongst pupils in order to reduce the risk of HIV infection...and aimed at developing pupils’ life skills such as problem-solving, informed decision making, and avoiding risky behaviour. Participatory methods and experiential learning processes are expected to be used to teach life skills (Gachuchi, 1999)

The program has been implemented in more than 6,000 schools (Ministry of Education, 2005). Ample training and materials were provided for national, provincial and district education officers including 2,000 teachers. An evaluation of the program after 3 years indicated that ‘only one-third of the teachers had received any in-service training and were unfamiliar with experiential learning and participatory methods and that many teachers felt embarrassed to handle sensitive topics related to sex and HIV/AIDS’ (Gachuchi, 1999). Coombe (2002:17), for example, through an analysis of the case studies from Ethiopia, Kenya, Malawi, Rwanda, South Africa, Tanzania, Uganda and Zimbabwe highlights the shortcomings of current prevention programmes in these countries and notes how teachers for the ‘greatest part are poorly prepared, generally lack knowledge and understanding, are poor role models and feel uncomfortable talking about sexuality’. Unfortunately, more than 10 years after the introduction of the Zimbabwe Life Skills Program not much progress has been made as shall be seen in the discussions under teachers’ perspectives.

One of the major strengths of this literature review is the detailed review of a report on the status of HIV/AIDS by doctors who were on the ground at that time (Ray & Madzimbamuto, 2006) whose

work was confirmed by experts at the UN (UNAIDS, 2006). While having research by resident experts does not necessarily guarantee good data by itself, the contributions of a local doctor and prolific writer on HIV/AIDS and children, Dr Foster, added a lot to the credence of the background. The inherent weakness, at the same time, is that the data was rather dated. The glaring weakness is that it did not readily cover works in surrounding African countries about the plight of children – which is later addressed under ‘A survey of HIV/AIDS Research on and with Children in Africa’.

Yet another strength is that the study contextualises the problem. Having only officially acknowledged the HIV/AIDS in 1985, the history narrates the progression of the country’s efforts – both negative and positive and hence, shows how the plight of children had been ignored for very long periods of time. The background shows how some pressing issues of silence and stigma, amongst others, are still prevalent. The complexity of the epidemic is communicated through the silence that ensued after the official announcement, allowing the epidemic to quietly ravage masses of Zimbabweans during the 1990s. Deeply embedded cultural constraints are revealed as the government used its media to suppress discussion. It shows that gender disparities that existed in the 1980s, blaming the spread of HIV/AIDS on women and refusing them access to medication in some cases, are issues to be borne in mind. How is the girl child who might be infected with the HIV virus viewed compared to her male counterpart?

The spectre that it took 21 years after the country was first aware of HIV/AIDS for the disease to be declared an emergency, by which time average life expectancy had fallen from 60 to 37 years (WHO, 2005), shows how slow the country had been to respond to the epidemic. The question that readily arises is how and what was being done for the invisible population of infected and affected children at that time. The chapter shows the unreliable estimation of children affected and infected by HIV/AIDS and hence, the depth of the enduring epidemic. The section shows, as already noted, that 50 percent of women who reside in the rural areas are responsible for 70 percent of the agricultural produce (Quisumbing, 1994; Mutangadura, 2000) and they tend to spend the greater part of their income on their families as compared to men who spend mostly on themselves. The stresses due to HIV/AIDS suffered by this important productive group - emotional distress, depression, hopelessness, suicidal ideation (WHO, 2003) – are passed down to their children,

creating psychological and other traumas, which Zimbabwe will have to find ways to deal with. These stresses need to be researched from children's perspectives.

Highlighted is the Zimbabwe Life Skills Programme in 1992 by the Ministry of Education and its many challenges of untrained teachers and cultural constraints that prevented it from being effective in reaching children on this very important topic. The chapter shows how demand, supply and the process of education are being affected by the epidemic and how it is likely to continue wreaking havoc if unabated. Stigma issues are addressed and show how children have not been given due consideration, especially from their own perspectives. In all, the chapter narrates a needed background that shows how slow the country was in responding to the epidemic – first and foremost for the actively sexual population of adults and of recent, children. It lays bare the need for continued research on and with children in the first instance and more importantly, I believe, an understanding of their circumstances in their own voices to help us have a deeper understanding of their experiences.

Once again, the inadequacies of the Zimbabwean response above are evident. The slowness of creating a National AIDS Policy – 15 years after the first case was diagnosed – means that Zimbabwe is further behind than it would have been in its fight against the epidemic. The belated and weak response, worsened by the adverse financial circumstances, means that the needs of OVCs remain dire and in need of further research for us to understand how they are being affected. There is an increasing number of works that show what has been done and what can be done in this area.

A survey of HIV/AIDS Research on and with Children in Africa

While work on infected and affected students as actors within the school system is still scant in Zimbabwe, there are numerous studies outside the country yet within the continent that have a bearing on my work. The volume of research on HIV/AIDS and children being vast, I will limit the studies in Africa, particularly those closest to issues most likely related to my topic of study. This brief survey touches on aspects of psychosocial aspects of infected and affected children, children as actors in the HIV/AIDS discourse on sexual knowledge and stigma and, the nuances of orphan enrolment in schools and a closer look at coping through migration.

In their work that details efforts to meet the psychosocial needs of children with HIV, Kanesathasan et al (2011:4) aptly remind us that the early provision of psychosocial support helps the infected group, in particular, to ‘face multiple stressors related to HIV, including the illness and death of a parent, disclosure, stigma, discrimination, isolation, loneliness, and family conflict or uncertainty’. Their work points to an often-neglected need for providing psychosocial supports to carers and parents of children with HIV, especially soon after disclosure when all concerned would be experiencing a myriad of distressing feelings. Yet another aspect that is not often thought about is training adults and older children who are HIV positive to be mentors and volunteer carers since they have first-hand experience and hence, a heightened understanding of the situation. Their work also recommends a comprehensive approach that connects village counsellors (carers, parents, educators and community leaders) to larger entities like the government and NGOs for needed support. (Kanesathasan et al, 2011:14). The extensive consultation of adult professionals⁴⁴ to arrive at some very useful conclusions nevertheless lacked the direct input of children themselves. Beverly and Thomas (1997:33), capturing the psychological and psycho-social issues prevalent among infected and affected children as reported by many others (Cluver et al, 2007; Boyes et al, 2012; Betancourt et al., 2013; Vranda and Mothi, 2013; Mellins et al, 2013) reviewed works that ‘examined developmental and psychosocial characteristics of school-aged populations infected or affected by HIV’, stressed the need to understand the developmental and psycho-social challenges

⁴⁴ The information presented in this brief was collected through a review of published and gray literature, as well as from interviews with researchers and practitioners addressing the clinical, psychological, and social needs of children around the world. In addition, the brief highlights experiences of eight programs in South Africa and Uganda (Kanesathasan et al, 2011:4).

that infected and affected students face for educators to be best equipped to reach out to the child. They noted that

children who are infected with the virus encountered a range of neurological and developmental problems, including growth delays and speech, motor and cognitive deficits...*and that* as a result of the effect of the virus on the nervous system ... *and that* HIV related disabilities are the greatest infectious cause of paediatric mental retardation in the United States (*ibid*)

Their list, albeit compiled with the caution that the listed symptoms can also readily seen in some children who are not infected, bears repeating to note if these may indeed be emblematic to infected and affected children regardless of geography and culture⁴⁵ -

Decreased Intellectual levels	Delays in expressive and receptive speech and language
Visual-spatial deficits	Attention difficulties (hyperactivity to withdrawal and lethargy)
Difficulties with visual motor integration	Poor concentration
Decreased alertness	Impaired memory
Inadequate generalizations	Limited pragmatic application of learned information
Limited comprehension	Impaired problem solving

Table 1:5 Developmental Manifestations of HIV Infection in School-Age Populations
Beverly and Thomas (1997:33)

With scant medical research in poorly resourced countries like Zimbabwe, especially in rural areas, we can only extrapolate. The list above, since it can also apply to children who are not infected, can only be useful in tandem with other observed physical effects of HIV on the child. It, therefore, a rough guideline as stated by the authors.

Bhana (2007), in a predominantly white elite primary school in South Africa, interviewed 50 seven to eight-year old's construct on how they negotiate HIV and AIDS discourse, as active actors and

⁴⁵ This work is supported by Erwin in his work on 'AIDS in Children when he notes that an AIDS child can be limited physically, psychologically, and socially in mastering the stages of development. At a time when the child is trying to master the tasks of autonomy, initiative, and industry, the AIDS child is faced with an illness which renders him/her dependent, vulnerable, and often helpless' (1988:154)

not asexual. Unlike almost all cases that I observed in public schools in Zimbabwe, they wanted to engage students directly since student ‘participation is mostly passive, framed by their emotional dependence and sexual innocence, *with a need for adult protection ...and yet* none of these framings encourage young children's active participation in making meaning of HIV, AIDS and sexuality’ (2007:10). While this study shows that when children were given an opportunity to talk about sex ‘they were often very keen to do so and showed much emotional engagement’ (ibid, 2007:12; McLaughlin et al, 2012), this is still taboo in Zimbabwean rural villages (Pattman and Chege, 2003). That the ‘research acknowledged the child as an expert and as strategist’ (2007:312) in openly talking about sex allowed researchers to get first-hand information which not only respects the child but also provides first-hand data that lead to less inference.

Beverly and Thomas (2007) discovered that girls were aware of the connection between sex and AIDS, the act itself and the idea that condoms can prevent aids; they show that the myth of childhood innocence when it comes to sex is that just that, a myth. They point to a fact that is still entranced in many educators or adults in general, the ‘core concern...that excessive sexual knowledge is dangerous because it suggests the erosion of innocence. However, it also suggests the passion for ignorance in the education of children’ (2007:319). Opportunities to work with young children proactively were easy lost due to cultural constructs This was my personal struggle as questions in my interviews were devoid of asking students directly about matters concerning sex and their views in relation to HIV/AIDS. Culturally, the view of a child’s innocence is still so strong had I attempted to include the questions pertaining to sex authorities would have requested their removal and/or rescinded permission to conduct my research. Amongst others, an obvious strength of this work is that it gave children a voice in critical matters that readily affect them and will inform their understanding about sexual matters in a world of HIV and AIDS. Bhana (2017) touches on an issue that is still front and centre in the Zimbabwean black culture at least, that ‘when ignorance in children is equated with innocence, then precocious sexual knowledge suggests defilement and culpability’ (Bhana, 2017:319). What Bhana discovered about the teachers’ stance on children and sexuality at the school, namely the ‘denial of children as active constructors and mediators in the context of HIV and AIDS’ (2007:319), is still strongly held amongst teachers in rural areas in Zimbabwe, if not within the population at large – despite this work that show that the ‘image of the children as innocent and asexual is not one which stands up to scrutiny’ (Ibid). Bhana’s work clearly shows that

given the opportunity and space to talk... given the right circumstances, children are very thoughtful... *can* actively negotiate their own sexual predicaments, their pleasures and concerns. Even at age seven and eight, boys and girls are capable of reflecting on their actual lives and are happy to talk about HIV and AIDS and sexuality (2007:322)⁴⁶

The absence of methods that would have allowed students to talk about matters of sex as part of their experiences remains a glaring limitation to my work, albeit constrained by cultural norms that would have made the work impossible to conduct. In another study that interviewed black students aged between 12 and 20 in an all-girls school in Eastern Uganda, Burns (2002:84) found out that the younger girls (12-14) – though much older than the sample Bhana (2007) engaged above, lacked sexual knowledge as revealed by the questions they asked – ‘What is sex? Why can't women produce without sex? How does sex bring HIV?’. Burns (2002) further alerts us that the older group of girls (15-20) also exhibited gaps, also exemplified by the type of questions they raised

I would like to know why boys do not get pregnant? How do people protect themselves without getting pregnant and what causes this? Why is it that when a man sleeps with a woman protected she does not get pregnant? (*ibid*).

What was clear was that due to cultural expectations, the school had neglected to fully educate and inform the girls about their sexuality since they are raised to be ‘be passive and subservient to men’ (Burns, 2002:84). In a male-dominated culture that encouraged males to be aggressive against females almost as a rite of passage, lack of knowledge about their sexuality left them vulnerable to both abuse and HIV infection. The teachers in the community, raised and steeped in a culture that entrenched the gender disparities almost unknowingly, could not be expected to engage the HIV/AIDS curriculum in a manner that catalysed a different perspective in how girls viewed their sexuality. Adults, Burns felt, ‘lacked information and experience in discussing topics of sexuality and feared the judgment of community members and colleagues should they engage in explicit discussion of sexuality’ (2002:87). My findings show that 13 years later, things are not much different in a rural village in Zimbabwe; that the same gender disparities due to the male-dominated culture are affecting girls similarly. What also stands out is that the younger white privileged students (7-8-year-olds) in Bhana’s (2008) work seemed to know far much more about sex than

⁴⁶ The implications, as Bhana suggests, is that Teachers need to be trained to not only move away from their dominant notions of childhood that see them as asexual but to broaden the scope and conversation of HIV/AIDS with children as young as seven and eight.

older and less privileged black students in Burn's (2002) research; the point here being that education and exposure through various forms of media seems to have played a sizeable role in Bhana's (2008) sample. Both works benefit greatly in that they involved the student's direct voice in the research. Burns also notes a crucial point that being an outsider allowed her to delve into the taboo sexual matter at length with students, which would have been difficult as an insider. One of my biggest challenges during my work was being an outsider (never having lived in that village) who, at the same time, was an insider as viewed by my participants and very much restricted by my own knowledge of what is permissible within the culture added to the gatekeepers who also reminded me about broaching sexual topic, debunked by Burns (2002) above in her work with younger kids.

Bhana's (2008:727), while noting that 'voices of young children in HIV- and AIDS-related stigma are absent from research and programmatic responses to the disease', reveals how children, once again given a voice, could relate their thoughts however incorrect or wrought from 'irrational anxieties' (ibid) as they gathered tapestries of anecdotes from the church, popular culture, including ears dropping from the adults within their families and their circle of friends. Bhana (2008:275) points out, once again, the need within Education to address children directly as active participants to help them sift through the complexity of HIV/AIDS-related stigma which they found in children to be mixed with care, concern and 'deep social roots connected to race, class, gender, age and sexuality' – factors necessarily related to South Africa with its racial past.

Bhana (2008) raises the urgency of the child's voice, the need not avoid undermining children by equating young age with ignorance and, also, the very pertinent finding that their comprehension of stigma is different from that of adults. Whilst HIV/AIDS efforts in Elementary School are still lacking in comprehension, there is an urgent need to introduce in Early Childhood in robust and direct ways that rightfully invite the child into a conversation relegated for adults only.

Castle (2004), researching rural children's attitudes to people with HIV/AIDS in Mali through interviews and focus groups discovered that their misconceptions of the mode of transmission largely added to their social stigmatization of those either infected or deemed infected. She also discovered that adults in the community lacked factual knowledge about modes of transmission and equally discriminated and stigmatized sufferers. The few adults and children interviewed, while showing a slight knowledge of modes of transmission, did not differ in their attitudes towards

infected people and Castle notes that the widely agreed perception was to avoid contact in all forms – either physically, using clothes or utensils touched by sufferers urinating and/or defecating in similar areas as sufferers. The ignorance and stigma brought about erroneous knowledge are still evident in parts of rural Zimbabwe, 14 years later. As in Mali, the adults in my research believe that those who were infected had been sexually involved outside the bounds of marriage and had, therefore, brought the scourge of HIV/AIDS upon themselves. Castle (2004) recommended a comprehensive HIV/AIDS Education curriculum as a possible solution to changing erroneous beliefs which in turn could dent the level of existing stigma. This sensible suggestion from Castle has been seen to be effective in places where there has been a sustained HIV/AIDS education component to the curriculum. For example, Chandarana et al (1990), in a controlled prospective study that involved 1,825 Elementary School students in southwestern Ontario discovered that the 848 children exposed to HIV/AIDS education exhibited more accurate knowledge and beliefs than the 778 in the comparison group⁴⁷. What they could not evaluate – it being the most important – was whether the knowledge attained would lead to behaviour change, as knowledge of its sake in this context is not very useful. The challenge some African countries like Mali and Zimbabwe face is that teachers in rural areas struggle to engage the HIV/AIDS curriculum because of taboo subjects of sex inherent in the curriculum. Despite the introduction of the HIV/AIDS curriculum in Kenya in 1999 to improve knowledge and beliefs about HIV/AIDS (Aduda & Siringi, 2000) did not lead to a reduction in the infection rate for young people as reported by the Kenya National Bureau Central of Statistics (2010). There are, however, large-scale and anecdotal examples scattered over the African region that show otherwise. One large-scale African example that can be viewed as showing causality between HIV/AIDS education and change in behaviour would be Uganda which decreased its prevalence from 30% in 1992 to 5% in 2004 by employing an aggressive HIV/AIDS education agenda (Chikwendu, 2004). Cuba is also lauded to have committed to marrying its education and health initiatives to curb HIV/Aids with the resultant 0.05% prevalence (*Ibid*). Tarantola and Gruskin (1998:61), alerting us to an alarming number of approximately 1500 children being infected daily through ‘unsafe blood and blood products, unsterile medical injections performed inside and outside formal health care settings, the sharing of needles in illicit drug use, and through sex, including sexual abuse’ call for a child-centered

⁴⁷ Prior to the research, they found out that most students largely obtained their information from ‘TV advertisements, magazine articles and TV documentaries were students’ 3 largest outside-of-the-classroom sources of information about AIDS... 70%, 68% and 66% of students respectively indicated these as sources from which they had obtained information about AIDS’ (Chandarana et al, 1990:228)

approaches that allows us to start involving children in decision that affect their lives on an hour basis.

Coping

Ansell and Blerk (2004), in their research on how families use children's migration as a strategy to cope with HIV/AIDS, interviewed 65 children between ten and seventeen years who are in and out of school in Lesotho and Malawi. They concluded, as supported by other researchers (Foster, et al, 2004; Richter, 2000), that relatives and other extended family members took in children as needed and that on the whole it 'was disruptive to children's school and social networks' (Ansell and Blerk, 2004:690). Because some guardians could not afford to pay school fees for the newly added orphan relatives, the latter often had to drop out of school completely. They also point out that some students dropped out due to increased chores in their new-found homes. Whilst most children stayed with maternal grandparents, they discovered that it was mostly along pragmatic grounds as to who could afford to take care of the child better at the time. As such some children lived in multiple households – depending on whom could provide at the time. This sporadic movement in and out of families, depending on the circumstances, calls for a need to 'build children's capacities for survival, within or outside their families' (*Ibid*).

While a sizeable number of studies (Rispel et al, 2006; Lewin, 2009; Brown et al, 2000; Rivers and Aggleton, 1999 and Bennell, 2002) point to poverty as imposing the greater impact on orphanhood, Case et al, (2004)⁴⁸, sought to examine these finding on the school enrolment of orphans and discovered that it was not so much poverty that determined their lack of enrolment as much as the closeness of the orphan to their new guardian. In other words, orphans who were adopted by a close relative were most likely to remain in school than those who were adopted by a distant relative. They argue, rightly so as supported by Foster et al (2005), that this nuanced research is apt in resource-poor environments that cannot simply look at all children as equally disadvantaged as refuted by Richter (2000)⁴⁹. In the village, I observed that almost all orphans at the school lived

⁴⁸ Case et al (2004), to arrive at their conclusion, used data from 19 Demographic and Health Surveys from 10 Southern African Countries

⁴⁹ Richter (2000: 20) reasons that 'an emphasis on the HIV/AIDS epidemic highlights a specific group of children, orphans and children affected by HIV/AIDS necessitates a focus on individuals ...in contrast, an emphasis on poverty takes in a much larger group of vulnerable children' – an idea that is welcome in a sense that all children are affected yet ignores that their experiences can be wildly different depending on the nature of care provided due to their particular circumstance.

with their grandparents attended school, albeit with noticeable absences – especially on the part of the students who were infected.

Chapter 2

In Search of a Conceptual Framework

In this chapter, I intend to critically survey the various research approaches⁵⁰ of some HIV/AIDS studies, which as I will show, tend to either have a singular focus and exclude other closely related determinants or are simply too generalised to account for the varying socio-cultural factors. Included in the discussion will be how some studies tend to over-generalise about countries in Africa and thus neglect the vast and divergent cultural differences. Undoubtedly the different studies have contributed to knowledge about HIV/AIDS; increasingly, however, there is a need to adopt a multifaceted approach to allow for a more holistic view of the research to combat what has proved to be resilient and complicated epidemic. Included in this section will be a deliberation on the inadequacies of developmental psychology, the traditional influential approach to researching children's experiences. I will also show how some social and cultural inferior notions of children undermine their positions and hence their contributions to research. From these, I will then discuss how I develop my psychosociocultural ecological conceptual framework, adopted from Bronfenbrenner's Ecological System's Theory, to address my research question in a more holistic manner. As researchers, however, our ontological and epistemological stances will to a large extent determine how we conduct our research. I will, thus, also discuss the philosophical underpinnings of the 'ecological' research approach because 'how we are seen determines in part how we are treated, how we treat others is based on how we see them; such seeing comes from representation' (Dyer, 1993:1 quoted in Hartley, 2002:202).

⁵⁰ The word 'approach' in this section will be used to mean the many number of related aspects a study or studies consider in researching a particular area in HIV/AIDS

The plethora of HIV/AIDS research poses serious challenges to critique all the work that has been done. I will thus discuss what I believe to be the main approaches in the field. Based on my literature review, I decided to divide the research approaches into the following areas:

1. Medical Approaches
2. Economic Approaches
3. Knowledge, Practice and Attitude Approaches
4. Projective Studies and Impact Studies
5. Studies about Interventions
6. Developmental Psychology / Social and Cultural Notions of Children

Medical Approaches

Medical approaches have been the dominant discourse in HIV/AIDS research (Baxen and Breidlid, 2009⁵¹) since the advent of the epidemic, which is understandable since the epidemic was precipitated by a virus. In medical discourse(s), HIV/AIDS is viewed scientifically in the body in terms of a compromised immune system, opportunistic infections, treatment and care; risk behaviours and transmission routes are identified, informing health education and disease prevention (*ibid*). Their approaches have contributed to better understandings of how the various HIV/AIDS medications work for both adults and children. For example, in my literature review⁵² of scientific reports showing the effectiveness of Highly Active Antiretroviral Therapies (HAART) in children, Cooper et al (2003)⁵³ and Doerholt et al (2002)⁵⁴ concluded that HAART has been highly effective in suppressing the virus in children to undetectable levels in some cases. These

⁵¹ In 2009, Baxen and Breidlid conducted a literature review of the past 10 years to trace the major trends on studies in HIV/AIDS and concluded that the field was largely dominated by the medical, epidemiology and economic sectors which largely ignored the socio-cultural contexts of the disease.

⁵² During my undergraduate degree at Harvard in 2005, I conducted a literature review to provide an overview of the effectiveness of HIV drugs, particularly HAART, in suppressing the replication of the virus. The methodology was a review of published scientific data which report the effects of HAART on children with HIV.

⁵³ Cooper et al. made a randomised 10-year retrospective study spanning from August 1992 – July 2002 to determine the effects of HAART on children in a paediatric intensive care unit (PICU) whose ages ranged between 2 months and 11 years. They started with 42 children comprised of 33 from African parentage, two from Europe, two from the Middle East, two from South Asia, one South American and two mixed race. They had 26 survivors with undetectable viral loads and the study concluded that HAART is effective in suppressing the viral load. Study was done in the US.

⁵⁴ Between January 1996 and September 1999 Doerholt et al. (2002), performed a three year retrospective cohort study of 114 HIV- infected children, 55 females and 59 males with a median age of 6.3 years. The purpose of the study was to audit the effectiveness of HAART following its introduction in South London. Their study concluded that 83% of the children in their study achieved undetectable levels

kinds of results have been used by hospitals and Ministries of Health in developing countries to help them chart ways to improve treatment and prevention options. However, most of the medical research, conducted in the United States and other Western countries, lacks a regional and cultural context when exported to developing countries (Baxen & Breidlid, 2009). Campbell (2003) also rightly observes that biomedical and pharmaceutical developments have for a long time focused on HIV strands found in the US and Western countries, with not as much development on HIV drug-resistant strands found in developing countries. She also warns how complacency about treatment should be avoided since treatments are expensive (in countries where HIV medication is still not freely available), have ‘negative side effects, are difficult to administer in deprived settings and also, how the inefficient health systems mean that long time efficient care will be wanting and about the adherence issues that often remained unaddressed’ (Campbell, 2003: 6). The traditional medical approach and its singular focus on the epidemiology of HIV/AIDS now has to face increasing evidence that depicts prevention efforts as inadequate, with no prevalence drops in countries like South Africa and Swaziland, as well as noted increases in Eastern Europe and Central Asia (UNAIDS, 2009). As recently as 2011 de Wit et al (2011:1) note that ‘to date, evidence of the effectiveness of biomedical prevention in real-life conditions is limited...’

Researchers in this field are beginning to realise the importance of looking at socio-cultural variables. Brown et al (2000:81), in their review of children and adolescences living with AIDS, succinctly note the interrelatedness of multiple factors, especially the family and social context of researching HIV/AIDS –

For people living with HIV, medical and social issues are highly interrelated. The social context for many children and adolescents with HIV involves poverty, a lack of resources, and multiple family losses. These factors may impact adherence to medications, delivery and utilization of treatment services, family relationships, bereavement, and disclosure of illness. Cultural beliefs also influence how people cope with illness and loss. Cultural attitudes may determine an individual's behaviour and reactions to disability or death, the role of families in medical treatment, and the nature of community support for an illness.

Campbell (2003:9) concurs about the importance of social context - ‘...understanding of the community and social changes are often necessary preconditions for health-enhancing behaviour change’. Even though a multi-faceted approach in medical research is now beginning to take root, most of the research is still steeped in the rather narrow evidence-based medicine approach, a position that has been given far more credence by governments and universities at the expense of other social and cultural approaches (Mykhalovskiy and Weir, 2004).

Economic Approaches

Yet another approach that has suffered from a narrow focus is the economic perspective on HIV/AIDS. This, also, has often overly-relied on quantitative methodologies and therefore neglected the holistic picture that regional and cultural contexts present. Economic approaches use quantitative methods to try and predict what will happen to economies faced with mortality and morbidity, in order to affect policy responses. Dixon *et al* (2000), in their bid to use economic theory to show the negative economic effects of the epidemic, reviewed empirical studies that attempted to quantify the macroeconomic effects of the AIDS pandemic. The 11 studies they reviewed, all of which used only one measure for economic competence, Gross Domestic Product (GDP), concluded that GDP would drop by between 2-4% across Africa, and also predicted that labour supply and exports would decrease while imports increase. These studies are too generalised and cannot possibly give a clear understanding of what is happening in different African countries which vary widely culturally and otherwise. For instance, Dixon *et al* (2000) were working on the whole of Africa – obviously important regional and cultural differences have been overlooked. The use of one measure, GDP⁵⁵, necessarily neglects most people in African countries who are not part of the formal sector; Booysen *et al* (2003: 31) point this out clearly:

One problem with these models is that they are highly aggregated. The impact primarily manifests in terms of the demographic and labour market aspects of the HIV/AIDS epidemic. Furthermore, the focus is on the formal sector, and the deductions are then made regarding the rest of the economy and labour force. This impacts negatively on the accuracy of the models as most Africans live and work in the informal sectors, in which market valuation of activities leaves much to be desired

⁵⁵ GDP represents all goods and services produced domestically

Whilst Economic Research helps to estimate the effects of HIV/AIDS on the African economy and the cost-effectiveness of prevention and treatment programmes (Dixon et al, 2000), lack of regional and socio-cultural contexts will render some of the models ineffective and perhaps irrelevant to certain regions; women who work mostly in the agricultural sectors are completely ignored. GDP as a measure tends to be ‘too mechanical... *and can be* a crude and incomplete measure of quality of life ...funnelling all human life in a... number’ (Sen, 93:3).

Knowledge, practice and attitude approaches

Studies in this domain seek to examine knowledge, attitudes and practices of teachers, youth, adolescences and others with the intention of producing more effective prevention strategies (Baxen and Breidlid, 2009). With the emphasis on knowledge and reproductive health matters, some of the assumptions are that teachers are able to effectively communicate this knowledge to young people which will lead to behaviour change (*ibid*). With prevention in mind, these studies necessarily target secondary school children and so neglect primary school children who are ‘perceived as asexual’ (Baxen & Breidlid, 2009: 7; Pattman and Chege, 2003). Coombe (2002: 18), writing about possible ways to mitigate the impact of HIV/AIDS, notes that ‘in Botswana, antenatal survey data and various surveys of knowledge, attitudes and practices indicate that despite high levels of awareness of AIDS and basic HIV/AIDS knowledge, there has been no change in behaviour that seriously begins to turn back the pandemic.’

The assumption that teachers are able to effectively transfer their knowledge of HIV has not shown much promise. Teachers, once educated about HIV/AIDS, still struggle against ingrained cultural constraints to communicate their knowledge since talking about sex to children for most teachers is still taboo – an issue already discussed in this work and to be revisited in the findings.

‘Knowledge, Attitude and Practice’ approaches seem to have neglected to address socio-economic aspects. Poverty also undermines whatever knowledge comes from research as young people are seen to be trading sex for material compensation (Rivers and Aggleton, 1999). Levine and Ross (2002) add that polygamy (the encouragement of multiple marriage partners), traditional

medicine⁵⁶, repressive customary law and culturally defined control over women all contribute to making efficient HIV protection more difficult. Their work is supported by Cohen (2002 quoted in Baxen and Breidlid, 2004:16) whose research shows findings of ‘disempowered women and images of masculinity that include promiscuity’. Even though these approaches have been able to alert us to prevailing knowledge, practices and attitudes among young people, teachers and others (with the exception of primary school children and orphans as noted earlier), research shows that simply having the correct information does not affect behaviour (Ahlberg & Pertet, 2006). Further, amidst socio-cultural constraints and other competition knowledges, information does not necessarily protect teenagers (Baxen & Breidlid, 2009). Campbell (2003: 10) also reports that ‘giving people information about health risks is unlikely to change the behaviour of more than one in four people and these are generally the affluent and better-educated members of the group.’ She notes many other factors that affect behaviour change in their Summertown project that sought to promote participatory peer education with young people (sex workers and miners too) over a 3 year period, where a series of baseline interviews and focus groups were conducted to investigate the social factors that make young people vulnerable to HIV infection. They found that young people had high levels of accurate knowledge about HIV/AIDS; the fact that it is incurable and also, that they were clearly aware of the ABC approach (Abstain, Be faithful or Condomise). There were, however, a range of factors undermining behaviour change, such as:

low levels of perceived vulnerability to HIV infection despite high levels among peers, peer norms around sexuality and condom use, limited access to condoms, adult disapproval of youth sexuality and condoms, gender inequality and a host of economic constraints that impacted on young people’s sexuality in a range of complex ways (Campbell, 2003:123).

Focus on prevention without taking socio-economic and cultural factors into account thus ‘leaves unattended the deeply complex social and cultural discursive fields which youth receive and interpret HIV/AIDS messages and how they understand, experience and use the knowledge...school is such a discursive field yet it remains unaccounted for’ (Baxen & Breidlid, 2009: 12). Most research in this field also tends to be done in Western countries and transferred to African countries in the form of prevention models, thereby ignoring local socio-cultural factors. Baxen and Breidlid (2009: 13) rightly note that ‘research needs to be located within situated contexts in which the participants construct their knowledge and identities’. Undertaking research

⁵⁶ On polygamy and traditional medicine, caution needs to be exercised, however, as Gausset (2000) rightly states that we need to look at the issues of safe sex within those practices and not consistently imply the culture is the barrier

with children within their socio-cultural contexts while situated in their natural environments has helped me to glean more into how their home, school and community experiences are affected by HIV/AIDS.

Studies about interventions

The failure of many intervention approaches, like those that come from Knowledge, Practice and Attitude approaches is that knowledge does not always translate to behaviour change (Gruuseit & Aggleton, 1998). Aggleton et al (2004:23), in a study of 53 interventions, found that 27 (50.9%) made no difference in the youth's sexual practices and they conclude that:

Two decades' experience shows there is no instant recipe for success. Instead, 'combination' approaches, in which action is taken on several fronts simultaneously, are important. Beyond this, experience shows that young people themselves should be centrally involved in needs assessment, planning and programme development. Without their wisdom, insight and experience, programmes are unlikely to achieve realistic targets and/or adopt suitable approaches.

The call for a 'combination approach' is a reoccurring thread in the discussion of these various approaches. Mirembe (2002: 10)⁵⁷ supports Aggleton (2004) in that learner involvement and participation might be more effective if 'learners were involved in designing and running the program,' whilst Wight (1999) argues that learner-driven programs are ineffective and advocates for teacher-driven programs which he believes are better. He argues that there are severe limits to the efficacy of pupil empowerment in sex and HIV/AIDS education. Skinner (2001) argues that teachers are out of touch with young people and that the latter are now moving away from the knowledge provided by educators in preference to competing sources. Smith, Lucas and Latkin (1999) agree with Skinner's (2001) assertions and add that social discourse is a factor in the efficacy of programs, since information about HIV/AIDS seems to be disseminated through rumours and gossip. The discord above highlights the need for a more holistic approach in order to produce the kind of knowledge that will improve the efficacy of interventions. Below, I discuss why school interventions have failed.

⁵⁷Drawing on a study of AIDS Education in Uganda, Merembe (2002) discusses the AIDS pedagogy and democratic education in Ugandan schools by examining possibilities using three illustrations derived from action research: pupil participation in curriculum formulation, pupils setting the agenda for AIDS education delivery and individual choice of AIDS education. The realities of teenage sexuality were being addressed with positive responses to the AIDS curriculum. Action research offered the opportunity for a democratic pedagogy and learning-fundamental to young people's response to the AIDS curriculum and adoption of safer sexual practices.

Interventions

It is clear that HIV/AIDS is overwhelming the education sector and that new ways of thinking regarding the provision and execution of education are urgently needed. Aspects of this assertion have already been touched on in the discussions about Zimbabwe's response to the HIV epidemic. There is a wealth of theoretical literature about what could be done and very little about what can actually be done (and has been done):

When it comes to interventions aimed at combating HIV/AIDS...evidence remains weak...little is known about designing cost-effective solutions, scaling them up, situating them in the larger strategies for obtaining complex development objectives, or monitoring the full multidimensional nature of such inventions (Gillespie, 2005: 24).

School Interventions

Intervention studies are typically aimed at secondary school children (Rivers & Aggleton, 1999). There is increasing research which shows that interventions are more successful before adolescents become sexually active and that primary schools are significant sites for construction and reproductions of sexual identity among children (Wallis & Van Every, 2000). Since 67 percent of children in rural areas stay in primary school until 6th or 7th grade, an opportunity is missed and this points to the limitations of this approach (Rivers and Aggleton, 1999).

As noted earlier, school programmes can be the most effective for implementing programs since they provide a long-term audience through large numbers of children; thus various interventions can be disseminated (Bennell et al, 2002). In this regard, many authors have discussed how the curriculum could be enhanced to challenge strongly held myths⁵⁸ about condom use and HIV/AIDS infection (WHO 1993; Kirby *et al*, 1994). Others have written widely about the inclusion of life skills in the curriculum and how enabling students to talk about HIV/AIDS openly might result in

⁵⁸ One of the long standing myths, sometimes supported by influential people in African governments, was that condoms were intentionally 'impregnated with infected microbes during manufacture' (Bennell *et al*, 2002:17) to cause HIV infection and that HIV/AIDS is a 'white, gay man's disease' (Epprecht, 1998).

behaviour change (Gregson et. al 1998; Kelly 2002). However, Bennell *et al* (2002) conducted surveys in Zambia, Malawi and Botswana with high school students and found that students were well-versed in the knowledge of HIV/AIDS and its consequences, yet their behaviour did not change. The education curriculum that targets behaviour change will, therefore, have to go beyond simple definitions of what HIV/AIDS is and what it can do in order to seriously address poverty issues (cultural, economic and social) that fuel unsafe sex among young people (Bennell, 2002). The inadequacy of the Zimbabwe Life Skills Programme as already pointed out by Gachuchi, (1999) points to the need for a different approach to get teachers engaged in the process. The focus, however, still seems to be centred on prevention and fails to look at the holistic needs of the child.

Missing from the literature are intervention programmes that specifically deal with the well-being of infected and affected children in primary schools. Foster (2000) writes about highly organised community groups who act as a safety net for orphans and try to keep them in school. Some of these are reportedly taking care of more than 6,000 orphans consistently – except that in Kumakomo I discovered that AIDS organisations like FACT that purported to serve more than 10,000 OVCs had long ceased to function and villagers did not have much recollection of the work they did while still in operation. There is a shortage of literature about actual programs taking place in schools that are designed to help orphans and other affected students to cope. What this means is that ‘the opportunity within the education system to make a lasting impression on children before they are sexually active has not been fully exploited’ (Bennell *et al*, 2002: 1). These opportunities must focus on more than the sex aspects and include the physical, mental and emotional development of the whole child, which might justify the time as ‘fully exploited’. The current narrow focus on prevention alone fails to see the larger picture in providing fully for children so they may have the necessary tools to think critically and be agents of change themselves.

The Summertown Project intervention

Though not focused on primary school children, my area of interest, Catherine Campbell (2003), in a book called 'Letting Them Die: Why HIV/AIDS Intervention Programs Fail' has important lessons to share about reasons why HIV/AIDS interventions fail. Campbell shows how carefully prepared research was lacking in the groups who were going to be part of the intervention so that the intervention could be appropriately tailored to the cultural environment.

What stands out is a need for a clear understanding of knowledges, aspirations and concerns of people who become part of the intervention before the implementation and a focus on cultural context. Referring to the failure of prevention efforts in South Africa, Campbell (2003: 14) notes that

...too often the language of HIV-prevention has become the language of western science and western policy approaches, not mediated by an appreciation of the extent in which they are inappropriate for local conditions. Externally funded project proposals may be written by overseas consultants and then handed over to local groups who have little sense of ownership of ideas in the proposal and who lack the organisation and technical skills, or the trained staff to implement them.

Despite having a group of researchers who would have been fully aware of what Campbell notes above, the proposal for the Summertown Project was drafted and completed in London by a 'specialist...based on his experiences in a range of African countries' (Campbell, 2003: 39). Whilst specialist need not always be based or be from the same locale, that the grassroots organisation that initiated the project had been sidelined 'meant that the local stakeholder had limited sense of ownership of the original ideas of the project...and during the implementation of the project stakeholders and the actors were not always familiar with the proposal or the project goals or the rationale outlined in it' (Campbell, 2003: 39). Campbell is right when she notes that the idea of the proposal being handed down could also reinforce the 'culture of believing that challenging problems are best solved by overseas experts' (2003: 39). This is a stereotype that has prevented many rural communities in particular from initiating and owning projects since foreign NGOs and missionaries are the ones expected to do so.

The handed-down proposal, complicated as it was to implement (Campbell, 2003), was further thwarted by lack of a common understanding about HIV, the best ways of intervention and therefore a fractured vision. Campbell (2003: 159) succinctly expresses this confusion and lack of vision

...Stakeholders often had very different understandings of the causes of HIV ranging from biomedical through behavioural to social explanations...diverging views about the best methods of intervention to prevent HIV...varying views about whether anything could be done to limit HIV-transmission, ranging from optimism to pessimism...with varying motivations for participation...some motivated by moral outrage and some by business interests

I hope that looking at the various constituents within the contexts of school, home and community will aid my research in being informed about the perceptions of the different groups.

Projective and Impact Approaches

Projective studies provide a framework for understanding the projected impact HIV/AIDS will have on education (Baxen & Breidlid, 2009). Johnson (2000), in a report written for the World Bank, suggests a shift from the discourse of teachers simply teaching children about HIV/AIDS to realising that most teachers themselves will be dying in large numbers, as already evidenced in Zimbabwe and many other African countries. Johnson is supported by Cohen (2002) who argues that the impact, amongst other things, will be related to the erosion of personnel. Using customised projections of levels of infection and illness, Johnson (2000 quoted in Baxen and Breidlid, 2009:4) also notes that social and health problems in education will be magnified:

schools will have to deal with children who are affected, infected and orphaned as a result of the pandemic...schools will need to be involved in identifying vulnerable children and in finding ways to enable them to cope under severe circumstances

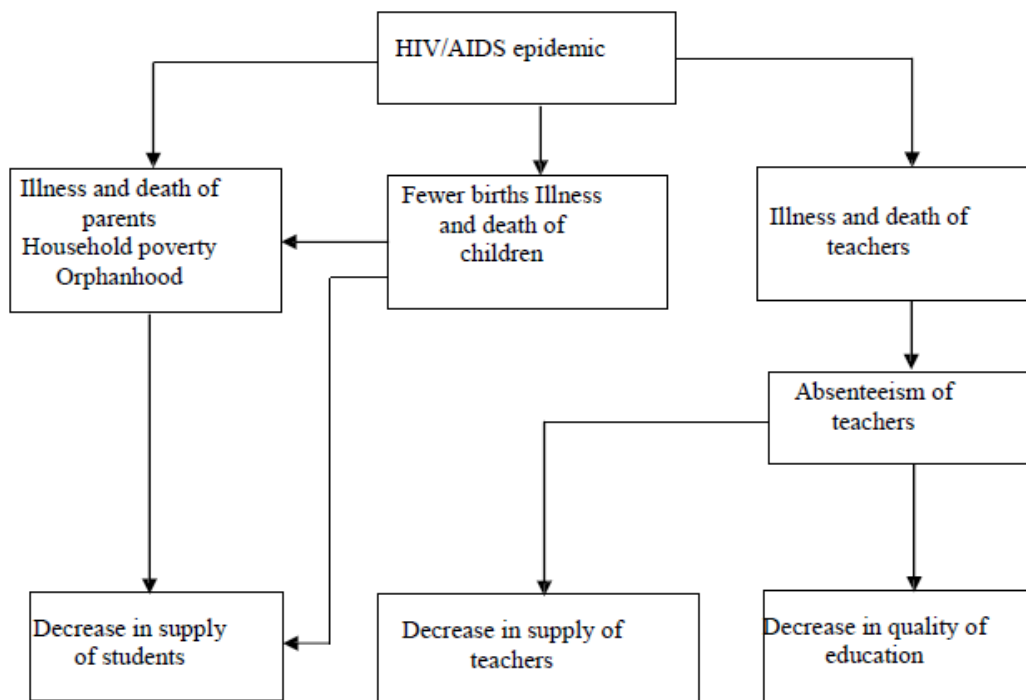
These projections are useful in helping us to conceptualise various issues. The plight of teachers and vulnerable teachers that he pointed to are currently important and urgent topics of research in education. As good as these projections are, however, they also suffer from insufficient and unreliable data and as such can only be considered as broad estimations (Baxen and Breidlid, 2009). An inherent weakness of projections is they can remain just that – projections, since no one knows if they will actually happen or not.

Coombe (2000), in her projections about declining teachers in South Africa, advises moving beyond the health perspective and adopting a multi-sectoral approach that looks at it as a social and institutional problem (Baxen and Breidlid, 2009). Here she advises that we should start educating teachers first and foremost about their own health and also train replacements. This otherwise sensible projection could have taken into account the fact that there will also be a crisis within the training staff such that replacement teachers will not be as easy to find nor train. Kelly (2000: 1) aptly summarises his projections, already felt in many parts of Sub-Saharan Africa that HIV/AIDS will affect education through a reduction in demand and supply, reduction in the availability of resources, adjustments in

response to the special needs of a rapidly increasing number of orphans, adaptation to new interactions both within schools and between schools and communities, curriculum modifications, altered roles that have to be adopted by teachers and the education system, the ways in which schools and the education system are organised, the planning and management of the system, and the donor support for education.

Kelly's work (2000) is strongly supported by Akoulouze, Rugalema and Khanye (2001) who had projected similar issues; some of their ideas can be seen on the conceptual diagram by the UN below. These broad projective overviews are invaluable in helping us to think ahead, to theorise and to draw attention to the need for a proactive response to strategic planning within education at policy and advocacy level. However, what is happening closer to the ground, in the communities, the schools and classrooms remain unaddressed (Baxen and Breidlid, 2009) and more empirical research is needed.

Figure 2.1 Conceptual framework for the impact of the HIV/AIDS epidemic on education



Source: United Nations, Department of Economic and Social Affairs, Population Division

Impact Studies

Impact studies, like projective studies, help to raise awareness at a macro level but they also point to existing conditions of the impact of HIV/AIDS. In this part, I discuss the issues that Foster and Williamson (2000) address through their extensive literature review of the impact of HIV/AIDS on children in sub-Saharan Africa. Reminding us that the epidemic will linger for decades, they review epidemiological characteristics of children affected by AIDS, coping mechanisms and current knowledge of the impact of HIV/AIDS. While these studies help us to conceptualise about the impact of HIV/AIDS on children outside school and at times within, yet very few of the studies have been conducted within the school with children as participants so that we can get a fuller picture of the impacts within an environment where children spend most of their time and equally important, from their own voices.

Foster and Williamson (2000) discuss the problems of quantifying orphans and judge that numbers may be underestimated by 45-70 percent in cases where paternal orphans are excluded and by 35 percent where the 15-17 age group is excluded. Most studies count maternal orphans and some do not even mention how they arrive at their numbers. Statistics are also not very clear between AIDS orphans and those orphaned due to other causes. The authors also point out how there is an unknown number of children affected by AIDS since there are lots of children living with HIV-positive parents. Such varied and uncertain statistics pose serious problems for policy planners. On the other hand, Richter (2000) reasons that all orphans and any other vulnerable children, despite how they came to be, should be treated similarly, as vulnerable children without worrying about distinctions. Richter (2000: 20) reasons that

an emphasis on the HIV/AIDS epidemic highlights a specific group of children, orphans and children affected by HIV/AIDS necessitates a focus on individuals ...in contrast, an emphasis on poverty takes in a much larger group of vulnerable children

This view generalises the problem and ignores important matters of subjectivity: orphans who are infected will experience life differently than orphans who are simply affected by not having both parents. Children who are affected by looking after sick parents will also have different experiences. I agree with Foster et al (2005: 3) when they reason that ‘focusing solely on children who have lost a parent fails to take account of those who are in similar or even greater need.’ As shall be seen later, children who were simply orphaned in Kumakomo had more friends at school, performed better in school compared to infected students and even ‘normal’ students whose home environments were more challenging. What remains and is not in contention, however, is that the numbers of orphans will increase substantially and further stress existing provisions. Within the age group that I was researching, Richter (2000: 10) points out an often-neglected issue:

Children over the age of ten years are most vulnerable to becoming orphaned but are a group neither specifically targeted by many current programmes nor by the increase in institutions to house affected children. For this older age group of children, family, community and school-based intervention are essential. Research with this age group is therefore pertinent. With an already large (and rising) number of orphans in developing countries, how are communities coping? Foster and Williamson (2000: 33-34) note that:

The extended family remains as the predominant caring unit for orphans in communities with severe HIV/AIDS epidemics. Extended families involve a large network of connections among people extending through varying degrees of relationship including multiple generations, over a wide geographic area and involving reciprocal obligations.⁵⁹

In my research, I observed that the fostering of orphans by relatives and the ‘wide geographical area’ stated above meant that once relatives could not take care of an orphan they passed them on to the nearest relative, who was often far away. This often necessitated the orphan’s relocation to a different school.

⁵⁹ Referring to the South Africa situation, Foster and Williamson (2000:57) state: ‘fosterage and community-based family care are robust care mechanisms that have long existed in the region—both as a result of cultural practice and as a way of maximising family resources and access to education for children.’ See also Richter (2000).

Psycho-social impact

The above discussion has noted the coping mechanism of the community. But what about the coping mechanism of children within the community? What are their issues? Through their literature review covering a range of studies, Foster and Williams (2000:87) point to a myriad of situations that become stressors for children affected by HIV/AIDS; they point out how the psychological impact on children has often been neglected since it tends to be invisible compared to the social and economic impacts in the sense that 'in some contexts, a blanket and food may be more appropriate than counselling.' They draw attention to stressors that lead to trauma in children – 'stigmatisation, dropping out of school, changed friends, increased workload, discrimination and social isolation of orphans all increase the stress and trauma of parental death' (*ibid*:88). They also identify how most children become depressed between the ages of 10 and 14, become solitary, and appear miserable and distressed. While the criticism of the generality of these observations cannot be avoided, it is nevertheless important that Foster and Williamson (2000) point out issues that are likely to happen with children in these circumstances – variables which I investigated in my work.

These issues, as has been emphasised throughout, need to be researched within regional and cultural contexts to get a clear picture of the various impacts. Not much empirical research focusing on the student's voice has been done within the Zimbabwean rural school context where students spend most of their time.

Migration

The impending death and eventual death of a parent has direct implications for the migration of remaining family members. Often more than 50 percent of young widows are forced to relocate to urban areas in search for work or new partners. Most apparent in Kumakomo is a reverse in the rural-urban pattern has been observed when people return to rural areas to die (Foster and Williamson, 2000). Children tend to be relocated before and after the deaths of relatives who can take care of them and sometimes siblings are separated to ease the burden on the receiving relatives (*Ibid*).

Economic impact and Poverty

Illness and death have resulted in rural families selling assets – goats, cattle for example – to survive; when the breadwinner dies, the situation worsens. Foster and Williamson (2000: 63-64) note that in Zimbabwe, 89 percent of families relied on women as the breadwinner and only 3 percent of orphan households had a member who was a breadwinner in employment. They add that the situation of children living in child-headed households was particularly dire with average monthly incomes of US\$8 compared to US\$21 for non-orphan neighbours (*ibid*). This way of measuring is weak in that it readily assumes that more money equates to better standards of living yet, as will be seen in the findings, some families with more money were not better off because of their increased responsibilities. What stands out is that the community safety net is weakened because of increased demand from an increasing population affected by the epidemic. Poverty, already a feature in most rural areas, is exacerbated. There is a reported increase in child labour as it is needed to make household contributions in dire circumstances:

The workload of children affected by HIV/AIDS starts when parents become sick and increases when children become orphaned; workload of orphans may be greater than non-orphans living in the same household. Increased domestic workload is often disproportionately greater on girls than boys. (Foster and Williamson, 2000: 71)

How these experiences affect children has been inferred from research done through observation or research mostly done outside the school environments. However, research from children's own perspectives within their environments will shed more light on how these impacts affect them in their immediate community and in school, for those still attending. This work by Foster and Williamson (2000) and others give us things to look for when researching HIV/AIDS. The impacts of HIV/AIDS are captured succinctly in the following conceptual map.

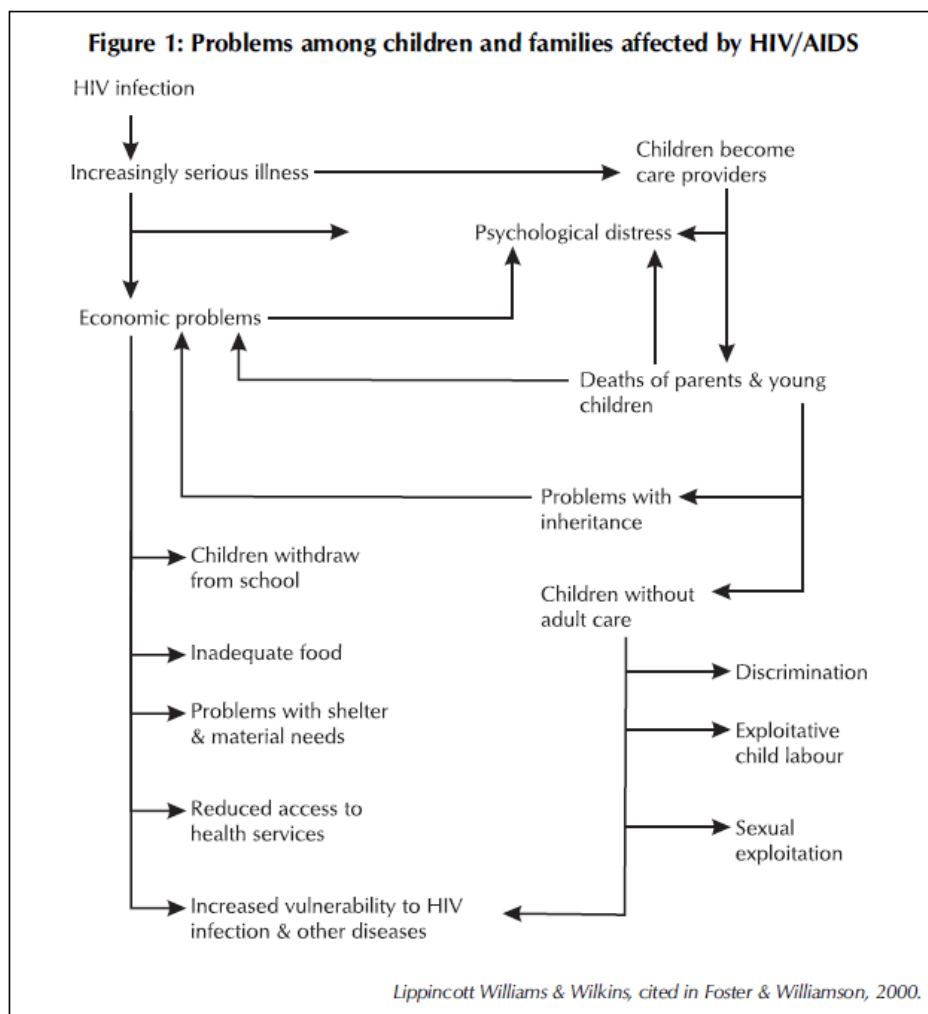


Figure 2.2 Problems among children and Families Affected by HIV/AIDS

Developmental Psychology

The dominant development psychology theory that has yielded great influences on how we research children is still used in the Zimbabwean education system and many other places. While developmental psychology has significantly contributed to our ability to contextualise our expectations for children at different stages in their development, its lack of context and visualisation of children as objects stands as some of its notable weaknesses.

Hogan (2005:22) argues that ‘most research with children conducted over the last century of developmental psychology has not sought to understand children’s subjective experience’. My research sought to engage with the subjective experiences of children, an approach which has not yet been widely employed in rural primary school research in Zimbabwe. Even though I agree with the idea of conceptualizing what we can learn from children at different stages in their development within the cultural contexts in the developmental psychology approach, I find that there is an ‘apparent lack of interest in learning about the content and personal meaning in children’s everyday life’ (Hogan, 2005:22). The search for a greater understanding of how children experience their lives remains a minor issue. In ‘...focusing on documenting age-related competencies at the expense of investigating what it means to be a child...the approach leads to a detached and impoverished understanding of children’s needs (*ibid*).

There is a strong tendency in developmental psychology to see the child as an object to be researched: ‘self-report is less trusted than observation’ (Hogan, 2005: 24).

The emphasis on documenting children’s age-related competencies to discover the factors most likely to predict a passage to mastery and positive functioning in adulthood necessarily undermines children in favour of adults. While my work employed a qualitative lens to research the lived experiences of affected children, the mainstream model in developmental psychology is positivist, characterized by ‘methodologies that are experimental, survey and objective testing... and largely quantitative data’ (Hogan, 2005: 25).

The notion in developmental psychology that context can be controlled, and that the child will emerge ignores the importance and impact of the culture and environment in which the child develops: ‘the child’s response to the research process is rarely considered...’ (Hogan, 2005: 26). From my 14 years of teaching primary school children, I find that the idea of the predictable child – the child developing linearly within predictable age perimeters - is clearly not what happens in the development of children despite the fact that most school systems believe this to be so. Children are also not seen as capable of contributing to research. This can be seen in what appears to be developmental psychology’s perception of the irrelevant child: ‘children are seen as uninformed, passive, dependent and having less to offer than adults, whereas the adult position is seen as the gold standard to judge accuracy’ (Hogan, 2005: 27); this is made worse by situations when children present conflicting stories. In summary, developmental psychology ‘produced a mainstream model with children that reflects a vision of childhood as important and distinct, but also universal and essentially known and predictable’ (Hogan, 2005: 27), thereby ignoring the very important socio-cultural contexts in which children develop. This, unfortunately, has been and still is apparent in parts of Zimbabwe where children are expected to be seen and not heard. This diminishes the voice of the child and also means that research conducted through such approaches remains largely one-sided. Below I will discuss how children are constituted socially and culturally in some environments and the need to either move away from such approaches so that we can look at the child as an active participant in the culture, has a voice and is capable of making contributions that can enhance research.

Social and Cultural views of children

Generally, there are social and cultural views of children that depict them as ‘becoming’ rather than as ‘being’ a social person (Christensen and Prout, 2005). Since the children are seen on a continuum to adulthood, there is an implication of a social and cultural opposition (*ibid*). By being perceived as ‘becoming’, their present value is read in terms of the future. The implications are clear: in such conceptualisations of children, research tends to be ‘on’ children rather than with them since they cannot be taken seriously. Christensen and Prout (2005: 45) summarize the European and North American views of childhood as follows:

Childhood is ascribed a special meaning as a phase in human life; the child is surrounded with care and concern which endeavour to prepare and protect the child; at the same time these perceptions attribute value to childhood and the child in relation to future adult life through the status of the ‘non-adult’; the child is more valued as being in the process, that is being socialized towards a goal through which to take his or her place in society than her present state

They rightly add that these views form a ‘remarkable contrast to the position of the child in cultures that depend on and emphasize children’s contributions to the family economy in the form of work, support of the elderly or taking care of the young or *ill parents*’ (*ibid*) – a view that was applicable to Kumakomo.

The role or value attributed to children is often ascribed through socialization of children, the process by which the child internalizes cultural values and through learning and development prepares for life. Christensen and Prout (2005: 46) note that ‘the value of children in contemporary society remains largely invested in the future, a view emphasized in socialization.’ In sociology, the concept of socialization was once about bringing people of all ages together in society but the shift to the individual psychological internalization in a society created ‘civilized’ and ‘uncivilized’ poles (Christensen and Prout, 2005: 46). Children were thus granted the latter and seen as uncivilized, therefore undermining their role in society. In psychology, socialization became understood as involving a passive recipient (almost always a child) instead of an active social person in

their relations and interactions with others: the child was seen almost as ‘an empty vessel with potential sociability to be developed by adults’ (Christensen and Prout, 2005: 46). In anthropology, the main concern has been the adult, their relations and their culture; children were seen only in terms of socialization (*Ibid*). I agree with Alanen (1988 in Greene et al 2005:42) who surmises that ‘socialization processes are held to provide seemingly convincing but in fact misleading, partial frameworks about understanding children.’ Moving away from the above presumptions and preoccupations with the child-adult relationships allows us to see children in the present. The sociology of childhood, to which I subscribe, allows us to see children as ‘active in the process of cultural learning, as interpreters and creators of meaning rather than simply observing the meaning of adults’ (Christensen & Prout, 2005: 49). As Corsaro (1997:24) states -

children do not simply imitate or internalize the world around them. They strive to interpret or make sense of their culture and to participate in it. In attempting to make sense of the adult world, children come to collectively produce their own peer worlds and cultures

There is a need to research children in their own right and in context, which is not new but has been neglected in HIV/AIDS research with children in Zimbabwe. Vygotsky (1978) and Dewy (1915) both advocated investigating the everyday meaning of children’s lives in their own contexts. Vygotsky (1978) and Bronfenbrenner (1979) supported the idea that ‘children grow in a social world in which both social and temporary context plays a critical role and that they are active agents in shaping their own lives’ (Hogan, 2005: 33). Further, Vygotsky ‘brought attention to the importance of research in children by observing children’s routine activities in the social world - a source of knowledge about their social world and intellectual development’ (*Ibid*). I concur with Bronfenbrenner (1979: 34) that ‘...research must be ecologically valid, that is, it must take place in real life settings and capture the experiences of children that have relevance to their lives’.

There are new research findings that point to the importance of researching children and how and why they should be taken seriously. Whereas developmental psychology can ‘box’ children’s thinking and ideas into their developmental stages, Margaret Donaldson has shown that ‘children’s language ability should not be confused with their intellectual ability’ (Hogan, 2005: 34). I have observed this in Zimbabwe where children’s views might be given some credence once they can articulate themselves well. Research shows that young children can give accurate accounts of personally experienced events (Bruck, Ceci & Hembrooke, 1998), especially when they are freely allowed to recall the details of events they have experienced (Baker-Ward et al, 1993). Waterman et al (2001) also add that children are capable of providing reliable responses but that the researcher must be aware of the most appropriate ways to phrase the question. The perception that children’s views should be valued has been strengthened by Article 12 of the UN Convention on the Rights of the Child:

State Parties shall assure to the child who is capable of informing his or her own views freely in all matters affecting the child, views of the child be given due weight, in accordance with age and maturity of the child (UN, 1989)

Even though research that involves eliciting a child’s voice is scarce in my area of research, there are examples in other areas and countries that show that a child’s own words can provide the researcher with knowledge that would not be accessible from observation alone. Gorin (2004), in a literature review of children’s experiences of parental problems, notes how children in those circumstances live in unpredictable world and quotes a child in Mullender et al (2002: 94) ‘it was the worst part of my life – constantly being shouted at, frightened, living in fear. You’ll never know what it’s like, thinking that every day could be your last.’ In another part of the overview, Gorin (2004, Quoted in Algate et al, 2006:293) notes two responses from children:

Child 1: Sometimes I help her get dressed and undressed to go to bed, if she goes to bed before me ...it is slightly embarrassing helping your mum when she hasn’t exactly got clothes on

Child 2: I am frightened to leave in case she goes into a fit or something. When we were little she got really down and started taking overdoses and that really

scared us...when she's really down she says I am going to take an overdose...I'm frightened to leave her'

From these insightful perspectives, Gorin (2004) tells how they realize the role changes in carer and the cared for and also in dependency and trust. For my infected and affected students who lived with sick parents, it was important to hear their own perspectives of the situation in the home since the carer-cared-for role reversal was likely to be applicable. Butler et al (2003, quoted in Algate et al 2006:292) in a study about children's experiences of their parents' divorce shares the following perspectives from 2 children:

I used to hear them arguing. They used to shout at each other ...me and my brother were at the top of the stairs and we used to hear them shouting in the kitchen. It felt horrible...it felt like I was the only child whose parents were getting divorced. Every morning you could hear them shouting and every evening when you got back from school and it was non-stop arguing (Sioned, aged 12).

I could hear him calling her things like, 'you stupid idiot', things like that. Then my father came and told me to go to my bedroom and he was just calling her names. In the night, he pushed her down the stairs. He used to do things like that (Jenny, aged 8)

Through these and other perspectives, these researchers discovered how children felt distressed by the growing conflict and also, how they felt different from their friends. (Algate et al, 2006: 291). These children's thoughts illustrate their ability to articulate their feelings and engage fully in research. Skuse et al (2003: 115), in a study of children's views of care and accommodation, found that the children's perspectives clearly expressed the anxiety that frequent change created –

I used to hate it when either I had to change social workers or change placements or something like that because it was just another thing to get used to – just settling into new families and starting all over again...fitting in with other kids that live there especially if it was their birth children ...it varied how they treated you, especially when they compared you to their own and when they got annoyed with you because you didn't know how to take them or anything

During my pilot and the PhD research, similar sentiments were reflected by children who had to move from one carer to another due to the fact that the one could no longer take care of them (Mtimbiri, 2008). Skuse et al (2003: 18) noted a running thread in their research that pointed to ‘experiences of multiple losses, with those losses, a severance of connectedness with people and places...which compounded the feeling of being different and loss of security’. Joanne, a participant in the study, described her experience as follows – ‘there are so many kids coming in and out of children’s homes, or foster homes. You have a best friend one day and if go to the shops and then they can be gone...’ (*Ibid*). This sense of displacement, hence disrupted friendships, significant adult relationships and environments that children were accustomed to, was not uncommon with infected and affected children in Kumakomo. Rose (2006: 296) succinctly notes that ‘children and young people can be very clear about who are the significant people in their lives, now and in the past, and the value to them of facilitating and reinforcing those connections comes through strongly from their accounts.’ There are many other studies that have engaged children’s perspectives successfully in research. Thomas et al (1999, quoted in Rose, 2006: 310), for instance, points to the idea that:

children want to be heard, that they want to be involved in decisions that affect them and or their families...and that wherever children live, learn, work, play, those researchers and professionals working with children must become more child-centred in their approach...be prepared to seek out children’s ideas and opinions, listen to what they have to say and act upon their views

Dyer (1993: 1) is apt in his observation when he notes that ‘how we are seen determines in part how we are treated, how we treat others is based on how we see them; such seeing comes from representation.’ I see children through a sociological perspective, which accords them conceptual autonomy, looks at them as the direct and primary unit of study, focuses on children as social actors in their present lives and examines the ways in which they are influenced by them. I ‘...see children as making meaning in social life through interactions with other children as well as with adults’ (Christensen and Prout, 2005: 43) in their contextual environments. That is why ‘the socio-cultural ecological perspective – with the individual child at the heart of the model...is a comprehensive unifying framework for understanding factors which have an impact on the child...and can be

used in assessment and for planning intervention’ (Seden, 2002:53). This perspective, which will be discussed next, has the capability to provide a ‘relevant framework for apparently competing frameworks, a structure within which researchers can consider the extent to which they have considered relevant factors and variables that have an impact on individual children and their families’ (Allen-Meares & Lane, 1987:39).

Conclusion and developing my own conceptual framework

The various approaches above, though their contributions to knowledge are serious, show the complexity of the HIV/AIDS epidemic in navigating its multifaceted nature. What is evident is that singularly focused approaches, wide generalisations that ignore socio-economic and cultural factors and lack of context will result in knowledge that is either too vague to employ or interventions that lack the efficacy needed to address an unabating epidemic.

The brief survey of the various approaches has provided factors that impact on infected children in the home, at school and in the community. It has also helped me to realise the importance of creating a conceptual framework that allows for the inclusion of other approaches and is holistic in nature. Since my research looks at the lived experiences of infected and affected students in the home, the school and the community and their relationships with their caregivers, teachers and any other people in their environments, I will adopt Bronfenbrenner’s Ecological System’s Theory to develop a socio-cultural ecology approach. Researching the children’s experience will necessarily include their inner feelings about various things ‘*being* happy, creative, ... *belonging* in social groups, and...*having* hope for the future’ (Richter et al, 2006) amongst other things. This then extends the socio-cultural perspective to include the psychological aspects. My perspective, therefore, will be psycho-sociocultural, which will mean looking through the children’s experiences through a psycho-social lens within their cultural context.

Bronfenbrenner’s Theory was suitable in aiding me to address my research questions holistically because it recognises the importance of both the biological development of

the child and his or her environment in ‘real life settings, with real implications’ (Bronfenbrenner, 1986: 287) and the interpersonal relationships therein. I concur with Bronfenbrenner’s (1993: 1) assertion that ‘in order to understand human development we must consider the entire ecological system in which growth takes place’. Aldgate (2006: 23), in agreement with Bronfenbrenner, asserts that

ecology theory suggests that children are surrounded by layers of successively larger and more complex social groupings (*embedded within environments*) which have an influence on them...they include family, friendships and social networks, school, neighbourhoods and work influences and the family’s place within the community...still wider is the influence of culture within which the family live

Bronfenbrenner (1993:1) postulates five different environments ranging from the ‘microsystems that address relationships between a developing person and his immediate environment such a school and family to the macro system that address the institutional patterns of culture, such as the economy, customs and bodies of knowledge.’ The different approaches discussed above raised issues of HIV/AIDS that impact on the various environments; I will thus use them as a guide to see how they impact children through their various interrelationships within the various environments. Below, I discuss what these different systems entail. Bronfenbrenner’s five environmental systems are the microsystem, the mesosystem, the exosystem, macrosystem and the chronosystem as shown below:

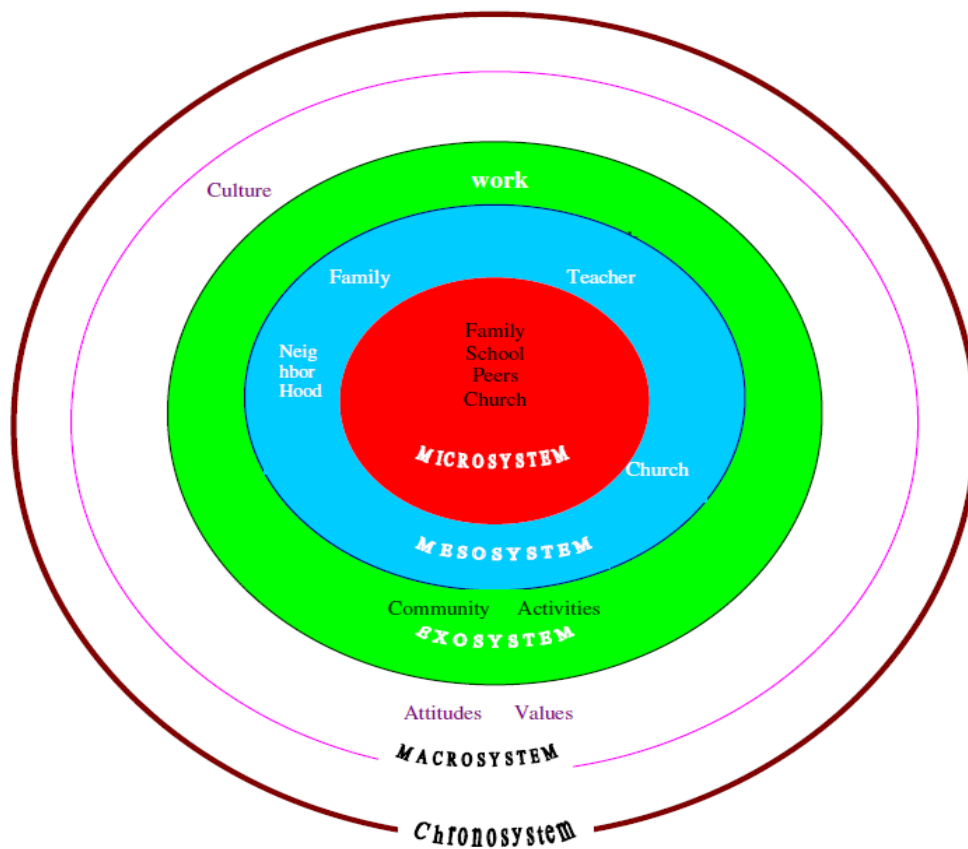


Figure 2.3 Bronfenbrenner's Five Environmental Systems

The microsystem is the where the child lives. It is the layer closest to the child where he or she experiences intimate interpersonal relations with people and his or her surroundings. In this space, depending on the situation between the child and his environment and relations, engagement is sustained or inhibited leading to either more complex interactions or less growth (Bronfenbrenner, 1993). Examples of settings in this environment include the family, the school, the peer group and the church. The church is shown in more than one system representing its pervasive nature in Kumakomo. In this environment, the child's experiences are felt directly, and s/he also influences the space and helps to construct the settings.

Secondly, the mesosystem ‘comprises the linkages taking place between two or more settings’, (Bronfenbrenner, 1993:39); it provides the connections between the two systems. An example is the relationship between home experiences and that of the school and the neighbourhood. The conditions in one area will influence another: the effects of family, school and community will have strong impacts on the child. Impact studies above have already alluded to how parents’ illness affects children in the home, school and community. The mesosystem, thus, represents the interrelationships within the microsystem.

The exosystem is the larger social setting in which the child does not exert influence but is nevertheless influenced by it indirectly. An example for the child is the parent’s workplace, where effects on the parent will trickle down to the child indirectly. Other examples are social networks and neighbourhood community contexts.

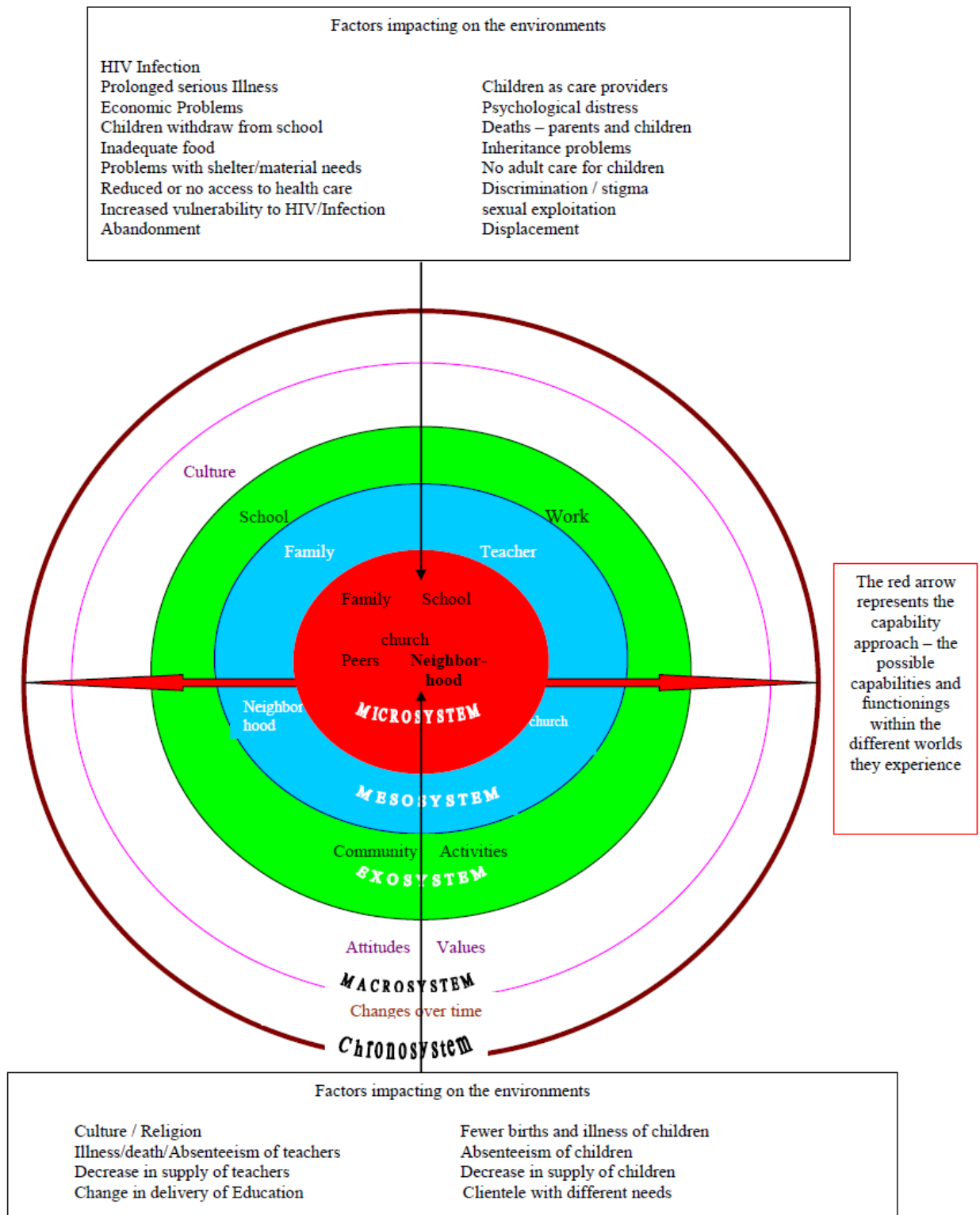
The macrosystem is the outer layer of the child’s environment (Paquette and Ryan, 2001), comprising the culture, values and norms, material resources and lifestyles. This layer may be thought of as ‘the societal blue-print for a particular culture ...identifies social and psychological features that ultimately affect the particular conditions and processes occurring in the microsystem’ (Bronfenbrenner, 1993: 40). The belief of a culture will affect what happens all throughout the other systems.

The chronosystem ‘encompasses change or consistency over time not only in the characteristics of a person but also of the environment in which they live; for example, changes over the life course in family structure, socio-economic status, employment, places of residence or the degree of hecticness’ (Bronfenbrenner, 1993: 40) and the long-term effects of colonialism and the recent past (30-year post-colonial period).

These interrelated layers of social context helped me to avoid adopting a narrow focus of looking at factors that only impact infected and affected children within their immediate microsystem, but also to consider those within the meso and exosystems as well since they do impinge on the lives of the children at hand. The reviewed research in this

chapter on orphans has been done mostly outside the school environment. My work takes a more holistic approach by looking at their experiences within the school, the home and the community in a defined cultural context. Below is a graphic presentation showing determinant and detrimental factors impacting on the different environments as raised by the various approaches:

Figure 3.4 Factors Impacting on the Environmental Systems



Using Bronfenbrenner's Theory of Ecology and the capability approach to inform my conceptual framework allowed me to research the experiences of infected and affected children in relation to their interpersonal relationships in their immediate setting (the home, school and community) – since that is where most of their experiences take place - without ignoring other overarching settings which impact their wellbeing. This is best expressed by Bronfenbrenner (1979: 21):

The understanding of *children's experiences*... requires examination of multi-person systems of interaction not limited to a single setting and must take into account aspects of the environment beyond the immediate situation containing the subject. In the absence of such a broadened perspective, much of contemporary research can be characterized as the study of development-out-of-context

This approach 'takes a holistic view of the person in his or her environment and has the capacity of incorporating other approaches' (Seden, 2002: 78 quoted in Algate et al, 2005). Looking at the experiences of the child within the multi-dimensional aspects of the disease (poverty, exclusion, displacement, identity, wellbeing) allowed me to consider a range of outcomes across a range of areas before intervening (Aldgate, 2006). Once we have contextualised their 'multi-person systems of interaction' (Bronfenbrenner, 1979: 21), I found that a fitting approach to understanding the differences among the infected, affected and normal groups' individual experience was to employ the Capabilities approach that looks at the child's ability to function within a given context – explained below.

The Capability Approach

I will use the capability approach to understand the individual experiences of infected, affected and normal students together with their caregivers and parents as applicable. According to Sen, (1973: 30 quoted in Robeyns, 2003:6), the 'capability approach to a person's advantage is concerned with evaluating it in terms of his or her actual ability to achieve various valuable functionings as a part of living'. Robeyns succinctly describes the main aspects of this approach as 'constituted of *functionings* and *capabilities*'. Functionings are the 'beings and doings' of a person, whereas a person's capability is

‘the various combinations of functionings that a person can achieve’ (Robeyns, 2003:5). The questions addressed by the approach, as suggested by Robeyns are pertinent and more relevant to my research –

whether people are well-nourished, and whether the conditions for this capability, such as sufficient food supplies and food entitlements, are met... whether people have access to a high-quality education ... to community activities which support them to cope with struggles in daily life and which foster real friendships, to religions that console them and which can give them peace of mind (Robeyns, 2003:7)

This approach will allow me to see if and how students are ‘free to participate in education in different settings, and *if* there is...equality in this freedom to participate’ (Unterhalter et al, 2007:5). ‘Freedom’ in this regard will be limited to those experiences in capabilities within their school, home community environments as communicated by the different groups.

This approach, which Sen emphasizes, ‘*must* be context dependent, where the context is both the geographical area to which it applies, as well as the sort of evaluation that is done’ (Robeyns, 2003:37), ‘is sensitive to diverse social settings and groups...*at the same time* ... suggests how one can think about evaluating education at an individual level’ (Unterhalter et al, 2007:9). It fits with my socio-culturally perspective that seeks to understand the students’ experiences within a much more relevant framework that compares functionings and capabilities among the 3 groups juxtaposed to aspects that will emerge from the research and those generated in the conceptual framework.

On the whole, the capability approach added a most needed layer to the ecological system in that it required asking deeper questions that provided potential to ‘develop a more complex idea of disadvantage in education settings’ (Unterhalter et al, 2007:3). In a study that looked at student’s experiences, the capability approach provided another lens to ‘evaluate the overall purpose of education in relation to human well-being’ (ibid). In a sense, while the ecological system was very useful in helping us to look the student’s

experiences within varying ecosystem in a holistic yet generalized, the capability approach,

by placing emphasis on the importance of what is valuable to the individual...allows us to shift our focus away from simply aggregating benefits that education has for the whole of society, and towards individual benefits. (Unterhalter et al, 2007:5)

It also provided a space to

‘evaluate the link between resources and capabilities...evidencing the considerable inequalities that standard evaluation methodologies tend to overlook...*the need for* basic measures of participation *and address* how the content and experiences of schooling relate to gender *and other types* of equality’ in educational environments (*ibid*, 2007:2).

Within Bronfenbrenner’s mesosystem, it allowed a space to be ‘critical of school processes...’ as places where ‘capabilities can be diminished through education as well as enhanced’ (*ibid*, 2007:4). While the prevalence of stigma within the school in my study diminished capabilities, Unterhalter et al (2007:6) concur that in ‘some schools in South Africa, where there is a high incidence of rape and high levels of infection with HIV/AIDS, attending school may have the potential to *reduce* some capabilities’.

It complemented the ecology system by adding nuance to a framework that was equally ‘sensitive to diverse social settings and groups’ (Unterhalter et al, 2007:5). The implications of using this approach are discussed at length in Chapter 9, the conclusion.

Continuing to build on my conceptual framework, below I discuss the theory that underpins the thinking behind the socio-cultural ecology and the factors and variables that have an impact on individual children and their families (Allen-Mears and Lane, 1987).

Sociology and the Psychosociocultural Ecology

Sociology has the strongest bearing on the concept of the theory of ecology above. Sociology 'points to social construction ...it can be argued that we live in a socially constructed world' (Stainton-Rogers et al, 1992: 28). Society has strong influences on people and can determine what a family and their children regard as problematic, which might not be relevant to a family living a different society (Dallos, MacLaughlin, 1993). What therefore is considered a good 'outcome about child development depends on the way the child's society and the people in their immediate culture think about children, parents and the relationships between them and the wider social environments' (Seden, 2002: 40 quoted in Aldgate et al, 2005). Lots of changes take place when a child goes through the various stages of education (in school) – conceptually, emotionally and socially (Daniel, Wassell and Gilligan, 1999). These changes, events within their families and siblings getting to know their wider family, are factors that need to be understood in order to understand the experiences of children (Seden, 2002). Below I discuss the influence of school and the various factors that impinge on children in that environment and also, the family, the extended family and the elements that affect those domains which then invariably affect the child.

The Influence of School

Dowling et al (2006: 153) note that a school setting should provide children with the following:

- opportunities for cognitive development
- growing understanding of the world around them
- formation of friendships
- development of mental, social and physical skills
- development of confidence and self-esteem
- experimentation with roles and responsibilities, utilising examples of role models among staff and pupils
- a source of personal support

Research shows that the school, extended family and community resources are highly effective in aiding resilience in children (Seden, 2002) and that positive experiences contribute to the development of significant factors for children under adversity (Gilligan, 2001; Rutter, 1985, 1990). Daniel et al (1999) concur that positive school experiences are associated with the development of resilience. Lack of material support and limited community resources in terms of adult support due to poverty presents a challenge for rural school children in Zimbabwe (Mtimbiri, 2008).

Howe et al (1999: 260) note that ‘school presents children with occasions to identify, develop and establish fresh, more robust and socially valued aspects of self.’ The forming of identity is very important in school since a child’s self-perception will affect how they relate and respond to others. The 10 - 13-year-old participants in the research were able to reflect on thoughts and feelings in a subtler way and to form more developed relationships with other people outside the family and fitting in was really important (Schofield, 2005 quoted in Aldgate et al, 2005). In this Psychosocial developmental stage, they are expected to show signs of developing relatively stable and comprehensive understandings of self and refining how the social world works and strategies for controlling their behaviour (Collin, 1984). Schofield (2005: 198 quoted in Aldgate et al, 2005) aptly reminds us though that ‘for children growing up in adverse family environments ...the capacity to think has often been damaged or distorted and may not have access to a protective caregiver that provides a cognitive scaffolding and enables them to face their multi-stressor situations.’ This readily affects their relationships with their peers in school. Peer relations in school have been shown to promote resilience. A healthy self-esteem would enable them to form relationships with peers, which in turn offer them increased opportunities to learn social skills, to improve self-knowledge and emotional support in times of stress (Cleaver et al. 1999; Daniel and Wassell, 2002). Together with other factors, these relationships can provide ‘capacity building...the creation of opportunities for schools to build self-esteem’ (Gilligan, 1998: 152). This capacity building is likely to be interrupted for infected children as their development, due to infection, might lead to stunted growth and ‘wasting’ (i.e. looking different can lead to rejection by peers, which affects the child’s identity in the process). This rejection

leads to complications. Foster et al (2000: 89), in their work with orphans, found that affected children tended to 'exhibit internalised behaviour changes such as depression, anxiety and low self-esteem.' This work was, however, conducted outside the school and Gilligan's (1998: 154) idea of the school as an integrator, 'providing a non-stigmatising access to all children' still has an opportunity to be developed by schools. However, research on issues of stigma and discrimination – first to see if they even exist and if so how children deal with these matters, is still sparse.

Schools can be places where children can have adult role models e.g. teachers and other adults (Gilligan, 1998), places where they can have enough positive experiences which studies show may act as a buffer against adversity (Dowling et al, 2006). There nevertheless remains an opportunity for schools to help students in forming their identities. More about their identities will be discussed in the light of how the home environments affect their identity formation.

School experiences are necessarily related to what happens in the family. Relationships between the parent/caregiver and child have a bearing on the child's attachment, which in turn affects their feelings of security, how they deal with the loss of a parent/caregiver and the formation of their identity.

Influences of the family (caregivers) and other family relations

Even though family structures have changed over time, the traditional family still has a father and a mother, with the latter staying at home to look after the children in the Zimbabwean context. Though parenting styles vary according to culture (as well as within the culture) it can be agreed that 'the aim of parents is to rear their young to be autonomous individuals who will be capable of participating fully in the culture in which they live' (Jones, 2000: 256). To meet the child's developmental needs, parents must provide basic care (e.g. food, drink, shelter, and clothing) ensure safety, provide

emotional, intellectual and spiritual growth and also provide guidance, boundaries and stability (Cleaver, 2006). In rural Zimbabwe, poverty plays a major role and therefore the extended family tends to be the primary resource for orphans (Foster et al, 1997). In Zimbabwe, however, increasing economic challenges mean that even the extended family is struggling to cope (Ntozi *et al*, 1999) – which has implications for the experiences of the orphaned children.

The parent-child relationship

Children are powerfully shaped by their immediate carers (Murray and Andrews, 2002). This relationship influences a child's progress in terms of how secure they feel with their parent/caregiver, how they deal with loss and is also important in forming their identity. I will start by discussing the attachment theory credited to John Bowlby.

Attachment behaviour is a biological response which arises from the desire of the individual, either adult or child, to seek security and protection from harm through proximity to an attachment figure who is seen as strong and wiser, with the ultimate aim of surviving from predators and thereby the prevention of the species. (Aldgate et al, 2006:69).

This theory helps us to understand children, especially when they are frightened. When this fear is not dealt with, it affects their development as Aldgate et al (2006:70), note: 'when fear is activated in a child, curiosity and exploration are suppressed'; the way a child's attachment is organised will have a strong association with the aspects of the child's development (Howe et al, 1999). When the child feels safe, attachment behaviour is not activated, and they tend to explore freely. It is important for the child to have significant caregivers to whom they can turn at times when they are unsettled: 'attachment behaviours refer to a range of behaviours which children display towards chosen individuals in specific circumstances of being frightened....' (Aldgate, 2000: 70).

I was interested in exploring how the theory applied to my participants, some of whom had changing caregivers over short periods of time. In describing the different kinds of attachment and caregiving styles, Ainsworth et al (1978), after their studies of families in

Uganda and the USA, tell us that each attachment type shows the relationship of the child to the caregiver as shown in the table below:

Secure attachment: Children use their caregivers as a secure base for exploration; they miss him/her on separation but easily unite when they return. These children have learned that they can trust their caregivers; they can explore their world freely because they know they can access their caregivers when they need them (Aldgate et al, 2006). This model of attachment seems to extend to build secure healthy relationship beyond the primary caregiver
Ambivalent: The child is ‘either excessively fretful or passive and fails to explore their surroundings; they are distressed at separation and at the reunion and not comforted, alternating bids for contact with angry rejection, or become passive. They would have experienced inconsistent response from a caregiver, which leaves them seeking aggressive behaviours and angrily focusing on their caregiver when the situation calls for play and exploration
Avoidant: The child explores readily, is minimally responsive to separation, actively avoiding the caregiver on the reunion, sometimes arching away and seeking comfort in a toy. The caregiver, in this case, tends to be rejecting, aggressive, ignoring or overly intrusive
Disorganised: The child lacks any coherent style of response to separation or reunion, showing incomplete or contradictory behaviours including fear, depression, and confusion. This attachment behaviour is seen to be the most extreme; children have learnt that no adult attachment in their lives was trustworthy or have often suffered abuse or neglect. They have had to rely on themselves for protection to survive emotionally

Table 2.1 Attachment Types (Aldgate et al, 2006:80-81)

Ainsworth *et al*’s (1978) classifications of attachment patterns are limited by the fact that the entire experiment to research about an attachment type lasts 20 minutes and brief separations and reunions at such short intervals can make it difficult to make corresponding caregiver styles conclusive. Older children in middle school, if they had the same test, would be able to sustain much longer periods of separation (Rutter, 1995). The attachment theory is also criticised for focusing too much on one primary caregiver – the mother (Aldgate et al, 2006). It does, nevertheless, help us to conceptualise about the parent-child relationship in various situations.

Loss / Death

From above, the parent-child relationship can influence the development of a child. It also affects the way they deal with loss when they lose an attachment figure: ‘clinical literature separated children who have suffered the loss of attachment figures through adoption, fostering and parental divorce or death and found that they displayed greater adjustment problems’ (Owusu-Bempala, 2006: 112). Fear, depression and anxiety have been documented among children who have lost an attachment figure (Stein, 2003).

Aldgate et al (2006: 23) point to this fear in these circumstances when they note that ‘loss of an attachment figure means that children cannot turn to that adult to protect them and a strong sense of fear develops’ and leads to developmental harm if not addressed. In rural villages in Zimbabwe, the orphan who has lost a parent would either be absorbed by the extended family or end up as a child house header, depending on their age (Foster, 1997, 2000). Aldgate et al (2006) acknowledge that knowledge about how children view their attachment relationships in a multiple carer situation where they have different experiences is still developing. These attachments and having to deal with matters of loss affect the child’s identity. As shall be seen, in Kumakomo caregivers avoided processing with infected and affected students about loss and the latter continuously struggled to cope with the shrouded mystery of their parents who seemed to never find time to come and see them – not knowing that they had died.

Identity

As already noted, children’s identities are affected by their own perceptions and those of their peers. Parents and caregivers help to shape this identity by the consistency they provide the children to then be able to build a narrative of who they are. Quinton (2006: 99 quoted in Aldgate et al, 2006) notes that identity is ‘the story of ourselves, where we come from, where we fit with social life, to whom we are related ...if we do not feel we have a coherent story, then our sense of self as individuals is likely to be compromised.’ The socio-cultural perspective was very important in looking at my participants to see how they formed their identities in the midst of their situation. Quinton (2006) also

makes a point about distinctiveness and inclusion, how young people want to remain distinct but also want to belong to their social group. How infected and affected students negotiate these identity positions in the light of possible stigma and fear of exclusion has an impact on their identity. In Kupisa infected students struggled to belong to the greater group of students and even struggled to socialise amongst themselves.

From developmental psychology, we learn that from the 'age of 4 children develop a theory of the mind, that is, the ability to understand that others have thoughts in their own heads and may see things from a different perspective...' (Baron-Cohen, 1994:103) and by age 10, children are much more aware of themselves –

The widening social world of school brings social comparison into play...which makes it possible for them to develop views of themselves as adequate or failing...the possibility of developing low self-esteem (Quinton, 2006:103)

Identity, therefore, was an important factor to be considered in the relationship of the child and all those around them, particularly the primary caregiver. Lastly, I would like to discuss the impact of the community which directly influences the parents and thereby affecting the child indirectly.

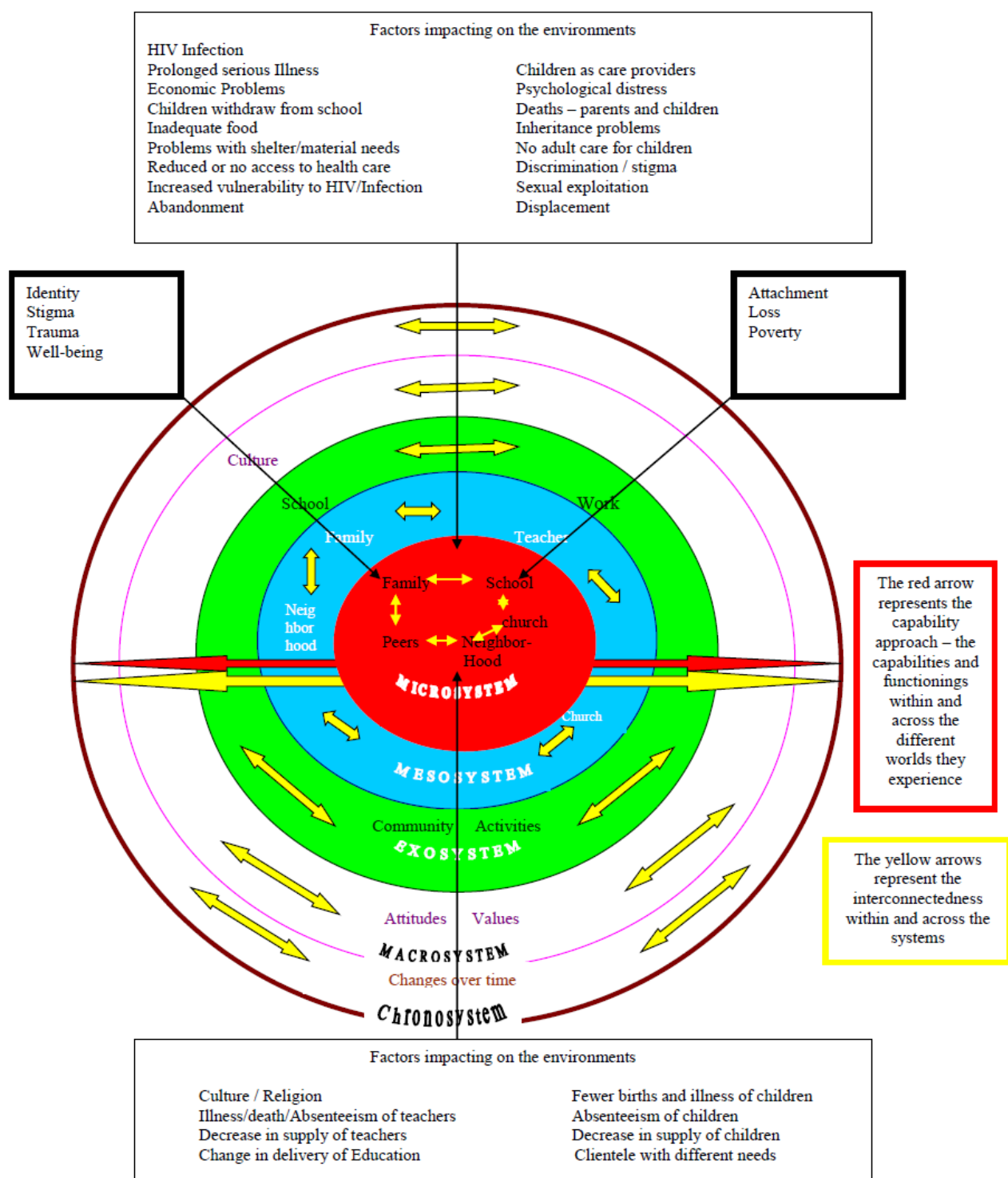
The Influence of the Community

The environment and neighbourhood in which children grow up have both a direct and indirect influence on the developing child (Dowling et al, 2006). The rural environment in which my study is located is traditionally poor, and since the advent of HIV/AIDS, its capacity to function has been tremendously reduced. Rutter (1974) rightly states that parents and other caregivers cannot accomplish parenting tasks unless they live in permitting circumstances; supported by Dowling et al (2006: 12) who state that 'to provide a wellness-enhancing environment...is based on the opportunities afforded them by the community in which they reside.' Zimbabwean rural parents, already stretched, find themselves in increasing poverty that 'diminished their capacity to care for their children...who may be relatively deprived...leading to stigmatisation ...because they are

different' (Aldgate et al, 2006: 143) and such experiences may diminish the child's developing sense of self-confidence. Poverty and stigma are some of the factors that impinge on the community. Gill and Jack (2008) also point to work influences – the kind of work that parents or caregivers have in the community will affect their children – if they are lowly paid, they have to work longer, which means less time at home with their children. This was evident in Kumakomo with most of the caregivers of infected and affected students who were mostly absent from home to tend the fields in order to accommodate increased demands for food.

The above information has raised issues of identity, stigma and trauma, well-being, attachment, security loss and poverty. These add to the conceptual framework as factors that I considered in researching the infected and affected children in multi-faceted socio-cultural ecological manner. As noted earlier, my main focus was on the micro, meso and exosystems. The final conceptual framework is presented below:

Figure 3.5: Psychosociocultural Ecology Approach



Chapter 3

Methodology

I shall, in the next section, justify my choice of the qualitative rather than the quantitative paradigm. Since I intended to understand the lived experiences of students, my study lends itself to the qualitative paradigm. The above background guides me to then describe my epistemological stance, the theoretical perspectives within which I draw upon my research, followed by the research design and methods which suit the case study approach which I employed. In this chapter, I will also be discussing the issues of trustworthiness i.e. internal and external validity, reliability, ethics and the limitations of my work.

Because the research that I undertook is an 'inquiry process of understanding a social or human problem, based on building a complex, holistic picture formed with words, reporting detailed views of informants (*the children's narratives, responses to interviews, observations*) and conducted in a natural setting' (Creswell, 1994: 2), it lends itself to the qualitative research paradigm. Even though the quantitative paradigm is also an 'inquiry into a social or human problem' (Creswell, 1994: 4), its theory testing approach, its reliance on quantification and statistical analysis to test the theory is not suited to understanding children's experiences, where I needed more than a questionnaire and survey to find out about their experiences. The following discussion, therefore, justifies the use of the qualitative paradigm and the appropriate epistemology and theoretical perspective for my research.

Paradigm: Qualitative Vs Quantitative

I agree with Creswell (1994: 4) when he notes that as far as the ‘ontology of what is real...for the qualitative researcher, the only reality is that constructed by the individual involved in the research.’ Because I sought to understand the experiences of my participants, the qualitative paradigm is more appropriate for the study since ‘reality is subjective and multiple as seen by the participants in the study’ (*Ibid*). The nature of the HIV/AIDS epidemic and how different infected and affected students experience it is subjective, and not an objective experience as implied by quantitative research ontology.

To clearly understand the children’s experiences and gain their trust in the process, it was necessary to minimise (Creswell, 1994) the distance between myself as the researcher and my participants, a qualitative research aspect. The quantitative paradigm would have required me to be ‘distant and independent’ from the participants, which in this situation would mean treating students as ‘objects to be researched’ (Creswell, 1994:6) as opposed to actors to be interacted with from whom personal accounts are imperative.

Yet another reason why the qualitative approach was more suited to my research is that I had values and biases about the impact of the HIV/AIDS epidemic on education through personal experience of observing aspects of it in Zimbabwe as an educator for more than 14 years and through research. I could actively report these biases within the qualitative paradigm, albeit ensuring that they did not impinge on the research, whereas my values are held out of the study for objectivity in the quantitative paradigm. Having decided to use the qualitative paradigm, how then would I know ‘the nature of the knowledge, its possibilities, scope and general bias, what would be the philosophical grounding for deciding what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate?’ (Crotty, 1998:7) In other words, what is my epistemology?

Epistemology

Epistemology, according to Scott and Morrison (2005:84) is ‘how education researchers can know the reality they wish to describe ...the belief they have about the nature of that reality.’ My understanding of the impact of HIV/AIDS on infected and affected children is that it is experienced differently by each child, even though it is the same phenomenon; each child will construct their own understanding relative to their own particular experiences. My epistemology is constructionist in nature as defined by Crotty (1998:9) – ‘truth or meaning *that* comes into existence in and out of our engagement with realities in the world...*where* different people may construct meaning in different ways, even in relation to the same phenomena’ (emphasis is mine). Constructionist epistemology is consistent with my socio-cultural ecology conceptual framework which researches children within ‘real-life settings, with real implications’ (Bronfenbrenner, 1986:287) and the interpersonal relationships therein. Children construct their meaning within the socio-cultural environments. A closely related epistemology is subjectivism whereby ‘meaning does not come out of the interplay between subject and object but is imposed on the object by the subject...the object as such makes no contribution to the generation of meaning’ (Crotty, 1998:9). Subjectivism lacks the ‘interplay and interaction’ factor between the subject and the object, an element evident in constructionism, which makes the latter more appropriate for my research where there is an evident case of meaning being made out of the interplay and interaction between the infected and affected students and the phenomenon at hand. The reality of infected and affected children is such that the meaning is likely to be derived from ‘experiencing’ the effects of the disease and not so much creating a meaning from a distant phenomenon which they would otherwise know very little or nothing about because they did not have to think or deal with it.

Theoretical Perspective

Having adopted a constructionist epistemology, interpretivism is the most fitting theoretical perspective; 'here taken to mean the philosophical stance lying behind the methodology' (Crotty, 2004:66). In interpretivism the 'social actor negotiates meanings about their activity in the world...attempts to interpret the world...and it is these interpretive processes that constitute reality' (Scott and Morrison, 2005:131).

Interpretivism is more appropriate for my research since my participants are trying to negotiate meaning within *their* situation and I, as a researcher, was 'interested in understanding how participants made meaning of *this* situation or phenomena' (Merriam, 2002:6). Experience is interpretive – hence my use of interpretivism. 'Experience is about interpretation, on the part of the self to self (as in reflexive mental processes) and on the part of self to others (as in attempts to explain experience) and further, on the part of others as they attempt to understand the original experience' (Greene and Hill, 2005:5). Interpretivist scientists attempt to make sense of how children understand their experiences and how this affects the way they feel towards others and themselves (Greig and Taylor, 1999).

An appropriate (fitting) branch of interpretivism is phenomenology, the study of human experience whose purpose is to uncover and describe the meaning of lived experience in a given situation for an individual or group; a study of 'being' and examining the way of being in the world (Van Manen, 1990). Phenomenology's task is to capture, in everyday language, distinct qualities in a child's emerging world, to understand experience as perceived by the person and derive meaning from those perceptions (Danaher and Briod, 2005). Jasper (1994) notes that phenomenology is about trusting the informant and placing emphasis on the lived experience in a natural setting. The above descriptions of phenomenology readily fit with my intention of learning from children's lived experiences within their natural settings of the school, the home and the community. This is also consistent with my psycho-sociocultural ecology framework.

Phenomenology was introduced by Edmund Husserl, 1859-1938, as a study of the structures of consciousness that enable the mind to refer to objects outside itself. This, Husserl postulated, requires reflection on the content of the mind to the exclusion of everything else – phenomenological reduction or bracketing, setting aside the real existence of the contemplated object (Kennedy, 2003). Husserl was influenced by Franz Brentano's (Jacquette, 2004) insight that consciousness is never an empty vessel for thought but always 'intends' an 'object', that consciousness is never simply vacuous awareness but an awareness *of*, the minding of something, a mental posture (attitude), towards some meaningful phenomenon (Dahaner and Briod, 2006:219). From that conception, he developed his notion of 'intentionality', which to him provided the 'initial idea to develop his phenomenology of consciousness' (Moran, 2000:118). This step allowed him to overcome the split between person and world, between subjective and objective thinking and to investigate the perceptions and experiences of the inter-subjective lifeworld (Dahaner and Briod, 2006). In this light, phenomenology has a direct bearing on my work as I seek to understand the children's inter-subjective life worlds in the middle of an epidemic.

Yet another crucial aspect of phenomenology on my work is its emphasis on language, 'where privileged access is not in numbers, but rather a perception, cognition and language' (von Ekartsbeg, 1986:2, quoted in Greene and Hogan, 2005:221). This empowers my participants to express their experiences from their own perspectives in their own languages if they wish. This space provided by phenomenology for voice is crucial because, amongst other things, understanding individual experience comes out of interpreting the language from others; 'people do not have direct access to mental processes of others and so they can only access the mind through language and actions' (Thompson, 1990:90).

A problematic area in phenomenology is phenomenological reduction or bracketing, the shutting out of the world and any presuppositions a researcher may have or as Burns and Grove (1993) put it, the art of laying aside what the researcher already knows about the experience to be studied. This is all in an effort to confront data in its pure form (Polit

and Hungler, 1995). Notwithstanding the impossibility of bracketing, I believe that beliefs, assumptions and preconceptions can be articulated reflexively to ‘facilitate openness and new insight’ (Kennedy, 2003), which will allow for continuous self-reflection so that I can check that those beliefs, assumptions and preconceptions do not interfere with the data but can either add to it, concur or be challenged. I also agree with Ashworth (1999) that

the whole world of preconceptions cannot and must not be bracketed or even held tentatively since phenomenological human science investigation involves fully interpersonal encounters ...necessary for social interaction to take place (Ashworth, 1999:179, quoted in Oduro, 2008:73)

Non-bracketing also has support from a contemporary of Husserl, Heidegger (1899-1976) who posits that phenomenology should reveal what is hidden in ordinary everyday experience and bases his argument against bracketing in that phenomenological reduction in one’s private life is impossible (White, 2006).

My chosen constructionist epistemology and interpretivist theoretical perspective have bearing on the kind of research approach that I will employ - the case study approach.

The Case Study Approach

In this section, I shall justify why the *case study approach* was the most appropriate for my research and proceed to explain the structure of the case study for the PhD. Thereafter I will discuss the relevant *methods* of collecting and analysing the data and the issues of *trustworthiness* pertinent to the case study approach.

Justification for the Case Study Approach

The case study, described by Yin (1984:23) as an ‘empirical inquiry that investigates a contemporary phenomenon within its real-life context...’ fits with my research since I intended to empirically investigate how infected and affected students (a contemporary phenomenon) experience schooling in school, at home and in their community (their real-life context). The case study allowed me, first, to study naturally occurring cases in-depth. Secondly, since my main aim was to understand the schooling experiences, I needed to look at many features of the cases for a better grasp of the children’s experiences, something that the case study methodology affords.

Although the case study approach is ideal for my research it nevertheless suffers from observer bias, despite any attempts made to address reflexivity; the case study can be too personal and subjective – making it difficult for others to readily cross-check the given data/information (Nisbet and Watts, 1984). Opposed to a questionnaire and survey, the amount of data in the case study can be more difficult to organize and interpret because of the lack of a rather simpler question-and-answer method (Adelman *et al*, 1980).

The structure of the case study

My attempt to examine the ‘in-depth’ case of infected and affected students within its ‘real-life context’ (Yin, 2004) therefore, made the case study method appropriate for the pilot as it allowed me to have an *intensive* and *holistic* description and analysis (Merriam, 2002) of their experiences within their school environment. The case is summarized in the chart below:

Location	Manicaland Province, Zimbabwe
Research Locale	Rural Primary School
Total Number of students in the school	607
Interviewees	<p>92 students - 65 boys and 27 girls; Age range 11 - 13 years 161 Parents / caregivers</p> <p>Status of students:</p> <p>Infected: 6 students (3 boys and 3 girls) Affected: 30 students (21 boys and 9 girls) Non-Affected: 56 non-affected students (41 boys and 15 girls)</p> <p>Other (stakeholders):</p> <p>Senior Research Officer in the Ministry of Education District Education Officer Local National AIDS Council Co-ordinator 5 Teachers and the Headmaster (Head) Community Leaders – District Councillor, Chief, Village Head, Local Minister (of religion), Researcher Staff from FACT</p>
Methods	<p>Interviews - unstructured; semi-structured based on sociograms, drawings, photographs, timelines, diaries, Observations/participant observations</p>
Interview Recording; Interview Observations	Digital Tape Recorder; Notepad

Table 3.1: PhD Case Study Details

My participants were 6 infected students, 30 affected students and 56 normal students. All the students were in the 6th grade, with ages ranging from 11 – 13 years. As discussed earlier, I worked with the whole class of 92 students in both Grade 6 classes to avoid children being further stigmatized⁶⁰. The 6 infected students were purposely selected by the Head at the school, with prior consent⁶¹ from their caregivers. This purposeful sampling – described by Patton (1990:169) as ‘the selection of information-rich cases for study in depth’ - was carefully done by the Head at the school who understood that I intended to investigate the experiences of infected and affected students⁶² in a normal setting with other ‘normal’ students. The 6 infected students sampled incidentally made for a fair representation of girls⁶³ who are disproportionately infected and affected (MOE, 2000).

The other 2 groups, however, were largely skewed against the girls, representing the serious and long-standing gender issues in Kumakomo and largely in the Zimbabwean culture in general (Leach and Machakanja, 2000). The reason that I chose to work with the 6th graders, apart from their ability to better articulate their circumstances (compared to younger students), is because I found, from my teaching experience and the theorising about school earlier in this work, that students at those stages become more aware of themselves in relation to others at school; they are more astute to the reasons why others might think that they are different. Including the Head, I interviewed 5 teachers (which included the 2 Grade 6 Teachers) who had taught the six infected students before and hence had more specific information about their experiences within the school in

⁶⁰ A smaller number would have readily exposed the participants as other children would have been able to identify the characteristics for selection – which could lead to further stigmatisation; this concern was also expressed by the school and therefore together we decided to include both Grade 6 classes in the research.

⁶¹ The idea of consent, dealt with further in the ethics section, is negotiated differently within the Zimbabwean rural culture; adults usually give consent on behalf the child. In this case the Head who chose the students spoke to the care-givers first about the proposed research and what it would entail even before speaking to the child. They then asked the child in the presence of their parents.

⁶² Information about students HIV/AIDS status and whether they have lost one or both parents to HIV/AIDS is kept at the school. It is obviously kept in confidence and I followed suit in making sure that it remained confidential.

⁶³ The 50% representation of girls in my sample is significantly high considering that by this age most girls would have dropped out. The representation of girls needs special mention (and attention) since the prevalence among young girls is increasing (Mutangadura 2000; Bennell *et al*, 2002).

particular. To find out more about the students' experiences at home, I interviewed 161 parents and caregivers; these were people who spend above 50 percent of the time physically looking after the children. The reason for defining the caregiver here is that in most cases in the rural village a number of people can claim to be looking after the children because they have them for a day or two during the week. Due to the paternalistic nature of the greater rural society in Zimbabwe, a man working in a foreign country and providing financial support is deemed as the caregiver. I interviewed those who physically look after the children – usually women – as they were more aware of children's experiences.

Since I was also interested in the perceptions of the community leaders, I interviewed 9 stakeholders comprising of a Senior Research Officer within the Ministry of Education, the District Education Officer⁶⁴, the Chief, a Village Head, a local Baptist Minister⁶⁵, a research staff person from FACT⁶⁶, an officer from the National AIDS Council (NAC), a NAC village representative and the District Councillor⁶⁷.

The reason for my chosen school is that it is rural – my area of interest and most importantly, that it fits the criteria of having infected and affected students in a region with the second highest prevalence rate of 19.7 percent, second only to Matebeland South with a prevalence of 20.8 percent (Central Statistical Office, 2005). This school is also one of the 2 that agreed to let me undertake my research due to the very sensitive nature of the topic. This was after very intensive consultations and assurances that I would do my best to make sure those children are not further stigmatised or 'exposed' since the school withholds health information from all other students.

⁶⁴ The District Education officer usually has information that pertains to other schools in the district and therefore was important to interview to find out the prevalence and what he thought were commonalities within the 3 schools in the area concerning the phenomena

⁶⁵ The local Baptist Minister who is an integral part of the community – all the teachers at the school attended his church and subscribed to his teachings

⁶⁶ FACT, an NGO founded by Geoff Foster, a Researcher and Physician who has written prolifically on matters of children and HIV/AIDS in Zimbabwe – albeit outside the school environments

⁶⁷ The District Councillor, another gate-keeper, usually has information about the different organization that work in the rural village where I intended to work and also, in the city which is about 20 kilometres away. I was interested to find out if he was aware of any specific trends in the rural areas and within the city concerning infected and affected students. The City Counsellor is also responsible for allocating resources to schools – I wanted to know what preference, if any, is given to the children at hand and how.

I believe that research in the second most affected area in Zimbabwe will highlight the experiences infected and affected students and pave a way for appropriate programs to be introduced into the school systems. Below are methods which I used for my data collection.

Methods

Having described the case study approach that I employed, in this section I will explain the methods – ‘the tools or techniques used to collect, analyze and interpret data in educational research’ (Scott and Morrison, 2005: 152) that were suitable for my research. These methods were effectively piloted during my MPhil and hence I will give examples where relevant.

To adequately capture the experiences of the infected and affected participants, I ‘collected a variety of empirical materials – personal experience... life story, interview, observational and visual texts – that describe routine and problematic moments and meaning in *children's* lives’ (Denzin and Lincoln, 1998:3). In this regard, I used unstructured and semi-structured interviews for the adult community of teachers, caregivers and other stakeholders, and narrative analysis or storytelling and observations for the student participants. Below is an explanation of how I worked with both groups of participants.

Interviews

Exploring meaning in interviews

In a village and cultural context where children are ‘rarely spoken and listened to unless they have done something wrong’ (Westcott and Littleton 2005, quoted in Greene and Hogan 2005:140), children might not be readily responsive in interviews. Addressing conceptual issues on interviewing children helped me as a researcher to be aware of what to expect and hence prepare appropriately.

As I reflected earlier, I see the child as an active participant in the research process and hence all efforts were made to give control to the child in the interview process. I emphasised that I wanted to learn from the child. I gave them as much opportunity as they needed to explain their responses and also enabled them as far as was possible, to take the initiative as necessary to help them to create a meaningful context with myself as the interviewer. This allowed each student to be an active participant in the interview so that the role of the teller and the told were shared and jointly created (Wetscott and Littleton, 2006). As already noted in earlier chapters, this way of seeing the child empowers them as opposed to traditional developmental psychology that views children as passive and tends to

define a researcher–child relationship in which children are objects of study, to be observed, tested and experimented on, where their feelings, behaviour and beliefs are interpreted as relative incompetence against those standards prescribed for adults (James, 1999:234, quoted in Greene and Hogan, 2005:146).

This blame, however, can be equally shared with Shona culture where the child's position of 'being seen and not heard' undermines the voices of children, where strict discipline forbids children asking questions (seen as talking back) and impedes child-adult interaction to the detriment of the former. This cultural pattern is carried forward to the school where the teacher takes over with the same if not more severe authority. Patience and creativity therefore in getting children to respond during interviews was crucial.

A pattern of the existing adult-child interaction was worth examining so that I could be aware of the needed adjustments. Westcott and Littleton (2006:148) point to a well-established adult-child interaction pattern in classrooms – 'the IRF classroom discourse pattern; this means that children are used to teachers *initiating* (I) a discussion or personal interaction with a question or comment, after which the child *responds* and is then given *feedback* (F)'. Children are aware of this expectation which nevertheless can hinder a more meaningful interaction during the interview. I consciously tried to avoid this since children's perceptions cannot be controlled. I also avoided control by adopting a non-authoritarian stance; thus I reminded children repeatedly that I wanted to learn from their experiences. I allowed as much free expression as possible as opposed to the classroom

interactions which tend to be restricted to the question asked usually with an expected answer from information given earlier – a comprehension style conversation.

Westcott and Littleton (2006) rightly warn that trust is not a property automatically present in the interview process and alerts us that it is up to the researcher to consider ahead of the interview as to how she or he may best establish a trusting relationship with a child. I believe that my manner, and the fact that by the time I conducted the interview I had done a variety of activities with the children, helped me to establish rapport and trust. Also, since I was living in the village, my presence and constant interaction aided me in building trust.

Some very useful reminders which I bore in mind when conducting the interview – which I successfully employed during interviews in the pilot - are summarized by Westcott and Littleton (2006: 151) –

- *In* open-ended question forms (i.e. ‘what’ type questions), I encouraged much longer responses from children with more detailed replies than focused or specific questions
- *I avoided* closed questions that require single-word responses from children (especially yes/ no response types)
- *I avoided questioning* children in a suggestive manner – for example, questions which lead the child to the desired response were avoided
- *I was careful not to* repeat questions in exactly the same form – *this* usually results in children changing their responses, as they think their first answer must have been somehow wrong
- *I resisted* the temptation to interrupt the child and tolerated long pauses in children’s narratives, *as* it is important not to be frightened of silences, even in a methodology designed for talk
- *I worked hard not to* take children’s language or terminology for granted – *all the quotes from children in the findings and discussion section are in their own words.*

In selecting the methods for how I conducted my interviews, I tried to avoid using interview techniques that are usually meant for adults and then simply altered to suit children; James (1999:246) puts it more succinctly

recognising children as people with abilities and capabilities different from, rather than simply less than, adults may persuade us to be more adventurous in our methodology to find ways in which we can engage children so our research on childhood can be affected through research with children

The spirit of adventure is needed and the methods I used not only worked well but were appropriate for doing research with children.

I used semi-structured interviews with my adult participants to understand the complex experiences of my participants 'without imposing any prior categorisation that *might* limit the field of study' (Denzin and Lincoln, 1998:56); there was due emphasis on letting the participant control the narrative within broadly structured themes. The interviews included a 'set of associated prompts' and open-ended questions (Robson, 2002:6) to guide the interviewee and enabled me to get answers to my questions such as the participants' physical well-being and where appropriate, emotional well-being in light of their situation. This made it possible for them to relate their thoughts and observations freely and at length since they have been working with the children for long periods of time. Schedules 5-9, **Interviews**, on page 303 – 307 in Schedules and Appendices show how I conducted the interviews. **Structured interviews** would have been restrictive as they 'aim to capture precise data of a codable nature in order to explain behaviour within pre-established categories that may limit the field of inquiry' (Robson, 2002, page 56). Unstructured interviews allowed participants to provide me with information that I might not have thought of before as some immediately shared information reminded them of some other event or when I asked a follow-up question.

Narrative Analysis

Since I intended to understand children's experiences from their own perspectives, the narrative analysis approach, discussed below, was the most appropriate in helping me to elicit pertinent information.

Narrative analysis, 'the use of stories as data...first-person accounts of experiences told in story form' (Merriam *et al*, 2002:9) by my participants enabled me to obtain much

more detailed information since most children tend to express themselves better in story form. Engel (2005 quoted in Greene and Hogan, 2006:208), writing about narrative analysis of children's experience, notes that

children use storytelling to...solve emotional and cognitive puzzles...to establish and maintain friendships...to construct and communicate a sense of self...to recast events in ways that are satisfying...and to participate in the culture...that narrative is a universal and ubiquitous form in which people construct, present and share experience...the stories children tell about their day to day experiences reveal ways in which they are organising experience

Gee (1991:9) points to three ways of narrative analysis – the psychological whereby the story is analysed in terms of 'internal thoughts and motivations'; discourse analysis in which meaning is derived from the detailed look at the intonation, pitch and pauses in the language and thirdly, biographical analysis which looks at the person in relation to their society. Specifically, I used biographical analysis which looks at the person in relation to their society and takes into account the influence of gender and family in order to understand how they articulated their stories in relation to others around them within the school, home and community context. I also relied on psychological analysis to learn about their feelings, thoughts and motivations. It follows then, that if I used this method that my participants needed to be actively involved in the research since they were relating their own experiences.

Children as participants

As already alluded, most research on children tends to be about them as objects (Christensen and James, 1999), I intended to give my participants a voice so that their experiences could be identified. Scott and Morrison (2005:17) aptly point out that though the 'purpose of the data sought may vary, *the* primary emphasis is upon giving the people of the case a voice - to the extent that the voice of the researcher as the external interpreter may be subdued in favour of the insiders of the case.' It was imperative in my choice of methods to choose those that would help students to communicate their experiences and visual methods accommodated that aspect. If the research will later be

used to design programs of intervention, it is paramount that the needs of the target population should be known as much as is feasible from the participants' own legitimate experiences rather than from inference collected mostly from observation.

With the narrative analysis approach and the intention of working with children as participants in mind, I, therefore, solicited stories (Scott and Morrison, 2005) by asking my participants to tell a story through the use of visual methods, sociograms, timelines and diaries. In all the activities, children were encouraged to use pseudonyms for anonymity and matters of confidentiality. During the pilot, most of my students were able to use pseudonyms though a couple, after they were certain that the stories would not be viewed by anybody else, insisted on using their own names.

The use of visual methods

Question-answer interviews tend to be too structured and some children find them intimidating. I, therefore, used visual methods – photographs, drawings and sociograms - as my main methods of eliciting information. During the pilot and the PhD research, the use of visual methods proved to be creative, interesting and less threatening for my participants; they also avoided making the interviews look like a test from school (Cappello, 2005; Clark, 1999). Van Manen (1990:9) aptly points out the importance of using visual imagery in learning about phenomena – ‘it is in this work that the variety and possibility of human experience may be found in condensed and transcended form.’ This method of data collection, more natural to students, gave them a voice and helped me to understand their experiences from their own observations and interpretations. Veale (2005:254) concurs about the use of these creative methods as ‘those that draw on inventive and imaginative processes, such as storytelling, drama and drawing...that such methods normally serve as constructionist tools to assist research participants to describe and analyze their experiences and give meaning to them.’

Due to the sensitive nature of the topic, I arranged the sequence of my data collection methods from ones which I thought were least threatening and more engaging to ones

which might have required a buildup of much more trust before they were implemented. I started with photography, followed by drawings and writing of stories. These were followed by socio-grams to allow students to discuss the relationships among them. By this time students were more relaxed and willing to discuss their relations with their peer and others with a fair amount of depth. I ended with timelines to get an idea of what their days are like. Following this sequence worked really well - by the time I did semi-structured interviews with the students, they were excited about explaining their photographs, drawings and stories – which enabled me to get glimpses into their experiences at school, at home and in their community. I will discuss the data collection methods in more detail below.

Photography

There is ample literature that shows that photo-elicitation interviews - the use of photographs in interviews - sharpens memories and elicits a longer response (Epstein et al, 2006). Photographs have also been used widely by other social science researchers in helping students to address and share important aspects of their lives and experiences (Wang, Burris and Xiang, 1996). Wang et al (1996) note that participatory photography involves groups or individuals taking and interpreting their own photographs in order to address and share important aspects of their lives and experiences.

Photography can be considered one of a range of kinesthetic (sensory) art-based approaches to research which provides a means of qualitative data generation and analysis, which has the potential to engage children and young people in meaningful ways, not as subjects of research but as core-researchers of their own experience (Stanley, 2003).

Kaplan et al (2007) engaged primary school children and young people in participatory school-based projects in the UK, Indonesia and Zambia to research student's experiences of educational inclusion. They reflect on photographs taken by the students and their

commentary and through that, their interpretations about their experiences of educational inclusion. I will discuss their work in the Zambian school since it is geographically and culturally close to Zimbabwe and exemplifies the method.

Kaplan *et al* (2007) worked with children using photographs of children's perceptions of spaces and places in and around the school. In their work with photographs, they found that 'the selective acts of photography and photographic interpretation served to transform general conceptualisations of space in and around schools to more specific understandings of place with particular meanings and significance for students' (*ibid*, 2007:26). They argue, rightly, that the 'use and ownership of school spaces and places as well as social relationships which take place within them are not often addressed directly but lie uneasily beneath the surface of the daily life in schools...students' photographs and commentary can be a useful way of beginning conversations which address those often unspoken issues and concerns (*Ibid*, 2007:27).

Zambian Schools and the Participatory Photography Project

Kaplan *et al* (2007) worked with 6 primary schools (ages 5-13) in Northern Zambia. Students worked in participatory photography to investigate school inclusiveness. Working together in small groups, they took photos of aspects of the school which they either liked or disliked, found welcoming or unwelcoming. They also engaged in drawing and mapping around issues of inclusion. In this paper, they focused on themes which emerged to be important to students – toilets and school outdoor spaces.

They found that the photographs and the activity itself, apart from being highly engaging, brought about discussions among the students, teachers and parents on how to improve the students' experiences around the school. They learned that what seems simply a material resource (i.e. toilets) can be as much about 'social resources, perceptions, attitudes and behaviours of members of a school community' (*Ibid*, 2007:33).

What I think was problematic in this study is that at one stage they speculated on two photographs which the students had neither commented on nor contextualised due to time constraints. One photograph depicted a girl coming out from a toilet with 2 boys who were standing on either side of the entrance and all of them seemed to be focusing on the camera. The other picture was of two boys, one with a clenched fist and the other karate pose. Kaplan et al (2007) then speculated on issues of violence and bullying – which I think is inappropriate since there could have been an endless number of possibilities about what was really going on. Sometimes children just like to pose in front of cameras in certain ways. This distracts from their goal of having the children interpret their own photographs to relate their experiences and this speculation will be avoided in my work. Only the photographs on which the students would have commented on were part of the discussion in my research.

What remains, however, is that photographs are a valuable tool for exploring students' experiences and for supporting them to express their feelings, beliefs and opinions as an aid to verbal narrative or in place of it (Carlsson, 2001; Schwart, 1994). The ease and lack of technical skill required to use a digital camera made it a particularly accessible method that did not rely on language or literary competence. It was, therefore 'ideal for use with students, who, for whatever reason, are less able or reluctant to express themselves in the written or verbal form' (Kaplan, 2007:48). In my research, all but 3 students involved used this method effectively.

Sometimes referred to as 'photo-voice', participatory photography seeks to alter the constructs of traditional qualitative research enquiry in which the outsider researchers investigate and assess the lives of insider research subjects (Wang and Buris, 1994). Photographs become 'a stimulus for reflection, commentary and interpretation...*and had* the potential to provoke elicitation' (Kaplan *et al*, 2007). The crucial linking of the photographer's intention and their interpretation can be achieved in a variety of ways – through written or spoken commentary (*ibid*).

The method of participatory photography, however, has its dilemmas. Traditional power imbalances between children and adults may mean that the former may not feel as free in communicating their views about the pictures they have taken for fear of possible repercussions. I spoke to the students about how they should feel free to take photographs of places and spaces that were meaningful to them and how it was only I who would have access to their opinions on the taken photographs. Taking photographs would normally require consent from people who might end up in the photographs. In my research, children were only taking pictures of places and spaces and we discussed not taking pictures of people. Safety can be another issue with students moving about the school and behind buildings. Since only 3 students were taking pictures at any given time, I was able to stand at a vantage point to make sure that they were safe.

By virtue of an aspect of the school being captured in a photograph, photographs represent a part of the whole and its interpretation can be problematic if it is interpreted by an outsider. Since I intended to find out the subjective experiences of my students, there was no need to worry about misinterpretation, since the students themselves provided their own commentary. On the whole, ‘engaging my students about issues behind their photographs yielded insightful and complex discussions about the contexts which underlie such issues’ (Kaplan et al, 2007:26) as friendship, stigma, safety, sanitation, displacement and others to be discussed later in the findings chapter. The photographs, therefore, yielded a lot of discussion and data.

To help elicit information about their experiences within the school environment, each student was given a digital camera that they could use to take pictures. For instance, they were asked to take 5 pictures in and around the school and then later describe why they took them, what made them stand out, what it reminded them of and so on. Apart from producing a lot of data which acted as prompts to elicit more information about student’s experiences, these were fun activities which enabled students to share experiences creatively. Schedule 1, Photography activities on page 287 in Schedules and Appendices explain how the activities were carried out. Photography activities helped students to

discuss their school environment were thus effective in eliciting pertinent information. An example of a student's picture is shown below –



Photograph 3.1 Solomon [I] – School Environment: roofless classroom

Solomon [I]⁶⁸, (Interview, December 2010) described how the roofless classroom made him feel unsafe especially *‘when there is a strong wind I fear that all of it will fall inside and hurt us’*⁶⁹. He further explained that it reminded him of his old school in the city that had proper roofs and windows where he felt safe. Students were moved to this classroom for extramural activities like singing. On one occasion one of the wooden poles was unhinged by a gust of wind but no one was hurt. Solomon, however, expressed the many changes that infected and affected students had to deal with because of displacement issues.

This activity worked well in that students shared much more in-depth about their school environment and about how certain aspects of it made them feel. As students volunteered more information, most of the discussions spread to what was not in the photographs to connections they made with other experiences around the school. They shared, for instance, what other pictures they would have taken (if they could have taken more than the prescribed⁷⁰) and why. Harper (2002:13) concurs that ‘photo elicitation evokes information, feelings, and memories that are due to the photographer’s particular form of representation’ and this was reflected in all of my students’ cases, albeit in different

⁶⁸ [I] in front of a student’s name stands for ‘infected’. [A] will mean affected and [N] normal

⁶⁹ *kana mepho yawanda ndotsa kuti zvose zwikadonere mukati zvotikwadza*

⁷⁰ I limited the number of photographs to be taken so that students could be more intentional about places and spaces that had meaning to them

forms. Although all of my students, except for one, had never used a camera before, it took relatively little time to train them and have them go on their own to take the pictures.

Since students were, however, limited in how many pictures they could take which limited the ‘triggers’ for my questioning. I thus used drawings to further learn about their experiences. There was a choice for students to either depict their home experiences simply through drawing or to combine that with a written story.

Drawings

Students were asked to make a drawing of their house, the people who live in it and whatever else they associated with their home. As they described what they drew, I asked follow-up questions from their descriptions. The idea was to get the child to talk about their environment and their experiences within those environments in a non-threatening manner. Their pictures and transcribed data formed part of their narrative. Because most of my students were older than 10, most of them were used to writing essays already. The picture drawing could be combined with a few lines so that they could also express themselves in their own written words. Schedule 2, *Drawings* on page 289 in Schedules and Appendices details how the activity was conducted.

Overall the drawings were an effective tool as they seemed to have a ‘compelling effect upon the *student*...an ability to prod latent memory, to stimulate and release emotional statements about the student’s emotional life...’ (Collier, 1957:858). At times drawings seemed to help students capture the impossible: a person gone, an event past (Harper, 2002). Vygotsky (1978) observes that from about 7 years, children begin to master the symbolic meaning of drawing and that drawing can serve as a cultural tool in the same way as sign and language, for mediation and transmission of experience.

Some drawings from the pilot depicted fathers who ‘had gone to work in South Africa’ – a safe term for explaining the absence of a father since migratory work to South Africa is now a common occurrence in Zimbabwe. They compared and contrasted the differences of staying with their parents before they had to stay with caregivers. During the PhD research, some students, sharing their drawings devoid of people, spoke about being

alone at home for long periods of time. An example, discussed at length in the Findings and Discussions Chapter, is shown below –



Drawing 3.1: Solomon [I] – Empty Homestead / Journey to the Village

Solomon [I] spoke about how he was often alone because his grandmother was in the fields working – *‘there was always someone at home’*⁷¹ (Solomon [I], Interview, December 2010). More about infected students and caregivers is discussed in the findings and discussion chapter - suffice to say here that this drawing helped Solomon to discuss when he was first left at the village and his new home environment that was often empty because caregivers had to work more to provide for added responsibilities.

Drawings, therefore, became a mine of information elicitation that jolted students’ memories and helped them to communicate their experiences in more detail than would have been otherwise.

⁷¹ *‘kumba kwayigara kunevanhu’*



Drawing 3.2: Phenias [A] – Home Environment (Mtimbiri, 2008)

During the pilot, the above elaborate drawing by Phenias revealed an interesting aspect of stigma when his drawings did not depict his home environment. I found this out when I went to the student's homes to interview his caregiver. I discovered, as I discussed with the student later, that he drew a home that he felt would look like those of his peers' homes – including of parents even though he no longer had parents. I found out that he was not absolutely certain that no one else at the school would see his story and pictures and he later told me that he was afraid of being seen as an orphan. During my PhD, this was confirmed by the story-drawing format activity -

Name: Trust Siyabona Grade: 6A

My Story – my experiences at school



Ini ndini unenzi Trust Siyabona Chikoro
ndino enawe Mbichana. Kumbama
na babandinaovese. Isutiri Shanumumburi
mwedu Ini ndiri wechi mana. Shamwari
yangu ndi ADmire Goba. ADmire uno
farira kuita zvechikoro. Mumhuri mwedu
vakomana vaviri mumhuri mwedu.

Drawing 3.3: Trust [N] – My Story

Trust [N]⁷², above, even though he only drew himself, in his story he spoke about having both parents. On arrival at his home, I discovered he was an orphan and was told by his caregivers that he maintained that narrative ‘so that others will not mistreat him’⁷³ (C-G: Trust [N], Interview, December 2010).

This activity also worked for shy students. What they wrote, no matter how little, was used as prompts to elicit more information that related to their experiences of schooling. I

⁷² Trust [N] is identified as ‘normal’ by the school who were not informed about his parents death

⁷³ *vamwe vasamu bathe zwakaipa*

then asked the students to describe the depicted relations, how different people shown in the pictures made them feel and so on. This enabled me to find out about their social experiences at home. All the students did both the picture story and just a picture of the representation of their home which we later discussed. Through their drawings, I found out that most students were able to tell me even more about their home experiences than they had related in their stories

It was, therefore, an advantage to be able to triangulate my data by interviewing caregivers at the student's home, which helped me to verify some information which students might have misrepresented – understandably with good reasons as noted above. I have the advantage of being able to read and write the main three languages that my students speak which means that they could express themselves in the language of their choice.

Drawings, apart from providing a relaxed atmosphere which allowed me to gain access to the student's experience, provided a structure for the discussion. This activity gave me valuable information about how the students experienced their home lives as they explained, sometimes in detail, the interrelationships with their caregivers and how it made them feel. I was thus able to effectively use photographs and drawings in my PhD to elicit information about the student's experiences at home, at school and in their community.

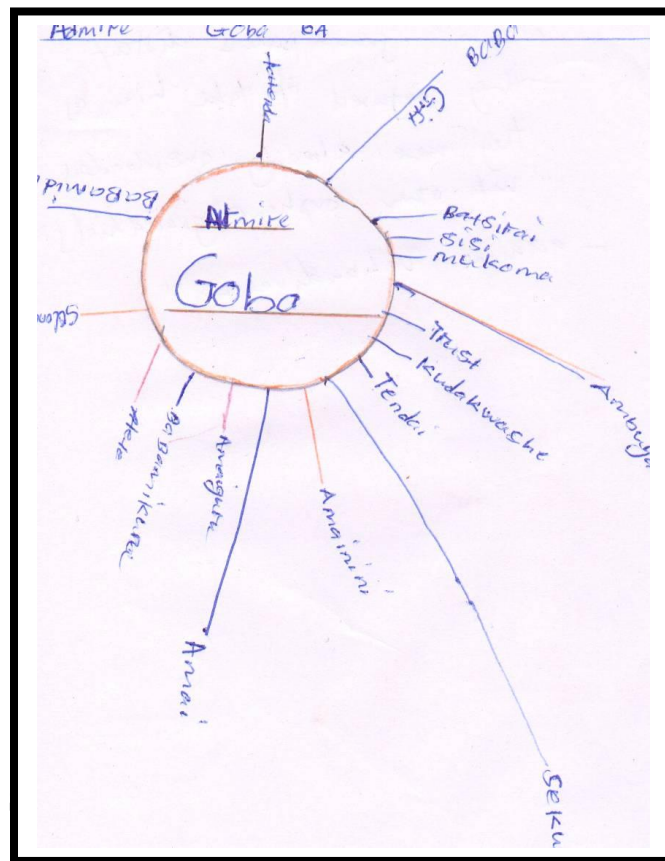
Sociograms

To find out more about relationships⁷⁴ – which gave me an understanding of who they viewed as the most important people with whom they were likely to go to discuss their problems – I used sociograms. As Piaget used drawings to capture children's

⁷⁴ Relationships are a very integral aspect in African culture and this activity helped me to further find out who the closest or furthest people in their relationships are and why; the most important people in their lives will, to a large extent, determine how long they will stay in school and in that community. Maternal orphans tend to drop out of school much earlier than paternal ones, especially in cases where the father remarries and the new wife is not interested in absorbing added responsibilities (Sanders and Sambo, 1992).

conceptions of space (Piaget & Inhelder, 1969: in Yeun, 2004), I used sociograms to capture their conceptions and perceptions of their relations around them, to explore their social relations with peers and adults within the school, home and community environments.

Students were asked to draw a diagram in which they put themselves in the middle and then space people in relation to how close or further they were from them. Schedule 3, Sociograms, on page 294 in Schedules and Appendices shows how the activity will be conducted. The students will later explain the diagram. An example of a sociogram from a student is shown below –



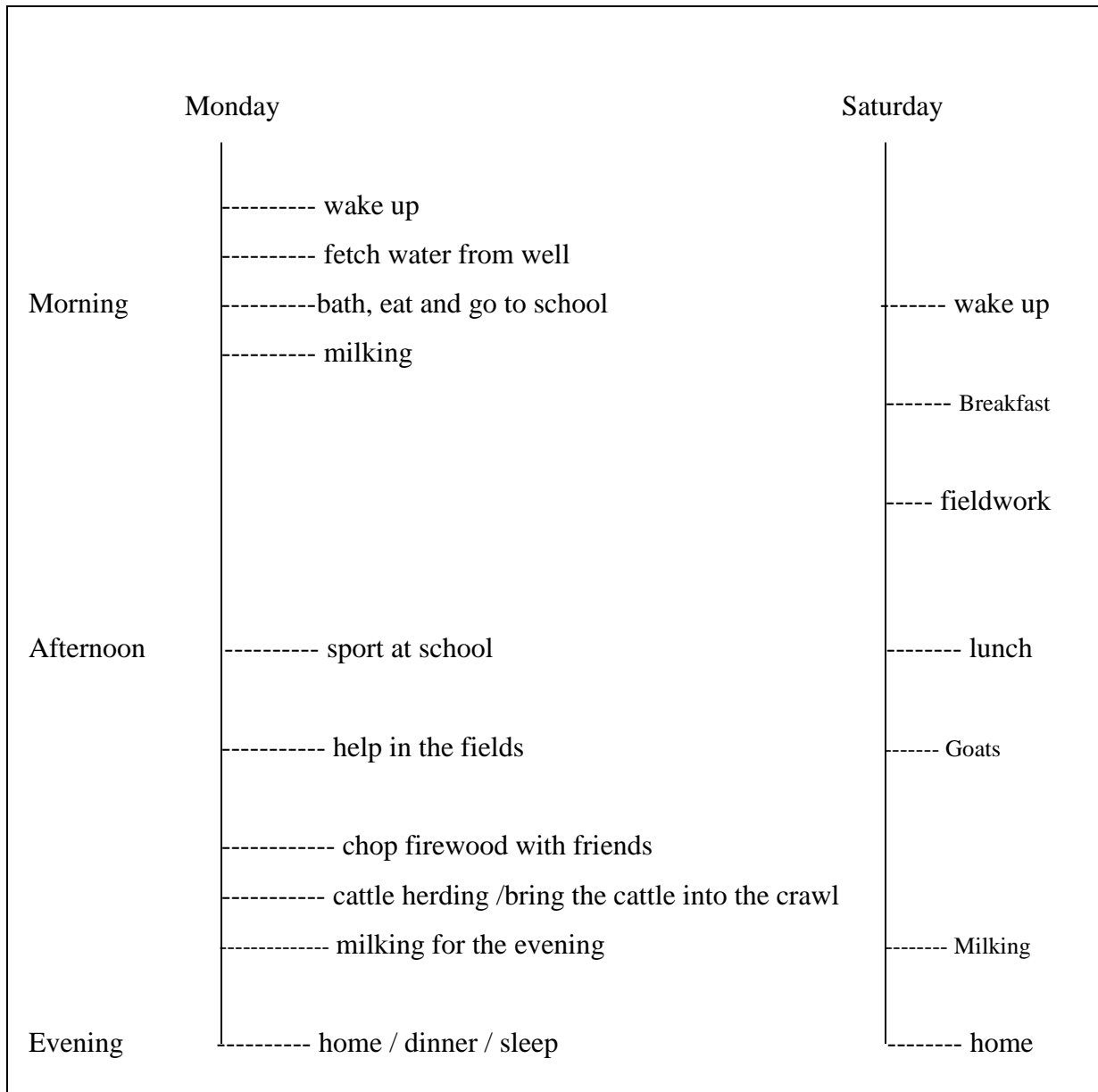
Sociogram 3.1: Admire [N] Relationships

The spatial nature of the sociogram helped students to identify who their closest relations were and why. Most normal and affected students had each other as confidants. Infected students hardly had any friends and those they included in their sociograms were not reciprocated. Only in a few cases were teachers included and hardly any caregivers were

included in the diagrams. Basically, students found most teachers unapproachable about what they felt would be petty problems to the teacher and as for caregivers, time constraints because of increased work responsibilities meant that there was less time to be at home with the students and relationships, eventually, were not intimate enough for students to feel safe in sharing their needs. Students described how the different relationships contributed to their experiences within the school, at home and their community. Even though photographs, drawing and sociograms aided me in eliciting a lot of information, I realized that there might still be gaps in the information that would necessitate a clearer understanding of their experiences – an understanding of their daily routine at home and in the community would certainly add to the study. I thus employed the use of a timeline discussed below.

Timelines

I presented students with a piece of paper with the days of the week under which they could tell me, as I asked them, what they did on each of those days at various times of the day. This helped me to have a better understanding of what their day-to-day living was like, the times that their experiences were heightened and the reasons thereof. I took the opportunity to ask follow-up questions where appropriate. An example of a student's timeline is presented below –



Timeline 3.1 Gift [N]

The timeline helped me to understand the different ways students perceived responsibilities. Gift above, spoke proudly about what he was able to do and how as he grew older, *'I can do even more work'*⁷⁵ (Gift [N], Interview, December 2010). An interesting aspect, therefore, is how normal and most of the affected students who grew up in the village viewed chores as a welcome sign of maturity and a rite of passage to

⁷⁵ *ndakugona kuita basa rakawakandisa*

adulthood. A few affected and all infected students who grew up in the cities, spoke about work as chores and complained about being tired because of all the things that they had to do on top of walking long distances to school.

In describing their timelines, students volunteered information about how much their home responsibilities had increased since they had to stay with caregivers. This activity was therefore very useful in helping me to elicit more information that related to the student's home experiences and how it impinged on their schooling experiences.

Yet another instrument that allowed me to understand some issues that may not easily be revealed by other methods was the use of diaries.

Diaries

Emond (2006, quoted in Greene and Hogan, 2006:133) in a study conducted in 2000 to investigate the experiences of young people living together as a group and how those groups were formed, maintained and ordered, found that the use of diaries that the young people kept gave her

an interesting insight into what the young people valued in their day to day interactions and the meanings that they attributed to them...it also provided data regarding the differences in the materials young men and young women chose to record...and also provided an opportunity for the group to own the research...empowered them and served to remind them that they are the experts in the field

Diaries yielded much data for discussion and reflection in my own work with children as a teacher and camp director. Whilst still teaching primary school in Zimbabwe, I had opportunities over the school holidays to conduct camps for children between 10-12 from different schools⁷⁶ within the province where I lived. For the first two years of camps, it

⁷⁶ I often combined my mostly white students from the private school where I was teaching and black students from the rural school where I used to teach and then a mixture of students from urban schools (black, white, Indian and occasionally mixed race). This mixture was intentional – the main idea was to

was often very difficult for children to articulate their experiences on what they had learned about themselves, about others and how they had enjoyed the camp generally. When we introduced diaries, we found that the children reflected more and discussed more of their experiences which I believe formed a better learning experience. I used diaries with my participants so that I could have an even better understanding of their daily interactions, thoughts and feelings about the happenings in school, at home and in their community. The diaries were simple – they recorded what they did, the things they were thinking about during that day and how they felt and also, included any other things of interest to them. I used the diaries as prompts to stimulate discussions about their experiences.

In addition to the interviews of the adult community and the narratives from the children participants, I also used observation to triangulate my data.

Observations

Within my psycho-sociocultural ecology framework, the most appropriate approach to observe children to glean their experiences was ecological, which allowed me to employ naturalistic observations of children and their families. Tudge, Hogan and Etz (1999, quoted in Tudge and Hogan, 2006:102) note that

...little is known about the fabric of children's daily lives – the activities, the social patterns and the interactions that form their everyday experience...the vast bulk of psychologist have conducted their research on children in the laboratory or laboratory-like settings or have relied on parents reports rather than examining children's typically occurring everyday activities

We can learn a great deal by observing children in their social and cultural contexts which my work intended to do. Context is necessarily implicated when examining

foster cultural and racial understanding among primary school children who, without those opportunities, would perpetuate the stereotypes handed down from their immediate relatives and other significant adults in their lives

children's activities in the locations in which they are situated (Tudge and Hogan, 2006). Tudge and Hogan (2006:115) rightly note that observation by itself, however, is rather limited in researching a child's experience since by nature it 'necessarily treats children as passive objects, specimens under the scrutiny of scientists' They further state that by 'putting the child in a contrived situation to see how they respond to that particular version in context may indeed imply that the child is simply the object of investigation' (*Ibid*). To avoid this trap, context becomes important; children need to be observed in their natural settings to get a glimpse of how they relate and respond to others around them. Vygotsky (1978 quoted in Anderson, 1994:265) states the importance of context in reminding us that 'experience...involves the individual and the interpersonal and broader cultural context in which the individual is situated'.

By observing children in their natural settings with no pre-existing constraints to settings' (*Ibid*), we may allow children to be participants in the study. I thus observed children during their normal lessons, play time within the school, when I travelled to their homes and within their immediate communities. Regardless of the natural setting, the information gathered on children through observation is limited to 'describing content than meaning...the types of activities in which they engage their social interactions and characteristics of the settings' (Tudge and Hogan, 2006:103). Other methods – interviews, for instance, were needed to get a fuller picture of the meaning of their experiences.

Naturalistic Observations

Naturalistic observations are key to the study of experiences within the ecological approach because they allow for a holistic approach to observation. They allowed me to take cognisance of how children

grow up in social worlds – complex networks of relationships with others ...*and that* it is within these worlds that they develop the powers of understanding, their ability to communicate, their sense of self, their adjustments and powers of coping with stress and with change...they also enable me to study children in real-life situations which have emotional significance to them (Dunn, 1993 quoted in Sheila and Hogan, 2006:87).

Observation played an important role in understanding their complex social worlds within the school, the home and the community. There are different approaches to naturalistic observations. Tudge *et al* (2006) did a 10-year study on the Cultural Ecology of Young Children (CEYC) – examining the everyday experiences of children between 28 and 48 months. In the CEYC project, they wanted to examine the everyday experiences of children and their approach to observation was that they simply followed children, putting no restrictions on where the child went and the people they interacted with (Tudge and Hogan, 2006). Each child between the ages of 28-48 months was followed for a total of 20 hours over a course of a week – they tried to make the equivalent of a day in their lives. The child who was being observed was fitted with a microphone so that they could hear the conversations (Tudge and Hogan, 2006). This is problematic because once the child is fitted with a mike they will know, surely, that they are being listened to and it might change what and how they say things. Another problem arises when they used video to study how children are drawn to the various activities – this readily creates a problem that they concur with as well that ‘the presence of the camera is likely to change the people’s behaviour more than the simple presence of an observer’ (Tudge and Hogan, 2006:109). Since I choose not to record children in my study, among the problems that I encountered, therefore, was not being able to hear some of the conversations between pupils which limited the effectiveness of observations. However, this was then addressed during interviews.

Then there is also the question of time – how much is enough time to observe a child to have a ‘reasonable sense of what is going on’? (Tudge and Hogan, 2006:115). Tudge *et al* (2006), in their CEYE project, report that they ‘could only say, weakly, that that they believe that observations over the course of 20 hours may be sufficient to get a reasonable sense of the types of activities and interactions that are important to children’s lives’ (Tudge and Hogan, 2006:115).

Others too have used observation in children. Darwin detailed observations of his own son, while Piaget did the same with his children and those of others (Piaget, 1928, 1932). Barker and Wright (1951) devised an ecological study documenting everything in the life of a boy in a day while Gaskins (1999) did observations of children naturally occurring in play; Corsaro and Molinari (2000) are the foremost examples of participant observation of pre-schoolers in the US.

Within the limitations, however, as Tudge *et al* (2006) believe they did in their CEYE project, my approach ‘captured children’s activities in an ecological way (children were not separated from their context) to give a reasonable sense of the types of activities that typically occur’ in their lives and their experiences thereof. I believe that my 4 months stay in the village, with daily observations at the school helped me to reach saturation; that it allowed me to observe their involvement and participation in lessons with the teacher and other children, their interrelations during group time in the class, outside during playtime and relations and responses to family at home and in their immediate community with their friends. I looked and noted any other behaviour that was of interest – highlighting, at all times, the differences between boys and girls too within the infected/affected and non-affected groups in the study.

Observing allowed me, therefore, to ‘sample the educational experiences of my participants first-hand rather than simply depend on what they say’; it also allowed me, as Foster (1996:13) states, to ‘record that which is rooted in informants’ actions and rather than distilled from remote theoretical reviews.’ Spradley (1980) notes how researchers should employ participant observation in activities that are appropriate, to collect thick data that reflects what participants actually do and make an attempt not to infer. I made

every attempt to naturally observe children learning in the classroom, their interactions with other students, the teacher and the whole classroom environment. I also observed them in the playground and in the afternoon sporting activities, to ‘get into the inside of their rich and vicarious educational experiences’ (Scott and Morrison, 2005:163) thereby gaining further understanding of their schooling experiences.

As a participant observer, I used the ‘shadowing’ technique of observation (McDonald, 2005) as I followed students closely to observe their experiences. To be able to gather a ‘fuller record’ of what I was observing, I designed my observation collection sheet based on 5 types of materials to be included in a report as proposed by Lofland and Lofland (1984): 1. Running Descriptions – specific, concrete, descriptions of events, who is involved and conversations – without any inferences 2. Recalls of forgotten materials – things that come to me later; 3. Interpretive ideas – notes offering an analysis of the situation; 4 Personal impressions and feelings – my own subjective feelings; 5 Reminder to look for additional information; a design with these 5 things in mind helped me to capture the information more effectively in my study – an example of the observation sheet is shown at the end of this section.

This method proved to be very useful during the study. I wrote down running descriptions of what I was observing in the classroom and on the playground. Since I worked with individual students, I started my day by observing students in class for at least 2 hours each day. Every break time I was out observing students interacting with others in the playground. I also observed students in the mornings before school started. The observation collection sheet allowed me to collect detailed information which gave me a glimpse of how infected and affected students related to the peers around them. An example of the observation sheet is shown below –

Name: _____ B G Date: _____

Subjects / Activity _____

Location: _____ Number of students in Class: _____

Teacher's name: _____

Time	Running Description	Interpretive Ideas	Personal Impressions
Recalls			
Reminders			

Observation sheet: Ideas on the design of the observer sheet are based on Lofland and Lofland's (1984) suggestions about what to record during observations

Below is a diagram of the various methods and briefs on the information that I collected.

Method		Aims	Sample
Narrative analysis (story writing)		To explore the school, home and community experiences through their child's own voice	92 students - 65 boys and 27 girls
	Photography	To elicit information about their experiences within the school environment – their perception and conceptualizations of school spaces and places within the school and how it affects their school experiences	Status: Infected: 6 students (3 boys and 3 girls) Affected: 30 students (21 boys and 9 girls) Non-Affected: 56 non-affected students (41 boys and 15 girls)
	Drawings	to explore their home environment (family life) relationships and interactions within the home and significant others in the family who may be depicted in their drawings (or left out)	
	Sociograms	To capture their conceptions and perceptions of their relations around them, to explore their social relations with peers and adults within their school home and community environments i.e. where they place certain people relative to why they are important to them; explore friendships, issues of discrimination and identity	
	Timelines	To explore the student's daily routine at home and in the community (in the playground after school) – as this forms part of their experience and impinges on their schooling experiences	
	Diaries	To have a better understanding of their daily interactions, thoughts and feelings about the happenings in school, at home and in their community.	
Observation		To allow me to sample the experiences of my participants beyond what they and others tell me, to record their actions as I perceive them	
Interviews	semi-structured	To gather perspectives about the schooling experiences of my participants	161 Parents and/or Caregivers Headmaster 5 Teachers Stakeholders

Table 3.2 Summary of Data Collection Methods

Scott and Morrison (2005:31) rightly point out, however, that ‘the collection of information does not produce data automatically ... what researchers do with the information is key.’ The section below details how I organized my information into ‘analyzable’ data that enabled me to write a plausible and descriptive narrative report that details the findings of their schooling experiences.

Analysis

I conducted part of my analysis simultaneously with my data collection. This was to ensure that I covered sections that might not have been answered satisfactorily or simply not afforded by the method used at the time. So at the end of each day, I looked over the information gathered to determine if I needed to follow up questions or if the remaining questions might be captured through the use of other methods. To structure my analysis, I adopted 3 ways of data analysis suggested by Huberman and Miles (1984): ***Data Reduction, Data Display*** and ***Conclusion Drawing / Verification***.

1. ***Data Reduction***: This is a fundamental step to data analysis (Scott and Morrison, 2005) as it ensured that I worked within the boundaries that I set at the beginning. Miles and Huberman point out that ‘data is reduced in an anticipatory way when the researcher chooses ...research questions, cases and instruments’ (Denzin and Lincoln, 1998:179). My research questions and methodology of the case study limited my work to the experiences of infected and affected students within the school, home and community environments. For example, in my taped interviews with adults, I removed a lot of introductory and information⁷⁷ so that I remained with relevant information. There were many other people whom I was required to see and ‘interview’ as part of access to the village – I ignored those interviews since they had very little to do with the work and more part of the village protocol.

⁷⁷It customary in Zimbabwean African culture to converse for a while about many other unrelated issues before embarking on the subject – sometimes my interviewees digressed a lot in the middle of the interview – I thus removed all the unnecessary information

2. **Data Display:** This is an important aspect where I needed to display my information in an organized and compressed way that allowed me to make verifiable conclusions (Denzin and Lincoln, 2005). Readily, since I had 3 specific groups – infected, affected and normal, data was put into the appropriate files with each student's work already compiled into a folder of its own. I then followed the steps below:

a) First, I read through the interviews and observation transcripts several times to get an overall sense of the data (Creswell, 1994) and develop categories and relationships in the process. I then created organizational categories - what McMillan and Schmacher (2001) call 'topics' - which are broad issues that are part of my research questions. For example, I had organizational categories of students' experiences at school, at home and in their immediate community; the caregivers' perceptions of the student's schooling experiences and lastly, what the community leaders' perceptions about the schooling of the students in question are. These acted as 'bins' for sorting the data for further analysis.

b) Using a ground theory approach together with patterns and codes developed in my conceptual framework, I read through my data repeatedly to look for patterns, themes, clusters and contrasts. I used coding to 'fracture' (Strauss, 1987:29) the data and re-arrange them into categories that facilitate ease of access to the data. I divided the table into 3 main subheadings – the school, the home and the community – under which I noted emerging themes. Opposite each noted emerging theme is where the data is located (or which method I used to collect the data) – this was easy for me to then find the evidence that supports the emerging themes.

School	Data	Home	Data	Community	Data
Learning Experiences	Children stories Photos Sociograms Observation Interviews teachers, caregivers	Scant attention from caregivers	Interviews, stories, drawings	Ignorance/lack of knowledge	Interviews with community leaders and teachers
Social and Emotional Support - friendships	Sociograms Stories Interviews Drawings Observations	Demanding Work schedules	Timelines, Interviews, interviews with children and caregivers	Lack of planning	Interview with education officer and AIDS organizations in the city
Anxiety – from watching own parents dying, not knowing what to expect next	Stories Observation Interviews teachers, caregivers	Fractured families	Stories, drawings, sociograms, interviews with teachers, children, caregivers and community leaders	Stigma – sick parents stay inside doors all the time – fear of victimization/shame	Interviews with community leaders and caregivers
Stigma – unaffected and orphans vs. infected; verbal, emotional and physical abuse	Observations, Interview with teachers, caregivers and children	Increased Family responsibilities Tension in caring as roles change – diversion of labour to caring; health and transport cost; job discrimination	Interviews with kids and caregivers	Enculturation problems	Interview with community leaders, caregivers
Real and imaginary scenarios	Drawings, Stories, Interviews	Increased anxiety – as some caregivers get sicker	Interviews with caregivers and children		
Poverty – school fees, materials, uniform	Observations, interviews with children, teachers, caregivers	Abandonment abandonment issues due to multi-roles of caregivers	Interviews with children, caregivers, Drawings		
		Overmedication	Caregivers		

Table 3.2 Organisation of data for analysis

Once my data was appropriately reduced, displayed in categories and coded into patterns, themes, clusters and contrasts - inside matrices and arrays, I was ready for the final section:

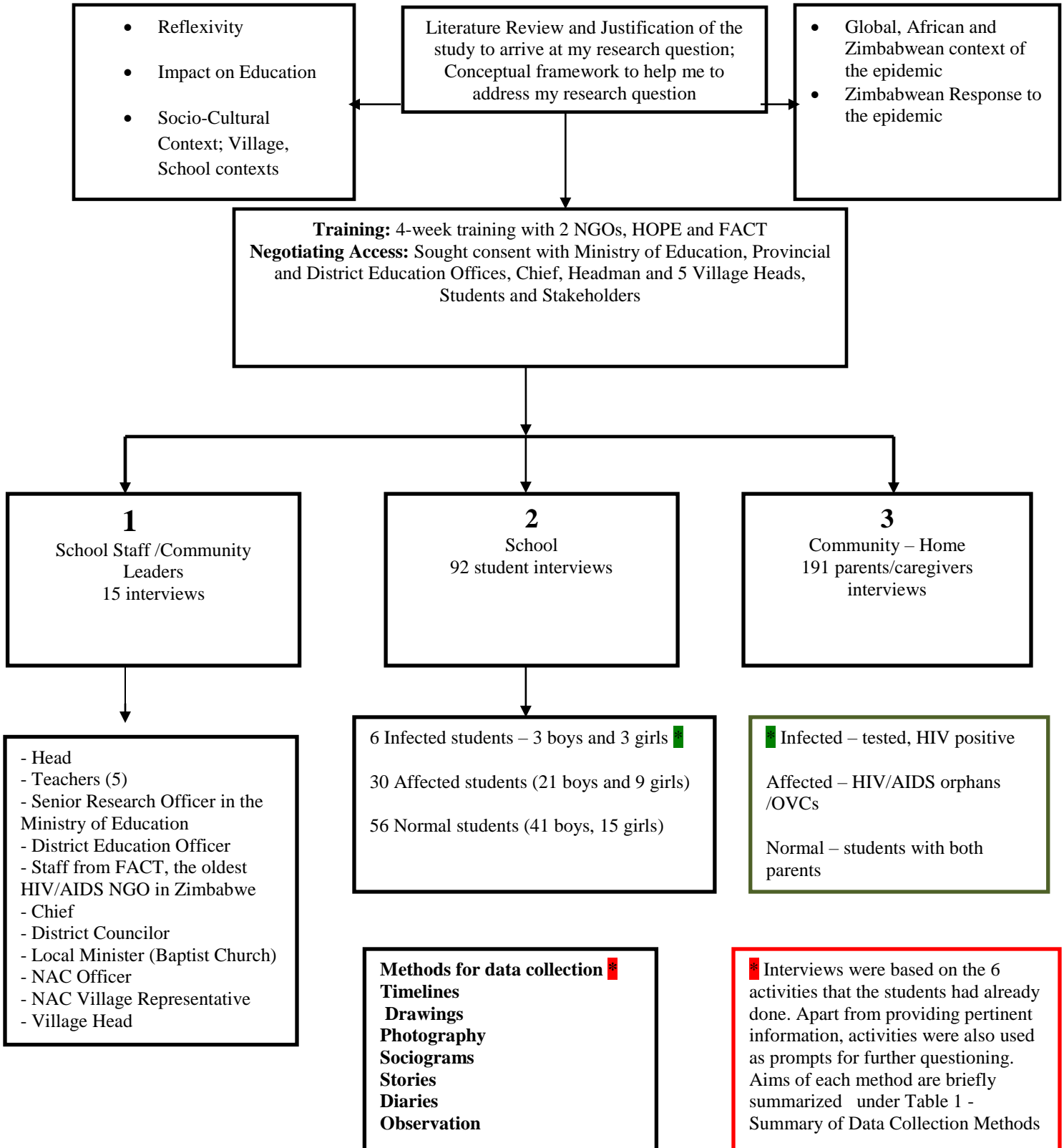
4. ***Conclusion drawing and verification:*** My results and discussion section is a 'descriptive narrative' (Creswell, 1994) about the experiences of my participants, noting the emergent themes, contrasts and patterns. I 'compared results with patterns predicted in theory or literature' (Creswell, 1984:156). Throughout the writing process, I try to maintain a chain of evidence – to ensure that the evidence fits the questions; the principle being to allow the reader of the case study to follow the derivation of any evidence from initial research questions to ultimate case study questions. My narrative attempts to make sufficient citation to the relevant portions of the case study database; the goal is to treat the evidence fairly, to produce compelling analytic conclusions and to rule out alternative interpretations. I concur with Yin (1994: 92 – 95) that my 'data, upon inspection, should reveal the actual evidence' implying that my data display should be transparent and easy to access. I collected a lot of information within which a large number of features were analyzed resulting in a descriptive narrative. Below is my research timetable – specifying what was done when and the appropriate schedule interviews.

Date	Activity
Part 1 August 2010	Consent paperwork with the Ministry of Education in Harare, with the Provincial Education Office in Mutare and with the District Education Office in Chimanimani
	Consent with Village Stakeholders, Students and Parents – travelling to villages
	4-week training with HOPE and FACT (NGOs)
Part 2 September – December 2010	Ministry of Education: Interview with Senior Research Officer in the Ministry of Education; 2-day internship at the Ministry to look at HIV/AIDS Policy and the curriculum; the ongoing work with UNICEF on infected and affected children and HIV/AIDS <i>Schedule 6</i>
	<ul style="list-style-type: none"> - Observations and Interviews with 92 students <i>Schedules 1-3</i> - Interviews with 5 teachers and the Headmaster <i>Schedule 5</i> - Interview with parents/ Caregivers (161 adults) <i>Schedule 9</i> - Interview with the Baptist Minister <i>Schedule 8</i> - Interview with Chief and City Councilor <i>Schedule 7</i>
Part 3 December – February 2013	Transcriptions leading to data analysis, Write-up and submission

Table 3.4: Data Collection Plan, Transcription, Analysis and Write up

Below is a graphic representation of my research design:

Figure 3.1: Graphical Representation of the Research Design



Quality Issues

Stake (2000:443) aptly points out that information from an investigation ‘faces a hazardous passage from the writer to the reader...*and that* the writer needs ways of safeguarding the trip.’ In the next section, I will thus discuss the pertinent issues of trustworthiness (quality), how I made attempts to ensure the validity, reliability and the generalisability of my research.

Internal Validity

Internal validity refers to how congruent the findings are with the reality and the credibility of the explanation (Merriam *et al*, 2002; Maxwell, 2005). To establish internal validity, I triangulated my data (Yin, 1984) by using intensive interviews from my participants, their teachers and caregivers and other stakeholders in the community. Quoting the participants’ actual words as part of the report, I believe, brings strength in validating my research. Through my analysis, I used ‘verbatim transcripts *from the taped* interviews’ (Maxwell, 2005:110). These interviews added to my personal observations, allowed me to compare information that was communicated to me with that which I observed. I made extensive use of member checks (Merriam *et al* 2002) whereby I took my analyzed⁷⁸ interview and observation notes back to the Head at the school to check if the tentative findings were credible. Cross-checking with the Head, though helpful at times, was mostly ineffective since he was not aware of what most children think about in his own school. An employee from Hope (an AIDS Organisation that works in the village with children outside the school), was helpful in cross-checking my information about events and material outside the school. I also did a form of peer review with a fellow graduate student who looked through the given data in my final write-up to see if it corresponded with the given explanations. This, however, has also been achieved through my Supervisor who has looked at the final report of my findings. Another way to ensure internal validity is through reflexivity – being able to give a detailed explanation of where

⁷⁸ I analysed my information on a daily basis so that I can take note of irregularities; it also helped me to know how to proceed with subsequent interviews where I needed certain data either clarified or enhanced.

I stand as a researcher will help the reader to understand how I arrive at certain conclusions (Lincoln and Guba, 2000). A greater part of this has been addressed in the introductory chapter. Another way that I maintained internal validity was to spend as much time as I could in the field such that the ‘data and emerging findings *became* saturated’ (Merriam *et al*, 2002), that there was no new information emerging. This was made possible by being able to stay in the village of my research for a continuous period of four months. Becker (1970, quoted in Maxwell 2005:110) concurs that ‘both long-term involvement and intensive interviews enable you to collect ‘rich data’, data that are detailed and varied enough that provide a full and revealing picture of what is going on’.

Reliability

Reliability refers to whether the research findings can be replicated. This is not possible in Social Science research because of people’s experiences which can change over time. I prefer thus to use Guba and Lincoln’s definition of reliability in social sciences which aims to look at ‘dependability’ and ‘consistency’ of the research instead (Guba and Lincoln, 1985). The question then to ask is whether the data and given explanation are dependable. I believe that I was able to achieve reliability through the various ways already outlined under validity above – triangulation, member checks, peer review and reflexivity. In addition, however, Dey (1993) suggests an audit trail whereby I show the reader how I collected my data, how I arrived at the various categories for analysis and how I carry out the inquiry- these have been discussed at length in the methods section.

External Validity or Generalisability

At the outset, generalisability is not possible in social research because small samples are collected ‘purposefully precisely because the researcher intends to understand the particulars in depth and not find what is generally true of the many’ (Merriam *et al*: 2002:28). I think, though, that my research contains aspects that can be used in certain studies that have some similarities to the conditions under which mine was undertaken - akin to what Guba and Lincoln (1981) describe as the transferability of conclusions from

one case to another *as* a function of similarity or ‘fit’ (Guba and Lincoln, 1981; Schofield, 1993). My research will, therefore, form what Cronbach (1970) rightly calls a ‘working hypothesis’ in the sense that due to its localized nature it cannot be conclusive, yet it can be improved and parts of it can be applied to certain situations that have similar conditions to those under which the research was undertaken. Walker (1980) also points to ‘researcher or user generalisability’ whereby the user (or reader) determines for themselves to what extent they can use the findings in one study in a different context. I believe that my work, with certain limitations as will be discussed below, has produced a wealth of information that can be applicable to other rural parts of the country, particularly in the northern rural areas of Zimbabwe where the socio-cultural environment amongst other factors seemed to be largely the same. Having done the main things that will ensure, as far as is possible, that the trustworthiness of the research is maintained, an integral part to that process is the cognisance of the ethics within which the research was done, discussed below.

Ethics

Denzin and Lincoln point out that ‘because the objects of inquiry in interviewing are human beings, extreme care must be taken to avoid any harm to them’ (1998:70). This relates even more so to the population of infected and affected children in my study. Punch (1986) suggests that ‘as field workers, we need to exercise common sense and moral responsibility...to our *participants* first, the study next and to ourselves last’ (Denzin and Lincoln, 1998:72).

Protection from harm, therefore, whether physical or emotional, was uppermost. To avoid infected and affected students being stigmatized, activities included all 92 students in both classes as noted earlier. In the event that a student became either uncomfortable, looking distressed or seemed like they were experiencing harm (emotionally or otherwise) during the interview, I asked if they wanted to end the interview immediately or have a short break. This only happened with one infected student and she did take her break for many days and then volunteered to continue. Students were also reminded that

they could stop the tape recorder at any point. If counselling had been requested or simply needed I had a Counselor from a local NGO at hand who had agreed to provide the counselling (BERA, 2004).

In the event that a child became ill, as was likely to happen with infected students, I had asked permission to have them seen by a Nurse⁷⁹ who is already known to the students and is acquainted with their condition. The Head of the school who regularly monitors the students had also offered to be of assistance as well. Parents of the infected students knew that the nurse was going to be providing medical help as needed according to their existing routine.

Informed consent – ‘consent received from the subject after he or she has been carefully and truthfully informed about the research’ (Denzin and Lincoln, 1998: 72) - is always problematic with children; it is not always clear to what extent children might be considered 'informed' (Lindsay, 2000). In the Zimbabwean culture, particularly in the rural setting where I was conducting my research, children are taught, from very early on, to do as they are told. My participants, thus, could have simply given consent as a duty to their caregivers. I had to make it very clear to them, by repeating the request, that they had a choice and most importantly, that they could pull out of the research as and when they wanted to. Initial ethical approval was requested from caregivers, teachers, the Head of the school, the community elders and the chief, on my behalf by the NGO leader from Hope who introduced me to the school. On arrival at the village, however, I had to seek consent in person.

Anonymity and confidentiality: Participants could maintain anonymity by using pseudonyms. This was problematic with most children wanting to use their own names – they wanted it to be known that they made a contribution to the study. Some simply did not understand the concept but they did all eventually have fun with finding their own pseudonyms. Since participant observation invades the life of informants and sensitive information is frequently revealed (Creswell, 1994:164), I maintained confidentiality by

⁷⁹ The nurse was married to the Head at the school and had already been working with all students at the school when needed

making sure that what my participants told me was not be related to anyone. Privacy was paramount. All interviews were private and no information was shared with anyone else. A class was provided where I could have individual interviews with students. Interviews, though private, were conducted in a space that had windows so that no allegations could be made about being alone with a child. Interviews with adults in the village posed a challenge due to lack of private space, I made an attempt to be as far from other people as possible i.e. I held interviews in the field away from the kids and others if the parent/caregiver was comfortable with that arrangement. No interviews were to be given to a child without the child's permission and also, that of their parent or caregiver.

Storage of information also needed to be protected. My digital interview scripts were password protected on my computer. My written notes and materials from students were collected as soon as students were done and locked into a suitcase. All the information will be used solely for research and I will ensure that the 'form of any publication, including publication on the internet, does not directly or indirectly lead to the breach of agreed confidentiality and anonymity' (BERA, 2004).

Risk Assessment

As part of avoiding harm, I had to think of various scenarios that could take place in the village, posing a risk to myself as a researcher, my participants and others in the village at large. A lot for risk was averted by the fact that I am from Zimbabwe and was thus aware of the general environment and being able to speak various languages fluently (I speak 4 main languages spoken in Zimbabwe) was useful in many ways. Below I will discuss a few scenarios that had potential to pose challenges and the possible solutions that I had planned.

The possibility of community disruption: Even though I am Zimbabwean, I was treated as an outsider because I grew up in the city for the greater part of my adult life, have lived abroad and also, I am a university student (though this was not much of a factor as most people in the village did not know much about universities and what they do). It was my presence that could have been disruptive to the community spirit as I could have been

suspected to be wealthier than others – an abhorred characteristic in the village. In the village, community cohesion is maintained by being the same and not trying to rise above the others. I had more access to the Chief. This was likely to upset some men in particular who still had to go through more than one headman to see the Chief. After my first month in the village, I had been granted permission to see the Chief by going through only 2 (instead of 5) middlemen in the protocol. In the village political affiliation is one of the ways people identify each other and the ‘in-groups’ within the village. I sensed that the village was almost evenly split between the two largest parties (ZANU PF and MDC). Choosing one over the other would have alienated me from a lot of people in the village.

Possible Solutions: The first time I entered the village I had already been warned to avoid any show of wealth. I was thus advised to keep 3 shirts and a pair of pants – which I did. That seemed to work well as far as avoiding the perception that I was the wealthy man in the village. I had previously thought of using a vehicle to cover the long distances to interview parents, caregivers and others, but that would have been a bad idea in the light of the above – therefore I simply walked everywhere like all the villagers. Also, once I was in the village, the rugged terrain was such that a vehicle would have been ineffective. Concerning access to the Chief - despite knowing that I only had to go through 2 people to get to the Chief (except in times when I had been summoned), I used the same village protocol of going through the 5 to avoid being seen as ‘special’ or ‘favoured’ by the Chief, which the Head at the school advised was a good idea to avoid friction with the local men. Politically I told the Chief- and others who asked - that I was an independent (a vague concept in the village) and did not align myself with any party. After a few times of explaining what being an independent is, most simply accepted that I was not going to take sides – which seemed acceptable to most.

Sexual threat: The Head at the school had informed me that I posed the potential of being perceived as a sexual threat to women in general and married women in particular since I was a single unknown man daily present in a village where most men, as migrant workers, were absent during the greater part of the week. For the first few days in the village, I had been fetching water (and firewood) by myself and noticed that I had been

the only male at the well. Later I was not allowed to be seen by the pond to get water so various women were appointed to fetch wood and water for me (it is seen as a female occupation and men doing either is suspected to be either trying to solicit sex from women or to be gay – both of which are serious offences in the village). Interviews with women (parents) or caregivers were also potentially problematic – single men are not encouraged to be seen alone with married women in particular.

Possible solutions: The first time a woman had brought me water and firewood, I had felt compelled to pay her for what I viewed as a great service and of course sacrifice on her part. Without saying anything she had refused the money but I was later summoned by the Chief as offering money to women – which, in whatever light in the village - was seen as a solicitation for sex. Thereafter I requested, from the Chief, that women who had been appointed to fetch water and firewood for me to be sent in pairs – that way there would always be someone to witness that I had not tried to solicit sex. Knowing how far it was to fetch water and the difficulty of finding wood in this area that has seen extreme deforestation – since wood is the only source of fuel – it was not only hard to simply accept the service without paying but I found that it re-enforced gender stereotypes which I find disagreeable. When I tried to discuss the matter with the Head he informed me that disobeying the Chief meant they I could be asked to leave the village.

To maintain confidentiality, all interviews were held in open fields, so that people could not necessarily hear what was being discussed yet they were able to see us. I made every attempt not to be seen with either single or married women alone.

Relationships with teaching staff at the school: Problems arose when absentee teachers expected me to teach their classes in their absence. The Head at the school put a stop to it by explaining that I was not meant to do that – except in instances where I volunteered - neither was I allowed by the Ministry of Education to teach without their permission. The solution to that problem was thus provided by the Head and limitations placed by the Education Ministry.

Security and safety – Since I stayed in a hut for the first month (until a 6 foot long black mamba crawled in and I was moved to a small brick room) the Chief provided a person to keep an eye on the place where I was staying, particularly on the days when I was further out in the village. My security person only lasted a week since he was not paid nor was allowed to pay him. The worst that could have happened is that some people would have broken in and stolen a few clothes. The issue of snakes in the village – there are a considerable number of poisonous snakes. Even though I was not bitten, I knew of 2 people who were fatally bitten. I was not very well prepared for the situation since the clinic was about 15-20 km away from the village⁸⁰.

Limitations

One of the limitations already discussed is limited usability of this study since at most it can only be applicable to studies that have the same ‘fit’; as a case study, it cannot be generalised. In using member checks, in order to avoid further stigmatisation of students, I was limited to the Head who was aware of infected students. Confidentiality, to an extent, was compromised by the lack of privacy; even though interviews were conducted in the open field far away from people in the vicinity, there was always a slight chance of voices carrying and thus conversations being overheard. In interviewing caregivers, even though the few men that I met did not possess a lot of information about the students - simply because they were often away and so we not conversant with what happened at home – being able to meet more men might have provided a bit more information. The very long distances to homesteads to interview parents and caregivers meant that some cases where I had been invited to return to interview the male guardian were simply impractical. The Chief, Teachers at the school and the Baptist Minister all made it very clear that there was to be no mention of sexual matters – either suggested by me or volunteered by the students. These issues are further discussed in Chapter 6, ‘Reflections on the Research Process and Limitations Thereof’.

⁸⁰ Once there was a cobra in the outhouse which I only really noticed once I had taken my clothes off to take a bath from a bucket. I immediately left the room – naked – simply out of shock. Once again, I was summoned by the Chief who had been misinformed that I was walking to and from the outhouse naked – the reason for stepping out in such a manner had been diluted and finally forgotten as news passed from one person to another on its way to the Chief. The abundance of snakes was due to snake poachers who often released the snakes to get rid of the evidence if they were about to be caught by the police.

Chapter 4

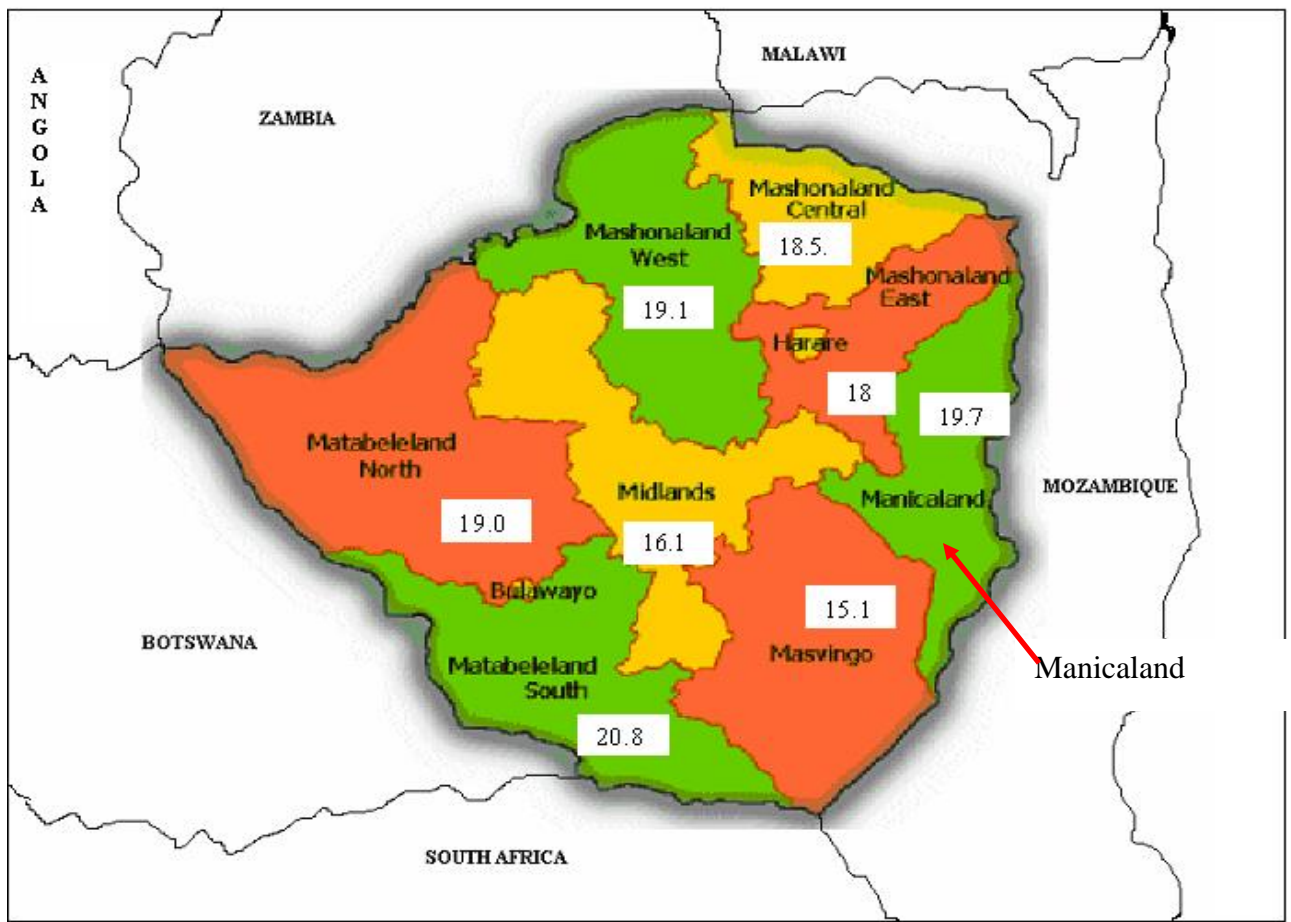
Introducing Kumakomo Village and the Kupisa School

In this brief anthropological history of Kumakomo Village⁸¹, I will relate the historical and cultural context of the Ndaу people now located in the mountainous District of Chimanimani in the Manicaland Province. First, I will describe where Kumakomo is located in relation to the whole district of Chimanimani, including statistics that are relevant to this work. I will then briefly relate how they ended up in their present location, which in part describes the poverty in the community and the distrust of outsiders that developed as a result of repeated dislocations due to civil wars and occupations; this distrust of outsiders has inherent implications for HIV/AIDS interventions. This chapter also describes the traditional Shona culture which defines the Ndaу people - this will help to set the cultural context of the immediate area of research and for the environment in which the Kupisa School is located. This history, though necessary to give the needed background, is detailed enough to make it relatively easy to identify the community that I worked with and as such, might interfere with the anonymity of those who were part of the research. In the event of a publication⁸² that is open to the greater public, I will, therefore, ensure that the necessary detail is removed so that participants remain anonymous.

The section below puts my village of research, Kumakomo, in context to the district of Chimanimani, in Manicaland Province in the eastern part of Zimbabwe. A map previously shown to reflect prevalence rates in Zimbabwe is repeated here to remind the reader of the location of Manicaland –

⁸¹ As already alluded in chapter 1, Kumakomo is the name I have adopted for the village in which the school of my research is located for anonymity. Similarly, the pseudonym for the school is Kupisa

⁸² My PhD manuscript has since been accepted for publication by Cambridge Scholars Publishing



Map 4.1 Location of Chimanimani District in Manicaland

The Chimanimani⁸³ Rural District Local Authority (CRDLA) has a population of 115,250 comprising of 55,433 men and 59,819 women. It has an estimated population of 16,921 orphans, of which 2,378 are maternal, 10,696 paternal and 3,847 are double orphans, as indicated below in Table 4.1 (CRDLA, 2010).

⁸³ The mountainous Chimanimani, is one of seven districts of Manicaland. The Chimanimani Rural District Local Authority forms the administrative centre for all the villages in the Province

<i>Orphan hood status (children under 18)</i>	<i>Chimanimani n(percent)</i>
Total Population of children under 18 in District	55,462
Maternal Orphans	2, 378 (4.3)
Paternal Orphans	10,696 (19.3)
Both parents deceased	3,847 (6.9)
Total number of orphans	17,194 (31 percent)

Table 4.1 District Orphanhood Statistics CRDLA, 2010

It is known that 126 school-going children (72 females and 54 males) are living with HIV/AIDS in the Chimanimani District (NAC, Chimanimani, 2010). Manicaland as a Province, as already seen in Chapter one, has the second highest HIV prevalence rate of 19.7 percent after Matebeleland South with 20.8 percent.

Kumakomo has a population of 1070 (Sabhuku, 2010). It is also part of a ward (i.e. group of villages) that comprises 5 villages, which makes for a total population of 3,482 (MDT, 2010). The ward population comprises of 1,692 males and 1,790 females (*ibid*). The ward is serviced by one under-resourced clinic that is 15 kilometres from the village centre (Nurse Tinofa, 2010). Even though there is no breakdown for the number of boys and girls in the population figures given, the ward does disaggregate the number of single and double orphans within the village. This is displayed below in Table 4.2

			Single orphans		Double orphans		Total
Village	No. of households	Population (for the whole village)	Boys	Girls	Boys	Girls	
Village 1	55		13	4	3	1	21
Village 2	60		9	12	2	4	27
Village 3	58		7	2	5	4	18
Kumakomo	290	1070	28	44	3	1	76
Village 5	302		11	16	1	2	30
Village 6	315		12	32	23	13	80
Total	1080		80	110	37	25	252

Table 4.2 Orphan statistics for the Ward (NAC, Chimanimani, 2010)

The school of my research, Kupisa, located in Kumakomo has 15⁸⁴ infected children in various grades, which accounts for 11.9 percent of all the cases of infected children in the district. The six infected students in both Grade 6 classes will be involved in my study. Kupisa School has 63 percent (159) of the total orphans in the ward, with another 26.5 percent (67) attending a smaller school also in the same village. The remaining 10.3 percent (26) are out of school (Chikavanga, 2010)⁸⁵. A further breakdown of orphans in Kupisa will be discussed under the introduction of the school later in this chapter.

⁸⁴ The total official number of infected children used to be 19 at the beginning of the year but 4 girls from grade 6 dropped out in the first term leaving 15 (Head, 2010).

⁸⁵ Chikavanga, elderly volunteer, is the Ward Coordinator for the National AIDS Council in Chimanimani and her main role is to collect and update the statistics on orphans in the Ward.

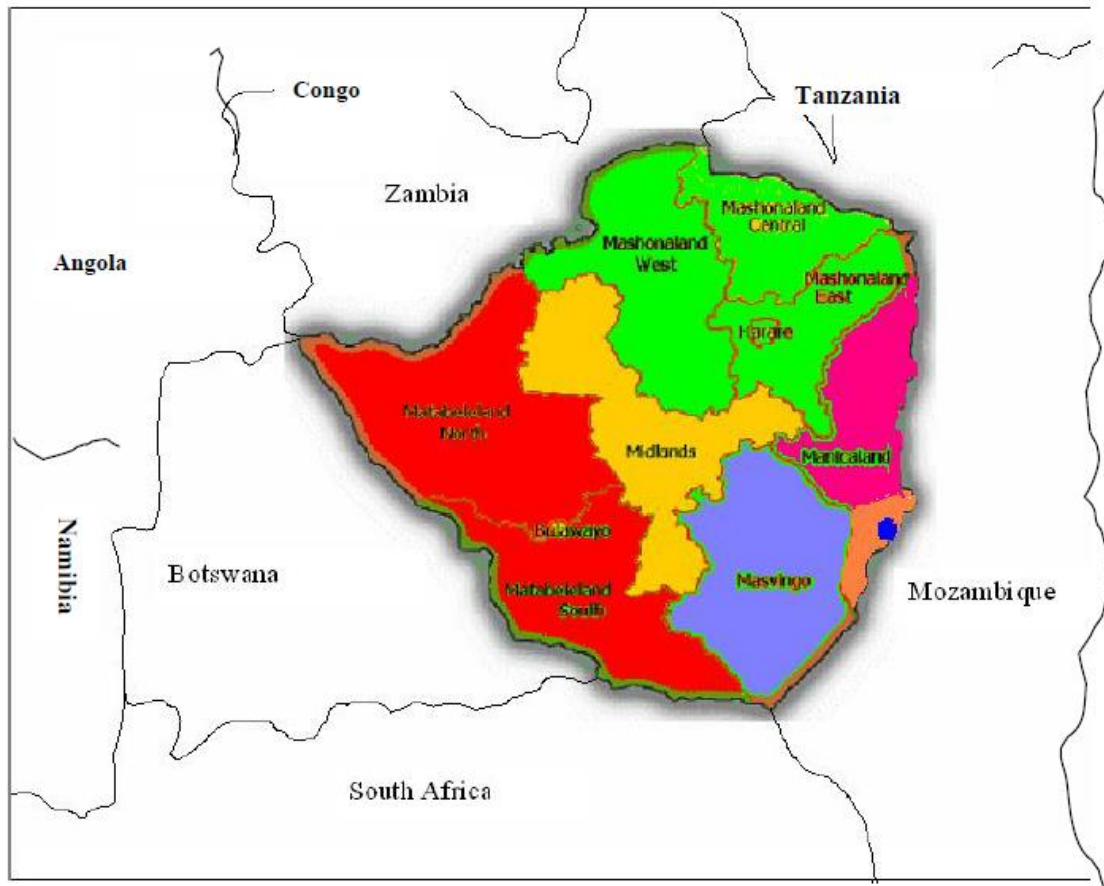
A brief overview of Shona History

Most Shona history, particularly its very early origins, has been pieced together by archaeologists from artefacts gathered together from various historic sites around Zimbabwe. Some of the artefacts were from the Portuguese settlers in East Africa who traded with the Shona, while other accounts are from British Missionaries who arrived in Zimbabwe in the early 1800s. Still, other aspects were passed down through oral history. The Shona originated from Bantu settlements between the tsetse-free and rich mineral (gold, copper and iron) plateau between the Limpopo and Zambezi rivers. The Bantu came from the Bushmen, the Khoisan hunters and gathers who later decided to become agriculturalists when they discovered that it was easier than wandering around. In the plateau, the Shona lived along rivers and waterways in large villages where they farmed millet and kept sheep, goats and cattle (Mukanya, 2008). They familiarised themselves with iron smelting from which they made their farming implements (Bourdillion, 1985)⁸⁶.

The improved economy led to a larger settlement with the result that clusters started to form. The name Shona, therefore, refers to the different groups of people who began as the Karanga and started speaking different dialects of the language as they moved from place to place. Thus, the Karanga, the Zezuru, the Manyika and the Ndau are called the Shona and their culture is similar with minor differences (Bourdillion, 1985). The Ndau were constantly displaced due to tribal wars.

The Shona spoken by the Ndau has Ndebele undertones, which makes it markedly different from the other Shona dialects spoken in other parts of the country. Being able to speak both Shona and Ndebele made it relatively easy for me to adjust to the Ndau language. A map below shows the main regions where the different Shona dialects are spoken –

⁸⁶ There was, therefore, evidence of developed ways of farming and smithmanship that was rather interrupted in 1890 at the arrival of the colonial powers. After the invasion black people were moved to infertile lands where their farming patterns were disrupted and hence, their development in their own ways of farming – as shall be seen later.



Map 4.2: Shona dialects and regions (Adopted from www.google.maps/zimbabwe, accessed November 2008)

	Zezuru		Ndau		Ndebele
	Manyika		Karanga		Ndebele/Shona
	Chimanimani				

The aridness of Kumakomo Village⁸⁷, which partly explains its poverty, means that even subsistence farming is scarcely enough to feed families. Due to few opportunities for employment in the village, migrant labour is very high since most men have to travel to the nearby town of Mutare, which is more than 180 miles away. There is also high

⁸⁷ For example, it is not uncommon to have temperatures of 40-45 degrees Celsius in the summer months (Mukanya, 1998) and annual rainfall of 600mm, far below the country average of 1700 mm (Metrological Services Zimbabwe, 2008)

migration into neighbouring Mozambique to look for work. Locally, the forestry commission provides lots of employment but suffers from lack of consistent transport⁸⁸ and so workers tend to stay at the location for 2-3 weeks before returning home (Mhakwe Development Trust (MDT), 2010). The migration to Mutare, Mozambique and other places for work has contributed to the high HIV/AIDS prevalence rate of 35 percent in Kumakomo (National AIDS Council (NAC), 2010); Mutare is pegged at 37.7 percent while Buhera, another rural village in Chimanimani, counts 50 percent prevalence (NAC, 2010).

On confirming aspects of this history with the Chief, the Headman and Head of the school at Kumakomo, I discovered that the constant displacements due to civil wars and colonization created a lasting distrust for almost any group that comes into the village from the outside. The chief related how invasions by the Zezuru, their own people, before the British even arrived meant that their group could never be safe and oral history has been passed along maintaining this distrust of outsiders; *'the people (meaning outsiders) and whatever they bring cannot just be accepted because from long ago we can never know their intentions'* (Chief, Interview October 2010)⁸⁹. After independence with expectations of things getting better thwarted cemented the distrust of all who came from outside the village. That this distrust extended to whatever the outside groups brought has serious implications for HIV/AIDS education; the message that they bring to the village might not be trusted due to a past that left the community distrustful. I found out then, that my welcome into the village was mostly due to two factors: first, the man who introduced me to the school (and the village) was born and bred there and still has a home in the village. It was upon the strength of his recommendation that I was even considered to stay among them. Secondly, the Head of the school has grandchildren who are infected and so he was interested in the work personally. Other than that my entry into the village might never have happened or could have been made very difficult at most. Discussing

⁸⁸ Transport in and out of the city is in the form of two minibuses that depart from 4:15 and 5:30 in the morning and take about 4 hours to get to Mutare – the capital city in the province where most men work. The buses leave Mutare between 1-2 pm to make the journey back. If one misses either of those two mini buses they would have to wait until the next day to get transport back home. Those who have jobs in the city and mines around the Province tend to stay between 2-4 weeks, usually coming back to the village when they have been paid.

⁸⁹ *vantu vashona nezwinu zwavanuhunza azwingo tendwa nokuti kubvira kure hatizive chinangwa*

with the Head at a later time, he informed me that staying in the village (as opposed to staying in the city and then occasionally coming to the village to conduct my research) helped to develop trust much quicker; people, he said, were able to identify more with me being part of everything that happened in the village – attendance at the funerals, church, the meetings called by the chief and walking the same long distances that the students walked ‘*made people believe that you really wanted to know how we live first and that we also know things*’ (Head, October 2010)⁹⁰.

It seems that if any programs are to have any chance of success, a constant presence in the village, building trust and constantly listening very closely to their fears, expectations, concerns and building on some of their own knowledge becomes indispensable. For real access into the community that may lead to the adoption of ideas to deal with the HIV/AIDS epidemic in its various forms, a clear understanding of the cultural context – to be discussed next - is fundamental to the process of change. Since culture can mean a lot of different things, I will adopt Taylor’s definition of culture as ‘that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society’ (Taylor, 1871:1 In Gausset, 2001:510); further simplified by Nanda as ‘the patterned way of life shared by a group of people’ (Nanda, 1987:68 In Gausset, 2001:510).

Traditional Shona Culture

As already shown, Kumakomo village lies within the Shona-speaking people of Zimbabwe, whose culture will be discussed next. In describing the traditional Shona culture practised by the Ndau, I will rely on 1) my experience as a Shona-speaking person who was raised in that culture and with communications with Head at Kupisa School who is conversant with the culture; 2) the writing of Mukanya (2008), a Zimbabwean who writes textbooks for Zimbabwean schools; 3) Bourdillion (1985) and Gelfand (1979), anthropologists who have both lived in and written books on Zimbabwe. This will help in giving a background of the rural culture where I conducted my research. The implication

⁹⁰ ‘*zwakaita kuthi antu atende kuti munoda kutanga madzidza magariro edu nokuti pane zwatino zwiva wo*’

for HIV/AIDS in this section is that a clear understanding of culture emerges as central to interventions of any kind (Airhihenbuwa and Obregon, 2000). It also presents us with a conundrum: the strong patrilineal nature of Kumakomo means that any program that needs to be introduced in the village will have to be through men, which reinforces gender inequalities. The models of communication about HIV/AIDS will thus have to be carefully thought through for both access reasons and equality purposes. In discussing the culture of Kumakomo, however, I sought to understand their culture as it stands and not see the whole culture as a barrier and by implication the cause for the spread of the HIV/AIDS epidemic. The discourse about 'cultural barriers' needs to be reconceptualised so that African Cultures are not perceived as the problem to the spread of HIV/AIDS and its related problems but rather, safe sex within the different aspects of it; this would allow us to have a more holistic outlook that includes socioeconomic factors amongst others (Gausset, 2001; Airhihenbuwa and Obregon, 2000). I will briefly discuss:

- Patrilineal kinship and how relationships are conducted therein
- Shona marriage
- Inheritance laws
- Sickness and Personal misfortune
- Witchcraft
- Death
- The Village – what it means and the hierarchy of leadership within

Patrilineal Kinship

In rural Shona villages, communities are based on patrilineal kinship: kinship through males is how relations are maintained and sustained. Patrilineal kinship names are distinguished by generation, age and sex, not by genealogical distance. For instance, the term *baba* (father) can mean the father's brother or any other man in the patri-clan belonging to the father's generation. My father has 5 brothers and all of them accept the term 'baba'. When talking to a stranger I would usually differentiate by calling my own father *babavangu* (my father), *babamnini* (young father) for those brothers who are younger than my father and *babamkhuru* (big father) for those older. My father's cousins can also be referred to as *baba*. In working with the orphans who have a remaining father

it was important, therefore, to ascertain which *baba* they meant - whether they meant their biological father or the father's brothers or cousins. Similarly, all women who are in my mother's generation and belong to her lineage can be called *amai* (mother). Here again, it was important to make sure whom the students were referring to exactly.

An aspect of the patrilineal nature of the Shona culture, however, means that men have unyielding power over women in general and their wives in particular. As I travelled to the villages to seek consent to work with families and their children, it was not uncommon for wives to defer granting permission to their husbands. In families with deceased fathers, permission had to be sought from the grandfather or the nearest male relative - '*in all things you first ask the father or the men in the family*'⁹¹ (Head, 2010).

Children (both boys and girls) are socialised into roles where women are seen as subservient (Leach and Machakanja, 2000; Head, 2010). This power that males have, added to the fact that most men in the village travel afar for work, contributes to the spread of HIV/AIDS as wives cannot say no to sex with their husbands even if they suspect that they had been unfaithful and had become infected (FACT workshop, 2010). Health workers at the FACT workshop spoke about the uselessness of condoms in the village since women could not even suggest it to their husbands (*ibid*).

Shona Marriage

Shona marriage is essentially an agreement between two families, those of the groom and the bride to be (Gelfand, 1979). The groom pays *roora*⁹² (the bridal price) in terms of cattle and/or goats which are usually provided in part by his father (Gelfand, 1979). Virgins, which girls are culturally expected to be at marriage, command very high *roora* and women who already have children can have the *roora* drastically reduced (Bourdillon, 2005). Children belong to the paternal family (Drew et al, 1996). The Head of the school informed me that virgins were also in demand for other unfortunate reasons

⁹¹ *parizvosve munotanga mavundza baba kanakuti varume vemusha*

⁹² Roora is a token of love, pride, gratitude and pleasure that a wife has been won and comes to the man.

driven by the myth that they can cure HIV/AIDS⁹³. He informed me that it was partly the reason why most young girls were being married young by older married men (Head, 2010).

Barika (polygamy) is still common in Kumakomo. It is not uncommon for a husband whose wife has a couple of children and is getting old to take a second wife. Gelfand (1979) notes that at times the wife actually advises whom she would like to be adopted into the family as the second wife. The chief related that this will remain for a long time since there are more widows with more men either dying from HIV/AIDS or disappearing to other countries in search of work and never returning (Chief, Interview, October 2010); *those with jobs and livestock could remain widowed but what about those with nothing? Also, one who has lost a husband sometimes must give everything to the in-laws*⁹⁴ (ibid). This practice is likely to remain for a long time in Kumakomo because of the economic inequalities of women and inheritance laws. Gausset (2001) warns against readily thinking of eradicating polygamy because it is likely to spread HIV/AIDS more than monogamy since safe sex in either relationship arrangement is what is more important.

Inheritance

In the event that the husband dies, the wife, the children and all the property are passed down to the brother or patrilineal cousin. This is called *kugara nhaka*. Despite the onset of HIV/AIDS, *kugara nhaka* is still practised⁹⁵ widely in this Ndau village, though a slight drop is expected due to the occasional campaign by government health workers on why it is no longer a good idea because of HIV/AIDS (Sabuku, 2010).

⁹³ Meel (2003), writing about 'The Myth of Child Rape as a Cure for HIV/AIDS in Transkei' points to similar problems in South Africa – where, even worse, the myth also leads to babies being raped.

⁹⁴ Direct quote in Shona: *anemabasa nezwifuyo anogora kugara chete nevana vake asi asina odi? Izvo anenge afirwa nemurume dzimwe nguva anofanirwa kwendesa zunu zvoswe kuvabereki vemurume*

⁹⁵ In 1994 Drew et al (1996), conducted a study to examine the cultural practices associated with death and their impact on widows and orphans in 211 families in the Nyanga North area of Zimbabwe. They found that 30 percent of the 211 families claimed that *nhaka* was still practised.

Children

Great effort goes into bringing up a child (*mwana*). Discipline is very strict from a very early age, so most Shona children are very well-behaved. Much stress is placed on the dignity and respect (*rukuzdo*) of elders and others. It is generally accepted for any adult to discipline a child in lieu of their own parents or close relatives. Part of this strict discipline entails children not speaking back to parents and also, not asking them questions. Since the latter sometimes is confused with the former, children are expected to be seen and not heard. This, unfortunately, is carried over to the school which tends to hinder discussions between teachers and students and affects the development of critical thinking skills. For my research, this was a potential challenge as some children, trained only to listen, were suddenly expected to share about their lives. Fortunately, my teaching experience, coupled with my training in research during my MPhil allowed me to design a well-constructed constructivist methodology that enabled me to work together with students to give them a voice which resulted in students speaking and sharing at length about their experiences.

The extended family teach the child about honesty, truthfulness and the most important goal in life: marriage. Boys are taught about sex by uncles (*sekuru*) and girls by their patrilineal aunts (*vatete*). The Chief in Kumakomo, who was not at all aware that there was no sex education provided at school, informed me that this ritual of educating boys and girls about sex from uncles and aunts had become rare; that children either get educated about sexual matters at school or fend for themselves (Chief, Interview, October 2010).

As they are growing up, girls and boys have marked expectations (FACT workshop, 2010). Girls are expected to do more chores from as early as 7 years old to ready them for marriage. They are mostly expected to get married soon after turning 18 for those attending school and as early as 14 for those out of school. They are also expected to be virgins at marriage, both to command a high *roora* and also to avoid the impression that they have been promiscuous, which brings dishonour to the home. Part of the sex

education provided by *vatete* (patrilineal aunts) when available is that they should never say no whenever their husband require sex (Sabuku, 2010). Before marriage, they are expected to be home before dusk. Girls are expected to go to school as far as high school (or finish earlier depending on the resources at home – which will be transferred to the boys in the family if a choice has to be made). Marriage before 26 is highly desirable before the girl is suspected to have been visited by a female spirit i.e. suspected of being lesbian (Runganga, 2001).

Boys, on the other hand, are not expected to do as many chores but are expected to help with ‘manly’ duties of looking after the cattle, learning how to build a home and to prepare to be a good husband when the time for marriage comes. They are expected to be educated as much as is possible. They are expected to have sex with many girls as they grow up (Pattman and Chege, 2003). Gender inequalities are therefore instilled very earlier in life in Shona culture which prefers male dominance over women (FACT workshop, 2010).

Sickness and Personal Misfortune

The Shona are not concerned with fleeting illnesses like coughs and diarrhoea since they are known to pass. They are concerned, however, with prolonged or abnormal illnesses, of which HIV/AIDS is one. They believe that these are caused by bad luck, misfortune, angry spirits or witchcraft. They believe that western medicine can treat the symptoms, not the cause (Bourdillion, 1985). The *n’anga*, (the traditional healer and diviner) is usually called upon to treat the illness by communicating with the spirit world. The *n’anga*, therefore, is the first point of call, with western medicine treated as a secondary alternative. Treatment by the *n’anga* comes in different forms. At times it is a cut on the wound with an application of powder, an aspect that is suspected of spreading HIV in instances when the same blade was used without being sanitised. Here once again caution has to be practised – instead of condemning the craft of traditional medicines an emphasis could be made about using clean razors. Gausset (2001:511), noting the different discourse in the west compared to Africa, succinctly notes that

when a correlation is found between HIV and the use of modern facilities, the facilities have to be improved and made safer; but when some correlation between HIV and an African cultural practice is found, it is to be eradicated.

Failure to separate the culture from matters of cleanliness will lead to wrong assumptions that can be more disruptive than helpful in interventions.

Witchcraft

The Shona believe that witchcraft can explain all types of misfortune – from losing a job to becoming sick over a prolonged period of time. Even though natural causes are accepted, they often go to the n’anga to ask about the ‘why’ – why it happened to him at that particular time and not others, what possessed him, for example, to fall into the river. Inexplicable events and diseases are attributed to witchcraft (Bourdillon, 1985). HIV/AIDS is considered inexplicable in the village and so there is a tendency for people to visit n’angas when the symptoms set in. (Chief, 2010).

Death

Death is seen as frightening entry into the unknown but once the spirit is brought back, it is considered to be on a friendly basis with the living and it can be approached for help. The spirit is also believed to ask favours from the family by causing illness in one of the descendants. The structure of the family remains dependant on the deceased and the continued good of the community is presumed to be linked to this spiritual power (*mudzimu*). Family ancestors are believed to maintain control of the family as when they were alive (Bourdillon, 1985). The implication for families with AIDS deaths is that the *mudzimu* is not happy with the family and that they have not responded sufficiently to its request for favours. During illness, most families who believe in the *mudzimu* make a lot of offerings in the hope that the spirit will be appeased (Head, 2010). In the discussion and findings section, a stark absence is the mention of the *mudzimu* by caregivers who refused to tell the orphans about their parents’ deaths; the silence about HIV/AIDS was so deep that even a strong cultural construct was ignored.

The Village (Dunhu)

Of uppermost importance in the village is community consciousness; trying to stand out – whether by talent or wealth can be met with severe disapproval. The rich bring unpopularity and suspicion upon themselves, though this can be overcome by sharing with kin and community (Bourdillion, 1985). Despite knowing this, before I arrived in the village I was reminded during my training to avoid any show of difference or wealth as it would make the community ‘unfriendly and uncooperative’ (Head, 2010). Hospitality and kindness to strangers are highly expected from *vanhu chaivo* (real, good and mature community people). A number of extended families live in a village (*dunhu*) usually around the ‘*sabhuku*’ (caretaker of the ‘home’ who is the village head), a position that is inherited patrilineally. The *sabhuku* has the responsibility of distributing land to villagers and delegating grazing land. The *sabhuku* also settles disputes and hands complicated issues to the next person in command, the headman, who will be discussed next.

Above the *sabhuku* is a headman (*sadhunu*) who overlooks a number of villages which can vary between 5 – 12. A group of villages forms a ward. The *sadhunu* (leader of a great area) meets with the *sabhuku* to discuss areas of common interest within the villages in his area of control and handle any unresolved cases that may be pending. The headman position is also passed down patrilineally. Above the *sadhunu*, also succeeded patrilineally, is the chief (*Mambo*) who is a senior member of his clan and overlooks all the wards. The chief makes sure that all the headmen are appointed correctly and that they are managing their duties in the wards appropriately. *Mambo* is the traditional guardian of the fundamental values of *upenyu* (life) and *simba* (strength, vitality and well-being) (Bourdillion, 1985), which are both necessary for the prosperity of his people. He performs rituals during serious droughts and what the community considers to be strange events. He is a very important gatekeeper for almost anyone coming into the village to do any kind of work. *Mambo* reports to the District Administrator who is appointed by the Government. The chain of command is represented in the diagram below –

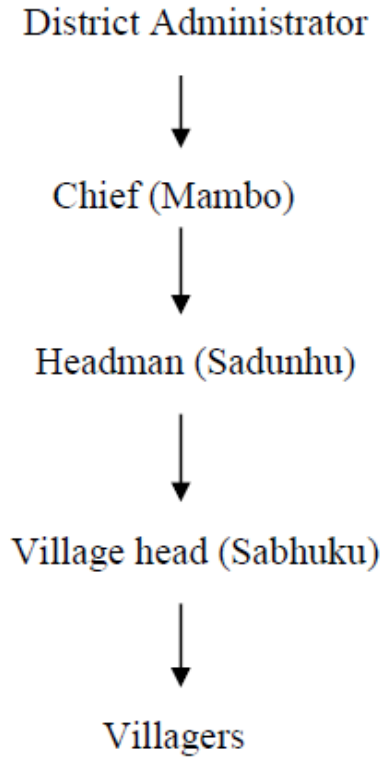


Figure 4.1 Village Power Structure

The chain of command is always composed of men. The implication is that rural patrilineal cultures that have developed a distrust for outsiders will need creative health communication models based on theories that work to earn the trust, avoid reinforcing existing gender inequalities and take the role of children seriously. The histories of these places, as part of their socio-cultural contexts, need to be taken seriously to begin to think of best ways to engage with rural populations in ways that can make a lasting difference. To be borne in mind is the

recognition of culture as central to planning, implementation and evaluation of health communication and health promotion in general...that it should be a central organizing concept in developing programs of HIV education and assessing their outcome' (Michal-Johnson and Bowen, 1992:148 quoted in Airhihenbuwa and Obregon, 2000:13)

The Kupisa School

Kupisa is thus located in the village of Kumakomo in the rural Chimanimani District in the Manicaland Province, within the Shona culture discussed above. It is about 180 miles from Mutare, the capital city of the Manicaland Province. It is a typical rural school⁹⁶ sustained by peasant farmers, most of whom are unemployed. Most of the men, as previously noted, work further afield and are rarely in the village.

Grade	Class size		Maternal		Paternal		Double		Totals		Total Orphans	Age Range
	Boy	Girl	B	G	B	G	B	G	B	G	B & G	
ECD	51	38	1	2	5	3			6	5	11	3-5
1	26	23	1	1	1	2	1		3	3	6	6-7
2A	24	23			4	3	1	1	5	4	9	7-8
2B	22	26	1	1	6	4		1	7	6	13	7-8
3A	23	22	2		3	2	1	1	6	3	9	8-9
3B	26	21	2	1	3	2	2		7	3	10	8-9
4	25	20	1	1	7	3	1	1	9	5	14	10-11
5	25	24	3	1	4	7	2	1	9	9	18	11-12
6A	30	16	3	2	4	3	5	4	12	9	21	11-12
6B	35	11	3	1	6	1	3	1	12	3	15	11-13
7A	20	20		1	1	3	2	5	3	9	12	12-15
7B	19	24	5		7		2		14		14	12-15
Special	4	9		1	2		1	3	3	4	7	10-12
	330	277	22	12	53	33	21	18	96	63	159	
Totals	607		34		86		39		159		159	
percent			5.6		14.1		6.4		26.19			

Table 4.3 Kupisa School Class sizes and related orphan numbers

⁹⁶ It was originally established by missionaries of the South African General Mission in 1911 as a preaching point but it has since grown to form a fully-fledged public school.

The fee-paying school, with 607 children from Early Childhood Development (ECD) (aged 5) to 7th grade (aged 13), sources the students from the surrounding 5 villages in the ward. The statistics above show the class compositions and the number of orphans for each grade. The two classes (6A and 6B) with whom I conducted my research have the highest number of orphans: 24 boys and 12 girls. The number of orphaned girls (44.4 percent) is very high considering that there are only 27 girls in both classes, compared to 65 boys (36.9 percent). Nine girls had already dropped out at the beginning of the year - five from 6A and four from 6B (Head, 2010). The Head (2010) related that the four infected girls had been in and out of school and did not seem to be coping well (Aikman et al, 2008). They eventually dropped out three weeks into the beginning of the first term. The other five, who are single orphans, needed to help their parents who are seriously ill and also, to complete chores at home, confirming studies noted earlier on how girls are the most affected (Rispel et al, 2006; Lewin, 2009). The home-based care group⁹⁷ had tried to intervene but were too irregular (Head, 2010). The Head related how most of the affected had stayed almost until the end of the first term. Caregivers cited preparation for marriage as reasons for removing students early from school; the reasons for lack of school fees were rather weakened by the fact that the Head had relaxed fees since most OVCs could not afford to pay.

In total, therefore, at Kupisa I worked with 92 students⁹⁸ and 161 parents and caregivers - 23 of the infected and affected students have single parents/caregivers. All of the double orphans are staying with two adult caregivers (married members of their extended family who have taken them in) whom I interviewed.

⁹⁷ There is a voluntary group of women who work as volunteers to provide home based care for people living with HIV/AIDS about once a month

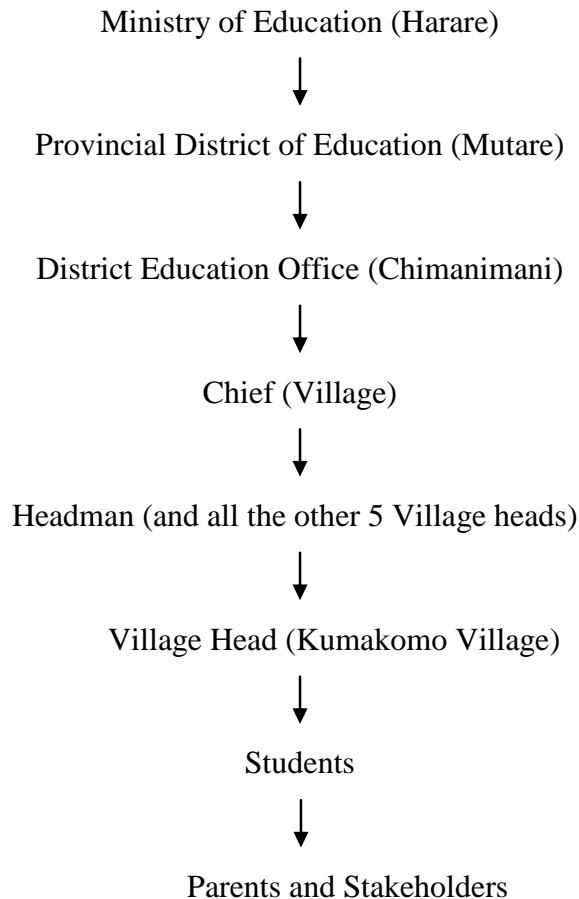
⁹⁸ The breakdown will be as follows: 6 infected students (3 boys and 3 girls) , 30 affected students (21 boys and 9 girls) and 56 non affected students (41 boys and 15 girls)

Negotiating Access

From my experience during the pilot, I knew I had to send letters to schools almost a year in advance to ask for permission to do research in their school and village due to the sensitive nature of the subject and the complications of getting consent from a wide range of people. I initially sent letters to 45 rural schools in Manicaland, the province of my research. Since I had to be in Cambridge to work on my First Year Upgrade Viva, I elicited help from the Director of HOPE, one of the long-standing HIV/AIDS NGOs, to do follow-ups for me in the village schools. Out of the 45 schools, I had positive responses from 3 schools, two of which later declined due to lack of consent from parents and caregivers of infected and affected children and also their village heads. The Kupisa school responded because, as the Head of the school later informed me, they have a ‘large number of infected and affected children – likely to increase - and they are interested in the research for themselves as a school’ (Head, 2010). As noted earlier, the school Head also had personal reasons for being interested in the research: he has also lost 3 sons due to HIV/AIDS, and 4 of his grandchildren were infected. He now has two remaining grandchildren. Mostly though, being introduced by someone from amongst them, as mentioned earlier as well, meant that I had an opportunity to do my work in Kumakomo village.

To avoid exposing the infected and affected students, the school Head (and the 2 teachers in the Grade 6 classes), decided that I should work with all of the children in both classes - 65 boys and 27 girls. Since the school is the central point where the community meets with the chief and various other meetings, they felt that I should start my research at the school and then move on to the villages once the children were familiar with who I was. They also felt that once I started working in the community, it would be almost impossible for children to opt out of the study since their parents would already have taken part. Even though the Head and the two members of staff asked for ‘provisional’ consent from the parents and the children, they informed me that was so that they had an initial indication if they could give me the green light to travel to the village. However, I still had to follow the same routes to ask for consent by myself – something I understood

before the process began. The Ministry of Education had also informed me to contact the school first and then the Ministry. Once Kupisa had informed me that I could conduct research at their school, I then had to follow the chain of consent depicted in the diagram below upon my arrival.



The Ministry of Education, having received the letter from Kupisa gave me approval to carry out research. The Senior Research Officer in the Ministry of Education informed me that this was the first research of its kind in the school and that I had to avoid exposing the children by following what the school and I had agreed on. He added that they looked forward to hearing about the research as it would help in the development of Education in Zimbabwe. Once I was given permission⁹⁹ from the Ministry of Education I was informed to go to the Provincial Education Department in Manicaland, located in Mutare who gave consent after the discussion about how the work was going be

⁹⁹ Appendix A, Research Approval, page 308

conducted and the ethical measures¹⁰⁰ taken to protect the children. Thereafter I was to proceed to the District Education Office (DEO) who is directly responsible for all complaints that may arise from the school or the community. The DEO gave consent but warned that department could take legal action if I pursued any other research beyond that to which I had been given permission. The DEO also advised that even though the Education Ministry had the legal power to give me permission to conduct research, the real power lay with the Chief and the village heads, the true key gatekeepers who had the respect of the people under them.

Whereas with the various education officers there was some minimal paperwork involved, the Head of Kupisa advised against any form of paperwork in the village, envisaging that it would be construed as suspicious and a lack of trust. Strong cultural norms dictate that one's word is enough. He added that once people felt that they had to sign something it meant being bound to something and they could never change their minds again – which is wrong according to what I told all research participants since anyone could stop anytime – even during the interview. The Head at Kupisa allowed me to speak to the students alone so that they did not feel pressure to agree. I let the students know that they could still change their minds whenever they decided to.

Fortunately, the Chief resides in the same village where the Kupisa School is located so I only had to walk 3 kilometres to his home. The Head warned me about various protocols to be observed and the many other people who would be there. The village head of Kumakomo was also there. Greetings alone, an important aspect of the Shona culture, took an hour. Various questions (some which had to do with the Queen, Tony Blair and George Bush) about the work were asked and then I was officially given permission by the Chief to enter the villages. Next in command was the Headman – the one who presides over the village heads. After that, however, I still had to visit the various village heads where children from Kupisa lived. Kupisa sources children from the neighbouring 5 villages. I meet with a village head who gave me permission to see the parents and /or caregivers of the children in his village from whom I asked for consent both to interview

¹⁰⁰ There were no ethics forms to be signed or some kind of guideline that they followed; I was informed that they looked at each case individually (District Education Officer, 2010).

them when the time came¹⁰¹ and also, secondary consent to work with their children. This whole process took two weeks. The furthest child lived about 15 kilometres away from the school.

¹⁰¹ Earlier I had hoped to interview them straight after asking for consent but the Head informed me that culturally it would have been a bad idea since it would be seen as too abrupt – they needed to meet me first. Also, it would defeat the idea of starting from the school as he had suggested. bb

Chapter 5

Findings and Discussion

Scott and Morrison (2005) rightly point out that the collection of data is only part of the research and that the analysis thereof is what gives meaning to the collected information. As much as is possible, I made an effort to use verbatim quotes from the children together with discussion in order to give meaning to the findings (Liamputtong & Ezzy, 2005). For ease of reading, the Shona quotes will be in red. In this section, I will discuss the emerging themes from the children's narratives in concert with perceptions from their caregivers. I will end the section by reflecting on the findings from the community leaders' perspectives on the experiences of the infected and affected students. I will thus respond to the reiterated questions below –

What are the infected and affected rural primary students' experiences in school, at home and in the community?

Similarly, what are parents' or caregivers' perceptions of infected and affected students' schooling?

What are the community's perceptions of the education of infected and affected students' schooling?

The Findings and Discussion session will be subdivided into 3 Chapters. Chapter 5 will discuss the students' experiences in the home before and after school (the microsystem) with supporting or contrasting statements from their caregivers. This will incorporate their time spent with peers in their immediate community (the mesosystem). This chapter will also delve into the issues of students' home experiences and poverty (the exosystem). Chapter 6 will discuss their experiences within the school (the microsystem). In particular, this chapter navigates the influence of stigma in and outside the classroom. Chapter 7 address both the student's experiences with religion and also, community perspectives on the situation of infected and affected students. Both lie within the

macrosystem, with the discussion on community perspectives impinging on the chronosystem. As a reminder, discussed in Chapter 2, using Bronfenbrenner's Theory of Ecology allowed me to research the experiences of infected and affected children in relation to their interpersonal relationships in their immediate setting; to 'take a holistic view of the person in his or her environment and with the capacity of incorporating other approaches' (Seden, 2002: 78 quoted in Algate et al, 2005). Once the students' 'multi-person systems of interaction' were contextualized (Bronfenbrenner, 1979: 21), the capability approach was fitting to incorporate in order to bring the level of analysis to the individual level and also, to understanding the differences within and among the infected, affected and normal groups' individual experience.

In quoting the students' words, I will use (I) to refer to 'infected', (A) for affected and (N) for 'normal' after a student's name. Caregivers will be identified by C-G followed by the name of the student whom they take care of; for instance, a caregiver for Proud (I) will be shown as C-G: Proud [I].

*The students' experiences in the home and immediate community
(neighborhood) – the micro and mesosystems*

This section represents the micro and mesosystems. As a reminder, the microsystem is the environment where the child lives and experiences the most intimate relationships. The mesosystem is the interrelationships within the microsystem, in this case, the interrelationships between and home and the neighbourhood. The background information that underlies in Chapter 2 (pages 102 – 106) under the headings of influences of the family (caregivers), The Parent-Child Relationship, Identity and the Influence of the Community. This information is analyzed together with data derived from student's drawings (the methodology which is discussed in Chapter 3 under Drawings) and the interview data that ensued thereafter. Included in this analysis are the interviews of caregivers collected using 'Schedule 9 Interview'. The capability approach, as in all other systems within Bronfenbrenner's Theory of Ecology discussed hereafter, can be seen at use in the manner in which students experiences are evaluated on an individual basis; they are viewed as learners who 'have different needs, and different interests' (2007:4) and care is taken not to 'simply...aggregate benefits that education has for the whole of society' but consider 'individual benefits' (Unterhalter et al, 2007:5) or lack thereof. As much as is possible, I 'take into account individual experiences, values and differences within groups' (Unterhalter et al, 2007:3). The approach allowed me to

evaluate a range of values that draw on an assessment of people's wellbeing, such as inequality, poverty, changes in the wellbeing of persons or the average well-being of the members of a group' (Robeyns, 2017:26)

Most of the infected students' home experiences were characterized by displacement and abandonment. They struggled with being displaced from the city where they were born and raised to adapting to their new rural environment in the midst of their health challenges. Being displaced and abandoned led to fractured relationships devoid of emotional support for infected students. The abandonment issues were due to being left at home for long periods of time by caregivers who needed to work more to provide for the

added responsibilities. Closely related to abandonment were fears of disclosure as caregivers did not know how, were afraid and/or felt students were too young for them to disclose the reasons of death for their parents (Brown et al, 2000; Campbell et al, 2012). Abandonment also brought anxiety about taking medication, food shortages, safety and the fear of snakes (Young and Ansell, 2003).

Caregivers, concerned about the health of infected students, reduced their chores and did not allow them to do much else outside the home, thereby denying them an opportunity to socialise outside the school environment where stigma seemingly played a lesser role. The infected students' experiences are compared to those of affected and normal students. Below I will, thus, discuss the effects of displacement and abandonment from the children's perspective, contrasted and/or complemented by their caregivers' perspectives. This section will also discuss students' chores, followed by a discussion of issues raised.

There was an ongoing theme of abandonment, reflected by the drawings of vehicles – cars and buses that left the students in the village. During the interview, I asked Solomon [I] to tell me about his picture below and how it described his home experiences.



He immediately spoke about the car and the events that unfolded.

Solomon [I] Interview, December 2010: ¹⁰² *'I came with my uncle's car and he said he was going to come back to get me but I don't know when he is going to come. My grandmother said he does not have time to come and get me. Father and mother are better but they are working very hard.'* He clearly missed them and said that every time he saw a car or a bus he looked to see if ¹⁰³ *'mother would get off the bus to come and get me'* (ibid). His grandmother told me that ¹⁰⁴ *'his parents passed away my son and we don't know how to tell him since he's still so young. And this business of the disease of nowadays (referring to AIDS) is complicated'* (C-G: Solomon [I] Interview, December 2010). She said that the only way she knew how to deal with him was to keep his hopes up especially as the boy is unwell. When I inquired when she thought might be the right time to tell him she simply said ¹⁰⁵ *'I don't know my child...where do I start? What do I say?'* (ibid). His picture above did not have any people in it neither did another which he drew later below –



Stories 5.1: Solomon [I] Home Experiences – Empty Homestead

¹⁰² *'Ndakawuya nemota yababamnini vakati vachadzoka kuzonditora asi andizive kuti vachawuya rini. Mbuya anoti hana nguva yokuwuya kuzonditora. Amai nbaba avenani asi arikuchanda zvikuru'*

¹⁰³ *'amai vachaburuka here kuzonditora'*

¹⁰⁴ *'abereki acho akachaya mwanangu asi isu atichaziva kuti tomutawurira sei iye mwana svezvo achirimudiki kudayi. Neyiyo nyaya yechirwere chemazuvano ayinzwisiki'*

¹⁰⁵ *'andizivi mwanangu....ndoyitangira payi nyayayachona? Ndotichi?'*

In explaining this absence, he said he was often alone - *'grandmother is always gone farming and sometimes she comes back late and grandfather works at the sawmill; sometimes I am scared to be alone'*¹⁰⁶ (Solomon [I], Interview, December 2010). His grandfather worked and stayed at the sawmill for 5 days a week because of transport costs – this is where most men in the village worked if they did not travel to the city, which was further than the sawmill. This meant that Solomon was indeed alone and had to cook for himself and his grandmother most of the time. He said that when he was scared he sometimes waited at the neighbour's house. His grandmother confirmed that Solomon [I] complained about being scared *'but there is nothing to be scared of here... but I can see that he is scared and now he is often quiet thinking a lot ... he only talks when I ask him something'*¹⁰⁷ (C-G (Solomon [I], Interview, December 2010).

From interviewing Solomon [I], it was clear that his grandmother worked in the fields for the whole week. When it was time for the caregiver interview, I had to meet her at the field. She informed me that she regretted not being home with her grandson whom she knew needed him more at home but added that *'if we don't dig these holes we will not be given food by Charitas'*¹⁰⁸ (C-G:Solomon [I] Interview, December 2012). Since I was living in the village for 4 months, I had an opportunity to learn about Charitas and how it detained caregivers for long periods of time in the fields.

Charitas, an organization attempting to help the community with better farming methods, suggested that farmers should dig individual holes for each stalk of corn to retain water. This was very labour intensive and families relied on children to dig the holes. Using the Charitas model of cultivation increases the field preparation and planting time from an average of 5 days previously to 120 days. Despite not yielding any better than the traditional methods which farmers had employed for years, the community had to engage in the idea because it was linked to food handouts from Charitas – if a family did not employ this method then they would not receive their monthly hand out of corn and a

¹⁰⁶ *'mbuya anogara arikumunda nukuti vanonoka kudzoka naiye sekuru anoshande kumapuranka; dzimwe nguwa ndinotska kusara ndega'*

¹⁰⁷ *'asi hapana zvinotsisa pano... asi ndowona kuti mwana achona anotsa nokuti akugara akanyarara achita kunge anofunga zwikuru anongotaura kana ndamuvunza'*

¹⁰⁸ *'ndikasayenda kunochera makomba hatizopiwi chikafu ne Charitas zwe'*

bottle of oil. During my interviews with 92 families and caregivers, it became clear that the new method required too much labour that tied them down from other obligations.

Almost all caregivers, therefore, were detained in the fields digging holes in exchange of food handouts from Charitas – at the expense of possibly caring for their grandchildren, some of whom, like Solomon, simply felt abandoned. The poverty in Kumakomo left caregivers with very few options such that they could not detach themselves from Charitas even if they knew it meant lower yields and drastically reduced the time at home to take care of the orphans in need; this points to the need to consider socio-economic factors in the research of populations affected by HIV/AIDS (Bennell, 2002; Foster and Williamson, 2000; Mpofu, 2008; Baxen and Breidlid, 2009) as it affects, amongst other things, adherence and the security of children (Campbell et al, 2012). In this consideration, noting that the caregivers functionings, their ‘being and doings’ (Robeyns, 2003:5), were severely altered by being detained in the fields due to the new methods of farming, leading to reduced capabilities that might have allowed them to better care for the students, was key to bear in mind. The community’s move to a different method of farming, with its relatively diminished yields, was tied to receiving food aid from Caritas.

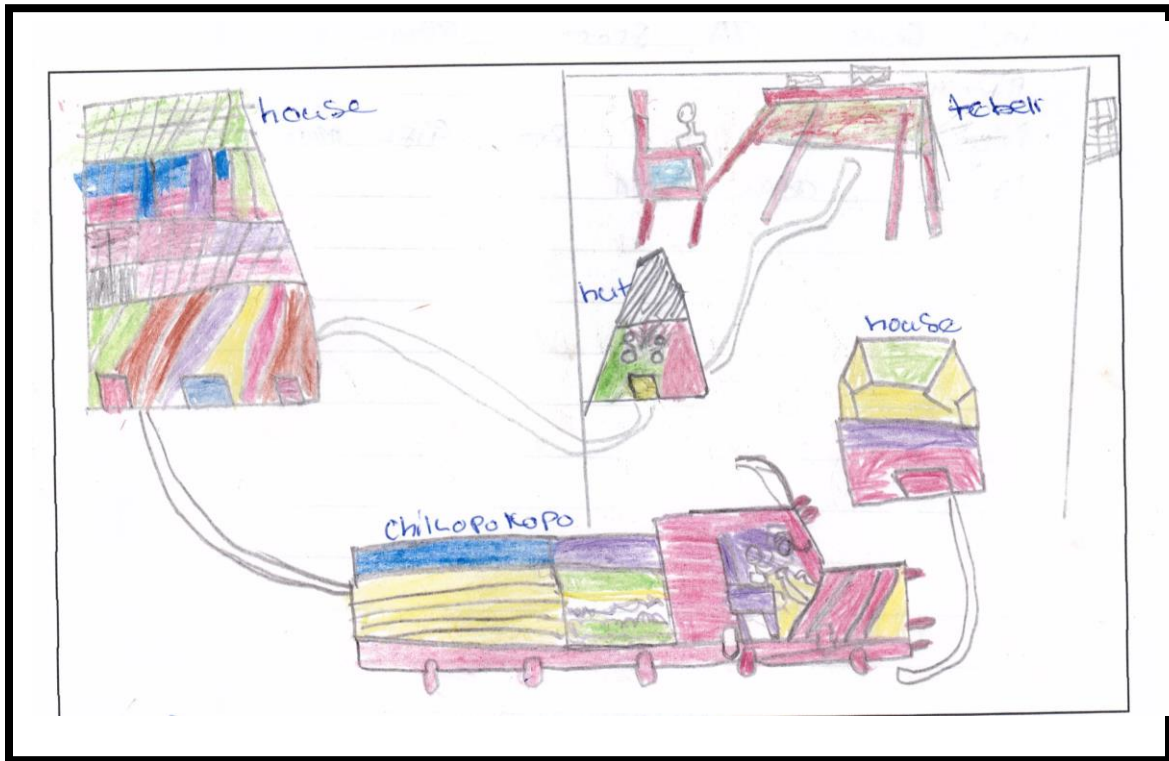
The theme of silence and abandonment was evident with all infected students and with a number of affected students as well. Tatenda [I] had her own picture showing the bus and the story was amazingly similar –

Tatenda [I] (Interview, December 2010): *‘I was very happy when I came to the village in the bus with my grandmother but I was very sad when I started thinking about my mother and father. Grandmother said they went to Joni’*¹⁰⁹ (Joni is a name used for working in the mines in Johannesburg, South Africa). The caregiver informed me that they had to adopt her as both of her parents were beginning to deteriorate and they did not want her to witness their deaths *‘but they took a long time being alive whilst still sick but we could not take the child back to them’*¹¹⁰ (C-G: Tatenda [I], interview, December 2010). She

¹⁰⁹ *Ndakafara zwikuru pandaka wuya kumusha nebazi nambuya asi ndakazosuwa ndakufunga mai nababa. Mbuya akati vakayenda kunoshanda kujoni’*

¹¹⁰ *‘Asi vakazotora nguva refu varivapenyu vachingorwara asi zwisingayite kuti tiyendese mwana’*

said she could not tell her that her parents died of AIDS - she was worried that Tatenda would be worried and waste away and ¹¹¹*if people find out that is what happened they will hate her and it will bring shame'*(Ibid)

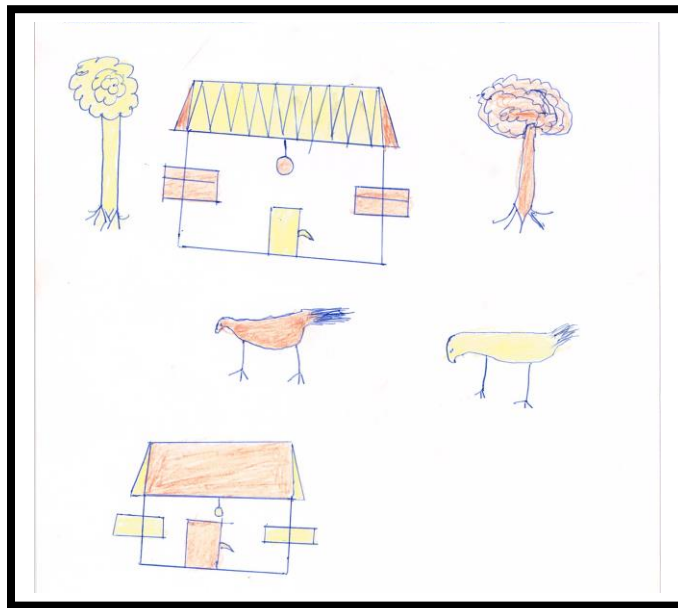


Drawing 5.2: Tatenda [I] Home Experiences – Journey to the Village

Tatenda's grandmother already had 4 other grandchildren staying with her and since she was getting food aid from Charitas, she was required to employ their farming method of digging holes to prepare for the growing season. As a result, she was away for long periods of time. The other grandchildren were older and went to help with the farming.

Tatenda [I], also thought as too young and sick to help by her grandmother, was left to fend for herself as she shared about her empty homestead below –

¹¹¹ *'futhi antu akaziva kuti ndizvo zwakaitika vanoanomusema mwana zvohunza nyadzi'*



Stories 5.2: Tatenda [I] – Empty Homestead

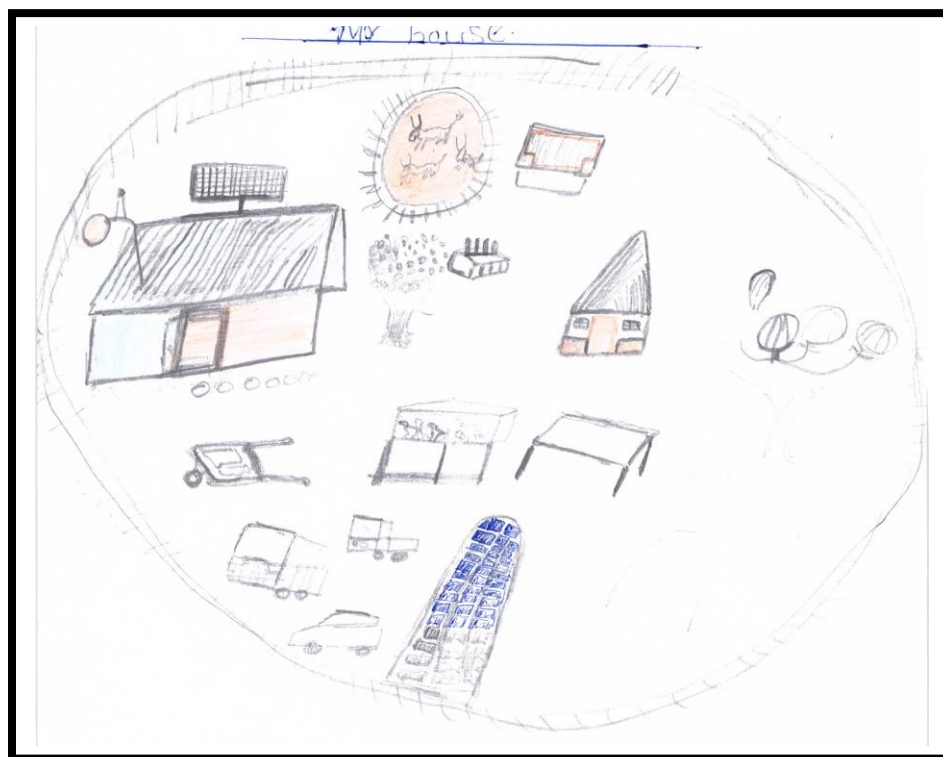
Tatenda [I] (Interview, December 2010) *'the people are never here... there are always at the field digging'*¹¹²

Praymore [I], who had a surprisingly similar drawing of the bus that left him in the village and the empty homestead, was also not informed of the real reason why he was left in the village – *'I want to go back home to my parents but grandmother said I must wait because my mother and father went to look for my brother who is lost'*¹¹³ (Praymore [I] Interview, December, 2010). As he described his drawing of the empty homestead below, he related how he looked forward to a time that he could go back and reunite with his parents – *'I want to go back home and stay with my parents... here I am always alone and there is too much work'*¹¹⁴ (Praymore [I] Interview, December 2010).

¹¹² *'Antu acho anogara asipho... varikumunda vachichera'*

¹¹³ *'Ndoda kudzokera kumba kuvabereki asi mbuya akati timbomira nokuti baba namai vakayenda kunosvaga mukoma wangu akarasika'*

¹¹⁴ *'Ndinoda kudzokera kumba ndinogara nevabereki vangu panondinogara ndirindega izvo mabasa achona akawandisa'*



Stories 5.4: Praymore [I] – Empty homestead

The response from the caregiver depicted silence –

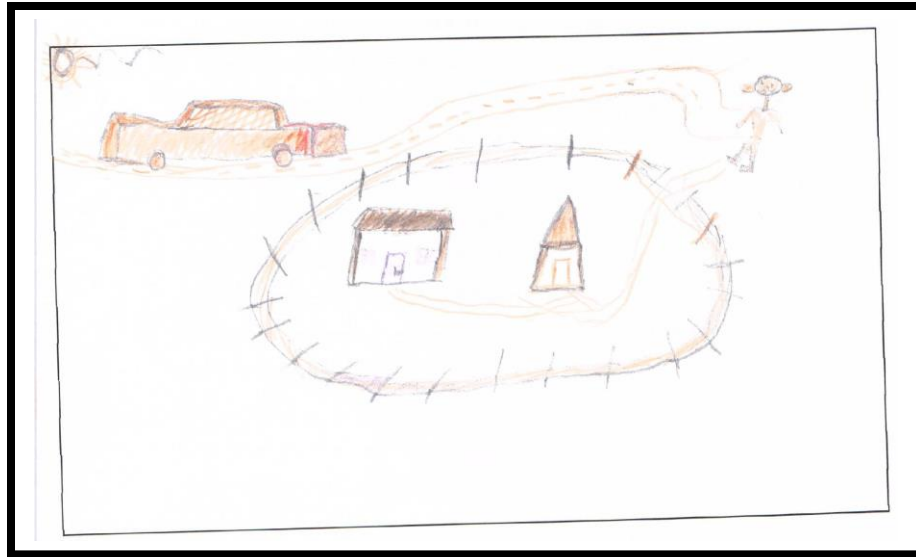
C-G Praymore [I]: Interview, December 2010: *'there is no way of telling this truth to the child it will kill him...to think that it bothers me as an adult... how about him as a child how could he cope with it?'*¹¹⁵ She said that she was not going to tell him that his parents died of AIDS because it would make him more anxious and kill his hope for living – *'even if I wanted to tell him, my son, where would I begin?'*¹¹⁶ C-G Praymore [I]: Interview, December 2010. A constant theme, therefore, was the fear of shame if the cause of death was known, the concern that students were too young to have such hard truths communicated to them and if so, that it would destroy their hope, and the difficulty of not knowing how to disclose to children.

Admire [I] shared a similar drawing and story. He lamented the day when he was left at the house by his own father who told him that he would come back to get him– *'it's been*

¹¹⁵ *Chokwadi chacho hachitawurike ku mwana chinowuraya...mukafunga kuti zvinondinesta ini muntu mkuru ko mwana uyu angazwikwanise'*

¹¹⁶ *'Nyango ndichida kumutaurira mwanangu ndingatangire papi?'*

a long time without him coming or even writing a letter'¹¹⁷ (Admire, Interview, December 2010).



Drawing 5.3: Admire [I] Home experiences – Journey to the village

Admire worried about being left alone for long periods of time because ¹¹⁸*'if I get sick no one will help me'* (Admire, Interview, 2010). Like all the other caregivers in the village, his grandmother had to spend a lot of time digging holes to prepare the land for farming which meant, like the others, Admire was mostly alone at home –

C-G (Admire [I] Interview, December 2010): *'This boy spends most of his time alone because we have too much work... as you can see there are now too many grandchildren and the holes are awaiting...he cannot help in the fields because he is not well.'*¹¹⁹

Admire spoke about how *'I want to go back home where there is food and light... it's too dark here in the village and I am always afraid of snakes.'*¹²⁰ His fear of snakes was

¹¹⁷ *'panenguwa refu vasina kuwuya kanakunyoka tsamba'*

¹¹⁸ *'kana ndikarwara nohla kuti hapana achandibatsira'*

¹¹⁹ *'Mkomana washona anogare ariyega nokuti mabasa atiwandira kuno baba...umuwone kuti vazukuru vawanda nemakomba akamirira...hazwigone kuti abatsire kumunda nokuti anorwara'*

¹²⁰ *'ndinoda kudzokera kumba kunechikafu ezo kunemariiti hezvo ndinotska nyoka'*

universal in the village. He lamented being hungry on most days as there was no food even if ‘I wanted to cook by myself.’¹²¹ (*ibid*)

Like the others, his grandmother informed me that she could not tell him about the death of his parents because ‘his heart would break’¹²² (C-G (Admire [I] Interview, December 2010). In this pervasive silence Admire was to remain in a false hope of someday seeing his parents who were no longer alive.

Miriam [I] – when she last left the village, her parents were still alive but also getting to a stage of being incapacitated. By the time the grandmother took Miriam, *the father had left the family because he said that it was the wife who had brought the disease to the home*¹²³ (C-G (Miriam [I]): Interview, December 2010)¹²⁴. The caregiver related that Miriam’s mother, instead of alerting her of her father’s death, had told her that he had gone to South Africa to look for work – a reasonable explanation at the height of Zimbabwe’s economic crisis and a runaway inflation of 2.2 million % (Mpofu, 2008) as already noted. When the mother eventually died too, Miriam was told that she went to visit her Father in South Africa.

The stress that surrounds issues of HIV/AIDS cements the culture of silence – C-G (Miriam [I]): Interview, December 2010) ‘For us to try to tell her that her parents died because of this disease is impossible... it will overwhelm her...she is always thinking a lot. She is also still very young to understand all this.’¹²⁵

The idea that they were too young to understand was a running theme for both infected and affected students whose caregivers kept the reason for the death – when and if communicated – a secret.

¹²¹ *ndichtida kubika ndega*’

¹²² *‘angawore moyo*’

¹²³ *‘baba vachona venge vatosiya muri nekuti vaiti mukadzi ndiye akawuya nechirwere*’

¹²⁴ Meursing and Sibindi (1995) note how the women usually get blamed for bringing the disease and often become ostracised from the family by in-laws

¹²⁵ *‘Kuti timutawurire kuti vabereki vake vakafa naicho chirwere azwiye chose zwingamukurire... iye agara anofunga zwikuru. Naizwo ichiri mwana mudiki kuti ayindwisise nyaya yachona*’

Miriam's grandfather worked at the sawmill from Monday to Friday. When I asked him to tell me a bit about what it was like to look after Miriam and their other grandchildren he told me to *'ask their grandmother, I don't live here, I live at work at the woods so that we can keep them... if I don't do that this hunger here will get worse'*¹²⁶ (C-G (Miriam [I] Interview, December 2010). He was referring to moments echoed by Miriam that often there was no food – as compared to when her parents were still alive, she said there was more for 'everyone.' Most men of retirement age – which is 65 and over – had gone back to work to take care of increased responsibilities.

Bridget [I], who was born and remained in the village, took a very long time to even talk about her own pictures let alone volunteer more information about her home life, explained how she looked after her mother (in the drawing) when she was getting ill and the many times that the church came to pray for her. When her mother died they buried her in the village and her father is said to have gone to South Africa to look for work and he never returned.

Talking about her drawing showing an empty homestead, Bridget surmised that *'Even when mother was sick she was always here and father worked close to here so he always came back home at night...I am often alone while grandmother is digging holes I am afraid of the rapist'*¹²⁷ (Bridget [I] Interview, December 2010).

There had been a grisly rape reported by the Chief at one of the community meetings to alert villagers to walk in groups at night. The newly found diamond mine in the village was bringing workers who stayed in the village during the week and returned to their homes on weekends. Bridget's fear was also echoed by many other villagers – women and school girls who often had to walk past the mine en route to their homes. She was also worried that *'sometimes when I am sick grandmother will not be at home'*¹²⁸

¹²⁶ *'yunza mbuya mwanangu ini andigare pano, nogara kubasa kumapanga kwashona kuti tigone kuvachengeta... ndikasadaro nzara iripo iyi indowande'*

¹²⁷ *'Nyango amai vairwara vaigara varipano ndababa vaichanda paduze zvo vachidzoke kumba maneru ezwinwo ndinogare ndirindega mbuya vachinochera magomba ndinotya mabinya'*

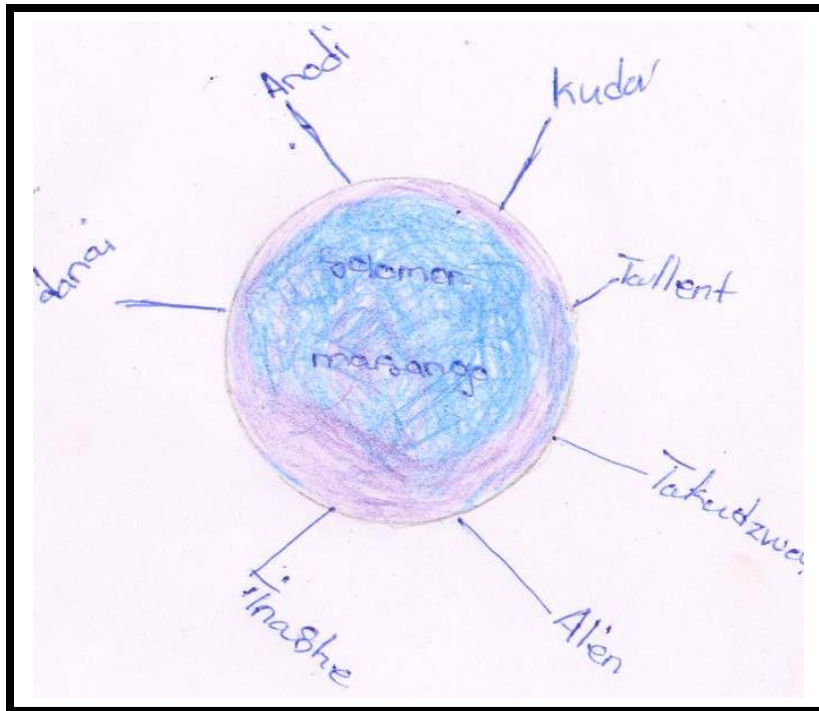
¹²⁸ *'dzimwe nguva kanandichirwara mbuya vanenge vasiphu kumba'*

(Bridget [I] Interview, December 2010). Bridget's caregiver believed that her mother–
*'was bewitched but we don't know who did it...the possibility that she might have died of
the disease...that we cannot touch'*¹²⁹ (C-G: Bridget [I] interview, December 2010). This
was the only situation that related the cause to witchcraft but the silence about the disease
as far as communicating it to guardians remained as intense.

The stark absences of adults within the drawings of infected students can be attributed to
how they felt in the physical and emotional migration process from the loss of parents to
adopting a new environment lacking in prior safeguards. Solomon's absence, 5:1 journey
to the village related more to how he felt at the time of being left at the homestead by his
uncle, not necessarily that there were no people at all times within the rural homestead. It
can be said that in the presence of grandparents, there was still a psychological
absence/loss of a previously known life, hence an 'empty' homestead. The grandmother's
limited presence, reduced by her need to work more to take care of him, registered as an
absence for Solomon – with students left feeling abandoned. That can be said for all other
infected students in this study. By looking to the 'functioning of each and every person'
(Nussbaum 2000, 56 IN Robeyns, 2017:58) and asking about the 'ways of being',
(Alkire, 2000:2), the difficulty of disclosure by caregivers and the uncertainty from
infected students who could never be sure if they would ever see their parents again,
coupled with the fear of feeling displaced and abandoned, the capability approach allows
us to see how a group's functionings and capabilities are severely reduced, and hence, the
freedom to achieve well-being.

¹²⁹ *'vakaroiwa asi atizive kuti ndiani muroi wachona...nyaya yokuti pamwe vakafa nechirwere ...izvo
hatingazwitange'*

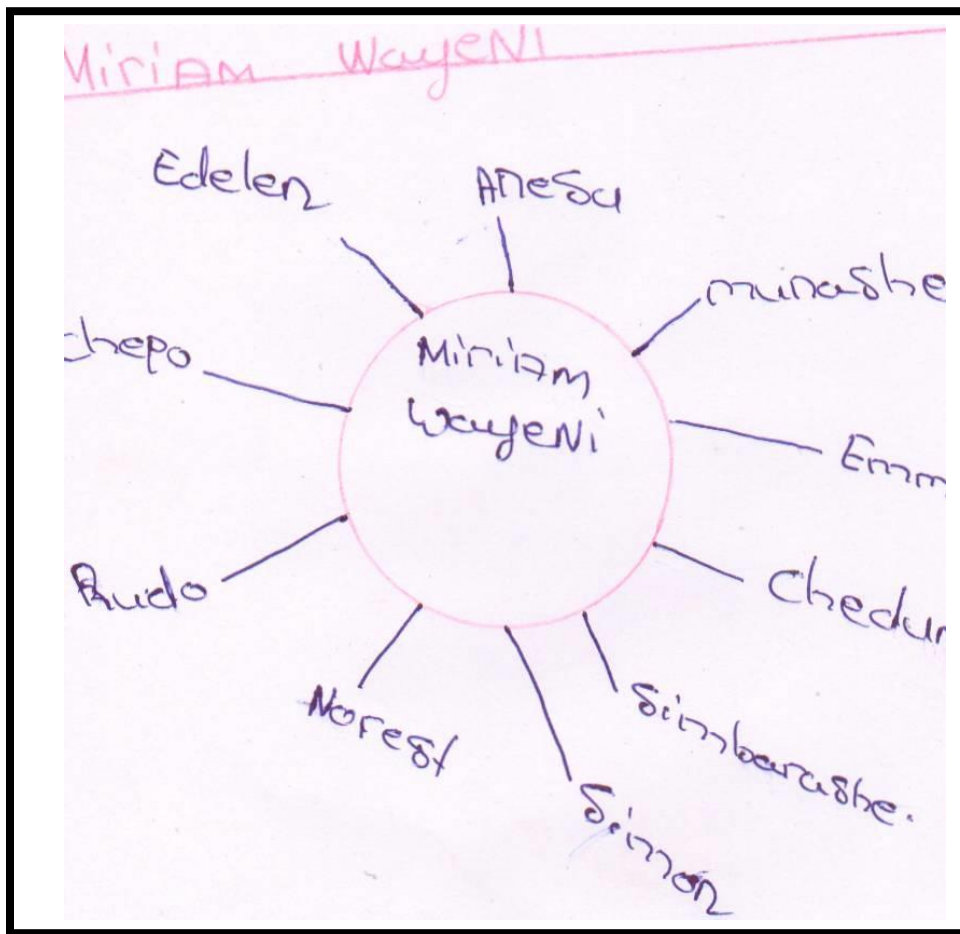
The results of being displaced and abandoned meant that students looked elsewhere for emotional support – children were largely, if not altogether, counselling each other. In all cases of the I/A group, there were hardly any adults listed as close confidants/friends – they mostly trusted their own friends in the school as this sociogram below avoids any mention of adults –



Sociogram 5.1: Solomon [I] Relationships

Solomon [I] above stated that the friends listed on his sociogram were the people he spoke to when he did not understand something or– *‘if I have things that bother me’*¹³⁰ (Solomon [I], Interview, 2010). Similarly, Miriam [I] and most of the infected and affected students had children only listed as confidants who counselled them in times when they needed it. None of the sociograms in the infected and affected groups had teachers or school administrators on them –

¹³⁰ *‘kana ndinezwinu zwinoninetsa’*



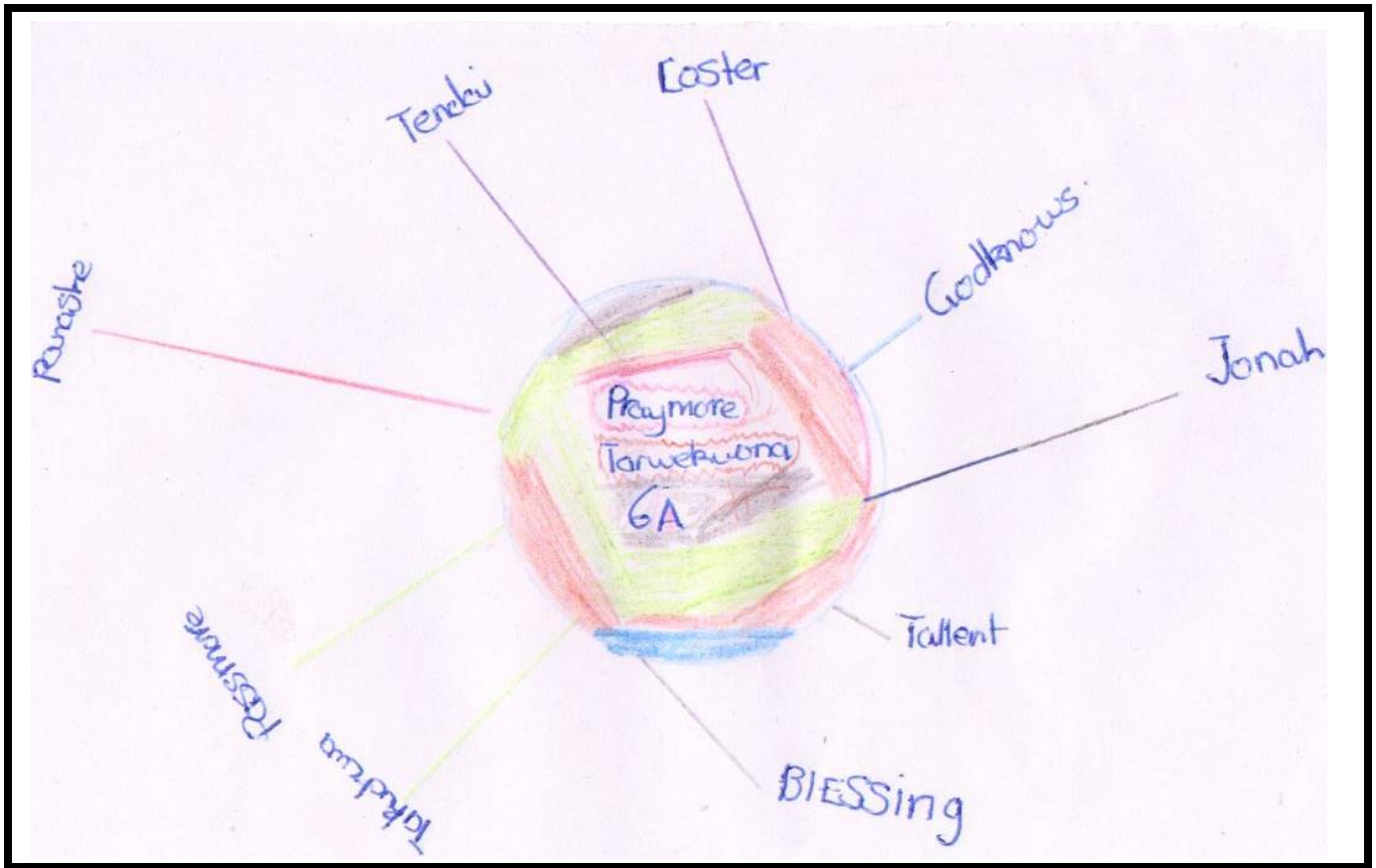
Sociogram 5.2: Miriam [I] Relationships

When I asked Miriam why she didn't have any adults in her sociograms she said *'these people are always away'*¹³¹ (Miriam [I], Interview, December 2010) – referring to the caregivers. As noted previously, those caregivers who were still able, could not be there as they had to cater for increased responsibilities brought by the added family members – *'work and more work my child...it increases as the mouths to feed increase'*¹³² (C-G: Miriam [I] interview, December 2010).

¹³¹ *'antu acho anogare asipo'*

¹³² *'basa basa mwanangu...rohwandiswe nekuwanda kwemiromo'*

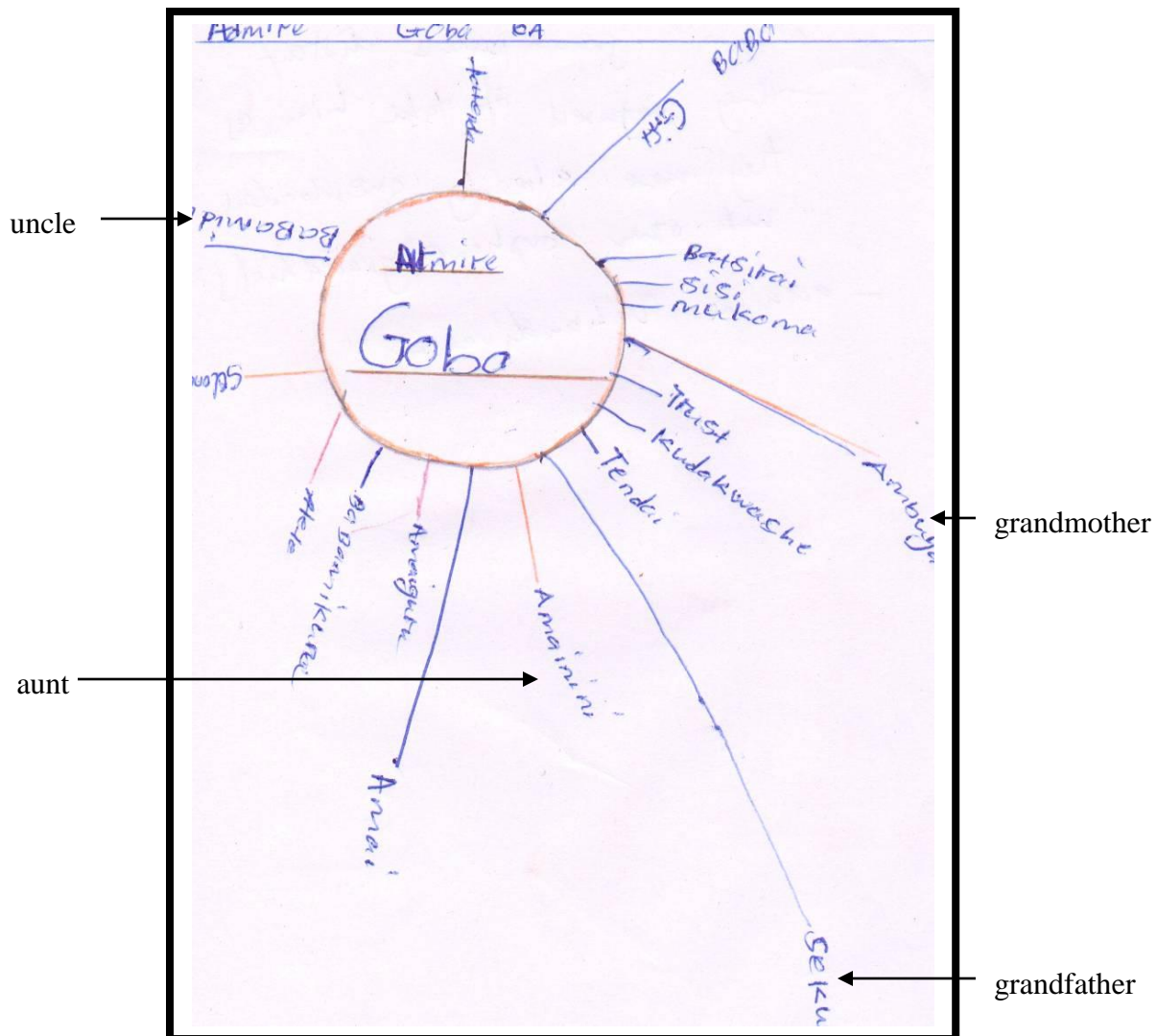
Praymore [I] presents yet another example below –



Sociogram 5.3: Praymore [I] Relationships

When asked why he did not have any adults on his sociogram and confided in his school and village friends, Praymore [I] responded by saying that *'the people (the adults) will be tilling the land but you cannot go there because you are supposed to look after the home'*¹³³ (Praymore, Interview, December 2010). The constant work necessitated by increased demands on caregivers meant that there was little time left for home relationships to develop. Admire (I), however, had listed his grandfather and his grandmother on his sociogram, albeit far –

¹³³ *'antu acho anenge arikumunda asi haungachiyende ikoko ndokuti onofanirwa kuchengeta musha'*



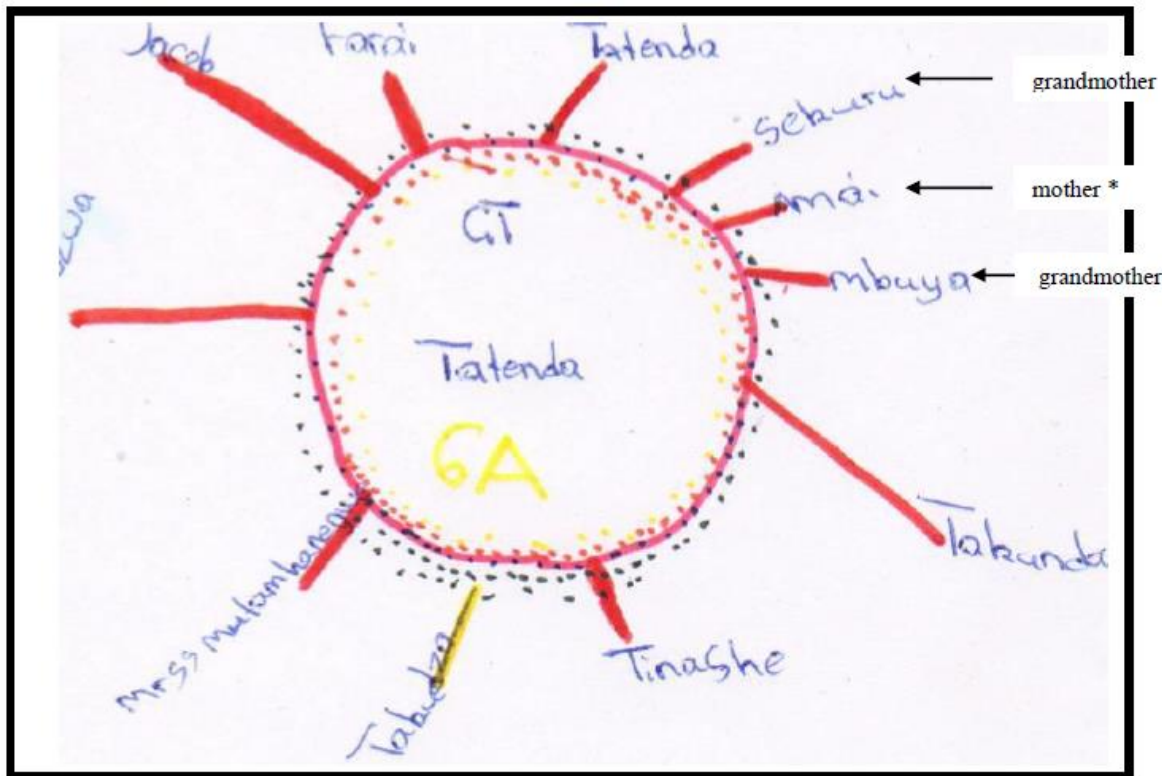
Sociogram 5.4: Admire [I] Relationships

Admire said he listed them far because – ‘they refused to take me’¹³⁴ (Admire, Interview, December 2010). His grandparents had passed him on to their oldest child (Admirer’s uncle) because they were already burdened with other orphaned grandchildren. He was upset because he didn’t understand why they didn’t take him – ‘when they took the others’¹³⁵ (ibid). He did list his uncle and aunt as close and mentioned how they spoke to him when he had difficulties at school or was worried about them ‘leaving too.’ When his parents died he too was told that they left to look for work and never came back

¹³⁴ ‘vakandiramba’

¹³⁵ ‘ivovakatoravamwe’

(Caregiver Interview, December 2010). He, however, received ‘counselling’ from his uncle and aunt regularly. This was the case with another infected student who listed caregivers close to them; when they were available, they were a great source of support as shown and reported by Tatenda (I):



Sociogram 5.5: Tatenda [I] Relationships

Tatenda [I] (Interview, December 2010) ‘Grandmother and grandfather are the ones who look after me very much and listen and talk to me when I am sad.’¹³⁶ The ‘amai / mother’ that Tatenda lists of her sociogram is her aunt. While, by and large, infected students perceived caregivers to be absent due to increased responsibilities as pointed out earlier, and therefore seemed to counsel each other, the nuances need qualification. Miriam (I) and Praymore (I) reported absences related to grandparents being away in the fields (signifying lack of time on the part of the grandparents) not total absence per se. Admire (I) and Tatenda (I) showed that they had support from their grandparents. By allowing us to look closely at the individual, the capability approach helps us to note that not all

¹³⁶ ‘Mbuya naSekuru ndiyo anondishengeta chose nokunditerera nokutawuraneni kana ndishishuwa’

situations are the same for infected students. In a culture where counselling is rare, we can not simply conclude that children were simply counselling each other due to the absence of adults. The relatively large number of students noted by infected students on their sociograms could potentially point to the student's preference to talk to people who are their own age. Even though the contrast of normal students shows they related more to adults around them, caution needs to be taken to not overly assume the opposite for infected students.

Chores for infected students

The chores for all the infected students in the study were much lower compared to affected and normal students – despite the former complaining about too much work. Caregivers for the infected students all spoke about making sure they reduced chores because the students were sickly and already tired from the long journeys to and from school.

C-G (Solomon [I] Interview, December 2012): *'My boy becomes a big problem when he is tired he does not sleep well and will sleep at school.'*¹³⁷ There were problems with infected students dozing off in class – and this caregiver attributed it to being tired and therefore did not allow Solomon [I] to herd cattle or help with the digging of the holes.

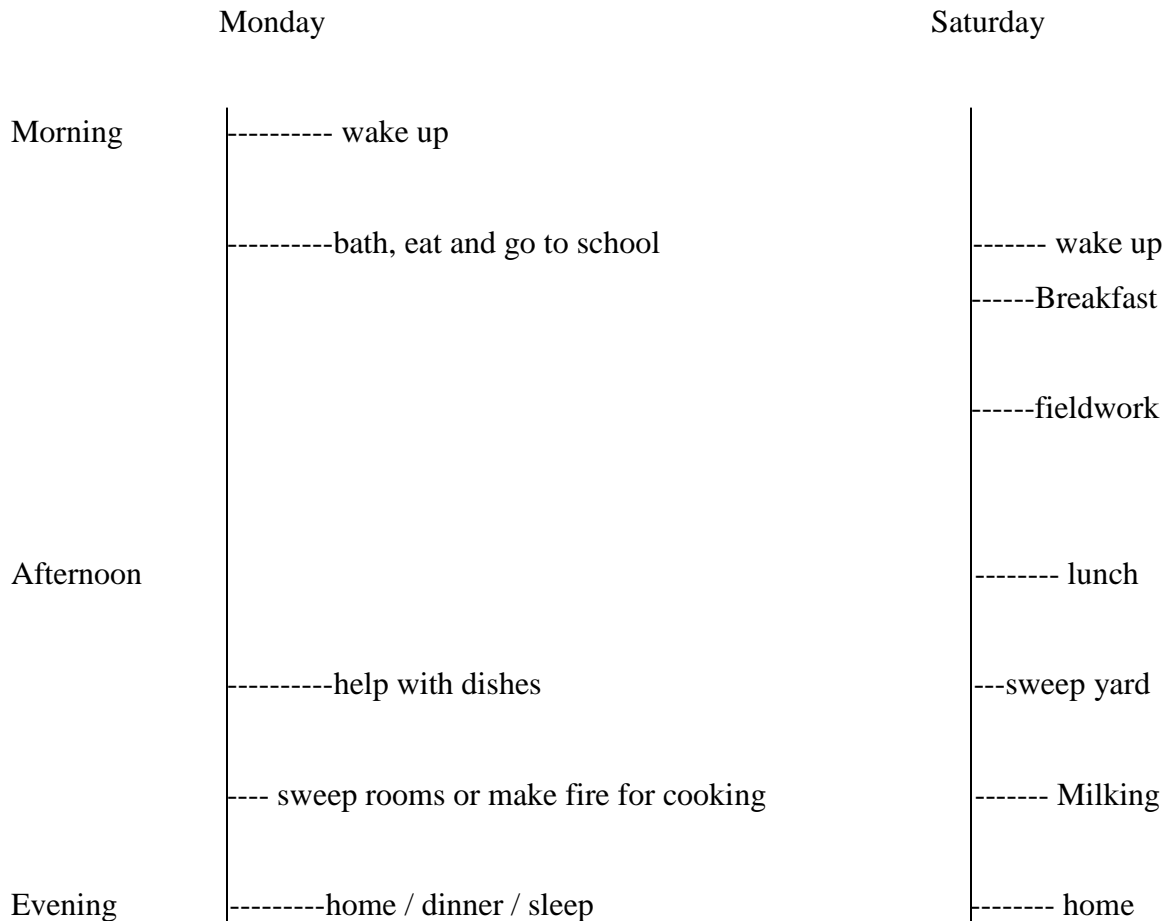
All the 3 infected boys, therefore, didn't do much in the village because caregivers were concerned about their health, that if they got sick they would be too far from home. For Praymore [I], unfortunately, a few episodes caused the fear when he had to be carried by other children from the mountains when he started vomiting and coughing uncontrollably *'that's when I realised that the boy is now too weak to herd cattle and do other such things'*¹³⁸ (C-G, Praymore [I], Interview, December 2010). For Admire [I] the caregiver related stories from the school teacher about his vomiting and napping episodes. This meant that the boys missed out on socialising with other boys during herding time. Here

¹³⁷ *Iyeu mukamana wangu akaneta anonetsa hagoni kuzorara mushe wuye anazorara kushikoro'*

¹³⁸ *'ndopandakawona kuti mkomana washo hachakwanisi kuyite basa remombwe nezwimi izwi'*

we can say that the infected students' functionings were reduced, that their 'basic...capabilities...to possess a sense of self-worth, interact with others based on mutual respect...' Wigley and Wigley (2006:292) were altered adversely. As shall be seen, this was most unfortunate as stigma played a less insidious role outside the school context – affected and normal students were more likely to identify infected students as friends outside the school environment.

With the slight exception for infected girls, the caregivers still gave infected students fewer chores due to the perception that they could not do much. Before I was banned from fetching my own water I observed that fetching water was a social time for girls and women of all ages. They sat and talked by the water pump for what seemed to be long periods of time. Below is an example of a timeline for infected students –



Timeline 5.1 Solomon [I]

Infected students reported being bored and not knowing why they were being kept away from doing things *'like other kids.'*¹³⁹ All that they knew was that they were not in very good health and that is why they did not want them to do much.

As can be seen above, a growing problem in the village is that of students being 'abandoned' (Gachuchi, 1999) first by their parents – unavoidably so - and then tacitly by their caregivers who necessarily had to be away in order to provide. Infected students complained of being alone and feeling unsafe, opportunities for emotional, intellectual and spiritual development (Cleaver, 2006) were obviously reduced. The fear of caregivers to involve infected students in work because of their condition meant that they

¹³⁹ 'sevamwe'

did not become socialized into the adult work environment as most affected and normal students were allowed to experience; they had reduced capabilities.

The lack of constancy to an ‘attachment figure’ as infected students lost their parents and moved to insecure environments resulted in some of them showing aspects of the ‘disorganized’ attachment styles (Aldgate et al, 2006:69) as students were constantly afraid not only of being left alone but to engage with other people as well. They exhibited internalized behaviour changes such as depression, anxiety and low self-esteem (*ibid*). The failure of caregivers to deal with aspects of death meant that infected and some affected students who have ‘suffered loss of attachment figures through ...death displayed greater adjustment problems’ (Owusu-Bempala, 2006: 112).

The capacity of caregivers in the poverty-stricken village is highly compromised as circumstances do not allow them to provide for essentials (Rutter, 1974; Dowling et al, 2006) and also have time to be home to provide for needed emotional, intellectual and spiritual support (Gill and Jack, 2008). The ‘absence’ of adults in the students’ lives meant that the forming of their identity was compromised as Quinton (2006: 99 in Aldgate et al, 2006) quoted earlier in this work aptly states that identity is ‘the story of ourselves, where we come from, where we fit with social life, to whom we are related ...if we do not feel we have a coherent story, then our sense of self as individuals is likely to be compromised.’ Unfortunately, the school environment did not provide a respite for these students to build their identities as the isolation experienced at home was largely continued.

The silence of the Zimbabwean government about HIV/AIDS that Ray and Madzimbamuto (2006) reported seems to be equally engulfing caregivers because of the fear and shame that surrounds it due to stigma. Earlier in this work Guest (2005:2) noted how stigma also meant that doctors ‘rarely put AIDS as the cause of death on a patient’s death certificate’, the village caregivers did not even address death in case a reason had to be given. With caregivers, the fear of communicating to kids because they were too young and simply the ignorance of not knowing how to broach the subject hardened the

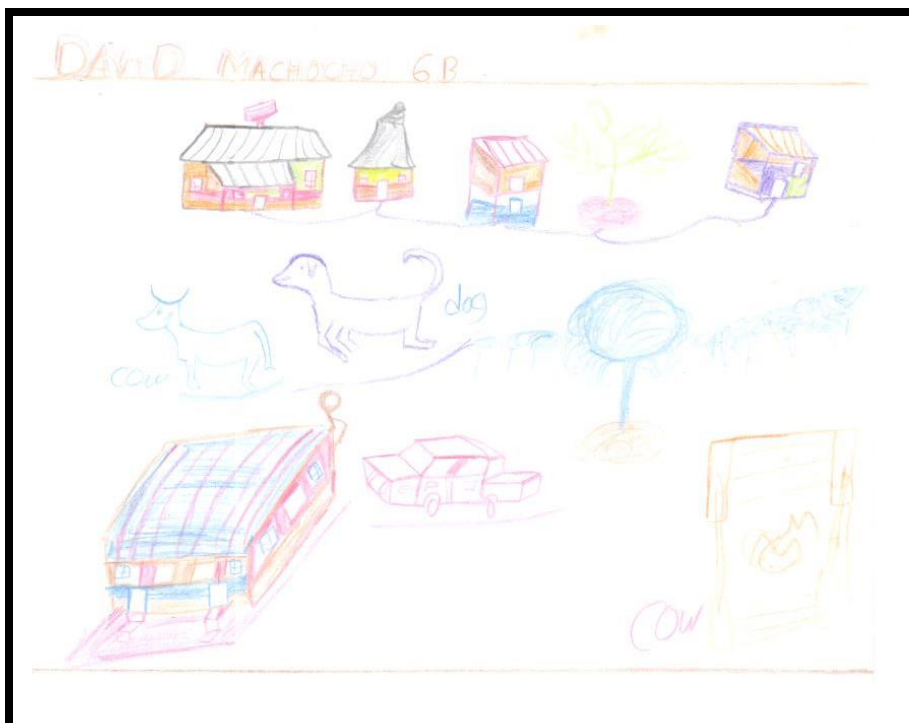
silence which in turn entrenched the stigma which propagates the epidemic (Basset and Mhloyi, 1991). The fear of disclosure that caregivers had is confirmed by Vreeman et al (2013:11), who found that ‘caregivers identified many barriers to disclosure within these settings, the most prominent being fear of stigma and of negative consequences for children's emotional and social well-being.’ Issues of disclosure to infected and affected children remain in need of thorough research in order to find ways to help caregivers to disclose in a manner that will not adversely affect the child.

The literature that looks at AIDS orphans as one group, Richter (2004) amongst others, overlooks the significant differences infected students have to overcome to be included at home and in the school compared to affected students. The capability approach, by considering individual values a difference within a group (McReynolds, 2002), gives us a better picture. This is highlighted in the section below that shows how infected and affected students shared a similar situation yet experience it differently.

Affected students also had similar drawings of empty homesteads and related how there was hardly anyone at home compared to when they still had either both or one of their parents still alive except that they experienced the absences differently from infected students. A few examples will be discussed below.

David [A] Interview, December, 2010: *‘There is hardly anybody most of the time but I am never there as well because I have a lot of things that I do’.*¹⁴⁰

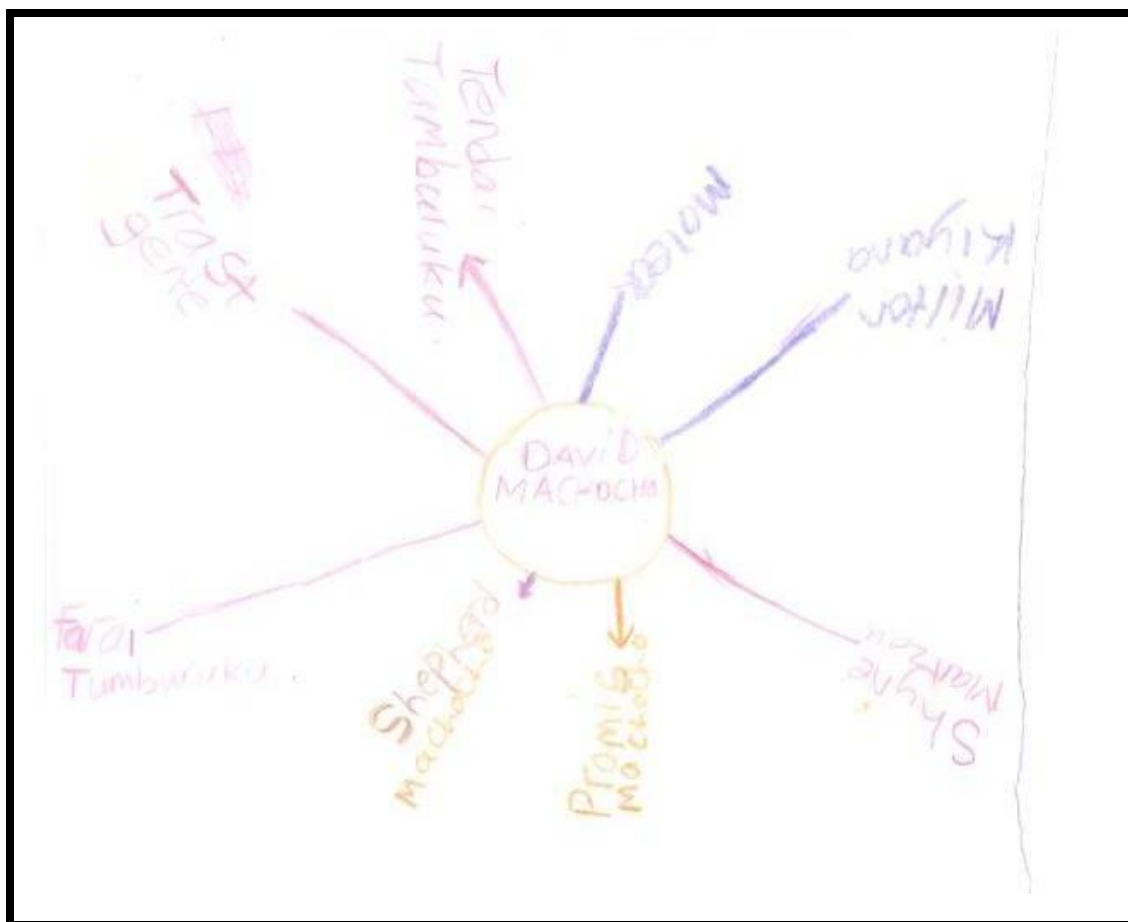
¹⁴⁰ ‘Pamba panogare pasinavahnu hongo ini ndinenge ndisipho wo futi nekuti ndinezwinu zwakawanda zwandinoita’



Drawings 5.9: David [A] Home Experiences Empty Homestead

Even though they showed empty homesteads, they did so to show that no one was hardly at home but they would be out herding cattle and playing with other students since they had healthy bodies and stigma outside school did not seem to carry the same weight as in school; they seemed to enjoy full lives despite no one being at home. Affected students were less lonely – some helped with the farming whilst a lot of them did most of the farming – the responsibility gave them more confidence since they did not seem to see it as an extra chore. Below David [A] shared how he is never lonely because of his friends from the village and from school – *‘these are my friends who help me not to get sad’*¹⁴¹ (David [A], Interview, December 2010).

¹⁴¹ *‘Idzi shamwari dzangu ndidzo dzinondiyita kuti ndisasuwe’*



Sociogram 5.6: David (A) Relationships¹⁴²

Below is one of many examples of students who reflected similar drawings as those of the infected students but had widely differing experiences.

¹⁴² David's sociograms is not very clear because the original was faint

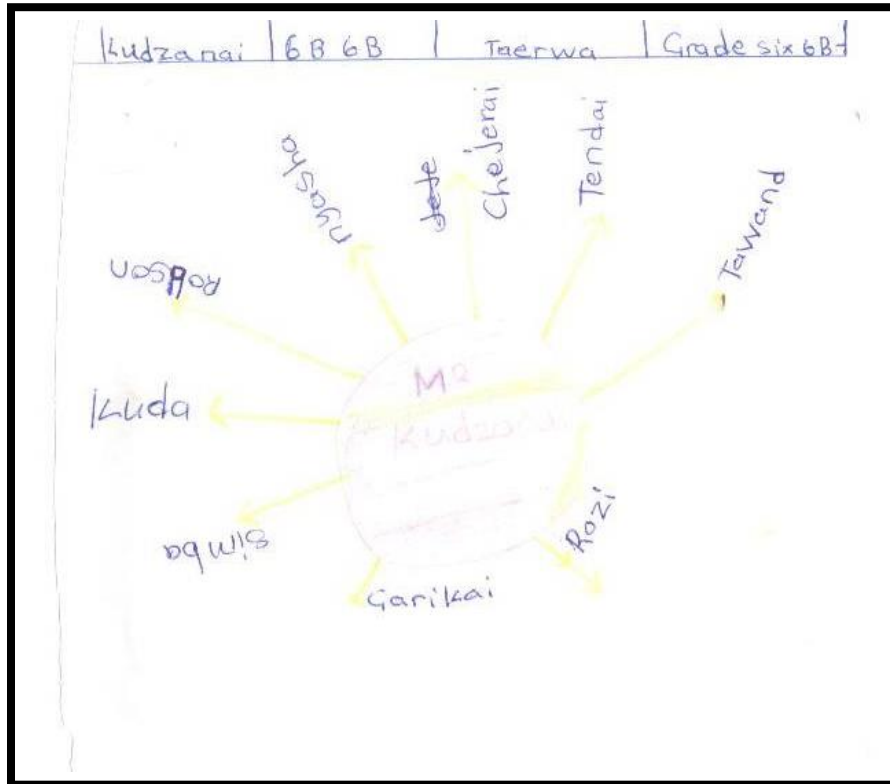


Drawing 5.7: Kudzanai [A] – empty homestead

Kudzanai [A], Interview, December, 2010: *'There is no one at home for most of the time. When we are not at home we will be fetching wood or digging holes with grandmother. Sometimes we go to fetch water.'*¹⁴³ Talking about the friends she listed on her sociograms below, Kudzanai [A] mentioned that they help with keeping her company even when *'grandmother has travelled far or when I am worried. We always walk together so we don't get scared by the men from the mine'*¹⁴⁴ (Kudzanai [A] Interview, December, 2010).

¹⁴³ *'Kumba akuna antu nguva dzakawanda Kana ndisipho kumba tinenge tichitswaga huni kana tina mbuya kunochera makomba Dzimwe nguva toyenda kumvura'*

¹⁴⁴ *'ambuya vayenda kure kana dzimwenguva ndichifungisa. Tofamba tese kuti tisatse varume vekumaini'*



Sociogram 5.7: Kudzanai [A] Relationships

There were sizeable differences therefore between infected and affected students' experiences at home.

For the most part, therefore, affected students' experiences at home were much different from those of the infected largely because they could be engaged in various chores and activities at home. Their functionings and ultimately their capabilities, were much advanced. The freedom to 'be and to do' was much more elevated than that of infected students.

Caregivers seemed largely pleased with affected students who came to stay with them as they seemed to be both low maintenance and helpful with work -

C-G, David [A] *'he is such a happy child... you would not think that he does not have parents'*¹⁴⁵

C-G, Kudzanai [A] *'He plays very well with others... he is like one of the family'*¹⁴⁶

C-G, Kuda [A] *'Sometimes he seems to think about things but most of the time he will be playing and happily doing various jobs with the other kids...they help me a lot with various jobs'*.¹⁴⁷

All the above affected students, however, grew up in the village and most of them enjoyed working as this was not only an opportunity to socialize with friends but a sign of maturity in the village; generally, these students spoke proudly of *'being able to do many different and varied jobs'*.¹⁴⁸ (David [A], December, 2010). Clearly, one of the things that the boys enjoyed doing and bragged about at school was being able *'to hunt and catch game'*¹⁴⁹ (Coster [A], December 2010); this was a major way of contributing to the food supply at home. For the girls being able to cook different meals was a source of pride. Growing up within the village meant that they understood the culture of what was expected at various stages of their development and adjusted appropriately; *'you must know that in the village for most of them the end of primary school is the beginning of adulthood as they will not be going to secondary school so they need to be ready'* (Head, November, 2010). Bearing in mind that we should not overlook instances where children are simply overworked, the above is a good example of how different cultures view children. Christensen & Prout (2005:45), quoted earlier commenting on European and North American views of childhood, note that there is a 'remarkable contrast to the position of the child in cultures that depend on and emphasize children's contributions to the family economy in the form of work, support of the elderly or taking care of the young or *ill parents*' (Christensen & Prout, 2005) – that can be said of Kumakomo. Children in Zimbabwean rural areas are given many responsibilities at an earlier age and

¹⁴⁵ *'Anofara mwana achona... hawungafunge kuti hana vabereki'*

¹⁴⁶ *'Anotamba nevamwe vake zwakanaka... anongoita semwana wepano'*

¹⁴⁷ *'Dzimwe nguva anosimbofunga asi kunyanya anenge achitamba nokuita mabasa navamwe achifara navo vanondibetsera zwikuru nemabasa epamba'*

¹⁴⁸ *'kugona kuita mabasa akawanda akasiyanasiyana'*

¹⁴⁹ *'kunovima uchibatawo muka'*

their contributions should not only be valued in terms of labour but what they communicate to others around them. In my research students were proud to be doing more work – it was seen as a rite of passage in Kumakomo for students at the age of 10 to start taking more responsibilities. Because the capability approach asks us to consider ‘gender *and other types* of equality’ (Unterhalter et al, 2007:2), we note that girls seemed to do considerable more work than boys as they had to fetch firewood, sweep the homestead and do laundry on top of cooking daily; this is supported by Foster and Williamson (2000: 71) in their observation that ‘increased domestic workload is often disproportionately greater on girls than boys.’ There was no evidence, nevertheless, of their assertion that ‘the workload of orphans may be greater than non-orphans living in the same household’ (*ibid*). Affected students who lived in the same homes as normal students did very much the same work as this was also part of how they socialized. The only affected students who did more work than normal students who lived in the same households were older and so were expected to do more. As shall be seen, most of the affected students developed positive relationships with normal students in and outside school whereas infected students struggled continuously. Enrolment of affected students who grew up in the village was said to be almost as good as for normal students (Head, December, 2010), a statement that has been confirmed by Grainger et al (2001:22) in their study of orphans in sub-Saharan Africa - ‘...in countries where enrolment rates are high for all children (such as Zimbabwe), little difference has been found in enrolment rates between orphans and non-orphaned children.’

Some observations by Richter (2000: 12) and others who surmise that ‘...orphaned children often ...endure exhaustion and stress from work’ aggregate orphans’ experiences and hence generalize and overlook important nuisances. Using the capability approach lens, while it was true of some affected students, it simply was not the case with the majority. The affected students who struggled were the ones who had not been long in the village and largely grew up in the city before they were orphaned. They spoke about the burden of too many chores and long distances to school – which were noticeably different compared to their previous lives as noted below by Justice [A] ‘*When I lived in Mutare (the city) I used to travel to school by bus and I did very little work at home only when I*

wanted.’¹⁵⁰ Justice also worried a lot about his sick parents ‘*I don’t know when I’ll see them again...here there are a few people who help me with things.*’¹⁵¹ They struggled with adjustment and one caregiver reckoned that ‘*with time he will get used to the way people live in the village*’¹⁵² (C-G, Justice [A], November, 2010) – which summarized how the other caregivers of the newly arrived affected students felt.

Their normal counterparts, however, always listed their parents as closest to them and vouched for their support and love.



Drawing 5.5: Gift [N] Home Environment - Presence of Family

Gift [N] (Interview, December, 2010) ‘*My father helps me with my school, with hunting and skinning goats and tells me to keep working hard at school.*’¹⁵³

Normal students always reflected adults on their sociograms and spoke highly about their friends with whom they enjoyed many varied activities. Gift’s [N] sociogram below

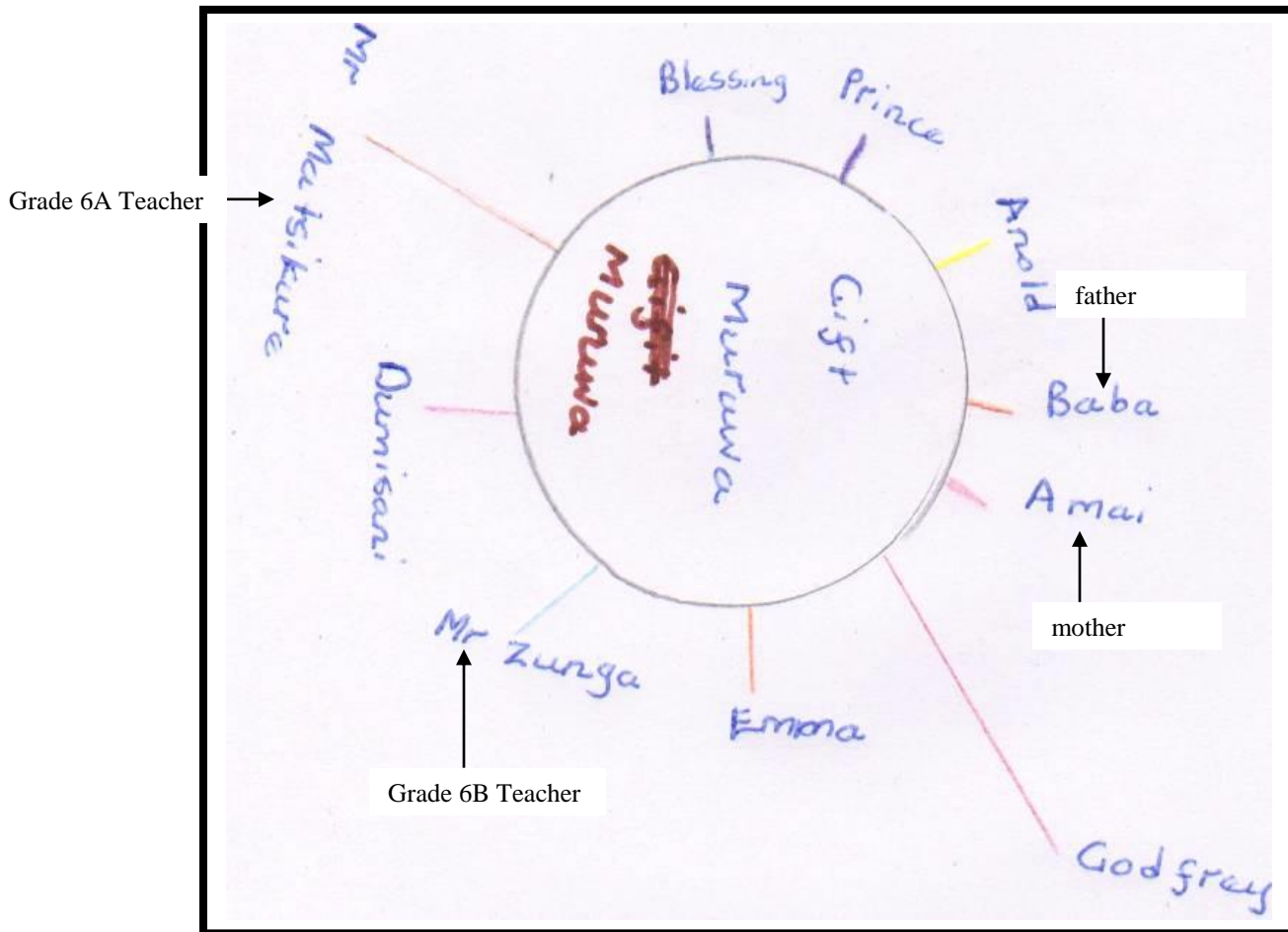
¹⁵⁰ ‘Ndichigara kuMutare ndayiyenda kuchikoro nebus zwe taita mabasa mashomana kumba kanatichida’

¹⁵¹ ‘handizivi kuti vakadinekuti ndichabawona rini...pano vanhu vanondibestera nezwunu vashoma’

¹⁵² ‘nenguva achajaira magariro ekumucha’

¹⁵³ ‘Baba vangu vanondibetsera kudzidza noku vima, nokuviya mbuzi vachiti rerambe ndichirurudzira pachikoro’

shows both his parents and 2 teachers at the school. He spoke fondly of his parents and admired his teachers because *'they teach me about things that I don't know'*¹⁵⁴ (Gift [N], December, 2010)



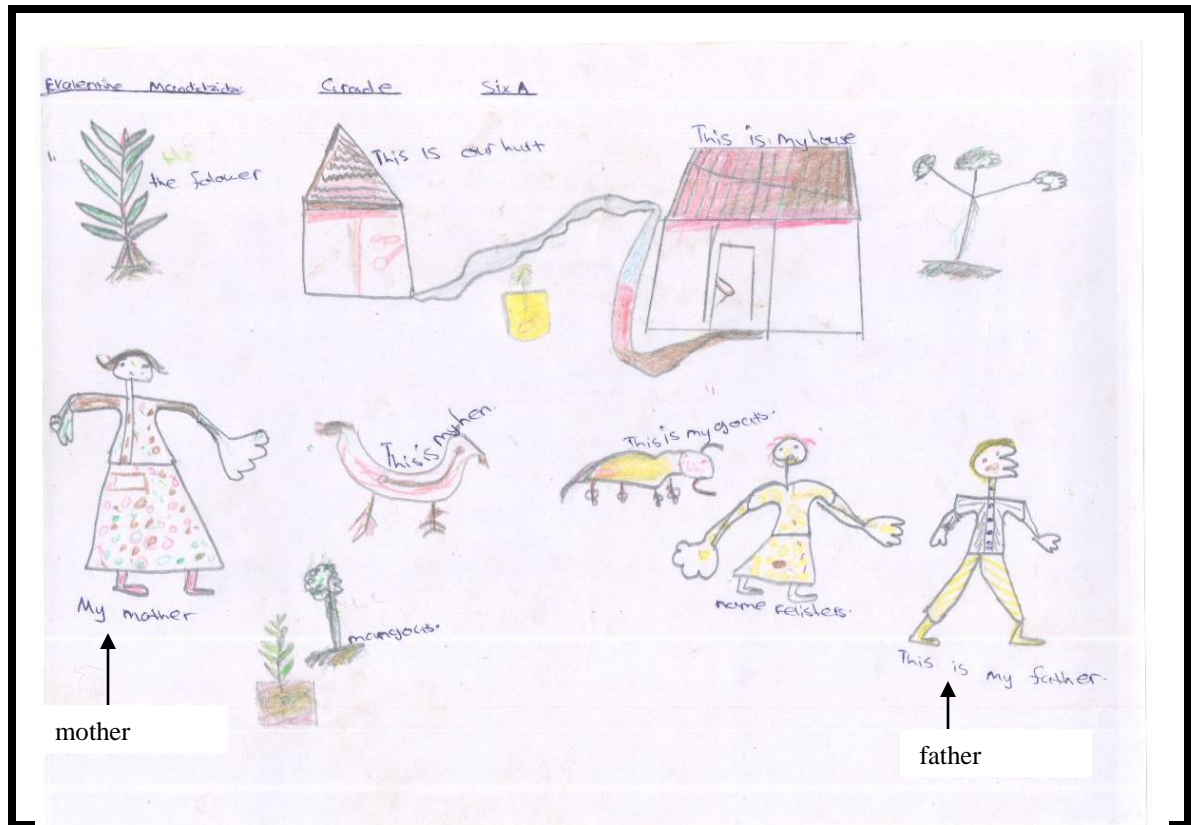
Sociogram 5.8: Gift [N] Relationships

His father, a retired teacher, spoke about how he had already found a place for him at the nearby secondary school and hoped that *'he will be the first doctor in our house'*¹⁵⁵ (Father: Gift [N], December, 2010).

¹⁵⁴ *'vanondidzidzisa zwinu zwandisingazive'*

¹⁵⁵ *'achave murapi wekutanga mumba medu'*

Evelintine [N] (Interview, December 2010) was delighted to tell me about what she does with her parents and how *'it makes me work hard at school because that makes them happy'*¹⁵⁶

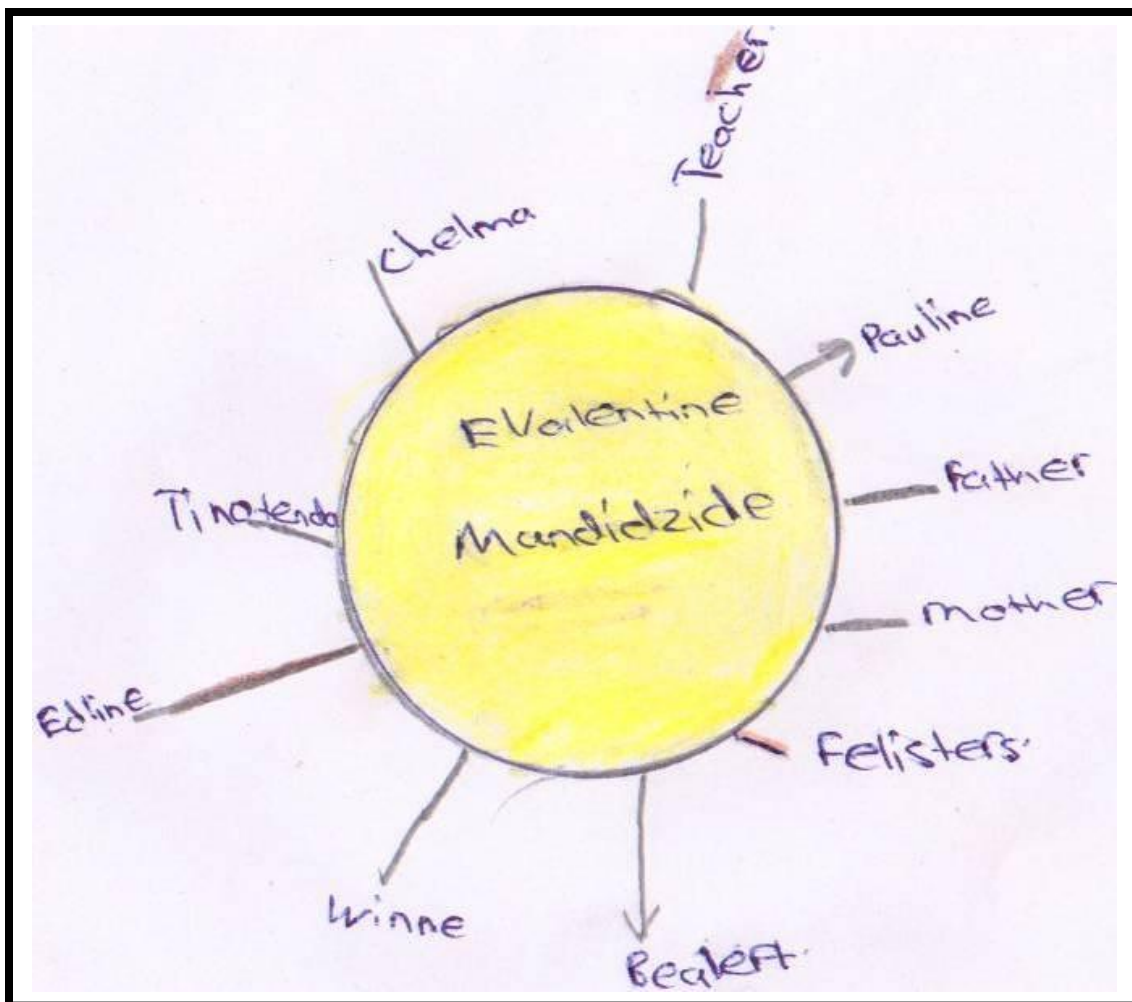


Drawings 5.6: Evelintine [N] Home Environment - Presence of Family

Evelintine [N] spoke at length about how her family always helps her *'with everything that I need or when there is something that is bothering me'*¹⁵⁷ (Evelintine [N], Interview, December, 2010).

¹⁵⁶ 'zinoita kuti ndishande zwikuru kushikoro nokuti zvinovafadza'

¹⁵⁷ 'nezwe zwandinenge ndichida kana kuti kana pane zwinondinesta'



Sociogram 5:9 Evalentine [N] Relationships

Beyond talking about the adults around her, describing her sociogram above, she reflected about her friends - *'we help each other to do things in the village and we also keep each other company'*¹⁵⁸ (Evalentine [N], Interview, December 2010)

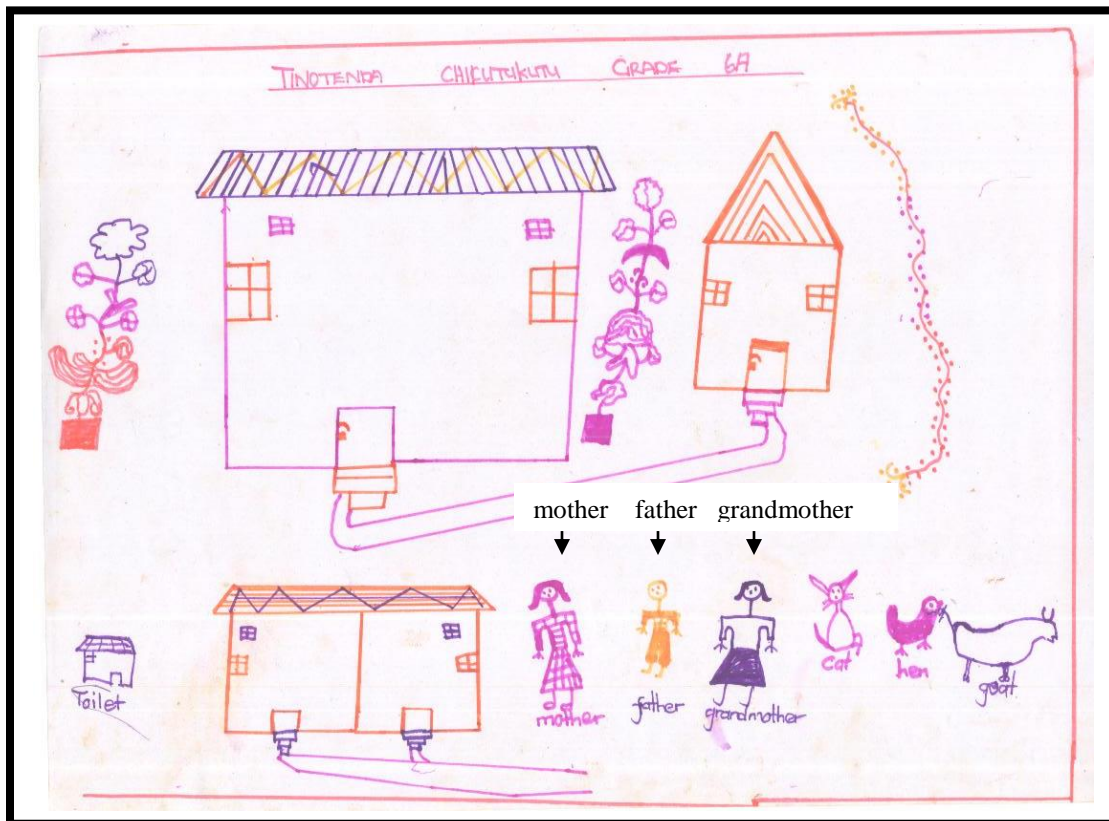
For Edelen [N] (Interview, December 2010) she liked that *'when I am late coming from school and the sun is setting my father comes and walks me back home...my mother cooks for me.'*¹⁵⁹

¹⁵⁸ *'tinobatsirana kuita zvinu kumba nemudhunu nokuvaraidzana'*

¹⁵⁹ *'kana ndikanonoka kubva kuchikoro zuva rovira baba vanowuya kuzofamba neni....amai vanondibikira'*

This security issue was especially important to her because there had been reports of a woman who had been raped – as reported earlier. A lot of the infected and affected students who travelled the same direction tried to walk in groups most of the time. Edelen [N] and other students with both parents had reduced anxieties because of this sort of help; also, being cooked for reduced the number of chores after a long day at school including the long walk home.

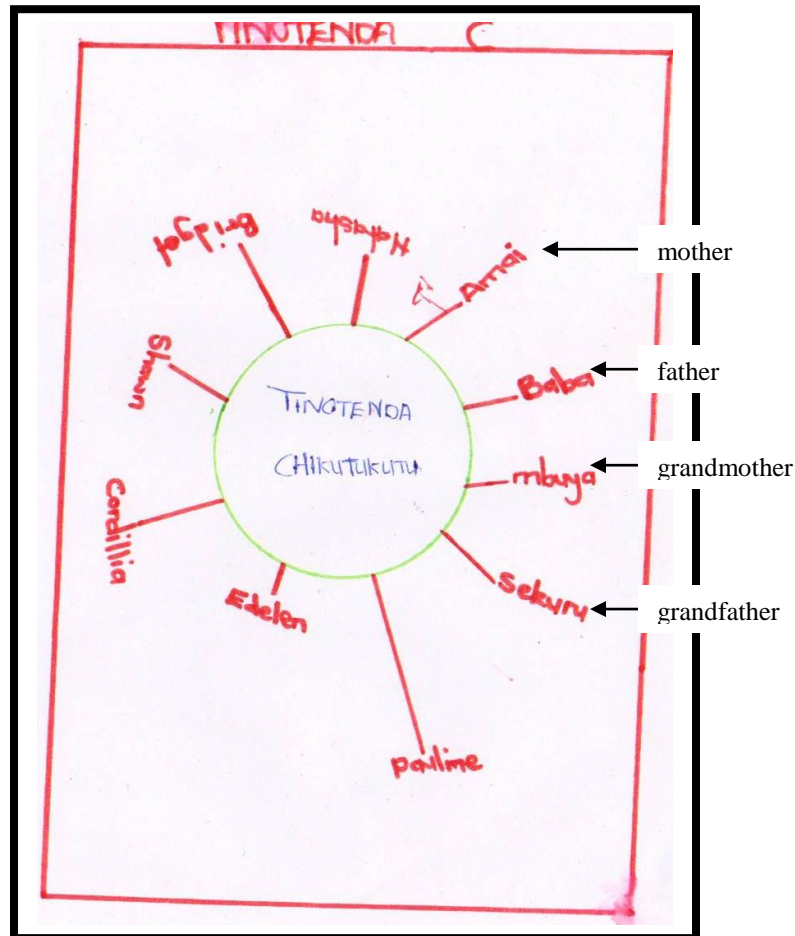
Tinotenda [N], commenting on a drawing showing members of his family, spoke proudly about how they support her in all her needs - *'I feel blessed because I have parents who help me a lot'*¹⁶⁰ (Tinotenda [N], Interview December 2010).



Drawing 5.7: Tinotenda [N] Home Environment

¹⁶⁰ 'ndinonzwa kukomborerwa nokuti in ndinevabereki vano betsera zvikuru'

Tinotenda [N] said she simply enjoyed *'making mud bricks to sell with my father and to go hunting for meat and to catch fish'*¹⁶¹ (Interview, December 2010). He was proud to be able to learn the family business and to be seen with his father in a village where most men were either available just on weekends or just twice a month due to work demands elsewhere.



Sociogram 5.10: Tinotenda [N] Relationships

Tinotenda [N] also spoke proudly about his friends *'we grew up together from first grade we play together all the time and we are also in the choir together'*¹⁶² (Tinotenda [N], Interview, December, 2010).

¹⁶¹ *'kukanya zwidina zwemadaka zwekutengesa nababa nekunovima nyama yemeriwo nekubatha hove'*

¹⁶² *'takakura tose kubva kugrade 1 tinotamba tose ngubva dzose izvo tirimu kwaya tose'*

Normal students, with constant support from their parents, other adults around them and their friends, thus clearly identified with the secure attachment style as proposed by Aldgate et al (2006) that ‘these children have learned that they can trust their caregivers; they can explore their world freely because they know they can access their caregivers when they need them.’ The Head credited their confidence and high scores in class to parental support and positive home experiences. He added that most, if not all, were likely to attend secondary school whereas some affected students, though enjoying almost the same high enrolments in primary school, were unlikely to be given a chance to proceed if a family had to choose between their own and the affected student. This contrast of normal students is important to show how infected and affected students are relatively affected in rural areas that are so disadvantaged that it can be difficult to tell the difference of experiences among different groups. By using the capability approach lens, we can see, however, that not all normal students enjoyed positive home environments and as much support – a few discussed in the section below struggled because of other pressures not evident in infected and affected homes. Although infected students were the most disadvantaged, a simplistic analysis of normal students, by virtue of having both parents still live, would overlook that the circumstances of the normal students in question meant that their capabilities to enjoy ‘valuable beings and doings’ (Alkire, 2002) were also reduced.

Home experiences and poverty – the exosystem.

As mentioned earlier, the exosystem is the larger social setting in which the child does not exert influence but is nevertheless influenced by it indirectly. Home experiences dealt with the conditions parents and/or caregivers exhibited either emotionally or financially. Beyond the emotional, infected and a few of the affected students often had to fend for themselves physically- with the former most affected. Normal students fared better with the support from their parents as shown above. Even though differences between the majority of affected and normal students sometimes were blurred, there were instances where some normal students had more challenging circumstances at home largely

because of parents who had become depressed or mentally ill; sometimes they were caring for a sick relative.

Evalentine [N] in a small but significant diary entry, shows how her situations was much better than that of her counterparts; writing about when she got home - *'I arrived at home, changed my clothes and fetched my sadza (sadza is the staple food) and ate'*¹⁶³ (Evalentine [N]: Diary entry, November, 2010). Evalentine presented mostly the 'normal' students who could have a change of clothes and a ready lunch because of the support of their parents. Other than that infected and affected students mostly used the same clothes for home and school. As mentioned earlier, caregivers had to work harder just to provide the extra food needed, let alone luxuries like clothes. Fortunately, the Head of school had relaxed rules about the uniform. Infected students were the worst affected in terms of resources at home and in school.

Solomon [I] (Diary entry, November 2010):

*'At our house when I come from school I wash the plates and then fix the yard. When I finish I water the garden and then eat but we don't have livestock like cows and goats but others do.'*¹⁶⁴ Solomon [I] did not know or understand why his grandparents did not have any livestock. When I was interviewing the caregivers they related how they had to sell everything to take care of health and burial needs for his parents who succumbed to HIV/AIDS – reminiscent of my family's situation almost 20 years ago. The main house was run down and near collapse – their son who used to fix things for them left a gap in provision since his two siblings were also lost to the epidemic. *'We have nothing my son...can't you see...this disease is unpleasant'*¹⁶⁵ (C-G: Solomon [I], Interview, December 2010).

This meant that Solomon [I] could not participate in the only school trip for the year because the grandparents could not afford the \$5 needed as part of the contribution to the

¹⁶³ *'ndakaswika kumba tika chinja hembe, takabura sazda tikadya'*

¹⁶⁴ *'Kumba kwedu ndichibva kuchikoro ndinowasha mandironekugadzira pamba. Ndapedza ndinodirira magarden, ndodya asi kumba akuna zwifuyo mombe nembedzi vamwe vanezwifuyo'*

¹⁶⁵ *'Hatina chinu mwanangu...awusukowona...chirwere ichi achinakunaka'*

trip. The Head at the school, who was aware of the situation, lamented that he couldn't pay for him simply because he would have to pay for the other 40 or so in the same circumstance as him – even though some of them were not infected. If anything, '*this is what could make the others know that he has the disease*'¹⁶⁶ (Head, interview December 2010).

Yet another example where it was very important that I could triangulate my data – Praymore [I] (Diary entry, November, 2010): '*The sun had set but nevertheless, when I got home mother had not yet cooked. By the time she finished cooking, I had gone to heard cattle and sheep*'¹⁶⁷

At first, this was a simple comment when I read through it. During the interview, Praymore [I] volunteered the information that most of the time his mother (his mother's sister – *mainini*) would not have cooked and that she is always late; that he did not like that because most of the time it meant that he spent the afternoon with an empty stomach. During a caregiver interview I learnt that when his mother died, he was passed on to his aunt who has 6 children of her own and said that she simply no longer had enough food to feed all of them. It was not that she was late in feeding them lunch but there were mostly 2 meals a day with the occasional lunch, but she had not gotten herself to telling Praymore [I]. I inquired about the livestock – why they would not sell some of it to survive, she related that it belonged to the chief who let them keep it in exchange for free milk and in turn her children would herd the cattle. The children did not know. While having 2 meals a day was not terribly out of the norm in the village, Praymore [I] was occasionally taking medicine and needed to eat much more regularly. The time he left for school – between 5:30 – 6 am to be on time meant that at times he missed breakfast if his 'mother' did not get up in time and prepare food for them – which would still be scant after being shared with 6 other kids.

¹⁶⁶ '*ndizo zwingazoita kuti antu acho azive kuti anechirwere*'

¹⁶⁷ '*Zuva range raro va nhongonya apo ndaka svika amai vasati vabika. Amai pavakazopedza kupika ini ndanga ndaenda kuno fudza mombe ne mbudzi*'

Other students simply stated that *'we don't have a cow or even a goat'*¹⁶⁸ (Bridget [I] Diary entry, October 2010). A series of diary entries from Bridget below show how constant food issues presented themselves with little respite in site -

Bridget [I] (Diary entry, November, 2010) *'On Saturday we went to Gwindingwi to fetch corn because we had nothing to eat...on our way back we got drenched in the rain...we came back yesterday... grandmother and grandfather were beginning to fear that we would not arrive.'*¹⁶⁹ The place where they travelled to try and get corn from relatives is about 20 kilometres away.

Bridget [I] (Diary entry, November, 2010) *'On Wednesday when I arrived home there was no one and I asked myself where everyone was... I was then told by grandmother that they had gone to look for food so that we could eat and not worry'*¹⁷⁰

Bridget [I] (Diary entry, November 2010): *'Yesterday when I arrived at home I thought they had cooked but they said there was nothing. I then went to the bush to find berries because then I was very hungry... once I started feeling better I went back home to collect the bucket to fetch water. Then I could feel that I was a bit stronger.'*¹⁷¹

During the interview, Bridget told about the fear of seeking shelter with strangers on the day when they had to travel a long way to look for food. The reason for her having to work hard to help with finding food is that her grandparents are now getting too old to do much – she is now taking care of them on top of taking care of herself. She was, in this case, one of the very few whose home could be identified as a child-headed household.

¹⁶⁸ *'isu hatina mombe kana mbudzi zvayo'*

¹⁶⁹ *'Musi wemugovera takayenda kuGwindingwi kunitora chibage nokuti takangatisina chikafu...pakudzoka dzoka taka naiwa nemvura. Taka dzoka nezuro musu wesondo... mbuya na sekuru vakanga votya kuti hatina kusvika'*

¹⁷⁰ *'Musi we chitatu pandakayenda kumusha ndakaswika panga pasina munhu ndokuziwwunza kuti vanhu maboyendekupi ko... ndakazo taurirwa nambuya kuti vaenda kunosvaga chikafu chokuti mudje noku chidzikama kufunga'*

¹⁷¹ *'Nezuro pandakaswika kumba...ndakangandichifunga kuti kumba kwabikwa sadza ivo vaiti itina kanachinu. ...ndokuyenda kunodya mhuri kusango apa ndakanga ndanzwa nenzara pandanga ndakunzwa kuti zwanani ndokuzoyenda kumba kunitora mugomo wangu kuyenda kumvura. Ndangandanzwa kuti ndatombova nesimbe zvirinani'*

Bridget [I] represents most of the infected students' repeated struggles with lack of food. This struggle could be seen with a number of affected students whose caregivers often travelled afar to look for food as exemplified by Winnie below -

Winnie [A] (Diary entry, 25 October, 2010): '*...that day we spent the whole day hungry without food since father had gone to Mutare to look for food*'¹⁷²

The caregiver, the uncle, had gone to Mutare to look for work. Most men in the village, as pointed out earlier, work in the timber plantations and mines further afield from the village and come back every fortnight or monthly.

Teachers at the school confirmed that infected and affected students struggled with regular food provision and added that '*This is what causes these children to start prostituting*'¹⁷³ (Teacher, interview December 2010). Interviews with the headman and caregivers also revealed that it was getting increasingly common with older orphans out of school, in particular, to resort to prostitution just to be able to provide food for themselves and their caregivers. The school explained that that is how they ended up with a feeding program using donated foods from the community. Kumakomo, however, no longer has surpluses from their own farming (Head, interview, December 2010).

There were, also, 6 normal families who struggled with food provision. Despite receiving remittances large enough to equate Teachers' salaries from their overseas relatives, health needs – physical and mental – depleted resources that left some families just as desperate as infected families. David's [N] parents were taking care of his uncle who was infected and needed to be transported often to the city to treat, largely, symptoms of HIV/AIDS. To ease the workload for his mother, they had employed a worker to help with the constant blanket changes because of diarrhoea. David's father laid off from the sawmill because of an acute pain in the leg that prevented him from standing for long periods of time, meant that they had reduced income. David [N], in addition to digging holes for his own family, had to work within the village to supplement his family income – at times given as food in lieu of cash.

¹⁷² '*...musi uyu takaswera nenzara...apo baba vakanga vayenda kwaMutare kunotswaga chikafu*'

¹⁷³ '*Izwi ndozwinozoiti kuti ana acho afambefambe*'

Even in his appearance, David [N] looked like the poorer infected students with only one pair of uniform. He too was unlikely to carry on schooling to secondary school as he had to assist as indicated above. Despite the fact that the father reported that *'I have a son overseas who sends me money every month that is about \$500... the same amount that teachers earn'*¹⁷⁴ (Father: David [I], Interview December, 2010), their 'functionings' were severely limited by their situation and the reduced 'capabilities' (Sen, 1973) as a whole meant that David was adversely affected to near infected student's levels.

I discovered the five other cases of normal students who were severely affected purely by happenstance. In visiting the homes of Prince [N], Jasper [N], Gerald [N], Marshall [N] and Innocent [A], I had noted that their fathers were home but they did not speak to me; culturally, the father would have been the one to welcome me and be interviewed first. When I had travelled to seek consent, I had not seen any of them - I assumed that they were migrant labours like the rest of the men in the village. When I had requested to interview them, Prince's mother summarized the answers for all the other wives— *'he is not well and he hardly talks anymore'*¹⁷⁵ (Mother: Prince [N], Interview, December, 2010). The Head, who was aware of the 5 men, since they had stopped requesting fees from them due to their complications, informed me that they were all suffering from severe depression. Due to inflation, they had lost their pensions for work that had spanned 25-30 years and as a result, they spiralled into depression. The grandmothers hence became sole providers for families that also catered for orphans. Though poverty was mostly visible with infected and most of the affected students, the normal students discussed above, affected in a different way, suffered the same fate of decreased functionings and their capabilities (Sen, 1973) for the future were just as diminished. The capability approach allows us to further ask the question of freedom to deal with the circumstance of poverty; as seen above, some infected and affected student ended up in prostitution while an equally disadvantaged normal student, David (N), chose to supplement the family income through work.

¹⁷⁴ *'ndinemwana wangu kumiri anonitumira mari mwedzi nemwezi inoswika kuma \$500 iyo inohorwa ne maTicha'*

¹⁷⁵ *'avanzwe zwakanaka avanyanyo taura taura'*

How HIV/AIDS exacerbates poverty is supported by several authors (Brown et al, 1995; Foster and Williamson, 2000; Richter, 2000; Aldgate et al, 2006) who cite it as a factor in affected children. Others (Bennell, 2002; Gill and Jack, 2008; Rivers and Aggleton, 1999) point to how in some cases poverty can lead to caregivers not being able to take care of affected children with some students resorting to prostitution – which was not the case yet with children at Kumakomo but one of the teachers did point out that it was happening with older out of school orphans. Without any planning in place to change the situation, the girls leaving primary school are likely to fall into the same fate - a concern expressed by the Head in the Findings section under Community Perspectives.

In the midst of the HIV/AIDS epidemic, however, students like David [N] could easily be overlooked – caution that is given by Richter (2000) except that she then advocates, wrongly, that all students should be treated the same. Part of what the above discussion shows is that the issue of poverty is very complicated, and more research is needed to navigate how different groups are affected – hence the need to further explore employing the capability approach in educational research. What was clearly visible, however, is that students like David [N] did not suffer the same stigma as infected and the few affected students who were known to have been orphaned through HIV/AIDS. Issues of stigma in school are discussed next.

Chapter 6

Findings and Discussion

The students' school experiences – the microsystem.

The background data which helps us to understand this section, mostly in Chapter 2, delves into Influences of the School, what they should provide (Dowling et al (2006), how positive or negative experiences contribute to development in certain ways (Gilligan, 2001; Rutter, 1985, 1990) and 'functionings' that include or exclude a healthy self-esteem (Cleaver et al. 1999; Daniel and Wassell, 2002). In conjunction with the background of the school in Chapter 4 titled the *Kupisa School*, interview data from diaries, photographs, sociograms and observations were used to frame the discussion which is analysed through a capability approach lens that looks at the individual, 'their group' and also, differences within and among the groups. Even though I had ample data to the point of saturation, a complication with sociograms, discussed at length under Chapter 6 about the research process, was that I had to infer more than I wanted simply because I could not ask certain questions due to confidentiality matters. Namely, asking a student why they did not list another on their sociogram could have revealed information about other students that might have been compromising, especially if it involved an infected student. The manner in which the capability approach is employed has been relayed in Chapter 5.

Very much like the home and neighbourhood, the school is within the microsystem as the child 'experiences intimate interpersonal relations with people and his or her surroundings...his/her environment and relations, engagement is sustained or inhibited leading to either more complex interactions or less growth (Bronfenbrenner, 1993). Students' experiences in school would have been very difficult to understand without the students' own voices in play. As will be seen infected students had mostly negative school experiences because they were largely excluded both in and out of the classroom.

Teachers had low to no expectations of them, affected and normal students seemed to ignore them and they (infected students) did not, despite sitting in a huddle in the middle of the classroom, work together nor socialise amongst themselves. Still, in the classroom, with limited space, an observer could easily be mistaken to think that it was either the seating arrangement of the students in the middle or students who simply chose to sit by themselves. Being able to observe in the classroom daily, interviewing the teachers and the students made it apparent that the infected students, in particular, were being stigmatised. Affected students seemed to be isolated for widely different reasons than infected students who were simply seen as sick, weak and unsociable – the latter being a result of being constantly excluded, resulting in self-stigma. Stigma issues were more apparent outside the classroom in the playground where infected students were more visibly isolated. In this section, I will, therefore, discuss issues of stigma in and out of the classroom, how it affected the infected and affected students in particular. Once again, the capability approach allows us to look at individual experiences together with group dynamics which allows us to look at dimensions of experience rather than, simply, rates of return (Unterhalter et al, 2007).

Stigma in the classroom

In class, infected students clearly sat separately – even from each other but mostly from the affected and ‘normal’ students. Affected students tended to blend in much easier. I noted a similar scenario in the playground – infected students were more aloof and when they tried to get involved other students took notice. Affected students at times seem to be part of the larger group. A situation that exacerbated the situation for infected students, albeit unavoidable, were instances of infected students being visibly sick at times in school which seemed to create suspicion that they were sick from HIV/AIDS – especially after rumours had been circulating in the village that it is how their parents died.

Praymore [I] (Diary entry, 26 October 2010): *‘Yesterday I wasn’t very happy because I was very sick, so sick that I was vomiting and sweating’*¹⁷⁶

¹⁷⁶ *‘Nezuro nengendisina mufaro nekuti ndairwara zvikuru uye zwekurwara kurutsa nekubuda ziya’*

This happened at least 3 times a week for Praymore [I] –the caregiver thought it was because of side effects from the medication that he was taking. He refused to stay at home – wanted to go to school at all times even when he was ill - *'he refuses to stay home'*¹⁷⁷ (C-G, Praymore [I] Interview, December 2010). School provided a space where he could at least be with other children rather than being abandoned at home. He related that he often got sick in the afternoon and didn't like it because *'sometimes when I have to go home they tell grandmother to come and get me and she comes late'*¹⁷⁸ (Praymore [I] Interview, December 2010). Since messages are sent through other parents passing through the school going to their own homes, it meant that at most times Praymore had to stay at school very late until his caregiver had been informed about his condition. At those times he simply sat in the school office and waited. All other students, being in the same class, were able to observe Praymore's [I] episodes of being ill, including that of Solomon [I] discussed below.

Solomon [I] (Diary entry, October 2010): *'Yesterday I was sick and I told Sir that I was sick. Mr Tsiku said to go home. I got home and I slept. Then I was given some pills by my grandmother and I felt better'*¹⁷⁹

When I inquired with the caregiver about what they gave him for the treatment she told me that they gave him a headache, flu and stomachache medicines. *'When we gave him the ones from the nurse for the disease (referring to HIV) he didn't do well'*¹⁸⁰ (C-G, Solomon [I], Interview December 2010). Since the side effects of HIV medication made him worse they put him on what they had in the house from another clinic. This irregular or substitution of medication was not uncommon with 5 other infected students. Solomon regularly fell asleep in the classroom. *'He is always tired this boy together with these other relatives of his'*¹⁸¹ (Teacher Interview, December 2010). By 'these other relatives

¹⁷⁷ *'Untu acho hadi kugara kumba'*

¹⁷⁸ *'kwakanzi ndiyende kumba dzimwe nguva vanodedza mbuya kuti vazonditora asi vanononoka'*

¹⁷⁹ *'Nezuro ...ndakatanga kurwara ndikati Sir – ndirikurwara. VamTsiku vakati yenda kumba. Ndakaswika kumba ndikamborara. Ndikazophiwa maphilisi nababa ndakamuka nditshinzwa zwirinani'*

¹⁸⁰ *'Patakamupa akawunzwa nanurse iwo wecherwre hanakumupata zwakanaka'*

¹⁸¹ *'Anogare akaneta mukomana uyu ne hama dzake idzi'*

of his' the teacher meant the other infected students who also slept a lot and tended to cluster in the middle of the classroom.

As I observed the events all the other students in the class witnessed - the infected students being taken in and out of the classroom – it became clear that the episodes of sickness, largely, set the infected students apart from others. Yet another public event took place when Admire [I], who later wrote it in his diary, had to be taken to the hospital

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Admire [I] (Diary entry, November 2012): *Yesterday I went to the clinic by a lorry. I saw the baboons standing by the road and when we arrived I saw big buildings and I asked my friend what the building was. Munya said: This is the clinic Admire. I saw the nurse, told him my problem and she gave me medicine to drink. After that, I was back on the lorry and we went to the shops and bought things to eat ...when we finished eating... we came home*¹⁸²

Admire [I] had been increasingly suffering from headaches and weight loss and both the school and grandparents were worried; they took him to the clinic which is about 20 km away. They used the NGO truck that had been to the village to deliver food on its way out back to the city. Since he was taken from his class to leave for the clinic, all the other students watched as he was being lifted by one of the teachers out of the class to the truck.

On interviewing Admire [I] about his trip, this is what he had to say:

Admire [I] (interview, December 2010): *'I was very happy to travel with grandmother. But I feel tired all the time. I always have to go to the toilet when I have eaten. The medicine that I was given is not working on my stomach.'*¹⁸³

There was no way of monitoring the children's medications even when they arrived at the clinic. The nurse who lives in the village informed me that *'even when they come here*

¹⁸² I left out his own Shona words since the quote was rather long

¹⁸³ *Ndakafara kukwira mota nambuya. Asi ndinozwa kuneta nguva dzose. Ndinoraga ndichiyenda kuchimbuzi kanadadya. Mishonga yandakombo phiwe asikuchanda nemudumbu mangu'*

*there is very little that we can do and also it will be a long time before they come back again to the clinic*¹⁸⁴ (Village Nurse, Interview, December 2010). This particular clinic, almost 15 km from the school and Village, has scant pain medications let alone HIV medication.

Tatenda [I], commenting on why she sleeps sometimes in the class, blamed it on being hungry – *I feel hungry in the morning because sometimes grandmother does not cook in the morning*¹⁸⁵ (Tatenda [I] Interview, December 2010). Affected students also complained about being hungry in the morning except that none of them napped or showed signs of fainting. All groups, except for a minority of students who lived closer to the school, complained about the long distances that they had to walk to school – these, of course, worsened the situation for infected students already dealing with other issues. Tatenda [I] also had episodes in the classroom when she coughed incessantly. Infected students were also aware that at times they were visibly sick –

Bridget [I] (Diary entry, November 2010): *Yesterday... school was exciting. But for me it was not exciting because I had a headache... I ended going home when I didn't feel like it, even anyone who saw me could see that I was sick.*¹⁸⁶

The teacher, who had no grades listed for the infected students, told me that *'it's pointless it does not help with anything, all year these kids come to school to sleep... it would be better if they stayed at home'*¹⁸⁷ (Grade 6A Teacher, interview, November 2010). The teacher said that when he attempted putting them in mixed groups he found it too disruptive as the other groups then spent time either trying to still move away by forming little subgroups or teasing the infected students – *'the learning which is already disrupted is even getting worse'*¹⁸⁸ (*ibid*). So he finally let them choose where they wanted to sit with the resultant island of infected students in the middle of the classroom. Whereas the

¹⁸⁴ *'nyango vakawuya kuno zwichoma zwatinogona kuita zwakare pachavanenguve vasinakudzoka kuchipatara'*

¹⁸⁵ *'ininonzwa nzara makuseni nokuti ndimwe nguva mbuya avabike mauseni'*

¹⁸⁶ *'Nezuro...kuchikoro kwainakidza chose. Asi ini kusingandinakidze nokuti ndinorwarane musoro...ndakazoenda kumba ndisachadi kuendanokuti musoro wangu wazonyanya zvokuti, kana muntu ayindiwona aiti asi urikurwara'*

¹⁸⁷ *'azwibetsere chinu, hapana zwavanoita vana ava gore rose vanongowuya vachizvo kostira zwirinani vagare havo kumba'*

¹⁸⁸ *'iko kudzidza kwasho kwaraga kurikushoma kwenge kwakuderera chose'*

Grade 6A Teacher thought that it might be better for the infected students to stay at home, the Grade 6B Teacher related that *‘this seemed better for them to be in a place where they knew other kids didn’t want to play with them than to be alone at home...at least there is a chance that they could socialize with other children like them...their caregivers cannot keep them at home like the affected because they cannot work as much in the fields’* (Teacher interview, December 2010)¹⁸⁹.

There were thus, very serious issues with illness, improper use and substitution of medication (albeit due to ignorance) and adherence (Campbell, 2003). For the students in question, despite being in the same classroom and having the same resources as all other students, their *functionings*, their ‘freedom to achieve well-being... (Robeyns, 2017:5)’... their ability to move around or to enjoy supportive social relationships...(ibid, 2017:26) became deeply compromised.

Whilst adherence in rural Kumakomo was still characterized by ‘lack of food, distance to health clinics, transport and opportunity costs...stigma and the age and physical and mental capabilities of some guardians’ (Skovdal et al., 2011b) who simply struggled to cope because of age, Campbell et al (2012), through a recent study, show that these barriers amongst others can be overcome. Through a small qualitative study of 25 nurses and 40 guardians in a rural community in Zimbabwe, they concluded that there were high adherence levels in children which were due to the social relations among ‘children, guardians, community members, health workers and NGOs’ working together whereby they had managed to achieve ‘normalisation of AIDS in the public sphere and improved drug and service availability to work collectively to promote optimal child health’ (Campbell et al, 2012:130). It has to be noted however that they admit that their ‘sample was biased towards regular, highly motivated child carers, who had overcome multiple barriers to access and adherence’ (Campbell et al, 2012:125). This, therefore, might possibly have given a slightly skewed picture of the whole village. Their village of research also had at least 3 health workers, an NGO that was present and worked with people and much easier access to ART – all of which lacked in Kumakomo and possibly

¹⁸⁹ Teachers often spoke in English – hence I only have verbatim English quotes from the taped interviews

many other rural villages in Zimbabwe. In addition, no children were interviewed and the study, also, over-relied on interviews; triangulation of data including observations might have strengthened their study since ‘what people say *can be* very different from what people do’ (Hodder, 1998:113)¹⁹⁰. Nevertheless, their conceptualisation of an ‘adherence competent community’ (Campbell, 2012:130) shows what is possible with collaboration within the available social relationships in helping infected children with adherence. Whereas ‘normalisation of AIDS in the public sphere’ (2012: 130) was achieved through people having experience with AIDS sufferers in their families and relatives, this process in Kumakomo for people who have experiences with AIDS sufferers is still muted by stigma and religious overtones. What is encouraging is that this research was conducted in a rural area in Zimbabwe – which gives hope for breaking the silence in places like Kumakomo.

Despite what seemed to be insurmountable difficulties for infected students in the classroom, they wanted very much to keep coming to school -

Bridget [I] (Diary entry, October 2010): *‘Yesterday I was working on Maths and it was very interesting. At break, we were playing with Michel. When we returned from break we started reading Shona and I felt very happy...I like to read school books’*¹⁹¹

Bridget was very happy at school despite the obvious incidents of stigma from classmates. Solomon [I] shared similar sentiments -

Solomon [I] (Diary entry, 22 October 2010): *‘When I am in school I feel very happy to spend time with friends and to play soccer...when I am in school I feel very happy to learn... I feel sad when I am at home’*¹⁹²

¹⁹⁰ Hodder (1998:113) is this case gives an example of ‘Bill Rathje and colleagues (Rathje and Murphy, 1992) who collected domestic garbage bags and itemized the contents’ and found out that ‘people’s estimates about the amount of garbage they produced were widely incorrect, that discarded beer cans indicated a higher level of alcohol consumption than was admitted to, and that in times of meat shortages that people threw away more meat than usual as a result of over hoarding’ – the main point being that ‘sociological analysis cannot be restricted to interview data.’

¹⁹¹ *Nezuro takanga tichi nyora maths. Asi dzanga dzishi nakidza chaizvo. Tavakubhureki tangatishi tamba naMichel. Patakazobva kubhureki takatanga kuverenga shona –tainzwa kufara chaizvo....ini ndinofarira kuverenga mabhuku echikoro’*

¹⁹² *‘Ini kanandirikuchikoro indinonzwa kufara tainge tichi tandara neshamwari tiri kutamba bora...kana ndirikuchikoro ndinozwa kufara nekudzidza... ndinozwa kusuwa kanandirikumba’*

This was despite the fact that he did not have many friends at school or played soccer. When I asked him to explain further he said he liked being with others and watching soccer at school – *‘here we will be with others’*¹⁹³ (Solomon [I], Interview, December 2010). Here Sen’s capability approach acknowledges that ‘persons have plural identities...and that they are able to reason and choose how to live these out’ (Alkire, 2002:141).

Affected students, however, blended well with normal students. There were only 2 affected students – Christopher [A] and Tallent [N]¹⁹⁴ – who were sometimes given a cold shoulder by other affected students and normal students. I found out from their caregivers that their parents had died from HIV/AIDS and the news had been inadvertently publicized through a church prayer group. In praying for their parents in the group news soon spread out that they were suffering from HIV/AIDS and by the time of their deaths *‘everybody knew’*¹⁹⁵ (Head, Interview, December 2010). Because of limited space in the classroom, I think that Christopher [A] and Tallent [N] seemingly blended much better in class than in the playground, where, as shall be seen, they also had a few complications of being accepted like the infected students who were blatantly left out.

Outside the classroom - Stigma in the playground

How the different groups related to each other was most evidenced outside the classroom. The playground, which was the most photographed by students, is where most of the relationships could be identified through observation and confirmed as students explained their pictures and sociograms to both describe why the playground was important and who they related to most. Stigma was thus most apparent outside the classroom.

¹⁹³ *‘kuno tinenge tinevamwe’*

¹⁹⁴ Talent is always designated as a normal [N] student since that is how his grandparents identified him but he is clearly an affected student as I later found out when interviewing his grandparents.

¹⁹⁵ *‘antu ose ange akuziva’*



Photograph 5.1: Gift [N] Playground



Photograph 5.2: Praymore [I] Playground



Photograph 5.3: Blessing [A] Playground

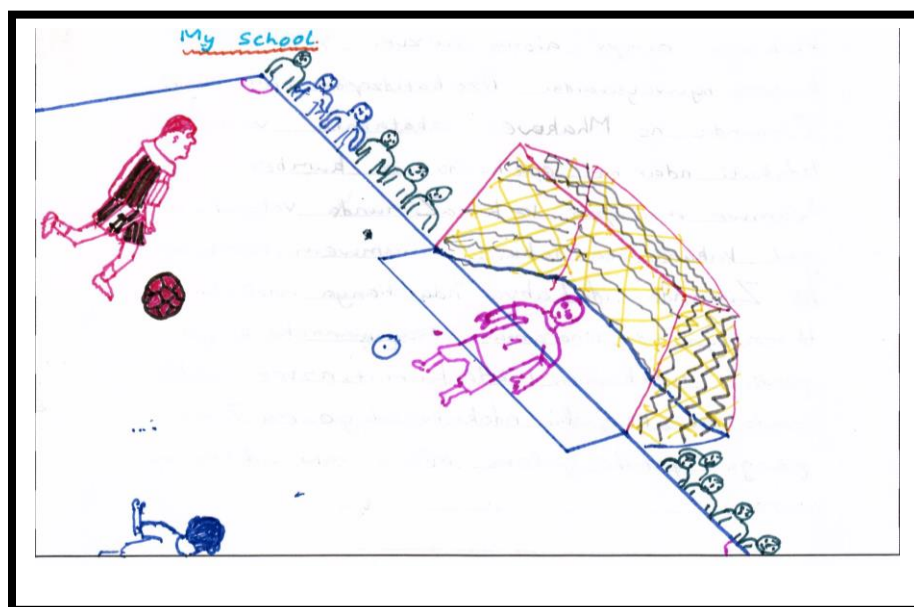
Sociograms revealed that infected students were the most stigmatised; though they desired friendships, affected and normal students mostly did not want to be their friends; in cases when they did, it was mostly outside the school environment where they could not be seen befriending *‘those who are weak and sleepy at school’*¹⁹⁶ (Gift [N] Interview, December 2010).

Before interviewing students about relationships that they deemed important in reference to whom they had listed on their sociograms particularly in school, I had noticed that most of the infected students listed friends who did not reciprocate by listing them as friends on their sociogram. This posed a dilemma for me since I wanted to know why this was, yet I could not divulge this information to other kids since that would be breaking confidentiality. By simply asking if there were other friends that they didn’t list on their sociogram I was able to avoid breaking confidentiality and mined a wealth of information about existing relationships among the 3 groups including the complex nature of stigma within. One of the areas where stigma was strongly reflected was during the selection of teams for the boy’s main activity – soccer, as Cain [N], one of the team captains reported in his dairy –

¹⁹⁶ *‘vanongopusapusa vachirara kuchokoro’*

Cain [N] (Diary entry, 22 October 2010): *‘At break time we were playing soccer with my friends. These are my friends – Kudakwashe was number seven, Consider number 9, Godknows number 8, Tendai number 6 and I was number 5...’*

These daily soccer activities started with 2 students choosing a team from boys simply waiting to be chosen. Infected students had given up standing in the group to be selected and affected students were often left out as ‘subs.’ Cain [N] was one of the captains who did the choosing. During the interview when I asked him how he decided who to have on his team he told me that he needed *‘boys who can run fast and didn’t get tired easily’*¹⁹⁷. The other captain, Gift [N], simply said *‘some of these kids are sick’*¹⁹⁸ – a clear reference to infected students. Christopher [A] and Tallent [N] were almost always last to be chosen into teams but all the affected students were chosen to play usually after most normal students had been picked. There was, however, one affected student, Artwell [A], who was picked early because of his size and he did indeed outrun the other kids. Part of his storytelling had a drawing (below) of when he had been chosen to take the penalty kick – an honour for any member of the team.



Drawing 5.8: Artwell [A] playground

¹⁹⁷ *‘vakomana vanogona kumanya zvikuru vasingoneti neti’*

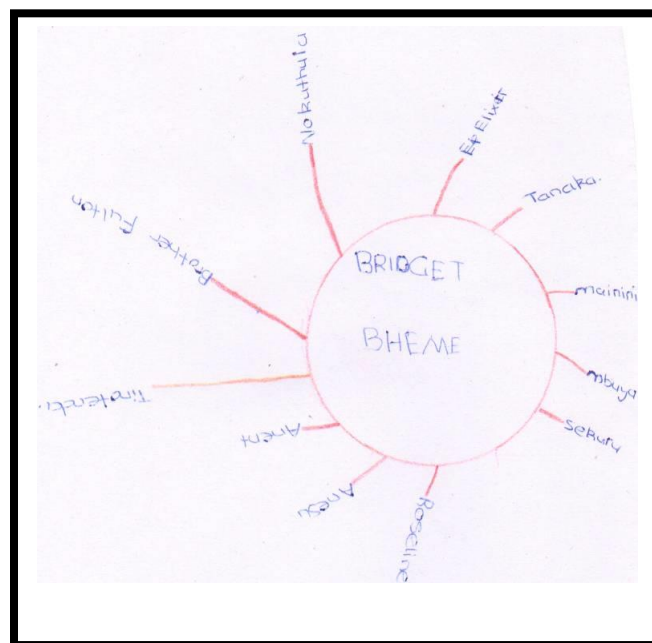
¹⁹⁸ *‘amwe antu acho anorwara’*

I observed that girls mostly sat and chatted since jump rope – the only sport for girls at this school – was populated with many younger girls jousting for one rope. Infected girls almost always sat together ‘alone’ while affected girls seemed to have much to chat about. It wasn’t clear here if any of it was stigma or self-stigma from the infected girls.

Simply through observations, however, I would have been diverging from letting the student’s voice be an integral part of the research. Below I will discuss a few students’ sociograms and the impending interviews to show how stigma was part of socialising.

Bridget [I]

Bridget spoke sadly about her experience in the playground – ‘*when Tatenda does not come to school I will have no friend at school*’¹⁹⁹(Bridget [I], Interview, December 2010).



Sociogram 5.11: Bridget [I] - Relationships

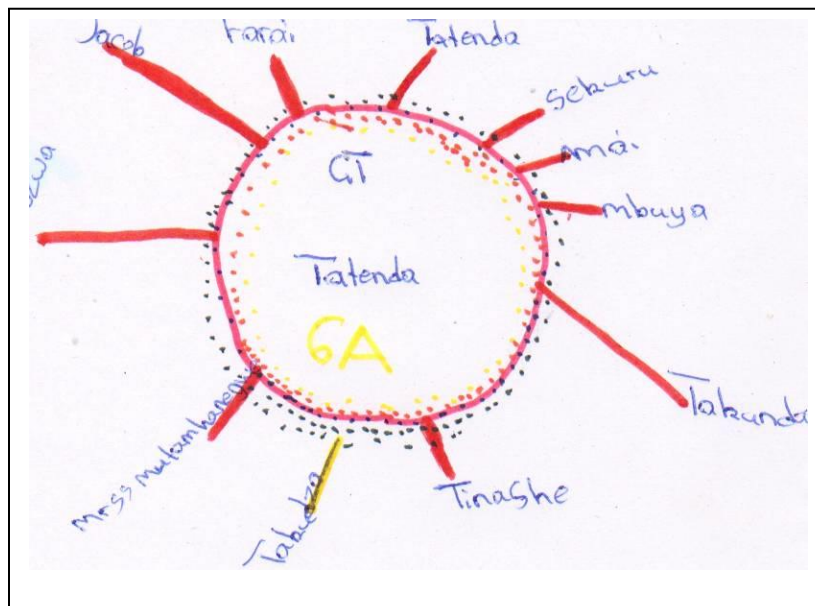
None of the people listed on Bridget’s [I] sociogram above were from school. Most of the people shown above were either adults or friends she claimed played with her in the

¹⁹⁹ ‘*kana Tatenda [I] asinakuwuya kushikoro ndinongendisina shamwari*’

village; also, Tatenda [I] did not list her on her sociograms as a friend. I asked her if she had tried to make friends at school and she responded by saying that *'I used to try but I don't know why they don't want to play with me'*²⁰⁰ (Bridget [I], Interview, December 2010). Apart from the clear reference of other students not wanting to sit next to her and other infected students in her class, it was difficult to determine if this was a clear case of stigma, self-stigma or simply failing to make friends. It remains, however, that she was very lonely at school.

Tatenda [I]

Similarly, Tatenda's sociograms listed friends who were not in school – all of them were friends that she played within the village.



Sociogram 5.12: Tatenda [I] - Relationships

I had observed Tatenda [I] occasionally speaking to Bridget [I] during recess while they sat on the sideline watching self-organised groups playing soccer, jump rope or *pada* – a Shona game. When I asked her if there were other friends that she did not list she mentioned Bridget [I] and said that *'Bridget is my school friend but she is always very*

²⁰⁰ *'ndaimbo zama asi andizivi kuti yindava vasingade kutamba neni'*

*quiet and thinks a lot*²⁰¹. When I asked her the same question as posed to Bridget earlier - whether she had tried to befriend other girls - she laughed and simply said *'they don't want to play with us these people'*²⁰² (Tatenda [I] Interview, December 2010) the 'us' was her and the other infected girls. Both girls were not listed on any of the others students' sociograms neither were they mentioned at all in the interviews. I observed that they were indeed lonely – both at school and at home as shown in the 'home experiences' section.

Miriam [I]

Miriam, on the other hand, had listed 4 school friends on her sociograms who, unfortunately, did not list her as a friend nor make mention of her. Miriam said that they played with her in the village – *'but when we get to school they seem embarrassed to play with me'*²⁰³ (Miriam [I], Interview, December 2010). When I tried to find out why she thought that, she said she did not know. My attempt to get a glimpse of the reason from the students she put on her list did not produce anything since they did not even mention her name. When I asked the Head why he thought this might be he said that he suspected that it was for the same reasons that they did not want to socialise with them in the class is *'that they are always sick without people knowing what it is so the conclusion when people are not sure is that its AIDS'*²⁰⁴ (Head, Interview, December 2010). Below is Miriam's sociogram that shows friends who did not reciprocate.

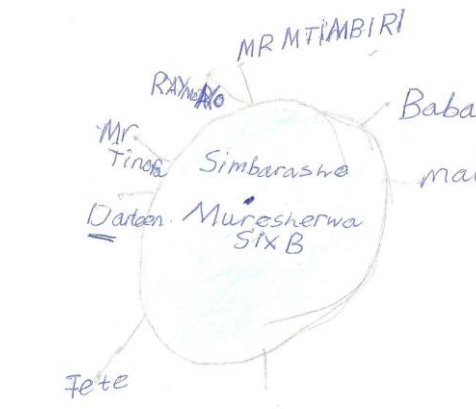
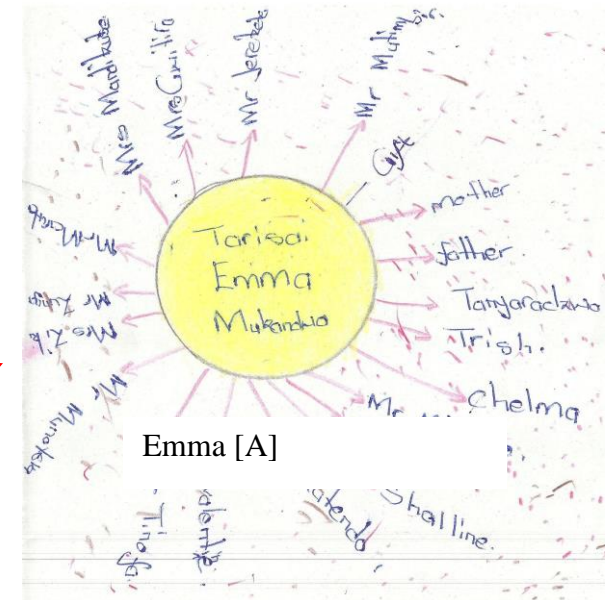
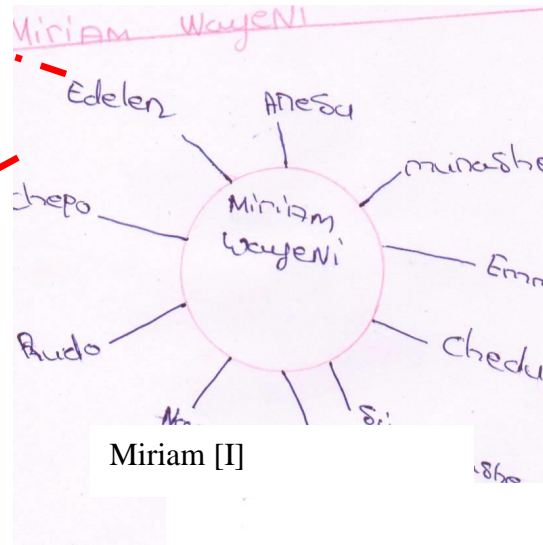
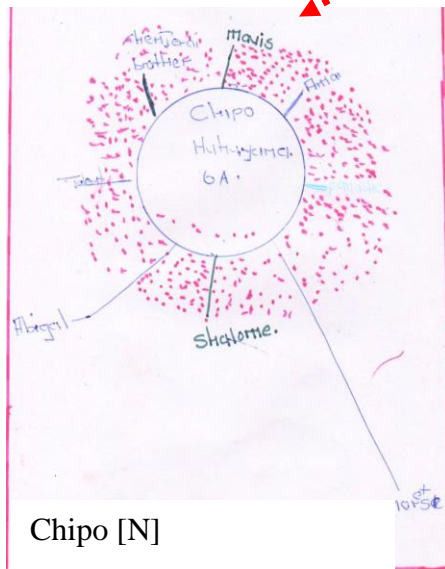
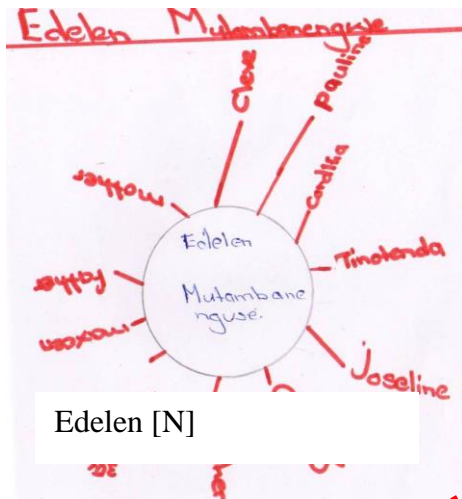
²⁰¹ *'Bridget ishamwari yangu yekuchikoro asi hana mutauro anogara akanyarara achifunga'*

²⁰² *'hadi kutamba nesu antu acho aya'*

²⁰³ *'asi kana tirikuchiroko vanenge vanonyara'*

²⁰⁴ *'kuti vanogara vachirwara vantu vasingazivi kuti chi saka vanhu vanobva vafungira chirwere'*

Sociogram 6.16: Miriam – non-reciprocated friendships



Admire [I]

Interestingly, Admire did not mention any of the infected students on his sociograms – despite spending almost all his time with them in class – albeit out of his choice. Out of the 4 friends he listed below, however, only one reciprocated and also mentioned him during the interview; he mentions the same student in his diary -

Admire [I] (Diary entry, 2010): *At school, I like to play with my friend called Trust this is the friend closest to my heart ...Trust does not bother others*²⁰⁵

During the interview Admire [I] related how Trust [N] showed him respect and never teased him. I asked him how he showed him respect and he mentioned how Trust did not act differently at the village than he did at school - *'others like to be friends at the village only but not at school'*²⁰⁶ (Admire [I], Interview, December 2010). I had observed that Trust [N] spent a bit of time talking to infected students both in class and in the playground. I understood better why Trust [N] spent time with them when I arrived at his home to interview his 'parents.' Trust lived with his grandparents, both of his parents had died of AIDS and he also watched his younger brother slowly disintegrate as the disease ravaged his body. His grandparents told of how Trust had helped nurse his little brother and eventually he had to be taken away to avoid being traumatised. They explained that when they were in a different village knowledge of how his parents had died had made them feel ostracized *'even at church'*²⁰⁷ (C-G, Trust [N], Interview, 2010) which is why they had not communicated his orphan status to the school. Trust [N] clearly empathized with the infected students due to his own experiences. Interestingly, Trust was always included by normal students in friendships because they did not know about his status. This then may show, in a way, that infected and affected students who are held at arm's length are stigmatized and treated negatively because of their known or perceived status, which could imply that it is not the disease itself that students are afraid of but association, as they fear it may affect their standing with other students.

²⁰⁵ *'Pachikoro ndinofarira kutamba ne chamwari inonzi Trust iyo ndiyo shamwari yangu yephamoyo...Trust hanesteni vanhu'*

²⁰⁶ *'Amwe anoda kuva shamwari kumusha chete hongo kuchikoro'*

²⁰⁷ *'nyango nekukereke chaiko'*

Friends

Kudakwa she
maposa

Jenah

Mather

babu

+atenda

beni

Solomon

+endui

+atadzwa

tamba

witins

A hand-drawn mind map with 'Tendai Maguwai' in the center. Lines radiate to 'Casper', 'Baba', 'mai', 'Taraka', 'Partson', 'Truth', and 'Artwell'. A red arrow points to the 'mai' branch.

A hand-drawn map of Goba, a circular town in Zimbabwe. The town is divided into sectors by radial lines. Clockwise from the top, the sectors are labeled: 'Goba' (top), 'Baba' (top-right), 'Batsirai Sisi mukoma' (right), 'Trust' (bottom-right), 'Tender' (bottom), 'Amasini' (bottom-left), 'Amasini' (left), 'Amasini' (top-left), 'Goba' (top). A red dashed line runs diagonally from the top-left to the bottom-right, passing through the center. A red arrow points to the 'Trust' sector. The map is titled 'Goba' in the center.

A hand-drawn mind map with a central circle containing the name "Cliff Muchai". Lines radiate from this central circle to various names written around it. Starting from the top and moving clockwise, the names are: mbaya, tote, Thomas, Trymorecha, Byron, Daniel, Itai, Pithon, Furett, Dahn, and Sekuru. The lines connecting the central circle to "mbaya", "tote", "Thomas", "Trymorecha", "Byron", and "Daniel" are blue. The lines connecting to "Itai", "Pithon", "Furett", and "Dahn" are red. The line connecting to "Sekuru" is black.

A hand-drawn mind map with 'Sigabona' in the center. It has eight branches: 'Trust' (top), 'Watkins' (top-right), 'Itai' (right), 'Mire' (bottom-right), 'baba' (bottom), 'Admire' (bottom-left, with a red arrow), 'Gift' (left), and 'Tymore' (top-left). A red star is next to 'Solomon' at the top.

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Trust [N], who reciprocated Admire's [I] friendship said *'he is a very good friend of mine indeed and we always play together and also walk to school together'*²⁰⁸ (Trust [N], Interview, December 2010). Trust [N] also listed Solomon [I] and spoke about him as a friend whose company he enjoys.

Praymore [I]

Like Admire [I], of all the 5 friends Praymore [I] listed on his sociograms and described as friends, only one, Tallent [N], reciprocated and also mentioned him as a friend; *'Tallent is the one who sometimes comes to play with me at our house and we used to herd cattle together'*²⁰⁹ (Praymore [I] Interview, December, 2010). About the other friends, Praymore listed he said they *'sometimes walk home with me'*²¹⁰ (*ibid*). Tallent [N] also listed Praymore on his sociogram and mentioned him as a friend. Tallent [N] empathised with the infected students having lost both parents and also *'had his brother taken away from him by the disease'*²¹¹ (C-G, Tallent [N], Interview, 2010). Once again, the pattern was a student who was familiar with suffering that was prepared to befriend infected students – all others seemed to treat them differently even though the infected students, by listing them and talking about them, would have wished to be included in their social circles.

²⁰⁸ *'ishamwari yangu chaizwo togara tichitamba tese kuguta izvo tofamba tose kuyena kuchikoro'*

²⁰⁹ *'Tallent ndiye anombowuya kuzoniwona kumba kwedu tichitamba tese taimbofudza tese nokuvima dzimwe nguva'*

²¹⁰ *'vanosi famba neni kumba'*

²¹¹ *'akatorerwa mukoma wake nechirwere'*

Solomon [I]

Solomon's situation was not unlike that of Praymore [I] as the only friends who reciprocated – Tallent [N] and Kuda [N] - have experienced relatives struggling with HIV/AIDS. Tallent's [N] experience has been alluded to above. Once again, it was only when I visited Kuda's [N] family that I became aware that they had a patient, Kuda's uncle, who was bedridden because of HIV/AIDS. *'He worked far away and by the time he came back the time for the medicine to work had lessened considerably'*²¹² (Parents, Kuda [N], Interview, December 2010). They explained that he worked in the mines in South Africa and when he came back to them he was too sick. The man had gone blind and could only recognize his relatives by voice only at times. He had been with them for over a year. Students like Tallent [N], Kuda [N] and Trust [N] were mentioned by infected kids because they were prepared to be friends both in and outside school. It can be concluded here that empathy plays a big role in breaking stigma (Pattman and Chege, 2003; Campbell et al, 2012); unfortunately, silence about matters of HIV/AIDS in Kumakomo means that the idea of empathy will be very difficult to explore fully publicly.

When I asked Solomon [I] if there were other friends he had not listed he mentioned Ruud [A] who had listed him on his sociograms. Solomon [I], however, did not want to list Ruud [A] because *'he wants to play with me at home only'*²¹³ (Solomon [I], Interview, December 2010). He showed resistance to being accepted 'at home only' yet listing friends who neither listed nor talked about him as a friend seemed to be a deep-seated desire to engage in any way he could. From what Solomon [I] said, the friendships with the other students who did not list him was very much limited *'walking to school and walking back home together after school'*²¹⁴ (Solomon [I], Interview, December 2010). Arnold [N], listed on Solomon's list, when talking about friends not on his list, mentioned Solomon [I] and stated that *'Solomon is my friend at home'*²¹⁵ (Arnold [N], Interview, December 2010). When I inquired further why he was just a 'friend at home'

²¹² *'Vayichanda kure pavakadzoka nguva yacho yokuti mushonga ushande zwakanaka wamushoma zwikuru*

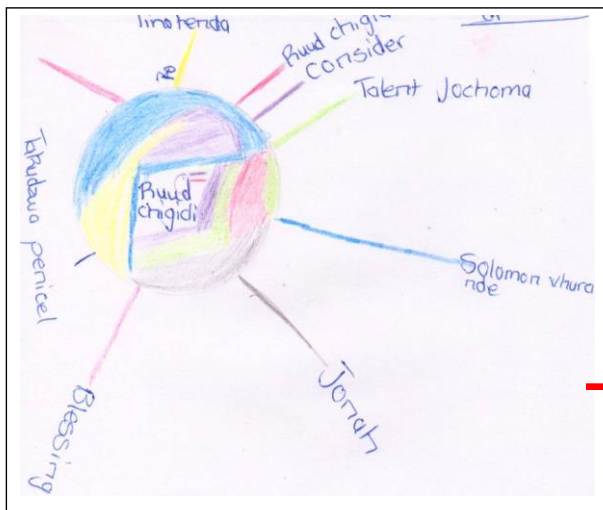
²¹³ *'anongoda kutamba neni kumba chete'*

²¹⁴ *'ku famba tose kuyenda kuchikoro no kudzoka kumba'*

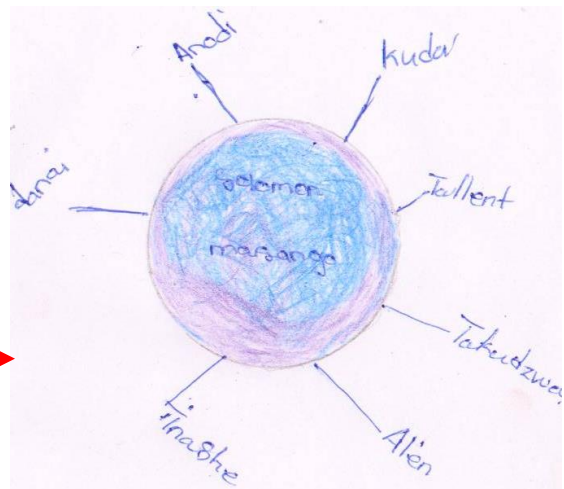
²¹⁵ *'Solomon ishamwari yekumba'*

and not at school and elsewhere he simply said he had ‘*school friends and village friends and some were friends both at school and in the village as well*’²¹⁶ (ibid) – not a very clear case of stigma except that Solomon [I] was the only one who was just his friend in the village and not both and the only one in Arnold's group of friends who is infected. But in other cases, it seemed very clear that most affected and almost all normal students would only recognize infected students outside the school environment. Once again, it seemed to be a fear of stigma by association and not the disease – had it been fear of the disease then I suspect that normal students and other affected students would not want much to do with them even in the village. Below are sociograms showing Ruud [A] who listed Solomon [I] but was not reciprocated by the latter and Solomon’s sociograms showing reciprocation from Tallent [N] and Kuda [N].

Sociograms 5:13 Ruud [A] Friendships

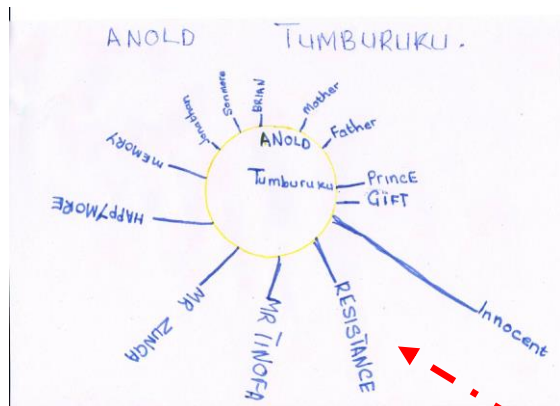


Ruud [A]

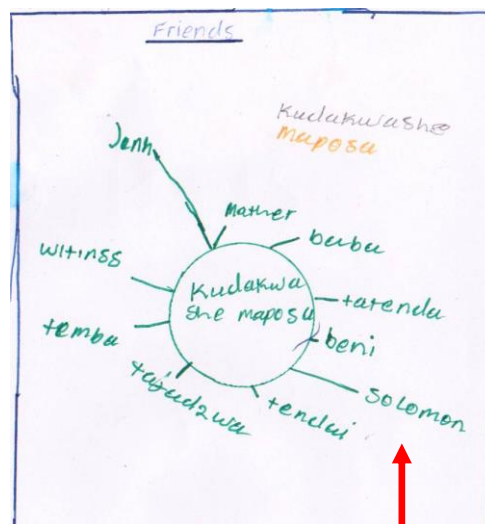


Solomon [I]

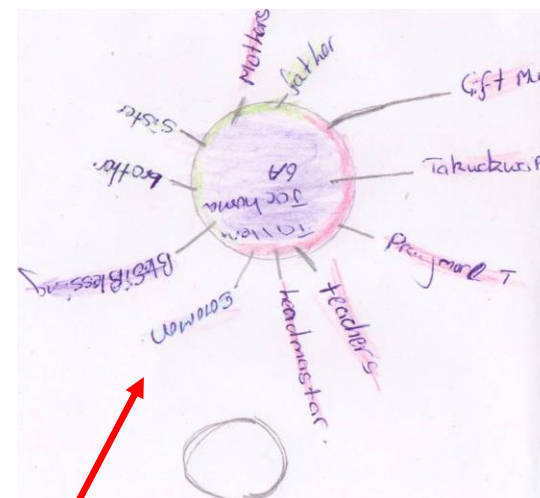
²¹⁶ ‘*shamwari dzekuchikoro nekudhunu neshamwari dzekuchikoro nekudhunu zwakare*’



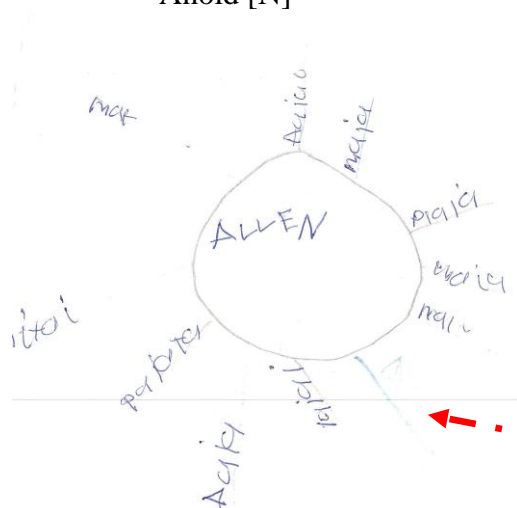
Anold [N]



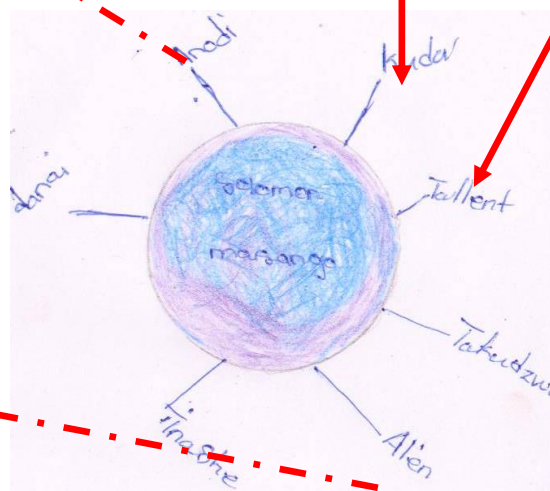
Kudakwashe [N]



Tallent [N]



Allen [N]



Solomon [I]



Takudzwa [N]

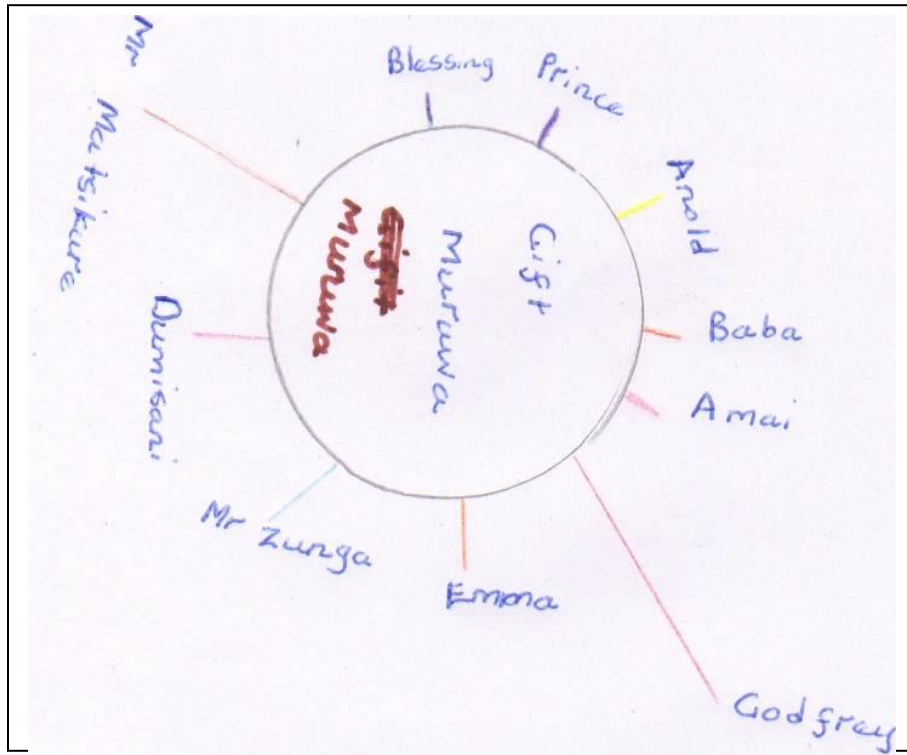
Sociograms 6.20: Solomon [I] Friendships

Affected and normal students largely played together with very few incidents and stigma was not readily discernible. They mostly enjoyed intermingled reciprocity in their relationships compared to infected students who listed friends who neither listed nor even mentioned their names. Below I will use 2 interviews with normal students – Gift [N] and Evalentine [N] – to show how each group related to another. Both had affected students whom they mentioned as close friends and vice versa. Having had the opportunity to observe the different groups of students in the school and village, these friendships seemed genuine and long-lasting. I will also show how the affected students befriended by Gift [N] and Evalentine [N] also had affected and normal friends other than these two who reciprocated their friendship. Except in instances of normal and affected students who related to infected students out of empathy as already discussed, none of the 7 students discussed below, however, listed or even mentioned an infected student – this trend was evident throughout all of the interviews with affected and normal students.

Gift [N], a confident and popular student who was often captain of one of the soccer teams, got to choose who played on his side. All the boys listed on his sociogram were always included on his soccer team and Emma [A] was always with his group of friends for the gardening project. In describing his friends, he said they all play well together at school *‘and we also herd cattle and hunt together’*²¹⁷(Gift [N] Interview, December 2010). His friends also spoke warmly about how close they were to him; Blessing [A] quipped that *‘I like him because he is my friend who knows how to relate well to others and he is also liked by everyone’*²¹⁸ (Blessing [A] Interview, December 2010).

²¹⁷ *‘zwakare tinofudza tose nokuyenda konovima’*

²¹⁸ *‘nidinomufrira nokuti ishamwari yangu inogarisana zwakanaka nevamwe nokuti anofarirwa nomunu wose’*



Sociogram 5.14: Gift [N] – friendships

Listed as friends on his sociograms are Prince [N], Arnold [N], Dumisani [N], Godfrey [A], Emma [A] and Blessing [A]. Had I simply observed, without knowing the status of the students whether they were normal or affected, I would not have been able to tell the difference in their interactions – whereas I could readily tell that the infected students were always sitting on the sidelines by themselves without much interaction even amongst themselves.

The above affected students also had normal friends at school. In fact, for Blessing [A] and Emma [A] their closets friends in and outside school were normal. Godfrey [A], with an existing friendship with Gift [N], also counted Christopher [N] as *'my friend who listens to me at all times'*²¹⁹(Godfrey [A], Interview, December 2010). Although Godfrey [A] was not reciprocated by Tallent [N], I took an opportunity to ask him about the latter since he spent time with infected students. He mentioned that *'I like him because he has compassion he plays with all the kids'*²²⁰(*ibid*). I asked Godfrey what he meant by *'he plays with all the kids'* (*ibid*). His response showed that he was very aware that infected students played by themselves most, if not all, of the time – *'he plays with me and others but he also plays with the likes of Solomon and Admire'*²²¹ (*ibid*). When I asked why he didn't play with the *'likes of Solomon and Admire'* he said he didn't know why.

Blessing [A] spoke about Gift [N] and Dumisani [N] as *'friends who live close to my house and we like to do things together and to keep each other company'*²²² (Blessing [A], Interview, December 2010). Similarly Emma [A] related how *'I grew up together with Chelma and Gift...they know me very well and we help each other with a lot of things'*²²³ (Emma [A], Interview, December 2010). Below are their sociograms showing friends who reciprocated their friendships.

²¹⁹ *'shamwari yangu indoniterera nguva dzose'*

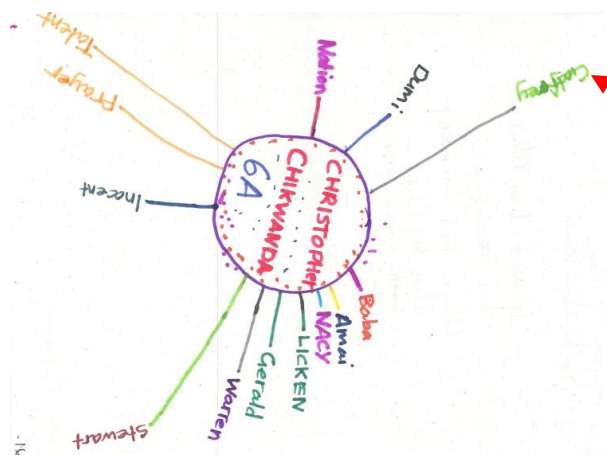
²²⁰ *'ndinomufarira ndokuti anetsitsi anotamba nevamwe vose'*

²²¹ *'anotamba neni nevamwe izvo anotamba nana Solomon [I] nana Admire [I]*

²²² *'ishamwari dzangu dzinogara duze nekwezu izvo tinofarira kuita zwinu tose tichipana hukama'*

²²³ *'takakura tose nana Chelma [N] na Gift [N]... ndivo vanondiziva chose nekuti tinobetserana nezvino zwakawanda'*

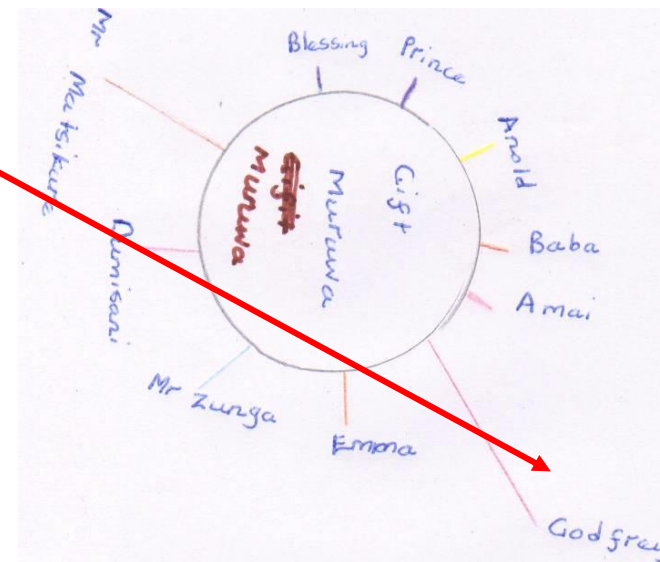
Sociograms 5.15: Godfrey [A] – reciprocated friendships showing a relationship with normal students



Christopher [N]

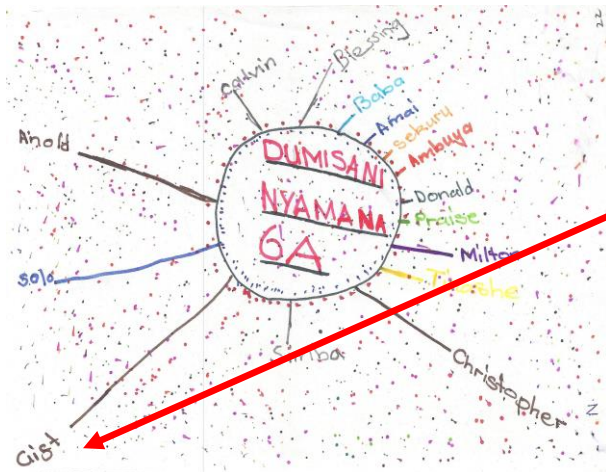


Godfrey [A]

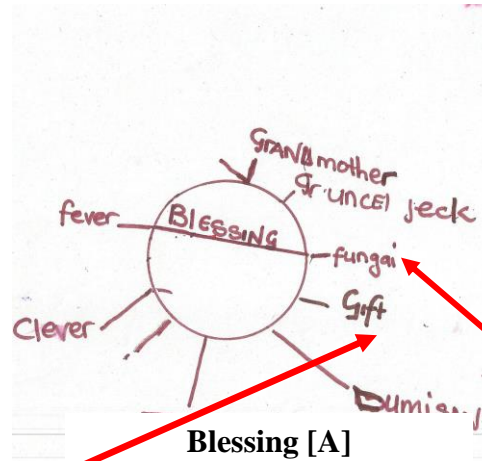


Gift [N]

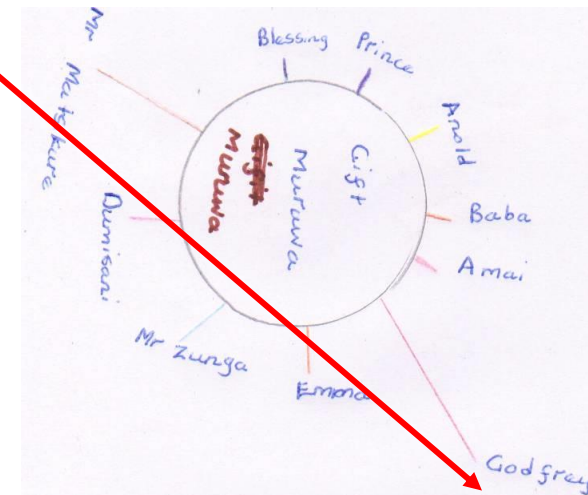
Sociograms 5.15: Blessing [A] – reciprocated friendships showing a relationship with normal students



Gift [N]



Blessing [A]



Dumisani [N]

Evalentine [N], described by her teacher as ‘*a girl with brains and very caring parents*’²²⁴ (Teacher Interview, December, 2010), listed Chelma [N], Tinotenda [N], Edeline [N], Winnie [A] and Pauline [A] and spoke about them as very close friends. She spoke about Pauline [A] as her best friend – ‘*we’ve been friends since grade 3*’²²⁵ (Evalantine [N], Interview, December 2010). These girls often stood and talked amongst themselves at break time and I observed them together at the well before I was banned from fetching my own water.

Noticeably, however, all the affected and normal girls, except for Tinotenda [N], did not play or engage much with infected girls. Tinotenda [N] listed and spoke about Bridget [I] as ‘*a friend of mine when we are at the village*’²²⁶ (Tinotenda [N], Interview, December 2010). When I asked her why she was just a friend at the village she just said ‘*it’s just like that*’²²⁷ (*ibid*), she did not elaborate. When I had asked the other girls a question I had been asking all the other students – if there were some other friends perhaps not listed on the sociograms - no mention was made of infected girls. At break time there seemed to be a well-established routine where affected and normal girls engaged each other while the infected girls sat together alone on the sidelines.

Apart from Evalentine [N], Winnie [A] had one other normal friend, Vimbai [N] who reciprocated her friendship – ‘*we play together at home, at school and also go to church together with others*’²²⁸ (Winnie [A], Interview, December 2010). Vimbai [N] concurred – ‘*we go to wash (at the river) together, fetch water together and also to dig holes and Winnie makes me laugh*’²²⁹ (Vimbai [N], Interview, December 2010). Winnie [A] also listed Emma [A] and Peace [N], whom, though they didn’t list her mentioned her as a friend and the latter said that ‘*she lives far away from us*’²³⁰ (Peace [N], Interview, December 2010). Winnie [A] was not treated any different by normal students neither did

²²⁴ ‘*musikana anenjere neyabereki vanejanya*’

²²⁵ ‘*taveshamwari kubva kugrade 3*’

²²⁶ ‘*shmwari yangu kana tirikumzinda*’

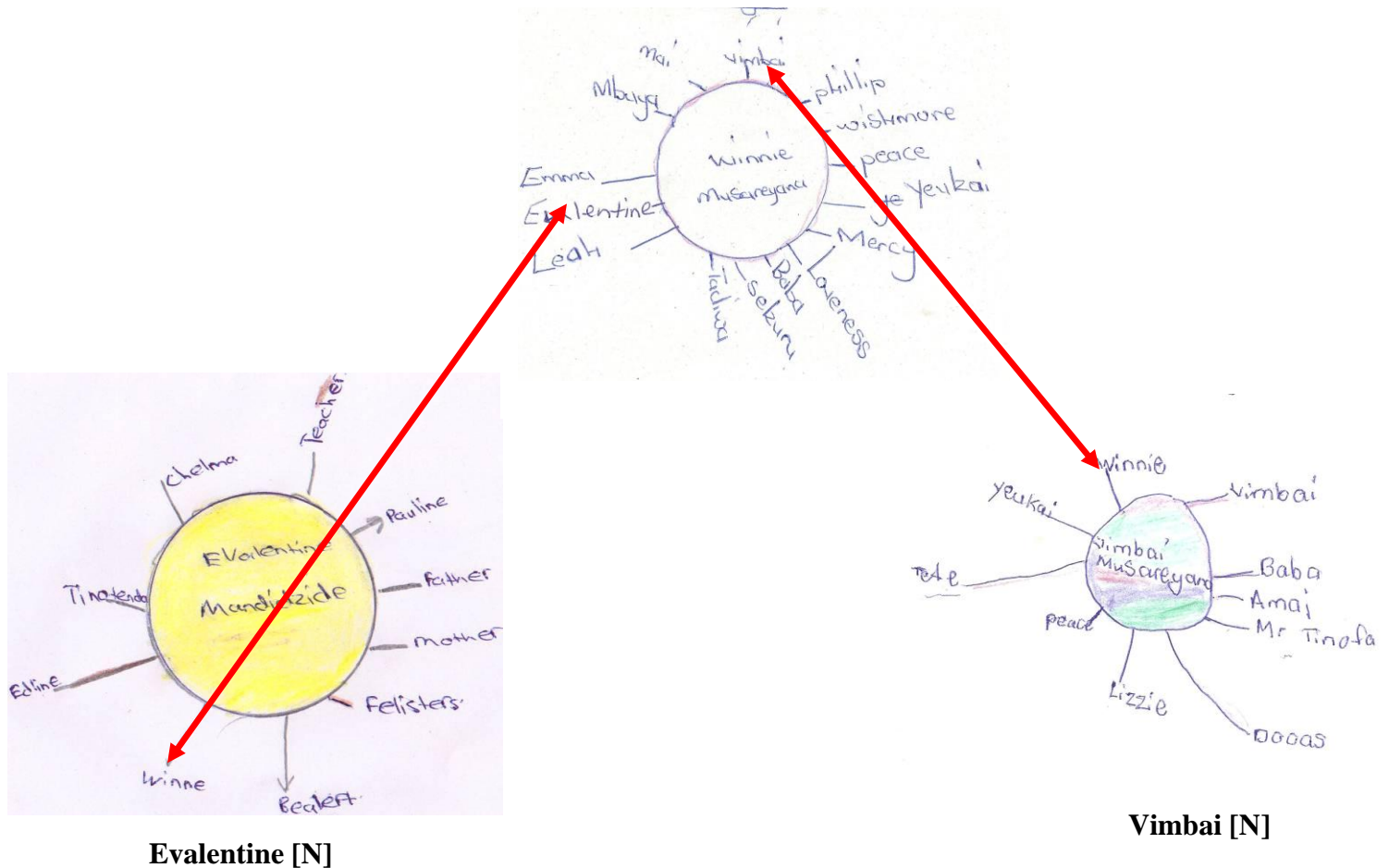
²²⁷ ‘*zvinongodaro*’

²²⁸ ‘*Totamba tose kumba, kuchikoro nokuyenda kucheche tose nevamwe*’

²²⁹ ‘*tonogeza tichinorera mvura nokuchera makomba iye Winnei anondisekesa*’

²³⁰ ‘*anogara kure nesu*’

she seem to see them as different from her. Below are Winnie's reciprocated friendships with normal students:

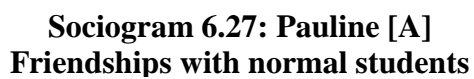


Sociogram 5.17: Winnie [A] Friendships with normal students

Further, Pauline [A] had Evalentine [N], Edelen [N] and Tinotenda [N] as her main friends with whom she said *'we tell each other everything'*²³¹ (Pauline [A], Interview, December 2010). The other girls spoke favourably of Pauline [A] as *'a real friend and she sometimes comes to stay with us when her grandmother is away'*²³² (Edelen [N],

²³¹ *'tinotawurirana zvose'*

²³² *'shamwari shaiyo ezvo anombowuya kuzogara nesu kana mbuya ake afamba'*



Apart from personal preference – seemingly according to character, there was not much evidence of stigma between affected and normal students. This trend, shown in above examples, was evident throughout the other interviews that I held with affected and normal students.

The exclusion of infected students, however, went beyond unreciprocated friendships to infected students being refused access to clean water and participating in events like the gardening project and sports activities in particular.

A rather clear instance of stigma was revealed when Bridget [I] shared about her photograph below –



Photograph 5.4: Bridget [I] Water bucket and cup

She explained: *'I don't drink water at school anymore because I think I disgust them if I drink water'*²³³ (Bridget [I], Interview, December 2010). I asked her how she knew that she disgusts them and she said *'when I drink from the cup no one else drinks from the cup after me'*²³⁴ (Bridget [I], Interview, December 2010). With temperatures at times exceeding 40 degrees Celsius under the shade in the village, there is always a bucket and a cup that students drink from every 2 hours or so. I had observed students drinking from the bucket many times but only after Bridget shared her thoughts above did I realise that

²³³ *'Handishamai mvura kuchikoro nokuti ndinovasemesa ndikanwa mvura'*

²³⁴ *'nekuti antu acho anoramba kunwa nekapu yo inikana ndamwa'*

none of the infected students drank from the cup. Praymore [I] also stated the same but had a different picture –



Photograph 5.5: Praymore [I] Water tap

Praymore [I], Interview, December 2010: *‘I used to drink from the tap but they locked it because they said there was a lot of water being wasted but I cannot drink from the cup because once I finish others will refuse to drink’.*²³⁵

The tap was indeed locked most of the time – except in times to fill the bucket which was done by one of the prefects (a student leader appointed by the school staff).

Admire [I], who did not seem fazed by not drinking from the cup, nevertheless had a similar photograph to Bridget, wanted to explain why he drank from his watering bucket–

²³⁵ *‘Ndayisimwa mvura papompi iyo asi yakazovarwa kutchindzi inotambisa mvura asi handigone kunomwa nekapu ndokuti vamwe vanoza ramba kunwa kana ini ndapedza’*



Photograph 5.6: Admire [I] Watering bucket

When I asked him why he did not drink from the cup like others he simply said *'these other people don't want me to use the same cup and I don't know why'*²³⁶ (Admire [I], Interview, December 2010). With this information I was able to observe that all the infected students drank from their 'watering buckets'²³⁷. This glaring trend prompted me to ask the class teacher if he was aware of what was going on. He advised that to his knowledge, it all started *'when one of the sick kids sneezed into the cup'*²³⁸ (Teacher interview, October 2010) – thereafter he said the other students simply didn't drink from the cup when any of the other kids from *'that group'* did.

Miriam [I], in describing her gardening picture below, I noticed that she had mentioned only infected students as part of her group – the other 2 girls and Praymore [I]. I asked her how she chose the people in her group and she responded by saying that *'we used to do it with others and then we realised that they did not want to farm with us'*²³⁹ (Miriam [I] Interview, December 2010). She said she did not know why they didn't want to farm with them.

²³⁶ *'antu acho hadi kuti neni ndimwe nekapu yachona andizivi kuti chi'*

²³⁷ Everyday at an appointed time all students went to fetch water from the well to water the school garden and each student had a watering bucket. They were not the cleanest of buckets since they were always left outside.

²³⁸ *mumwe we vana vanorwara paka hostira mukapu'*

²³⁹ *'taimboita navamwe asi takazowona kuti antu achona hadi kurima nesu'*



Photograph 5.7: Miriam [I] Gardening Project

The gardening was done in self-selected groups, with each group manning a bed of greens. Solomon [I] and Admire [I] did not join any group and sometimes watered with Miriam [I] and the other infected students. All other groups seemed to be arbitrarily mixed between affected and normal students. This was one of the very few times that I saw infected students working together – albeit without as much chatting as the other student groups. It very much seemed to be a group buoyed much more by exclusion than choice. The Head had witnessed what he called segregation with his own infected grandchildren but felt that *‘there is nothing that can be done...we are just thankful that they still come to school...they have their own ways of looking after themselves’*²⁴⁰ (Head, Interview, December 2010).

Stigma has made infected and some affected students not only feel separated from other students (Duffy, 2005) but also, undervalued and ‘significantly discredited’ (Goffman, 1963:3). This exclusion meant severely reduced ‘functionings and capabilities’ (Sen, 1973) to ‘identify, develop and establish fresh, more robust and socially valued aspects of self’ (Howe, 1999:260) which invariably affects how they relate to others around them. Quinton, (2006:103) aptly notes that ‘the widening social world of school brings social

²⁴⁰ *‘asi hapana zvokuyita...tongotenda kuti vachirikuwuya kuchikoro nokuti venenzira dzavo dzokuti vazwichengete’*

comparison into play...which makes it possible for them to develop views of themselves as adequate or failing...the possibility of developing low self-esteem’.

The latter, ‘failing’ and ‘developing low self-esteem’ (*ibid*) is clearly evident in infected and some affected students. School has been a place where stigma is most evident and Gilligan’s (1998: 154) idea of the school as an integrator, ‘providing a non-stigmatizing access to all children’ will not be realized in this village because of silence reasons, which, amongst other things, prohibit teachers from engaging about the wellbeing of infected and affected students. Also, as noted earlier, silence means lost opportunities to capitalize on empathy to break stigma. At home there is no provision for support either; infected and some affected students simply don’t have ‘access to protective caregivers *who* could provide a cognitive scaffolding and enable them to face their multi-stressor situations’ (Schofield 2005:198 quoted in Aldgate et al, 2005). This compounded rejection, severely heightened by instances where infected students could not even drink from the same bucket, approximates what Bond et al (2002:53) call ‘blatant neglect.’ Stigma is an example of a social conversion factor (Robeyns, 2005) that made it difficult for infected and some affected students...to *convert* resources into capabilities (Unterhalter et al, 2007:2) due to exclusion.

As pointed out earlier, infected and affected students who struggled because of stigma still wanted to attend school despite what seemed like insurmountable difficulties. This is a departure from some authors who have suggested that students under such duress become reluctant to attend as Bond *et al* (2002:355) reported on the impact on teachers and children -

In school HIV/AIDS-related stigma manifested itself in the forms of rejection... as a result, the taunted children were reluctant to go to school. Interviewees also reported feeling it was unsafe to send children who are HIV-positive to school, for fear of discrimination and bullying

Students in Kumakomo wanted to go to school and as was shown earlier, did not always want to be sent home even when they were ill. Also, caregivers reported about students wanting to go to school often -

C-G: Solomon [I]: *Solomon is really happy when he talks about school; he likes to go and does not like to spend much time at home*

C-G: Praymore [I]: *He is very sad when he cannot go to school because he is sick or when I am called to go and get him. He talks a lot about what he does at school and always wants to go*

C-G: Admire [I]: *I was told that he really likes school and that he is very happy there. He does not talk much – the few times he talks and looks happy is when he is talking about school*

C-G: Bridget [I]: *Bridget likes going to school because she can do lots of things there. Here at home she can only do a few things because I worry that if she does a lot she will get sicker. She talks a lot about school and how she wants to spend more time there*

C-G: Tatenda [I]: *She loves going to school and she cried a lot when we did not have school fees until the Head said she could still attend without it. She does not want to miss school at all even when it's raining sometimes*

C-G: Miriam [I]: *Miriam gets up very early to get ready for school. She likes to walk to school with her friends and wishes that school was much longer.*

It might seem contradictory that a place where students suffer the most is a place where they seem to gravitate but as the Grade 6B Teacher suggested, it is better than being alone at home and also, the school still carries the possibilities of being able to socialize with other students. Once again, the capability approach alerts us to acknowledging the plural identities that people have – at once feeling secluded and at the same time desiring to remain in the same environment because of the possibility of functionings that may ensure. Unfortunately, the feeling of helplessness shown by the Grade 6 teacher and the Head together with the silence on issues affecting students overshadow the possibilities of the school being a place that can provide the needed assistance, also revealing how ‘attending school may have the potential to *reduce* some capabilities’ Unterhalter et al (2007:6).

For all students, however, there was a fear of using the toilets – their sentiments are summarised by Miriam [I] below -

Miriam [I] talking about her photograph of the toilets below, said: *'I do not use school toilets they are so dirty you cannot go in there... when I want to go I use the bush... at our home (before she was moved to the village) we used to have an indoor toilet'*²⁴¹ (Interview, December 2010).



Photograph 5:8 Miriam [I] – School Environment: school toilets

Most students resorted to using the ‘bush’ which caused a lot of anxiety for girls in particular because of privacy issues and fears of being ‘seen by boys’ (*ibid*). The school blamed the situation on limited resources that needed to be concentrated in the classroom (Head, 2010). The school toilets represent the broken infrastructure of the school in particular that is caused by the increasing poverty in the village.

²⁴¹ *'in handipindi muchimbuzi chekuchikoro makazoswiba hamupindiki parizwino... ndongoyenda kusango kana ndoda kuyenda kunze... kumba kwedu taive nechimbuzi chemumba'*

Chapter 7

Findings and Discussion

Student's School Experiences and Religion – the macrosystem

The background information for this chapter is discussed in Chapter 2 on the direct the influence of the community (Dowling et al, 2006) and the environment on a child (Dowling et al 2006) – touching on issues of identity, stigma, trauma and well-being. Also considered was the adult's community' over their children and yet, their decreased resources to take care of them due to the epidemic. Limited data in this section was due to the relatively smaller number of people interviewed, compared to data that directly involved students. The data from interviews from the Baptist Minister, select community leaders and students was used to discuss this chapter.

Religion was so pervasive in the village that it could be represented in all systems. At the school students had to be involved in religion because the teachers made it mandatory; outside school students were explicitly required to attend church. The community prided itself as Christian and prior to that, the religious influence was brought about by missionaries who were part of the colonial era. In the discussion below, it is closely identified within macrosystem as it is 'considered to be the outer layer of the child's environment (Paquette and Ryan, 2001), comprising the culture, values and norms, material resources and life-styles...the societal blueprint for a particular culture ...identifies social and psychological features that ultimately affect the particular conditions and processes occurring in the microsystem' (Bronfenbrenner, 1993: 40). As will be seen, most students did not have the 'freedom to promote or achieve 'functionings' which are important to them' (Unterhalter et al, 2007:9), the 'the real opportunity to accomplish what they value' (Alkire, 2002:6), as they were not given a choice for church attendance.

Religion, therefore, has a strong influence both in the school and within the community; a reoccurring photograph from the students from all groups was that of the church – which happens to be located close to the school.



Photograph 5.9: Solomon [I] Church

Solomon [I] Interview, December 2010: *'I like to go to church because that is where we sing and rejoice with others and God loves everyone.'*²⁴²

Even though 'God loves everyone' seems like something children who attend church might say, I was aware of Solomon's struggles with friendships at the school and so I asked him to elaborate. He said that the Minister (Pastor) and the Sunday School teacher said that all the time and that *'at church we all play together and no one sits down'*²⁴³ (*ibid*) - this was in reference to school where infected students sat on the sideline during playtime. The reason they 'all played together' at church was because playtime was arranged by the Sunday school teacher who chose the teams and made sure that all students were involved. All 3 infected girls – Bridget, Miriam and Tinotenda – shared similar sentiments about the church. The other 2 infected boys – Praymore and Admire, did not mention anything about church and also, they did not attend as regularly – the reason was unclear, but I knew that they stayed furthest from the church. Church, however, was also popular with the majority of other students –

²⁴² 'Ndinofarira kuyenda kusondo nokuti ndokwatinoyimba tichifara nowamwe izvo mwari vanoda vanu vose'

²⁴³ 'kukereke anhu tinotamba tose apana vanogare pasi'



Photograph 5.10: Abel (N) Church

Abel (N), Interview, December 2010: *'I like church because I get to meet with my friends and also sing to God...also, that is where we get the blessings'*²⁴⁴



Photograph 5.11 Emma (A) Church

Emma (A), Interview, December 2010: *'It is exciting at church because we meet with others to praise God and I also sing in the choir'*²⁴⁵

The church is very pervasive in Kumakomo – while it provides solace for many, those who didn't attend were pressured in all manner of ways; Kudakwashe [N] had to bow to her aunt's pressure –

Kudakwashe [N] (Diary entry, 8 November 2010):

²⁴⁴ *'Inindinofarira kereke ndokuti ndinosangana neshamwari dzangu nokuyimbira mwari... zvo ndokwatinowana makomborero'*

²⁴⁵ *'Kusondo kunonakidza nokuti tinosingana navamwe thichikudza mwari izvo ndinoyimba mukwaya'*

*'Went to church and then to wash at the river, water was dirty...church ended but people where sleepy (overnight churches)...I did not want to stay but my aunt said I didn't like church anymore so I stayed'*²⁴⁶. Not liking church was synonymous with choosing to live badly – *'Church is all that makes people decent nothing else is as important'*²⁴⁷ (Sunday School Teacher, Interview, 2010).

The Baptist Minister spoke about early indoctrination and their²⁴⁸ push to parents to encourage their children to attend, how it was important to give them tools for the future. Specifically, to me he quipped – *'the best you can do for these kids while you are here is to tell them about Jesus...you will see, most of them will go soon* (meaning that they would be dead) *and they need to be ready for heaven... that is my contribution to this village problem'* (Baptist Minister, Interview, October 2010). He was acutely aware of the HIV problem in the village because of the many visitations to sick patients and eventually, funerals that he had to conduct both in Kumakomo and other surrounding villages. The Minister said had he seen several groups visit the village – from researchers, NGOs and Government Funded Agencies - to talk about HIV/AIDS to adults but said nothing changed *'people keep dying...these people have no idea that we are still dying...that's why I say Jesus is all we've got'* (Baptist Minister, Interview, December 2010).

Religion permeated most of school life. Every school assembly began with the Lord's Prayer, a Christian song and the national anthem. This insistence on church by adults and the children themselves mentioning that they loved church obviously raises questions of coercion.

There were no parents or caregivers in the village who gave their children options about going to church – there seemed to be a blanket acceptance that that is what all children did – attend church. Even though church provided solace for a lot of students including

²⁴⁶ *'Takayenda kukereke ndobva tazonogeza kurwizi, mvura yakanga yakaswiba...kereke yakati yobuda vanhu venge vanehope...inidakangadisingade kuyenda asi tete vakati handichada kuyenda kusondo ndakabva ndagara'*

²⁴⁷ *'Kereke ndo yoga inoita kuti antu ave nani hapana chimwe chakakocha'*

²⁴⁸ By 'their' he meant his church leadership which is mostly comprised of the teaching staff at Kupisa

the infected students who were segregated at school, its view of people who are HIV positive remains a concern. The Minister reemphasized the importance of compassion but spoke at length about punishment for those who sin, that the Lord will not tolerate sinful behaviour which is what brought AIDS in the first place. '*Compassion, yes, but what they've got (referring to HIV/AIDS) they came across it in the dark*' ²⁴⁹ (Baptist Minister, Church Sermon, October 2010) – the condition was framed in the context of sin.

That the Baptist Minister in Kumakomo framed the spread of HIV/AIDS in terms of sin is not uncommon. This is supported by the work noted earlier from DFID (2006) whose 5-year study on stigma noted that 'in Zimbabwe, although the majority of people know about HIV and AIDS, there is still a widespread belief that being HIV-positive is a punishment from God' (DFID, 2010) ²⁵⁰. Josephine et al (2001:9) who studied 10 countries in West Africa to establish the religious positions of most churches on HIV/AIDS also found out that most churches believed that the 'real cause of the rampant spread of the illness is the non-respect of God's laws which is expressed by fornication, infidelity, loose living and the sex trade.' They conclude that most churches have started taking a more compassionate view to those who are infected but still strongly advise that to prevent infection people should 'revert to moral values and to God's law...in short, fidelity, abstinence and chastity are the most advisable means of prevention' (2001:14).

The church, which yields a lot of influence in the village, prevents discussions of HIV/AIDS issues in a detailed manner. Contrary opinions are seen in opposition to the indisputable word of God and hence the existing silence is upheld. That children are already socialized into an institution that refuses to consider other options means that even when opportunities arise to discuss issues of HIV/AIDS students are likely to baulk and maintain the position of the church despite the widespread evidence that what the church advocates is not working. Religion remains a force that threatens to silence other voices who try to engage with HIV/AIDS issues directly. Boler *et al* (2003:5) rightly

²⁴⁹ '*Tsitsi hongo, asi zwavanazwo vakasangana nazwo kurimi*'

²⁵⁰ www.dfid.org/Zimbabwe/stigma - accessed 25 November, 2010

state that ‘an unchallenged culture of silence can only serve to exacerbate the AIDS epidemic and increase confusion, denial and stigmatization’.

The Community Perspectives – the macrosystem

Community Perspectives lie within the macrosystem as comprising embody the ‘culture, values and norms, material resources and lifestyles (Paquette and Ryan, 2001) that are outside children’s control yet affect them directly within the micro and mesosystems. It also touches on the Chronosystem since the adults interviewed largely reflected a prevalent culture that has been passed down for generations. The depth of the Chronosystem is captured in Chapter 4 that addresses the background of the village and the culture which has defined it to this day.

The adage that it ‘takes a village to raise a child’ is still relevant in the African village context; the next section, therefore, looks at the findings among the community leaders’ and educators’ perspectives on the situation of infected and affected students. Caregiver’s perspectives have been reflected in the home and school experiences of students. The community leaders in villages in Zimbabwe are responsible for resource allocation and hence their knowledge about the situation will determine, to a certain extent, how the challenge of infected and affected students will be dealt with, depending on the resources allocated for the problem. Most importantly, the Ministry of Education decides on policy issues that affect how education in Zimbabwe is undertaken – their knowledge of the situation will determine how they will decide to tackle the existing issues and prepare for other eventualities as the situation is getting increasingly worse.

The former Ministry of Education, David Coltart²⁵¹, assured me that to his knowledge, the work on infected and affected students within the school system had not yet been done. UNICEF had approached him to see about doing research in that area but nothing

²⁵¹ I had an opportunity to meet David Coltart, the Minister of Education, twice in July 2010 – first in Cambridge when he came to give a speech and then in London when I was invited to a high-level session organised by the Commonwealth Society to address the education situation in Zimbabwe to formulate the five year Strategic Plan

had come to fruition at the time. There was a muted emphasis on dealing with orphans and vulnerable children in the school system – both largely due to lack of concrete data and knowledge of where to begin, despite ambitious goals to meet ‘the learning needs of all disadvantaged children including OVCs’ by 2015 (MOE, 2011)²⁵². Upon my arrival in Kumakomo, the District Education Officer confirmed the same

There are too many other pressing needs at the moment for this still important area to be tackled... you will see when you get to the village - there is no time nor resources to work on infected students even AIDS orphans are being treated the same as everyone else right now...we are not unaware but the recent economic crisis has made worse the situations which was already near collapse in rural schools (District Education Officer, September, 2010).

These sentiments had been expressed by other important Education Officers during my pilot in the south of Zimbabwe as earlier stated –

District Education Officer (Mr. Gwenya): *We don't have any information about students who are either infected or affected. The Ministry does not deal with that – at least in this Province there is nothing in our 5-year plan to touch on that. We've only just introduced HIV/AIDS education, but no thought as yet has been put towards what you're talking about* (Mtimbiri, 2008).

National Aids Council, the Government organisation mandated to coordinate and facilitate the national multi-sectoral response to HIV/AIDS has an office close to Kumakomo. I intended to interview the Local National AIDS Council Co-ordinator but on arrival the office was manned by a high school graduate who informed me that all they did in that area was ‘*to collect data from villages and surrounding towns mostly via email and phones from those in the village*’ (Student, interview, September, 2010). When I informed him that there was no cell phone reception in Kumakomo, and definitely no internet, he said that the information was very scant and mostly unreliable as it was largely communicated through well-wishers who were embarking on a grocery shopping trip to the town centre where they were located. As far as the possibility of intervention his understanding was that ‘*for now there is nothing being done about children who have*

²⁵² The MOE Medium Term Plan 2011-2015 (MOE, 2011) might have grossly underestimated the scope of the problem if they thought they could reach so many children in 4 years when there are hardly any programs on the ground in most rural areas

*the disease (referring to HIV/AIDS) or the AIDS orphans we are still looking for statistics but it will be a long time before any program is created to think about doing anything*²⁵³ (Student Interview, October 2010). During my pilot, similar comments had been relayed by a much senior person within NAC

Director of the National AIDS Council (Mr. Mupa): *Our focus is on prevention and care...we work with adults only for now. We do not have any information about young school going children even though we are aware, however, that there is a growing orphan problem* (Mtimbiri, 2008)

The lack of urgency, 27 years after the first HIV/AIDS case was diagnosed in Zimbabwe, is staggering. It follows then that without the knowledge of infected, affected and normal students' experiences in the home, the school and the community there will be scant planning at best to address the most pressing needs of the students within the school in particular.

I had an opportunity to interview workshops leaders from FACT, the first AIDS organisation in Zimbabwe that was started by Geoff Foster, a medic who has written prolifically on HIV/AIDS issues in Zimbabwe and elsewhere. Chipo, the leader of the volunteer group, informed me that '*FACT had long abandoned work with children because it was not popular with donors...it is much easier to count numbers of people in workshops than to quantify emotional counselling with children*' (Chipo, Interview, October, 2010). They, therefore, had no information on infected children in particular nor any plans to start working on children's issues.

Closer to the village, I was able to interview the Chief, one of his headmen, and the Head and teachers at the school. The Chief said that he was aware of the adults who were succumbing to HIV/AIDS '*you have been coming to the funerals all the time...most of those were because of the disease...but I don't know much about the children who are sick because of the disease...but we have those who were left by their parents*' (Chief,

²⁵³ '*parizwino hapana zwirikuitwa nevama vanechirwere kana kuti iwo maids orphans tichirikutswaga mastatistics acho asi pachava nenguava pasati pava newurogwa*'

Interview, 2010)²⁵⁴. When I asked the chief how he knew some of the deaths were AIDS-related, he informed me that some of the families had approached him for financial help to cover medical expenses and that *‘when they die at a young age then we know that they died of the disease’*²⁵⁵ (ibid).

The government, he said, *‘just come during election time and even then they don’t do much’*²⁵⁶ (ibid). There was no help from the government and the Chief had heard that the National AIDS Council sometimes tried to collect statistics for the number of HIV positive adults – not children - who had HIV/AIDS; *‘I don’t know how they would know since people are scared to talk about the disease’*²⁵⁷ (Chief, 2010).

The headman was also more aware of AIDS orphans than infected children – *‘I didn’t know that there were children who had the disease who could survive until age 10’*²⁵⁸ (Headman, Interview, October, 2010). He confirmed that nothing is ever discussed in their meetings about the plight of AIDS orphans beyond making sure that they are with their extended families in the village.

There were 2 teachers (Grade 6A and 6B) responsible for my cohort of students. The teacher from 6A, who did not have recorded marks for all infected students felt that the infected students should stay at home because they were disrupting learning and making it impossible for other students to make progress (Grade 6A, Teacher Interview, December 2010). He expressed frustration that they had not been trained to deal with this group of infected and affected students.

²⁵⁴ The reason that I had attended almost every funeral and church service was because I had been informed by the Head at the school that *‘this is what is done in the village’*²⁵⁴ (Head, September, 2010); without attending I risked being seen as uncaring and absence from church would make me someone who could not be trusted since I was a single male visitor whom no one really knew (Head, 2010). I thus witnessed a funeral every week and had to attend church every Sunday.

²⁵⁵ *‘kana vakafa vachirivechiduku tobva tazika kuti vafa nechirwere’*

²⁵⁶ *‘vanonguwuya kana yanguva yemaerections izvo zvishoma zwavanoita’*

²⁵⁷ *‘handizivi kuti vangazive sei ivo vantu achona achitsa kutauta nezwechirwere’*

²⁵⁸ *‘andizivi kuti kune vana vane chirwere panopona kuswika makore egumi’*

Under a pile of donated books from foreign countries, I found a copy of ‘Let’s Talk’ the main textbook meant to be used to cover the HIV/AIDS curriculum for Grade 6²⁵⁹. Upon asking the Grade 6A about the program he confirmed findings in literature (Pattman and Chege 2003; Coombe 2002; Baxen and Breidlid, 2009; Gachuchi, 1999) that he had not received any training, that he was embarrassed to talk about the issues – *‘the difficulty of talking to kids about adult issues...issues about sex... where and how would you begin to talk about it’* (Grade 6A, Teacher Interview, December, 2010) - even though the book does not touch on issues of intimacy in any culturally offensive way (my own assessment after looking through it a few times). The Grade 6B teacher added that *‘the parents would want to know who gave us permission to talk to their children about such embarrassing things...this used to be done by aunts and uncles in the village’* (Grade 6B, Teacher Interview, December, 2010)²⁶⁰.

The Grade 6B teacher had neither heard of the Life Skills Program nor ever seen the book. Both teachers added that the material, in any case, was not in the exam – a sentiment lamented by the Head who said it left him powerless to ‘push on the matter’ (Head, 2010). In terms of resources, this was the only copy available in the school for 92 students. This, however, is not a factor in a place where the books would not have been used anyway. Nevertheless, in the event that the school wanted to use them, it would have presented a challenge.

My discussion with the Chief revealed that embarrassment to talk about sexual issues emerged when traditional and other informal methods of educating the young became undermined by formal education structures introduced by the colonial system. He confirmed what the Grade 6B teacher had said - how young people in rural Zimbabwe used to be taught about sex by specially appointed adults to avoid issues of embarrassment. The boys went camping for one or two months for *iwela*, male initiation

²⁵⁹ The book, called ‘Let’s Talk - An AIDS Action Programme for Schools: Grade 6 Pupil’s Book’ was developed by the Ministry of Education’s Curriculum Development Unit with assistance from UNICEF

²⁶⁰ Experientially, when I taught in Zimbabwean Primary Schools more than 10 years ago, parental approval was needed for students to be part of an hour long class about the biological aspects of sex; this was conducted by a parent or trusted adult in the community who did not have children either in that class or the school. I observed the same, however, in the 2 State schools where I taught in New Hampshire and Massachusetts.

rites; Girls spent a month doing *ukuthomba*, female initiation (Bozongwana, 1983). In both cases, they were taught about sex, marriage, responsibility and adulthood (*Ibid*). Beyond formal education disruption in this regard, however, socio-economic and some cultural constraints have led to increased migration, disrupting cultural networks and creating a vacuum in the process. This, in turn, meant that most young people who traditionally received sex education from the community have to get it from peers and various other places (Rivers & Aggleton, 1999). This structure would have allowed discussions about HIV/AIDS without the constraints embedded in formal education systems. Unfortunately, this vacuum still exists in Kumakomo. The Ministry of Education in Zimbabwe does not allow researchers to engage in sexual matters with children under 16 (MOE, 2010; Pattman and Chege, 2003).

Other African countries seem to have been able to at least recognize that young children are not asexual. Pattman and Chege (2003:2), on a study focused on ‘young people, gender, sexuality and HIV/AIDS education in Botswana, Kenya, Rwanda, South Africa, Tanzania, Zambia and Zimbabwe’ were able to converse with Zambian children as young as six about sex; children expressed how they were having sex. Another recent study by McLaughlin et al (2012:124) with primary school children in Kenya, South Africa and Tanzania concluded that children willingly and freely spoke about sexuality and that they had ‘a wide-ranging and fairly sophisticated knowledge of adult sexual practices and sexual worlds...’ The noted research above shows that it is possible for young students, given the voice, to talk about sexual experiences and that they are not as innocent as purported by the village leadership in Kumakomo; their constant checking that children were not talking about ‘adult issues’ (Head, 2010) simply meant the children and I as a researcher also become silenced on the matter.

The suggestion that ‘HIV/AIDS/life skills education ...should aim to address and encourage young people to talk about their sexual feelings, desires and concerns’ (Pattman and Chege, 2003:5) is a long way from the reality that presently exists in Kumakomo. The learner-centred approach advocated by Pattman and Chege requires a

complete change of philosophy in education; Zimbabwe is still mired in the ‘banking’ concept as stated by Freire (1970). Pattman and Chege, realizing the difficulty of employing a learner-centred approach, ‘advocate outsiders, trained to teach HIV/AIDS education in pupil-centred and gender-sensitive ways, be invited to schools’ (2003:9), which would allow for students to discuss sexuality issues at length. In Zimbabwe, however, as noted, outsiders are still forbidden to engage with students on sexual matters as Pattman and Chege (2003:9) discovered in their study almost 10 years ago that

the Ministry of Education in Zimbabwe, assumed that children under 16 years old were either not having sex or not even thinking of, or talking about sexuality. Indeed our researchers in Zimbabwe were refused permission to interview school children who were under the age of 16 years

At Kupisa, as far as interventions are concerned, the Head reported that there was no directive from the Provincial Office or the Ministry of Education on how to deal with infected children in school and he wasn’t even sure that *‘they know that we have children with such difficulties’* (Head, Interview, October 2010). The only intervention the school had been able to implement was to let infected and affected students attend school without paying school fees.

Girls, the Head reported, were a worry since the dropout rates were increasing every year. The 9 girls who dropped out at the beginning of 6th grade constituted 25% of all the girls and the Head worried that the drop out numbers would be even worse in 7th grade when most parents know they will not be able to afford the required examination fees. On top of the reasons given for dropping out - illness, the need to help with the sick, chores at home and preparation for marriage – the Head commented on how 7 of the 9 girls had been ‘shunted from one relative to another due to the inability to care for them’ (Head, 2010), which meant moving from one school to another in most instances. This migration was very disruptive to children’s relationships within the home, school and community as they had to uproot and relocate to a different environment as needed (Head, 2010). In such cases where children are shunted from one relative to another, Foster and Williamson (2000) note that children, particularly adolescent girls, are seen to be

‘pawned’ by foster parents to bring in extra income. This is supported by Richter (2000), who notes that children are trafficked primarily as bonded labour and for the purpose of sexual exploitation in the Southern African Development Community (SADC) region. This ‘pawning’ was nevertheless not evident in my 4 months stay in the village.

Even though I did not hear about any cases of sexual abuse from caregivers, the Head, who was not altogether sure of what became of the 9 girls once they dropped out, noted that it would be very difficult to know since people will almost always be silent about abuse; the shame that surrounds issues of sexuality means that the security of children is undermined (Head, 2010). These notions have been explored by Wanaka et al. (2006, p.77, quoted in Onyango, 2010:21) who observed that most of the abuses go unreported in many communities in Africa because sexuality is a taboo subject resulting in ‘a culture of silence surrounding sex and sexuality.’ Rispel et al (2006:8) note that ‘children who drop out of school, but who are not already infected with HIV, are more likely to become infected...a study among 15–18-year-old girls in Zimbabwe found that those enrolled in school were more than five times less likely to be HIV-positive than those who had dropped out’ (Rispel et al 2006:8). There were no plans to try and keep girls in school or to track those who simply left. The girls who had already dropped out from Kumakomo were simply waiting to be married to the earliest suitor (Head, 2010).

Early marriages were not uncommon. I observed that there were lots of young girls who were married in the village and was informed that it was legal as long as the parents or caregivers gave consent. The Headman he informed me that it was common in villages and beyond; that staying in school is what actually curbed the number of girls getting married young (Headman interview, December 2010). This readily presents a glaring contradiction of the refusal of the Ministry of Education to engage children in comprehensive sex education (Pattman and Chege, 2003) when they are aware of early marriages.

Despite staggering statistics that show that ‘in sub-Saharan Africa, women account for close to 60% of adults and about 75% of youth infected with HIV’ (Rispel, 2006:25), no

programs have been designed nor attempted to begin to solve the problem. Unfortunately, well-meaning organizations like CAMFED and UNICEF who are seen as champions of supporting education for girls mostly ‘ensure girls are enrolled in *existing* schools ...*which* does not translate into institutionalized arrangements to secure gender equality in curriculum, language of instruction, teacher training, pedagogies in use, or management’ (Unterhalter, 2010:16). Even though using female teachers as a strategy to attract girls to primary schools has been found to be statistically significant in several studies (Kane, 2004 quoted in Rispel, 2006:25), not much has been done in most rural schools to attract female teachers. Kupisa only has 3 female teachers out of 14 and all of them were delegated to teaching lower grades.

Overall, the picture that emerges is of a group of students whose suffering is largely undetected. Even though the caregivers are aware of most of the things going on at home, they have very little knowledge about the struggles the students face at school. The school is certainly lacking in information about these students and there are no plans in place to address the problems in a proactive manner from any of the community leaders involved. The vacuum of leadership from the Ministry of Education means that the problems are likely to persist for much longer with many students falling through the cracks, particularly the infected and girls across the spectrum.

Chapter 8

Reflections on the Research Process and Limitations thereof

Below I reflect on the process of research, the strengths, weakness, and questions that remain. Amongst others, this section touches on the efficacy of methods used, maintaining validity, the challenges of consent and confidentiality that ensued.

Whilst I was largely satisfied with my methods – ‘the tools or techniques used to collect, analyse and interpret data in educational research’ (Scott and Morrison, 2005: 152), there were areas that either needed improvement or reduced numbers to be more effective. Even though photographs did indeed help to sharpen memories and elicited a longer response (Epstein et al, 2006) and therefore mined a lot of data on important issues, this was a cumbersome exercise due to a large number of students and time needed to process the materials. Because the turnaround between taking the pictures, processing and returning to the student took 3 days at the least, it is uncertain if the students still fully connected to the pictures they took during interview time. There were at least 3 instances where students said they could not remember why they took a photograph. A smaller sample of students²⁶¹ taking fewer photographs and a quicker turnaround of materials would make this method more effective. For instance, reducing the number of photographs from 5-3 would have eased both the mechanical processing and encouraged students to be more thoughtful about which places were most meaningful to them. Also, this process alone would have reduced the total number of photographs from 460 to 276. Living in a rural village with no electricity, making 6-hour long trips on the weekends to the city to recharge my computer and printer, in addition to purchasing ink, made this method expensive and excessively time-consuming. Unless one is working with a small group with solar energy equipment, this method may be impractical in rural areas. Drawings, which had a ‘compelling effect upon the *student*...an ability to prod latent memory, to stimulate and release emotional statements about the student’s emotional life...’ (Collier, 1957:858) were the most effective tool. The elaborate depictions of home environments allowed students to discuss their home environments at length. With

²⁶¹ For reasons already deliberated on earlier, I had to engage all 92 students to avoid stigmatizing infected and affected students.

students analyzing their own drawings, a better interpretation of their circumstances ensured (Punch, 2002; Clark, 2005a; Veale, 2005), than if I had attempted to infer. However, there were 2 students who misrepresented their home situations on their drawings as they suspected that the pictures were going to be displayed on the walls - the usual practice at their school when it comes to students' work. Since I travelled to interview all the students' parents and/or caregivers, I discovered otherwise, and the students confided, then, that they wanted to be sure that they would not be stigmatized or bullied once their orphan status was discovered through their drawings if they had shown the absence of parents. Thus, a complication that I had been concerned about, that the inclusion or exclusion of a person in a picture could have varied meanings was helped by the triangulation of parents/caregiver and student interviews in filling in the gaps. The triangulation also helped me to verify, somewhat, that some students had not imitated other's drawings, which is not uncommon. The simplicity of using pencil, paper and crayons made this activity much easier than photography and also, provided many more entry points for discussions as students related to their home situations.

Whilst the use of sociograms to capture the conceptions and perceptions of relationships around a student was useful and brought sizeable data, it was very challenging to analyse the 'absences', people whom the students did not show on their sociogram. There was a clear pattern of affected students being befriended by normal students and later reciprocating and also, infected students largely not being shown on affected and normal student sociograms. This does not readily mean there was stigma, but I found myself thinking that way. Sorting through the sociograms to see the reciprocations took a long time and the notable absences of adults in infected students' lives could also have been due to a number of factors not fully communicated by the students. This is another activity that would be best suited for smaller groups – not 92.

Having taught young students for a number of years, I was acutely aware that children's vivid imaginations, and hence the occasional tension between fact and fantasy (Keats, 2000; Greene & Hill, 2005), was a possible challenge. Pictures and drawings do lend themselves to that conundrum as they are often used to encouraged children to spur their

imagination. Trying to navigate the possibility of that tension with my explicit belief in the child's voice, hence the authenticity of their words, was difficult at times.

Triangulation of data was the only method of minimizing this effect.

I managed to establish the internal validity by writing a thick narrative of the work supported by triangulated data (Yin, 1984) of interviews using verbatim words from students and adults (Maxwell, 2005), observations and staying in the village for a sustained period. However, the use of member checks (Merriam et al 2002) was ineffective because the Head of school was simply not familiar with what he was hearing. Also, I stopped asking him after the first instance because it also meant that the students' confidentiality was compromised; even though I tried to use pseudonyms, the Head knew the students so well that he could have been able to tell which student was being referred to since he helped with the selection of the infected students.

Other problem areas that remained unresolved revolve around issues of consent and confidentiality. Consent, described as that which is 'received from the subject after he or she has been carefully and truthfully informed about the research' (Denzin and Lincoln, 1998: 72) readily posed the problem of how much the different entities fully understood the information given. Even though I only discussed the possible dangers of the study with adults, the perils of exposure for infected students in particular and the debilitating stigmatization that could ensue, I was uncertain how much they comprehended the dangers within the study (Bogdan & Biklen, 1998). This was further aggravated by a required progression of asking for consent to undertake the work in the village.

Coming from the Ministry of Education (first stop) meant that those below would have had to do some serious paperwork in denying me entry. Education Officials in the Provincial District, the next huddle, were mostly concerned about approving the paperwork from the Head Office. On informing them that they could still say no, there was audible laughter as one of them quipped that my acceptance letter from the Ministry of Education was a directive to them to give me passage and assist as much as they could. This was the same with the next authority. The Chief has immense power in the village

and by the time he had given his consent, he had already conducted a meeting to let people know that ‘they had a visitor in their midst who was to be assisted in every way possible’. It was not clear, therefore, to what extent students and their parents and/or caregivers gave ‘informed consent’ as described by (MacNaughton *et al.*, 2001; Parson & Stephenson, 2003). Even though I asked them individually and constantly told them they could opt out, I could tell that the power of authority from the Chief would have made it difficult to either refuse participation or withdraw as I suggested they could anytime (Balen *et al.*, 2000). This was a cultural construct that is impossible to avoid since anything that has the resemblance of disrespecting the Chief would result in some form of disciplinary action. It would have been even harder for students; with both classes taking part, I wondered how much peer pressure would have made it near impossible for a student to opt out.

Yet another cultural construct that placed a very serious limitation on the study was that imposed by the Chief, the teachers and the Baptist Minister who were emphatic in not allowing me to probe or even allow any discussions about the student’s sexual lives, even if they brought them up. This was the situation more than 15 years ago when Pattman and Chege (2003) tried to work with children under the age of 16 in Zimbabwe – they were forbidden by the Ministry of Education to engage about sexual matters. This meant that an extremely important part of the student’s life, especially in light of the topic at hand, had to be ignored. Yet another closely related limitation was due to disclosure issues – caregivers’ failure to disclose the infected student’s condition and reasons for their parents’ deaths meant that I could not directly ask the students about their experiences with HIV/AIDS medication, their coping mechanism in the light of knowing that they were infected. These, therefore, are important areas that remain in need of further research. Although there was a need to work with both classes to avoid infected and affected students being further stigmatised, the numbers were rather large which affected depth.

In interviewing children there is a salient imbalance of power within the child-adult relationship; with the students looking upon me as an authority figure. This, despite all

my attempts to lessen the ‘authority figure’ stance, any residual of that perception might have induced students to tailor their answers according to what they think I wanted to hear – not an unusual occurrence in work with children (Robinson & Kellett, 2004; Flewitt, 2005; Hill, 2005; Punch, 2002; Einarsdottir, 2007). I think this power imbalance can only be reduced but not completely eliminated as suggested by Einarsdottir, (2007) and others (Graue & Walsh, 1998, Barker & Weller, 2003; Punch, 2002; Brooker, 2001). It also means that students, in particular, might have found it very difficult to say no to an adult who had been allowed by other adults to enter the school. I also found that my privileged position of attending a top University made the authority somewhat circumvent in their prodding about the details of the research, raising doubt about how fully informed they would have been in granting consent.

While it might have been ideal if the Chief had not intervened in any way whatsoever, it is also impossible to enter the village without his permission. Then there is the community aspect where the village seemed to share almost everything. The line between voluntary consent and coercion (Emanuel et al. 2000) was thoroughly blurred. There is a need to rethink the idea of consent in this situation; what can be reasonably accepted as voluntary knowing the challenges of unquestionable authority embedded within the culture? Is consent something that can be done within this culture and what would constitute adequate understanding? If not, what are the implication beyond possible exposure and the resulting stigma and discrimination that might follow? What are the other ways of doing this work in such environments? These are some of the remaining questions in this work.

Confidentiality was compromised in more than one way. A teacher at the school had informed me that parents and caregivers ‘had a right to know their children were being asked’ and what they shared. Culturally they would have to talk about the research in whatever way they saw fit but, he continued, that there would be no confidentiality. While I interviewed students individually, that aspect was a challenge that I could not control. Interviews with parents posed a challenge with confidentiality as well. Some were in open fields and I simply could never be sure who was behind the bushes and

what they heard. Some were in adjacent rooms with thin walls and if a parent or caregiver got animated about an issue and raised their voice, there was no way of telling if they would be heard or not.

Transcribing and translating the interview from Shona to English was a mammoth task. The community spoke a dialect of Shona called Ndau – so the first step was really to make sure that I worked through the complexities within the two before translating to English. In Shona, it is not uncommon for people to constantly use the plural ‘we’ when talking about themselves – it is an inbuilt cultural construct that embraces the idea of community. It was, therefore, very important to listen carefully to the context and know what was being said. Adults, as a sign of respect, are addressed in the plural; for example, instead of saying that ‘he (father) went to the city’, one would say ‘they went to the city’. The pronoun for him and her is the same (Iye). While simple sentences in English might have a subject, verb and object order, in Shona the subject is often part of the verb. Then there was the issue of meaning. Literal translation does not always carry the same meaning (Sechrest et al, 1972). To find the right context meant changing the actual word in many cases. This worked best when the transcription was done not long after the interview as the context and tone would have still been fresh in my mind. Having taped interviews helped immensely to retain the context since I could listen to the script many times. Overall semantic, cultural differences and the lack of syntactical equivalence between the English and Shona language means that there had been unavoidable losses through translation (Philips, 1960). A friend who had agreed to do ‘member checks’ in that regard found the draft too long and was not able to check all the translation. A better way to solve this dilemma would be to employ a professional translator to do member checks.

As a novice researcher, I later realized that I had invested a lot into my methodology and very little into my emotional stamina. I wrongly assumed that I had become somewhat emotionally removed and healed from HIV/AIDS-related deaths that happened within my family yet attending a few funerals in the village brought all the memories of death in a sweeping flood. The confusion in the village about the PhD and Doctorate nomenclature led some to think that I was training to be a medical doctor. This confusion brought about

a horrifying incident that haunted me for months. There had been a knock on the door in the middle of the night and I reluctantly opened the door to an unforgettable sight of a man who was, then, a bag of bones in a wheelbarrow. His loved ones asked if I could help since I was a doctor. Hopelessly, I explained the misunderstanding. The man was pronounced dead the next day. The feelings of hopelessness, sadness, and guilt weighed on me for a very long time. I had flashbacks to my own brother being in a wheelbarrow in the same condition. The experience aroused deep-seated feelings of depression that left me temporarily incapacitated to continue my work in the village. In a culture where counselling is not practised as intensely as in western countries, and being far from any forms of telecommunications, I realized that doing research that is too closely related to one's own experiences may be harmful to the researcher. Ethical guidelines in this regard could present a few ideas of safeguards to the researcher. I remain uncertain how the cloud of depression, which later lifted, only to return when I started processing my data, affected my work. Analysing my data seemed to open the wound afresh and I struggled to stay focused and fell into long bouts of depression. Returning to the village, as I had promised, was again a deeply painful encounter as I discovered that all 6 of the students infected students had passed. I had become very close to the students in my research. Beyond questioners that attempt to check the readiness of the researcher approaching such emotionally intense areas of work, a session with a trained psychologist might be worth including in the repertoire of ethical guidelines. My Department in Cambridge does strongly advise students to find an internal country advisor – the person who might have been helpful in the different circumstances mentioned above – but there were no available people qualified for the role. Might it be that what is needed in this case is not necessarily an academic but a person who might be a spiritual/emotional attaché?

A question had arisen many times from adults in the community on how and when the work was going to benefit the students. I had informed them of the work's potential, in the long term, to add to ideas of solving health, education and social challenges both in the village and the country at large (Flicker, 2006). I also informed them that I would, in the short term, help with school resources. A book drive with a few schools in Boston

enabled me to take close to 2000 books and school materials to the school. The school is now linked with my previous school in Boston for networking.

Chapter 9

Conclusion

Of course, we need to do careful planning and deliberation about the actions we shall take, but any moment spent on deliberations that does not lead to decisive action in support of orphans and other children made vulnerable by HIV/AIDS is a moment tragically wasted Nelson Mandela

The gravity of HIV/AIDS in Zimbabwe, with more than 3000 deaths a week (UNAIDS, 2006) is apparent. With an estimated 115,000 children living with HIV/AIDS (Central Statistical Office, 2005) and a sobering estimated 40,000 new child infections and an increase of 160,000 HIV/AIDS orphans annually (UNICEF, 2005), the plight of infected and affected children in Zimbabwe cannot be overemphasised. That education is the area most impacted by the epidemic has also been made clear by research (Bennell *et al* 2002; Kelly, 2000; World Bank, 2000; UNICEF, 2005). Bennell *et al.* (2002) remind us that most children, 67%, stay in school until 6th grade and this seems to be a crucial window of hope within which we can reach out to children before they drop out, the infected and affected in particular. This necessitates research that will enable education planners to make the best of the available resources within the given short space of time that children are in school. My PhD makes a contribution to the discussion and in stimulating a conversation in an area that has not been given urgency.

Whereas general research about the plight of children affected by HIV/AIDS (albeit done ‘on’ children) in communities is fairly well documented (Ray and Madzimbamuto, 2006; Sanders and Sambo, 1992; Kelly, 2000), their experiences in schools where they spend most of their time have hardly been explored; neither had the connection between school, home, and community – which would allow policymakers to plan with a clearer perspective on the issues affecting these children. My PhD has explored these connections at length.

Since most of the work about children affected by HIV/AIDS has been ‘on’ children rather than ‘with’ them, it has reduced children to ‘objects’ (Christensen and James,

1999), with inherent risks of reflecting mostly the researcher's perspective, leading to skewed projections which inadvertently create programs which do meet the needs of the target population. Giving my participants a voice has, equally, made the research more meaningful as the combination of the subjects' views and the researcher's provided with a fuller view of the situation. Adding to the increasing research that includes children's perspectives (Pattman and Chege, 2003; Gorin, 2004; Butler et al, 2003; Skuse et al, 2003; Rose, 2006; McLaughlin et al, 2012), the work provides ample evidence that young students, even in a culture that does to allow them to converse with adults in a two-directional way, given the opportunity will share their experiences in detailed ways that will enable us to have a deeper understanding of their predicaments and hence plan accordingly. I believe that giving children a voice in a culture that traditionally expects them to be seen and not heard on many levels will begin to open possibilities for adults and children to communicate on deeper levels which is imperative to their growth and for the subject at hand; it will create a space where adults can delve into subject matter with honesty and integrity paving ways for possible solutions.

An important contribution to research, therefore, has been the demonstration of using detailed and well-designed creative data collection methods to give my students a voice and treat them as participants in the research process (Druin et al, 1999). The constructionist nature of the methods meant that even infected students whom teachers suspected would not engage much participated fully in the research. I believe that my work adds to the broader base of knowledge since it entails the voices of young children, an element lacking mostly in research done in the Zimbabwean rural contexts.

Though simply giving children a voice is important in itself, I believe that it is also a right as has been bolstered by UN Convention on the Rights of the Children. My PhD work has been consistent with Article 12²⁶² and 13²⁶³ of the Convention.

²⁶² **Article 12** States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

The ‘freedom to seek, receive and impart information and ideas...’ (*ibid*) is still vastly limited for children in Zimbabwe – this research nevertheless contributes towards its increase.

Even though the issue of stigma is well documented in literature (Duffy, 2005; Holzemer, et al, 2007; Chesney & Smith, 1999; Parker and Aggleton, 2002; Goffman, 1963; Bond et al 2002; Guest, 2005), it mostly covers adults’ perspectives and not children within the rural Zimbabwean school-home-community environments. The subtle nature yet acutely felt stigma by the subjects needed to be explored further and communicated in ways that practitioners can recognise and address. With detailed interviews from students based on the given activities and exemplified by appropriate evidence, my work makes a contribution to the exploration of aspects of stigma on infected and affected children in the home, the community, and the school. The work shows that infected students were the most stigmatised and that the exclusion went beyond unreciprocated friendships to being refused clean water and participation in activities. With the responsible adults in the community being unaware of the issues raised, their suffering continues unabated, which amount to neglect (Bond et al, 2000). That affected students who had experienced HIV/AIDS-related deaths were more willing to engage with infected students points to the power of empathy (Pattman and Chege, 2003; Campbell et al, 2012) and its possibility to break the stronghold of stigma. Yet the silence around issues of HIV/AIDS and the ignorance about the experiences of students surrounding issues of HIV/AIDS mean that the role of empathy cannot be fully explored publicly, beyond engaging with children in other ways. Issues of anxiety, loneliness, lack of security, food shortages and lost opportunities for socialising with other students due to displacement and abandonment have not been addressed (Foster et al, 2000; Donald & Clacherty, 2005; Skuse et al 2003; Stein, 2003; Young & Ansell, 2003).

²⁶³ **Article 13** The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice (UN, 1989)

The work has confirmed other research (Foster and Williamson, 2000; Brown et al, 2000; Richter et al, 2004; Munyati et al, 2006; Gill and Jack, 2008; Richter & Sherr, 2009; Messner et al, 2012; Campbell et al, 2012) that details how caregivers, overburdened with responsibilities, are struggling with food shortages, disclosure and adherence issues amongst other things. Campbell's conceptualization of an 'Adherence Competent Community' (Campbell et al, 2012:130) would serve Kumakomo well. Within the adherence community conceptualization there is a need, however, to further investigate the health model of communication that was employed by the NGO contrasted to existing religious views; how that community normalised HIV/AIDS²⁶⁴ and also, how the caregivers overcame barriers to adherence are all lessons (*ibid*) that could help Kumakomo to move forward.

Their work shows that there is more coverage needed in the literature regarding the plight of infected students in rural primary schools in Zimbabwe. Experiences of infected and affected students are hardly understood by the teachers and community leaders who are custodians of their education. What emerged was a dearth of information from the local HIV/AIDS leading organisation (the National AIDS Council) and the Provincial Education Department – both of whom admitted that they were not working to address these issues nor were they planning to in the near future. The local authorities and gatekeepers – the chief, the city councillor and the Minister also showed ignorance about these children. There was '...lack of mutual engagement between organisations engaging in frontline HIV prevention and treatment efforts' (Nguyen et al, 2004:3; Munyati et al, 2006) At the University of Zimbabwe no one at the time was working on the issues and I was informed that visiting professors who might work on similar issues simply did not have the time to connect with organisations working in distant rural areas (UZ Administrator, 2010). On coordination, an NGO officer informed me that it was not the case that they did not want to cooperate and prevent duplication, make use of economies of scale and many other advantages that come with working together but that funding was

²⁶⁴ Campbell et al (2012) in their study note that the normalisation was through large numbers of affected families – Kumakomo has large numbers too but progress had been stagnant if at all, because of religious views; therefore, a closer look will be necessary to find other enabling factors or the absence of disabling ones

based on results of individual organisations and in collaborating, the lack of a clear claim to what an organisation has accomplished could lead to reduced funding and therefore loss of jobs for the NGO workers (Mishake, 2010). There is a need to fully understand the politics of funding to come up with a framework that would help organisations to work together yet be able to report fully on their separate activities within the joint efforts. This ignorance and lack of coordination, however, implies that the problem might exist for much longer before it can be effectively addressed.

The work has shown how silence issues are still major, 28 years since the first case of HIV/AIDS in Zimbabwe. The paternalist nature of the rural community, coupled with the existing distrust of outsiders and cemented by religious notions that continue to frame the epidemic in moralistic terms, will impede progress in many ways. There is a need to move away from the idea of a community that is largely defined by a few males to one defined by

a number of people held together because they are working along common lines, in a common spirit, and with reference to common aims. *And a recognition that*²⁶⁵ the common needs and aims demand a growing interchange of thought and growing unity of sympathetic feeling (Dewey, 1968:28)

thereby allowing women, children and other disenfranchised men to be part of the decision making in earnest. Religion will have to be challenged to take cognizance of the reality on the ground and encourage ways to allow other discourses about HIV/AIDS. There is a need, therefore, to carefully navigate the historical and socio-cultural spaces where interventions need to be implemented and adopt an intensively careful approach to the model of communication to avoid reinforcing inequalities. In some rural communities, to implement lasting interventions, being present on the ground on a long-term basis becomes indispensable. Being within the culture is more likely to help us to glean more into the underlying approaches to communicating about HIV/AIDS (DeWit et al, 2001; Airhihhenbuwa and Obregon 2000), understand the culture much deeper and find an approach that works more within a community mindset and one that will allow

²⁶⁵ Emphasis in italics is mine

for all segments of society to be reached equally (Gausset, 2001). The importance of cultural context cannot be overstated. In the same vein, ‘the metaphorical coupling of “culture” and “barrier” needs to be exposed, deconstructed and reconstructed so that new, positive, cultural linkages can be forged’ (Airhihenbuwa and Obregon, 2000:4).

The work has confirmed other studies that show how HIV/AIDS exacerbates poverty (Richter & Sherr, 2008; Amoateng *et al*, 2004; Shaeffer, 1994; Campbell, 2003; Rivers and Aggleton, 1999; Bennell, 2002; Foster and Williamson, 2000). The work, however, also shows how increased workloads in the village were seen in a different light by children; being able to do more was seen as a ‘coming of age’ as they seemed to revel in accomplishing many tasks on top of going to school. The students who complained were those who had grown up in the city and then transported to the village because of being orphaned – the work and long distances to school were relatively problematic for them. This, however, does not negate other studies that claim increased workloads for infected children and other OVCs but cautions about making blanket statements that may not be true in other contexts. It reminds us also, that views of children will differ – and therefore the expectations - according to the socio-cultural context (Christensen and Prout, 2005).

Although infected students were the most affected, the study cautions against assuming that all other non-infected students are not as affected in other ways (Foster et al, 2005) that can reduce their ‘functionings and capabilities’ immensely (Sen, 1973 quoted in Robeyns, 2003). It shows that the use of the GDP as a measure of poverty, as traditionally used by most Economists, is inadequate, in rural areas mostly; that in some instances it is better replaced by the capability approach that inherently includes the socio-cultural context and allows us to evaluate at an individual level (Unterhalter et al, 2007). Simply assuming that those with more money live better gives a skewed view of Kumakomo and other rural villages. The implications of employing the capability approach are discussed below.

In my work, the capability approach allowed me to learn about students' experiences in a more sophisticated and nuanced manner, a departure from other simplistic approaches (to be discussed later) that fail to take a holistic gaze. That I was able to fit it within Bronfenbrenner's perspective allowed me to take a more nuanced look at the student's experiences by delineating what the different groups (infected, affected and 'normal') are exposed to and enjoy due to their circumstances; to 'take into account individual experiences, values and differences within groups' (Unterhalter et al, 2007:3). Since 'the key idea of the capability approach is that social arrangements should aim to expand people's capabilities – their freedom to promote or achieve 'functionings' which are important to them' (*ibid*, 2007:2), the approach assists in helping us to understand the extent of the 'freedoms' - 'the real opportunity *or lack thereof*, to accomplish what they value' (Alkire, 2002:6) - for the different groups within the ecological system.

I was able to look at poverty, for instance, in its multidimensional aspects by noting what a group lacked and why, within 'real educational choices that have been available', (Unterhalter et al, 2007:2) hence, moving beyond assessments that only look at 'desire satisfaction' (*ibid*) within the village, to look at 'dimensions of education' (*ibid*) and thereby grasp the deeper complexity of issues involved. The approach helps us to avoid the narrow view of assuming or 'looking towards identical inputs and outcomes...' and acknowledging 'human diversity *were* learners will have different needs, and different interests' (Unterhalter et al, 2007:4) and a different expectation of the meaning of the given education. The capability approach, therefore, 'suggests that dimensions of education other than rates of return should be considered' (*ibid*, 2007:3) – a needed lens within education research if we are to fully comprehend student's experiences in a meaningful manner. It's all-encompassing framework means that it 'can be used to evaluate a range of values that draw on an assessment of people's wellbeing, such as inequality, poverty, changes in the wellbeing of persons or the average well-being of the members of a group' (Robeyns, 2017:26) – all of which are part of what constitutes one's experience in a given time and space. Sociology analyses, while taking power dynamics in schools seriously, fail to 'take into account individual experiences, values and

differences within groups...' (Unterhalter et al, 2007:3). Similarly, medical approaches and social models fall short for reasons neatly summarized by Terzi (2007:6):

the capability approach provides an analytical framework that goes beyond the medical model which looks to education to 'fix' a disability and the social model which sees the problem for people with disabilities as located in discrimination practised by the wider society

Terzi rightly suggests that 'it is the valued aspirations of those with disabilities that must be evaluated' such that 'difference *does not* become disadvantage and inequality' (ibid).

In a village that is considered generally poverty stricken because of drought and other challenges explored in earlier in this work, the capability approach encourages us to think through what is considered poverty and how that is experienced by the individual. In a class where all student groups were receiving similar learning instruction, the psychosocial and physical condition of the student, coupled with the perception of the people around them mean that the manner in which they were 'able to *convert* resources into capabilities'²⁶⁶, and thereafter potentially into functionings' (Unterhalter et al, 2007:2) could have been affected adversely. These conversion factors either enabled a student to make substantial use of resources or not. While Robeyns (2017) gives an example of how a disabled person might not be able to make full use or take full advantage rather, of what a bike can enable them as opposed to one who is not, in my work infected students were necessarily limited to convert resources of situations to their full advantage (functionings) due to their physical conditions. That the capability approach provides a space for us to look at a student in three overarching conversion factors – the personal, the social and the environmental²⁶⁷ – was ideal for looking at the experiences of infected, affected and normal students in that it obviates employing simplistic and broad evaluations and requires an

²⁶⁶ '... A third core idea of the capability approach is that *persons have different abilities to convert resources into functionings*' (Robeyns, 2017:46).

²⁶⁷ *Personal conversion factors* are internal to the person, such as metabolism, physical condition, sex, reading skills, or intelligence. *Social conversion factors* are factors stemming from the society in which one lives, such as public policies, social norms, practices that unfairly discriminate, societal hierarchies, or power relations related to class, gender, race, or caste. *Environmental conversion factors* emerge from the physical or built environment in which a person lives (Robeyns, 2017:47).

‘acknowledgement that it is not sufficient to know the resources a person owns or can use in order to be able to assess the wellbeing that he or she has achieved or could achieve; rather, we need to know much more about the person and the circumstances in which he or she is living’ (Robeyns, 2017:47)

As Wigley and Wigley (2006:288) concur,

...the resourcist approach entails an overly narrow metric of the value of education... *and limits to growth whereas...* if we gauge the value of education in terms of the capability to achieve valued functionings (human capabilities approach) rather than the accumulation of resources (human capital approach) it becomes clear that society is duty-bound to enable each child to complete at least a basic education, irrespective of their relative contributions to growth’

The capability approach provides a space, therefore, to ‘evaluate the link between resources and capabilities...evidencing the considerable inequalities that standard evaluation methodologies tend to overlook (Unterhalter et al, 2007:2).

That the ‘value of education should be measured in terms of the capability for functioning rather than the production of resource’ is an idea that needs to be explored further in matters of development pertaining to education. In thinking about improving education, it will be key to think about how ‘incomes, and resources more generally, should be distributed so as to enable each person to avoid capability deprivation, not merely resource deprivation (Wigley and Wigley, 2006:292). The capability approach acknowledges the multidimensional aspects of poverty and pushes us to interrogate how, due to their circumstances, they are ‘deprived of basic capabilities and achieved functionings’ (Biggeri et al, 46). On the whole,

...what the capability approach does in poverty analysis is to enhance the understanding of the nature and causes of poverty and deprivation by shifting primary attention away from means to ends that people have reasons to pursue, and accordingly, to the freedoms to able to satisfy these ends (Sen, 1999:90 In Biggeri et al, 2011:47)

By ‘prioritising certain people’s beings and doings and their opportunities to realize those beings and doings (such as their genuine opportunities to be educated, their ability to move around or to enjoy supportive social relationships)’ (Robeyns, 2017:26), the

capability approach allows us to refine our questions; for instance, does stigma affect how the teacher responds and/or groups certain students with others? How do these interactions, in turn, reduce the affected student's 'capabilities' to achieve various 'functionings'? Is even student 'A' affected by stigma in the same way as student 'B' and for what reasons? Would an infected student, for example, perceive stigma aimed at her as a result of her gender (which would, we can make a reasonable assumption here, thus be generalized to other girls in the classroom) or the result of her HIV status which might alarm her more because she is aware of the stigma associated with such and the possible ramifications thereof, coupled with the fear of thinking she is the only one in that particular circumstance. The capability approach helps us, once again, to avoid generalizing one perception to other simply because a group of people were involved in either a similar activity or activities that are very closely related.

Alkire (2002), in an introduction to a book about Value and the Capability Approach, tells a more illuminating story. Eight poor Pakistanis used the money they received from Oxfam to do a rose cultivation project that resulted in different participants experiencing change in different ways. One enjoyed the respect that it brought her, the delightful smell of the roses and the inner peace that ensued – all beyond the income. Another spoke of her increased 'capacity and confidence' (Alkire, 2002:1) that she developed and the many other projects that came about as a result. On this, Alkire (2002:2) concludes, rightfully so, that 'analyses of income generation alone exclude benefits such as empowerment, knowledge and meaningful work which, though difficult or impossible to price accurately, were highly valued by participants'. In working with the students in the village, I was interested in hearing their experiences and what was valuable to them; what 'valuable activities or ways of being' (ibid) were either availed or denied due to their individual circumstances. Individual stories are important, and the approach allows for that. Clearly articulated by Nussbaum,

The account we strive for [i.e. the capability approach] should preserve liberties and opportunities for each and every person, taken one by one, respecting each of them as an end, rather than simply as the agent or supporter of the ends of others... We need only notice that there is a type of focus on the individual person as such that requires no

particular metaphysical position, and no bias against love or care. It arises naturally from the recognition that each person has just one life to live, not more than one...If we combine this observation with the thought... that each person is valuable and worthy of respect as an end, we must conclude that we should look not just to the total or the average, but to the functioning of each and every person

(Nussbaum 2000, 56 IN Robeyns, 2017:58)

For any student, let alone those who wrestle with a life-long illness, the education experience is intensely personal and the approach, by

placing emphasis on the importance of what is valuable to the individual...allows us to shift our focus away from simply the aggregate benefits that education has for the whole of society, and towards individual benefits... *based on equality of capabilities* (Unterhalter et al, 2007:5).

Whilst this incomplete (Alkire, 2002), ‘flexible and multipurpose framework’ (Robeyns, 2017:5) that is the capability gave me great latitude to understand my work in different ways, there are questions that remain about ‘how capabilities *are to be* measured and how value conflicts are to be resolved (Alkire, 2002:11) if the approach is to be operationalized. Operationalization, which is defined as ‘the sequence of activities transforming a theoretical framework into standardized procedures applicable in practice, by users and beneficiaries (Biggeri et al, 2011:80) has to do with ‘defining a list of relevant capabilities...*with a qualifier of an* ‘open and public validation of such a list *which* is a necessary condition to confer legitimacy on it’ (Sen, 2005 IN Biggeri, 2011:198). The ‘list’ then, would serve as a guide. Sen, however, does not condone definitive lists because

...pure theory cannot freeze a list for all societies for all time to come...irrespective of what the citizens come to understand and value...because we use capabilities for different purposes...*and that* social conditions and the priorities that they suggest may vary...*and also, that* public discussion and reasoning can lead to a better understanding of the role, reach and significance of particular capabilities (Sen, 2005 in Biggeri, 79). Such a ‘fixed list...*denies* the possibility of fruitful public participation on what should be included and why’ (Sen, 2005:198 IN Biggeri, 80).

The struggle then, is not so much the list but how it is attained through a democratic process that also allows context – space and time – to be an integral part of the process.

Invariably, ‘the participation of the stakeholders is essential to the process and implies the reflection of subjects on their own condition, opportunities and constraints in their cultural, social, economic and political environments’ (Biggeri et al, 2011:80). The child’s voice, as debated at length in this work, is essential.

While the challenge of measuring valuable functionings was somewhat offset by detailed interviews, knowing what the student’s real aspirations are, remains obscure. Here I relied on the child’s voice as communicating their real aspirations and also, noted ‘achieved functionings’ (Unterhalter et al, 2007:7) for instance, a combination of positive comments about well-being as ‘proxies for certain educational capabilities’ (ibid). I think it is near impossible to remove the pressures of the culture and the educational experiences in which one was raised, such that aspirations will always be tainted by such pressures. The closest, therefore, we can come to realizing one’s real aspirations would be to use a variety of questioning techniques that might help us to somewhat reduce cultural pressures.

There is also the question of how ‘much should we listen to the values of young children in relation to their schooling (Unterhalter et al, 2007:7)’ – what if what they value is, to our knowledge as adults, eventually ‘a negative impact on their future capabilities’ (ibid). I think that those responses should be seen in the context of their present circumstances and therefore accepted as is; the voice of the child is very important and the ‘future capabilities of the child should be prioritized’ (ibid); ‘...there are many issues that even very small children are capable of understanding to which they can contribute by thoughtful opinions’ (Bigeri, et al, 2011:80). The genuine response of the child observed, whatever discrepancies deemed should force us to investigate the culture and education within the environment of the child, measured against what Nussbaum deems to be what we regard as ‘functions...of central importance to human life’ (McReynolds, 2002:143) or a democratically generated list within the village of the research, in tandem with known works in the field of education. With the given focus on experiences within the school environment, we could juxtapose what we already know and largely agree on

without overly imposing on the will of the child; here succinctly summarized by Wigley and Wigley (2006:292)

The basic education capabilities encompasses those realized functionings such as being able to read, write, communicate, argue, count, calculate, practically reason (i.e. the ability to choose well amongst the bundles of functionings at one's disposal), possess a sense of self-worth, interact with others based on mutual respect, and so on that constitute the necessary (but not sufficient) preconditions for human agency - being able to choose and pursue one's goals and overall life-plan - and effective participation in the community's cooperative enterprise - political, social and productive agency

The approach allows us to avoid the traps of mental satisfaction, which 'provides an inaccurate guide to well-being because we adapt our preferences according to the expectation horizon defined by the circumstances in which we are born' Wigley and Wigley (2006:301). The capability approach allows us to note a positive change in events where students 'could realistically choose to enjoy a greater set of valuable activities or ways of being...' (Alkire, 2002:2)

As a novice researcher, employing the capability approach allowed me to learn about a much broader way of evaluation experience in its different forms; to 'conceptualize and evaluate' causes of education inequality' (Unterhalter et al, 2007). I am very aware that this is a huge work with many aspects still heavily debated yet I see it as a worthy struggle to employ as it gives us a deeper understanding of looking at individual experiences that can also be viewed within themselves alongside differences within and among groups; the capability approach

...is a way to think about our lives in our societies and how we can engage as human beings in a struggle for justice and dignity for all...to *address* many injustices and forms of exploitation that befall children... *a way of* thinking about 'beings' and 'doings' not *as* just a strategy of broadening the information base beyond utilities or resources, but a way of engaging with individuals in order to reflect upon the things that are relevant to their daily lives and close to their hearts and minds (Biggeri et al, 2011:341)... *a consideration that* what children have today and will have tomorrow, in line with what they can be reasonably expected to want, is a matter of public policy and social programs...(Sen, 2007:10 In Biggeri et al 2011:341)...*that* the responsibility of policy is to create an environment which...facilitates the ability of children to pursue worthwhile and flourishing lives...(ibid)

On the larger scale, various aspects of Kelly's (2000) framework on how education will be affected in Zimbabwe can be seen at play in the findings. HIV/AIDS' effect on demand on education was already in motion by the time I left Zimbabwe after my research. Most of my participants, as related, will not be able to attend school by the end of the term because of their situation. As numbers of infected and affected students increase, the dropout rates are likely to be higher. Others, however, were dropping out due to other reasons i.e. lack relevance for education as claimed by some caregivers and also, some who felt that girls who married earlier stood a chance of being married to a better suitor (Head, 2010).

Kelly's (2000) point about how the clientele for education will change was reflected both during the pilot and in my PhD research where all the infected students and some of the affected students – if not all of them, needed to be educated in different ways because of their multi-stressor situations and environments. The way education is conducted needs to change to address children grappling with stigma issues since, amongst other things, infected and some affected children - for those who have not yet given up - have to spend a lot of time trying to negotiate their way into activities.

The content of education (Kelly, 2000) will have to change to embrace the situation – HIV/AIDS education will have to be included in a more holistic way. During the pilot, while teachers were not aware of the experiences of infected and affected students, they at least taught parts of the HIV/AIDS curriculum (Mtimbiri, 2008). The once-a-week 30-minute sessions focused on teaching HIV/AIDS from a prevention perspective; lessons on HIV/AIDS were done in a very rudimentary way that focused on prevention and ignored the many other factors which affect infected and affected students. The teachers mostly did the talking (*ibid*). As noted, during my PhD research the entire HIV/AIDS curriculum was ignored. The Ministry of Education will have to find ways to encourage teachers first to teach the HIV/AIDS curriculum and secondly, to do so in a comprehensive manner. Teacher training 'programmes should provide opportunities that will enable teachers to explore, understand and clarify their values, attitudes, inhibitions, prejudices, anxieties and fears' (James-Traore et al., 2004; Schenker & Nyarienda, 2002

quoted in Onyango, 2012:21). The challenge within Teachers' Colleges in Zimbabwe is that most of the trainers themselves are constrained by similar sexual taboos and therefore it will be difficult to know how well they will instruct and debate with trainee teachers differently.

In a study to investigate how teachers are prepared to teach about HIV/AIDS in a primary teacher training program in Kenya, Onyango (2012:9) concluded that 'on-site collaborative in-service education that focuses on subject content, as well as pedagogical content knowledge, can result in a change in tutors' instructional practice.' The study that included 10 tutors and 98 teacher trainees, observed that 'eliciting teachers' implicit knowledge and beliefs and then providing them with the opportunity to practice new innovations lead to re-conceptualization of their roles as teachers, as well as the role of students in knowledge construction (Koutselini, 2008 quoted in Onyango, 2012:11). This 'reconceptualisation' is what is desperately needed in rural areas in Zimbabwe. Onyango observed that it was 'the opportunity to practice and bring back the experiences for further learning that made the on-site model effective' (*ibid*).

In-service training will be a challenge in Zimbabwe since there are no tutors willing to travel to rural areas to work with teachers still mired in silence about HIV/AIDS issues, whereas Onyango's work was to see if teachers can teach about HIV/AIDS more comprehensively. What is encouraging in Onyango's work, however, is one of his findings that 'change in teachers' attitudes and beliefs occurs after they have seen evidence of improvements in student learning outcomes (Dunst *et al.*, 2011 quoted in Onyango, 2012:12). This carries the hope that once in-service training can be introduced, that it may result in breaking the silence within teaching and eventually a change in attitudes and beliefs leading first to covering the HIV/AIDS syllabus and eventually teaching in a comprehensive manner – ideally doing both at the same time. As teachers are the trusted leaders in the dissemination of knowledge, this could pave a way for breaking the silence in the whole village – working together with the church and other stakeholders. The Ministry of Education will have to include ministers of religion in curriculum building to arrive at a consistent message to students (Boler *et al*, 2003);

findings show that religion yields a lot of power in the community and any action that does not include their input is likely to be sabotaged by the church.

The role of education (Kelly, 2000) will have to change to adopt a more caring role – students in Kupisa were already taking care of each other in certain ways but more awareness among the teaching staff and community leaders would go a long way in creating a suitable environment for students. Counselling, non-existent in this and other rural schools, will have to be introduced, bearing in mind the availability of resources. On the demand and supply of education – fewer teachers due to illness and uncertain demand from pupils – is beginning to be evidenced in Kumakomo. Students complained of teacher absences and being lumped together with other classes. In such oversubscribed classes, the needs of infected and affected students would barely be considered, let alone addressed. A serious shortage of resources is heightened by the distant location of the school in a poor rural setting; scant resources make the plight of all students dire, particularly those already worst affected.

Kelly's (2000) suggestion about the reorganisation of education is apt. With students walking more than two hours to school and some eventually not able to because of illness, education might need to be taken to the students. That, however, is a long-term goal that for now is unforeseeable under the existing economic climate bereft of resources. As far as management and planning of the education system, the findings clearly point to the need for Zimbabwe to engage more research in this field in order to educate the community responsible for making decisions – the dearth of information in this regard, if not addressed, will render any future education planning useless. In a word, the impact of HIV/AIDS on education is complex and overwhelming; its multi-faceted impact in all areas of education calls for a new way of looking at education. As Kelly (2000) notes –

Education in a world with AIDS must be different from education in an AIDS-free world. The content, process, methodology, role and organisation of school education in a world with HIV/AIDS must be radically altered. The entire educational edifice must be dismantled. Every brick must be examined, and where necessary, re-shaped before it is used in a new structure that has not yet been designed.

I agree with Kelly that a world with AIDS will require an ‘altered education’ system. In this regard, a clear understanding of students’ experiences will be indispensable is the creation of a new system that attempts to address challenges brought about by the epidemic; a learner-centered education becomes imperative. Pigozzi (2006:5) has provided us with a well thought out framework on ‘how education systems can and must change their operations in relation to HIV and AIDS’ that looks at the quality of education at the level of the learner and also, at the level of the learning system as captured in the diagram below -

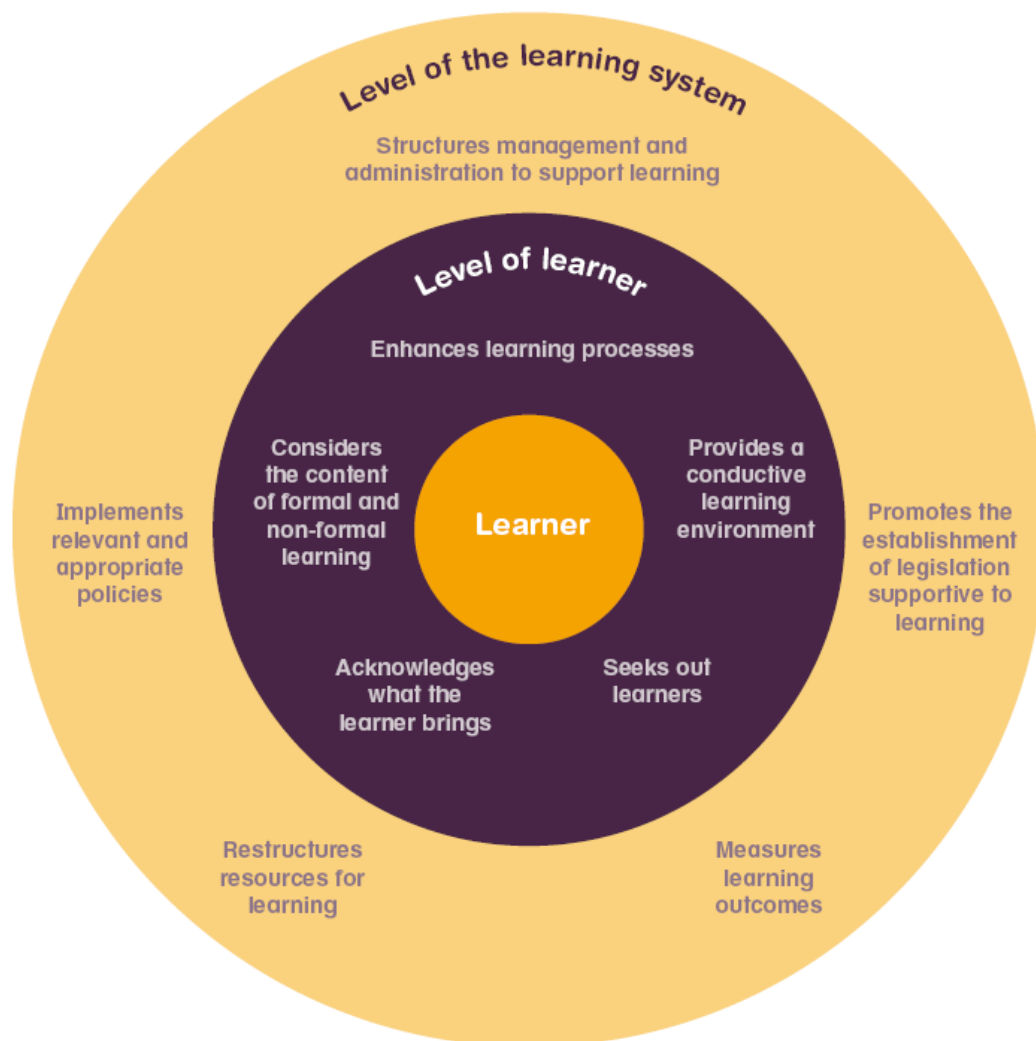
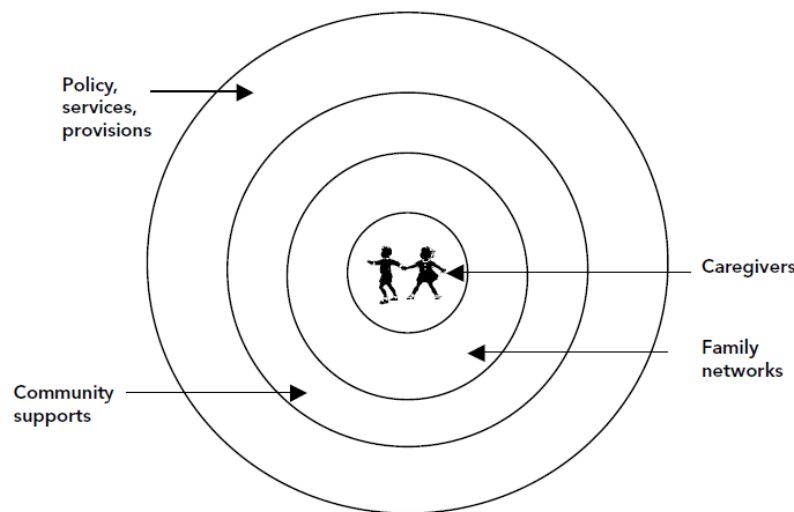


Figure 7.1 From Educating to Learning – A Framework for Considering HIV & AIDS and Quality Education (Pigozzi, 2006:10)

This framework allows us to consider factors that enable effective learning and is, amongst other things, intentional about strengthening a learner-centered education (Pattman and Chege 2003, McLaughlin et al 2003; German, 2005) that would allow for children to be participants in their learning and engage with both peers and adults in meaningful ways. Presently, in the Kupisa village school, ‘the centre of gravity is outside the child...it is in the teacher, the textbook, anywhere and everywhere you please except in the immediate instincts and activities of the child himself’ (Dewey, 1907:51). The idea of learner-centred education, whilst pursued in a number of private schools²⁶⁸ in Zimbabwe, is still a long-term goal for the rural village.

This framework, however, needs to be nested within the 'entire ecological system in which growth takes place' (Bronfenbrenner, 1993:1) so that the 'surrounding... layers of successively larger and more complex social groupings...like the family...social networks, neighbourhoods and the culture' (Aldgate, 2006:23) can be borne in mind as they remain the indispensable support systems. I return here to Bronfenbrenner:



Source: Adapted from Bronfenbrenner 1979

Figure 7.2 Circles of Care (Richter et al, 2006)

²⁶⁸ The private high school that I attended and the primary private school where I was trained to be a teacher and later taught, employed constructivist learning methods - starkly opposed to the traditional teaching methods in most government schools, particularly in rural areas where they have more untrained teachers

A holistic approach will be maintained by focusing on the cycles of care above which Richter et al (2006:11) sum up succinctly

The best way to support the wellbeing of young children affected by HIV/AIDS is to strengthen and reinforce the circles of care that surround children. Children are best cared for by constant, committed and affectionate adults. When the caregiving circle is broken for some reason, extended families normally plug the gap. When the circle of care provided by kin is broken, community initiatives need to stand in, and when the circle of care provided by the community is broken, external agencies need to play a part. Embracing all efforts should be a strong and continuous circle of support provided by government provision and legislative protection. The optimal use of the resources of external programmes is to assist communities in supporting families. Families are best placed to provide for the psychosocial needs of young children

In all the suggestions that Kelly (2000) raises and ideas in Pigozzi's (2006) framework above, however, considerably more detail is needed to know exactly how the changes need to be implemented.

To reiterate, the significance of conducting research on the impact of HIV/AIDS on primary schools in rural areas is that it will bring a clearer understanding of how children and their education are being affected by the epidemic, which is prerequisite to educational planning that will be most effective in implementing meaningful changes (Shaeffer, 1994; World Bank, 2000; Kelly, 2000 and Bennell *et al* 2002); the kind of planning that will not only curb the problem but create conditions for the emerging population of infected and affected student, together with their normal counterparts, to learn effectively and become self-sustaining individuals who can make gainful contributions to the society at large.

The implication is clear – the education system will have to provide for orphans through 'circles of care' (Richter et al, 2006) since the extended family net is now weakened due to increased demands and will either no longer be able to absorb the increasing number of orphans (Foster and Williamson, 2000), added to the new and growing population of infected children with different needs. In the absence of careful planning for this population, children (especially girls) are at risk in that they might be abused outside

family structures (Mutangadura, 2000; Munyati et al, 2006; Leach and Machakanja, 2000; Tichatonga *et al*, 2001; Foster, 2000). There is also a danger that without education the one million plus orphans will end up alienated on the streets (Guest, 2005) with no prospects of being self-sufficient or making meaningful contributions to society. Planning that ensures children's well-being after normal school hours will have to be implemented. Zimbabwe, in this regard, faces a major challenge since it is struggling to take care of existing schools²⁶⁹, let alone the emerging population with special needs brought about by the epidemic. Research that has been done about actual programmes in schools to address the challenges of the growing AIDS orphan population is sparse (Gillespie, 2005). More focused research is needed on actual experiences of students and appropriate programs to meet their needs as 'experiences and data on real-world interventions and outcomes remain under-explored' (Nguyen et al, 2004:3). On existing research that offers many good suggestions about orphans outside school and some inside school environments, 'there is a desperate need for better dissemination of information' (Nguyen et al 2004:59). There is a need to train teachers to address students' specific challenges brought about by the epidemic. Bearing in mind that most of the Zimbabwean population resides in the villages which are facing the worst onslaught of the HIV/AIDS epidemic, failure to deal with the plight of infected and affected students will have dire implication for the children's future and that of the country. Personally, I have learned a lot of research as shown in Chapter 6. This work has enabled me to formulate a large part of my future plans (partly shown in Appendix B on page 306) in building a school and a clinic in rural Zimbabwe to try to address some aspects brought out by the research.

²⁶⁹ The MOE (2011) reports that 1282 primary schools need major repairs; that 13,582 primary and 4,324 secondary classrooms are needed; that at least 555 primary and 399 secondary schools have no desks to write on – that is on top of severe teacher shortages and an economy that has only just emerged from the world's highest inflation of 2.2 million percent (Mpofu, 2008).

Schedules and Appendices

Schedule 1 Photography Activity – The School Environment

Camera: I gave students a brief lesson about how to use the camera, how to take care of it and reminded them not to take pictures of people without asking for their permission if they had to

Goal: To find out about the students' physical experiences within their school environment. This activity required students to take pictures of their school surrounding to be discussed later. This was an ideal first activity since it was less intimidating because most students readily knew the parts of the school that they liked and those that they do not like, where they felt most comfortable etc. The questions were intended to find out how they perceived their school physical environment, an important aspect of a child's 'cumulative' experiences about how they perceive schooling (Greig *et al* 2007)²⁷⁰. For instance, how do the spaces, symbols, textures, buildings, entrances and playgrounds make them feel; what does it remind them of etc?

Instructions to students were as follows:

1. Take 6 pictures of things that you like and things that you do not like. You can decide how many pictures to take of things you like and how many to take of things that you do not like
2. Ask someone to take a picture of you next to two places around the school

Discussions after the pictures were taken:

1. Tell me about your pictures
2. Why did you take this one first?
3. Tell me more about the pictures that you like – what do they remind you of – why do you like them?
4. Tell me about the pictures that you like; how do they make you feel?
5. Tell me about the places where you had your pictures taken – why did you choose those places?
6. Which picture makes you more comfortable and why?
7. If you could have taken more pictures, what would they have been? Why?

An example below is of pictures taken by a particular student

²⁷⁰ Greig *et al* (2007:31), amongst many other children researchers, concur that 'a child's learning, understanding and thinking is influenced by their environmental conditions, social relationships and cultural conventions.'



Schedule 2 Drawings and Writing - The Home Environment

Goal: This activity was to further understand the children's experiences more in their own interpretation and observation. Through drawings of their home environments, I was looking to see how students interpreted and experienced social relationships around them at home and in their community. The community in this sense mostly comprises of the student's extended family – uncles, aunts and neighbours whom they have known for a long time. Their drawings and stories became prompts for interview questions. Students who chose not to write could simply do drawings. Some students also drew and wrote about their school experiences too.

These were the instructions given to students:

We will write about ourselves and make drawings about ourselves then talk about them. Some of you might want to just want to tell the whole story through drawings – that is fine too. Draw a picture of yourself, your house, your family and relatives etc

- On the paper given, write a story about your life. What can we learn about you?
Some ideas of what you can write about:
- Some things about your family
- Things that you like
- Things that you don't like
- Things that make you happy
- Things that make you sad
- What you think about yourself
- What you think others think about you / when I grow I up I will like to ...

Below is a story that was written by a student. This is followed by an example of a drawing from another student

Name: Miriam wageni

Grade: 6A

My Story – my experiences at school



Zita rangu ndinanzi ^{wageni} miriam ndinangwa kuzimu
da. Village shamwari yangu inanzi Priviledgi zimu
nda. inofanira chikara bayinabutsiye inofanira mabe
u. inada chikara zvikuru inofanira mudzidzisi wake
inada inofanira sadza nenguma. bayina butsiye
ini ndinofanira shamwari yangu iyo inanzi fashawa.
ini ndinofanira mudzidzisi wangu zvikuru a nekuli ano

Name: Miriam Wanyeri

Grade: 6A

fundi'sa zvakanaka havana kutiye. ndino fanhasoda
fa ne yama yehuku yama iyi inopaka pachikoro che
du tina nava mabeu ti hivanura pamupanga tina
kutibwopa ini ndino fanha chikoro chedu chikoro
ichi chakanaka zv'kuru vadzidzisi vedu vano
fundisi. Zvakanaka hedzema vedu vano dawa
na vaka zv'kuru kuvadi vana vano kumbira
muradhi vanocha kuti vanatsika nemata
kuvadi vana vanemisi'kawa. ini ndino fanha
nhaka inanzi hake hukandisa idanokuti ibo ibo
botsera. kana kubereka vasabaya mun' yechikoro
vanotigona kutengesa vana ozari yechikoro
haindino fanha hake inobatsira zvaka wandu
kuchya kutengesa kumamandira mun' yechikoro
yo. mudzidzisi wangu Mr Zunga vanodzidzisa
zvakanaka nezvanoma. Mr Inofa vanatanga
zvinakidza zvanoratsoza kuti tina hedzema
vakanaka vanoseka pekanta hake tsamwa
nemunhu. mudzidzisi wewandiro fanha ndi Mr
Zunga. vanodzidzisa zv'kuru. ini ne shamba
ani yangu tinolambi kugira ndi nesbanyu
nyu.

Eleonore Madzikhe

Grade

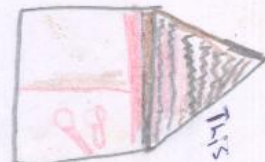
Six A



the flower



My mother



This is our hut



This is my house



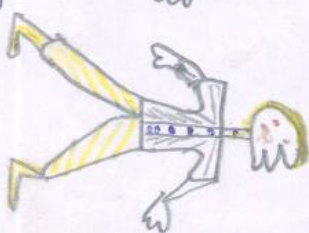
This is my hen



This is my goats



name felists



This is my father



meagous

Discussion of Drawing and Writing are below: (for the students who mostly do the drawings – some questions also apply to those who did writing too.

A sample is of questions relevant to what the students drew or wrote is below -

1. What is your favourite part of the picture? Why
2. What is your least favourite part of the picture? Why?
3. What makes you happy in this picture and what makes you sad?
4. What part of the picture do you wish was different and why?
5. Who are the people in the picture? Who else do you think you might have put in if you had more space?
6. Can you tell me something about your picture that you think shows what you would like to be when you grow up?
7. Tell me more about what you think about yourself and why?
8. What do you think your friends think about you? How does it make you feel?
9. How do you feel when you are with your friends?
10. Who are the people in your family?
11. What work do they do? What is your favourite thing to do as a family?
12. Who do you think you are closest to in that picture of your family? Why? **OR**
 - *If you were to go on holiday who would you take and why?*
 - How do you feel when you are with / away from your family?
 - The people who you said are important to you but are not members of your family – who are they? Why are they important to you?
 - When you wrote aboutdid you mean ...can you tell me a bit more about...

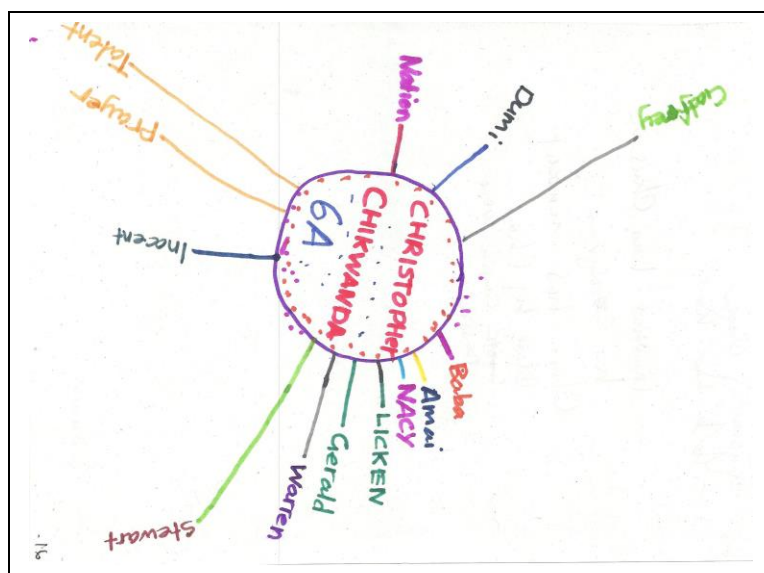
Schedule 3 Sociograms– Social network experiences within the school environment

Goal: This activity was to find out how students experienced relationships within the school environment where they spend most of their time during the week. Even though they would have touched on some of these aspects during the photography session in Schedule 1, this was more focused on relations with the people in their class and beyond. I was interested in finding out how welcome they felt, how much a part of the class/group they felt, who their closest friends in the class were and why; why they feel they might be distant to certain people or indifferent and thereby explore issues of stigma. This was a very effective method as students shared much more in-depth about their relationships in class.

The following instructions were given to students:

1. Draw a picture of yourself in the middle of the page
2. Draw a picture of a friend in your class who you think is the closest to you near your picture
3. Draw pictures of other people in the school (for example - teacher, nurse, caretaker, Headmaster, NGO worker who feeds the kids, school counsellor)²⁷¹ and put them where you think they might be according to how close you are to them

Below is an actual student's sociogram, which was later discussed using question below:



Sociogram: Christopher - Relationships

²⁷¹ The examples given in brackets – I was interested to see where they placed those people whom they interact with everyday – to get more of an understanding of how they perceive adult relationships within the school and how, in turn, it affects their schooling experience. Most students did not have any adults in their sociograms

Discussion of sociogram was as follows:

Please tell me about the people in this diagram

1. Tell me about Gerald and Warren. Are they in the same class as you or are they in another class?
2. How often do you see Dumi and Innocent? What do you have in common with your friends?
3. Why is Nancy closer to you?
4. Tell me about Godfrey, Praymore and Tallent
5. Who do you go to when you need help? Why?
6. Who would you not go to and why?
7. Tell me how you feel when you are with the different people that you have put on your map
8. – the questions then proceeded in the fashion above, depending on what the student's map looked like; I will be looking to understand how they experience their relationships within the school environment

Schedule 4 Observation Sheet

Goal: This was to help me effectively observe the infected and affected students experience of learning in the classroom – how well they participated, their interaction with the teacher and normal students. I followed students closely (shadowing) and took notes as I went along.

Name: _____	<div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;">B</div>	<div style="border: 1px solid black; width: 30px; height: 30px; display: flex; align-items: center; justify-content: center;">G</div>	Date: _____
Subjects / Activity _____			
Location: _____	Number of students in Class: _____		
Teacher's name: _____			

Time	Running Description	Interpretive Ideas	Personal Impressions
Recalls			
Reminders			

Ideas on the design of the observer sheet based on Lofland and Lofland's (1984) suggestions about what to record during observations

Schedule 5 Interviews – Teachers and the Head

Goal: To gather the teachers' perspectives about the experiences of infected and affected students. These interviews were augmented by continuous informal conversations with teachers and the Head as I worked with the students at the school. Below is how I conducted it -

Introduction: Thank you for allowing me into your school and for setting time aside to speak to me specifically about your infected and affected students. I am currently doing research on these students to get an understanding of their schooling experiences and I would very much like to hear your perspectives. The information that you will provide will be confidential and used solely for the purpose of my research. Unless you desire your name to be used as an interviewee, your name will remain anonymous when I write my final report. I would like to request your permission to record this interview so that I may be able to concentrate on our conversation. I will bring back the transcript of the tape to show you so that you can verify what we talked about. Are there any questions before we proceed?

1. What is your position here at the school and how long have you been here?
2. What grades have you taught before teaching 5th grade?
3. What is your understanding of the general HIV/AIDS situation in the country? In the Village?
4. I was told that you have a population of approximately 50 infected and about 120 affected students – is that your understanding? How does the school get this information?
5. What have your observations been of infected and affected students in the classroom in regard to a) learning b) relating to other students c) joining in sports activities d) their self-esteem? (**barriers**)
6. Have you observed any issues of stigma/discrimination on the part of the infected and affected students?
7. What are the absence rates of these students if any?
8. What does it mean to you to be teaching infected and affected students? What were your reactions when you first found out that some of your students were a) infected and b) affected?
9. How do infected and affected students deal with illness in school (and at home if you happen to know)?
10. Does the school have any counselling/intervention programs for this population of students?
11. (For the Headmaster) How has this the situation of having infected and affected students changed your administrative role?
 - a. Have you noticed any changes in child relation dynamics?
 - b. Do the other students even know that they are learning with infected and affected students? What is the school policy on that?
12. What other issues do you think affect the schooling experiences of these students?
13. What are some of the things that you think could be done to help these students?

Schedule 6 Interviews – Senior Research Officer and District Education Officer in the Ministry of Education

Goal: To understand the ‘official’ policy about infected and affected students, the prevalence in the area where I was working and also if they had any common ‘experience’ features of the population at hand among in schools. There was very little information elicited from these interviews – they simply have not even begun to address the problems. The interview was conducted as below -

Introduction: Thank you for setting time aside to speak to me specifically about your infected and affected students. I am currently doing research on these students to get an understanding of their schooling experiences and I would very much like to hear the official position of the district and country at large concerning this matter and also, your perspectives. The information that you will provide will be confidential and used solely for the purpose of my research. Unless you desire your name to be used as an interviewee, your name will remain anonymous when I write my final report.

I would like to request your permission to record this interview so that I may be able to concentrate on our conversation. I will bring back the transcript of the tape to show you so that you can verify what we talked about. Are there any questions before we proceed?

1. How long have been a Senior Research / District Education Officer and how many schools are you responsible for?
2. What is the official position of parents having to report the HIV/AIDS status of their children to you to pass on to the schools?
3. What are the official numbers of infected and affected students in these village schools? How about the numbers for the whole Province of Manicaland?
4. According to gender, which sex is the most affected?
5. What has been the impact of having infected and affected students in schools?
6. From your oversight of the 3 schools in this area, what common features concerning the experiences of infected and affected students are you aware of?
7. What reports do you have about their schooling experiences?
8. Are you aware of any issues of stigma?
9. What intervention measures are there for these students and how are they implemented?
10. What are your own perceptions about the education of infected and affected students?
11. Are there other issues pertinent to this student group that you would like to share with me?
12. What are some of the things that you think could be done to help these students?

Thank you very much for spending the time to share this important information with me. I will show you the transcript, together with some of my thoughts so that you may be able to verify that I have not misquoted you and that my understating of the situation has not been taken out of context. Thank you!

Schedule 7 Interviews – The Chief and District Administrator

Goal: To understand what the leaders of the community, the Chief and his headman, perceive about the education of the infected and affected students; to find out about their involvement and perceptions of how they thought various schemes, if any, were working.

Introduction: Thank you for allowing me into your village (and school) and for setting time aside to speak to me specifically about your infected and affected students. I am currently doing research on these students to get an understanding of their schooling experiences and I would very much like to hear about perspectives, as leaders of this community, of the education of infected and affected students here in the rural schools in Manicaland. The information that you will provide will be confidential and used solely for the purpose of my research. Unless you desire your name to be used as an interviewee, your name will remain anonymous when I write my final report.

I would like to request your permission to record this interview so that I may be able to concentrate on our conversation. I will bring back the transcript of the tape to show you so that you can verify what we talked about. Are there any questions before we proceed?

1. How long have you been (Chief / District Councillor Administrator) for this region?
2. What is your perception of the general HIV/AIDS problems in this rural community?
3. How much contact do you have with these rural primary schools? Would you be aware of how many infected and affected students they have?
4. Are you aware of some of their experiences at school, at home and in the community?
5. What is your perception of the education of these students?
6. What are some of the things that you think can be done to help these students?
7. What do you foresee in the next 10 years – do you think the population of infected and affected students will increase in the schools? What are some of your thoughts on what could be done?
8. What other things would you like to share with me about the infected and affected students?

Thank you very much for your time and for making it possible for me to do my research in your rural school here in Manicaland. I will make an attempt to send you my finished report.

Schedule 8 Interviews – The Baptist Minister

Goal: To find out what the Minister, as both the representative of the church and as an individual, had observed; if he could shed some light about the experiences of the infected and affected students since most churches in Zimbabwe seemed to be taking the role for taking care of increasing orphan population due to the HIV/AIDS epidemics. I also wanted to see what role religion played in the lives of the infected and affected students. Below is how the interview was conducted –

Introduction: Thank you for setting time aside to speak to me specifically about infected and affected students. I am currently doing research on these students to get an understanding of their schooling experiences and I would very much like to hear your perspectives, as a religious community leader, on their education at school and in the community at large. The information that you will provide will be confidential and used solely for the purpose of my research. Unless you desire your name to be used as an interviewee, your name will remain anonymous when I write my final report.

I would like to request your permission to record this interview so that I may be able to concentrate on our conversation. I will bring back the transcript of the tape to show you so that you can verify what we talked about. Are there any questions before we proceed?

1. How long have you been a priest at this church?
2. How involved are you in matters concerning HIV/AIDS in the community?
3. You would be aware that the adult numbers of people with HIV/AIDS have increased drastically over the years; so have the number of infected and affected students. What is your perception of the education of infected and affected students?
4. What is the church's involvement, if any, with this group of children?
5. What do you think is the role of religion in this matter?
6. Are there other observations that you would like to share with me?
7. What are some of the things that you think could be done to help these students?

Thank you very much for spending time to share this important information with me. I will show you the transcript, together with some of my thoughts so that you may be able to verify that I have not misquoted you and that my understating of the situation has not been taken out of context. Thank you!

Schedule 9 Interviews – Caregivers

Goal: To understand what the parents/caregivers perceive about the education of infected and affected students. I was also looking to understand what they perceive to be the experiences of these vulnerable children at home. I conducted the interview with a series of questions below -

Introduction: Thank you for allowing me into your home and for setting time aside to speak to me specifically about your child/children. I am currently doing research on these students to get an understanding of their schooling experiences and I would very much like to hear about your perspectives on their education and your observations about their experiences at home and in the community. The information that you will provide will be confidential and used solely for the purpose of my research. Unless you desire your name to be used as an interviewee, your name will remain anonymous when I write my final report.

I would like to request your permission to record this interview so that I may be able to concentrate on our conversation. I will bring back the transcript of the tape to show you so that you can verify what we talked about. Are there any questions before we proceed?

1. Are you the parents or caregivers of this student? If you are caregivers, how long have you been taking care of him/her?
2. If you have been known the child for a long time, did you notice a drastic change when they became affected and also when they found out that they were infected (for those that are infected)?
3. How would you describe those changes?
4. Tell me about the times that they seem to be most anxious – what triggers those feelings?
5. Tell me about the times when they are happy – what makes them happy and how long does it seem to last – the happiness?
6. What would you say are the most difficult things for these students?
7. What do they tell you about their time at school?
8. What are your feelings about the education of infected and affected students?
9. What support systems are available for you?
10. How do you think the community treats them?
11. What are some of the things that you think could be done to help these students?

Thank you very much for spending time to share this important information with me. I will show you the transcript, together with some of my thoughts so that you may be able to verify that I have not misquoted you and that my understating of the situation has not been taken out of context. Thank you!

APPENDIX A

All communications should be addressed to
"The Secretary for Education Sport and Culture"
Telephone: 734051/59 and 734071
Telegraphic address: "EDUCATION"
Fax: 794505



Ref: C/426/3

Ministry of Education Sport, Arts and
Culture
P.O Box CY 121
Causeway
Zimbabwe

Siza Mtimbiri
University of Cambridge

Re: PERMISSION TO CARRY OUT RESEARCH

Reference is made to your application to carry out research in the Ministry of Education, Sport, Arts and Culture institutions on:

Impact of HIV/AIDS on Education with a Focus on Children on Rural Primary Schools

Permission is hereby granted. However you are required to liaise with the Provincial Education Director responsible for the schools from which you want to research. Parental consent has also to be sought for minor subjects in the study.

You are also required to provide the Ministry of Education, Sport and Culture with the final copy of your research since it is instrumental in the development of Education in Zimbabwe.

MINISTRY OF EDUCATION
SPORT AND CULTURE
09 SEP 2000
P.O. BOX CY 121 CAUSEWAY
ZIMBABWE

C. Mazondze

For: SECRETARY FOR EDUCATION, SPORT, ARTS AND CULTURE



Land availed for academy of excellence

Plumtree Correspondent

THREE local authorities, Plumtree Town Council, Bulilima and Mangwe have availed land for the construction of an Institute of Academic Excellence and Medical Centre.

The project spearheaded by a United States based organisation, Hope Academy will see underprivileged people within Plumtree, Mangwe and Bulilima benefiting from the education and health facility.

Speaking during an all stakeholders meeting on the establishment of the academy and medical centre, executive director of the organisation, Mr Siza Mtimbiri said the institution would house an Early Childhood learning facility, primary and secondary school as well as a medical centre for the underprivileged.

"As an organisation we have realised a huge gap in the delivery of health and education services within rural communities, which is the reason why we wish to establish this facility. With regards to improving education standards, we will be establishing an academy that will benefit underprivileged children.

"The academy will house an ECD learning facility, primary and secondary schools that will enrol underprivileged children from within the three locations which are Plumtree, Mangwe and Bulilima as well as neighbouring rural communities," he said.

Mr Mtimbiri said the institute of academic excellence would also offer lessons for elderly people who had not able to attend school.

He said the medical centre would be providing free health services to the underprivileged.

"We will also be establishing a medical centre where the underprivileged people will be accessing free health care services. It will be a state of the art medical centre which seeks to improve health service delivery," he said.

Speaking at the same event, the Minister of the Organ of National Healing, Reconciliation and Integration, Moses Mzila Ndlovu said the model of educational provisions that would be introduced by the institution was what the province needed to spruce up education standards.

"The institution which Hope Academy wants to set up promises to be a state of the art model of educational standards. The Institute of Academic Excellence is for underprivileged children that have great minds but fail to develop those minds because of limited resources

"The whole of Matabeleland South is constantly losing young people who fail to complete their secondary education when parents fail to pay fees. Plumtree is a border town like Beitbridge and they are the most affected areas. The establishment of this institution is a step towards containing this situation," said Minister Ndlovu.

The Deputy Minister of Higher and Tertiary Education, Lutho Tapela said the establishment of the institution would help improve the uptake of Matabeleland South pupils into tertiary institutions as it was very low.

"The uptake of pupils from secondary schools in Matabeleland South into tertiary institutions is still low because a few pupils make it through to secondary education.

"Those who are able to make it through fail to compete with pupils from other provinces for places in tertiary institutions because of poor results caused by the poor learning environments that are prevailing in rural areas such as having to walk long distances to reach schools," he said.

Deputy Minister Tapela said the institution would help produce pupils who would have received quality education from primary level right through to secondary education thereby enabling them to progress to tertiary level.

"The institution will be housing primary and secondary schools which will help the province produce pupils who would be able to complete their studies. This will go a long way in addressing the problem of poor education standards faced by the province," he said.

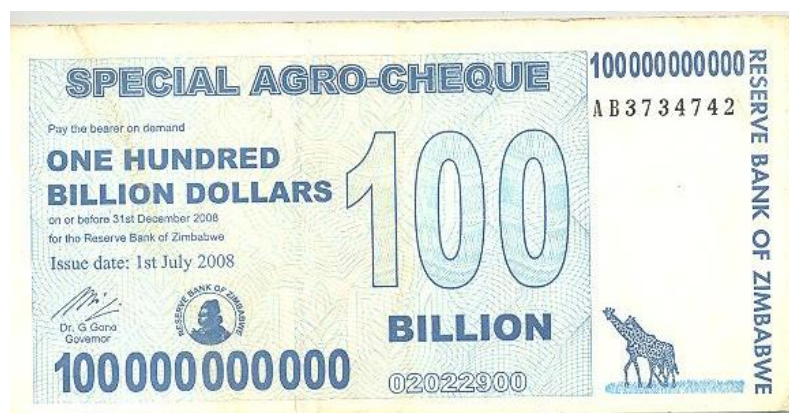
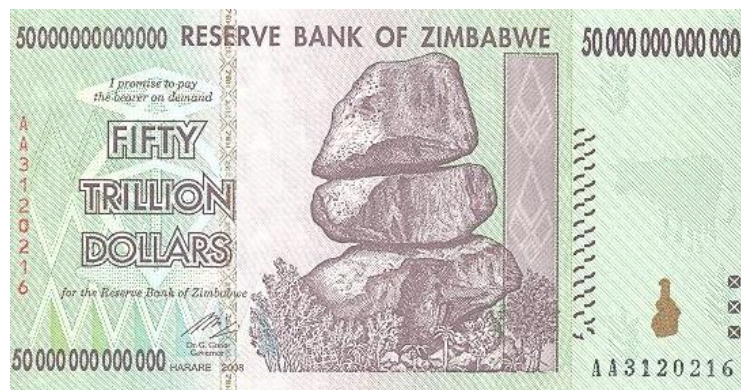
Mangwe chief executive officer Mr Nketha Mangoye Dlamini said the local authorities had welcomed the idea of constructing the institution as the three local authorities were competitively low with regards to education standards.

"The standard of education in the three local authorities is low and we need to spruce it up by pushing our pupils across primary to secondary right up to tertiary education. Pupils are performing poorly in primary education and when they move on to secondary the standards of education would be compromised, which makes it difficult for pupils to move on to tertiary education.

"With the advent of this institute of academic excellence, at least we will have a breed of quality pupils and at the same time our local schools within the area will be forced to improve on their performance," he said.

APPENDIX C – ZIMBABWE CURRENCY UNITS DURING THE INFLATION

Personal copies of bills used in Zimbabwe during the inflationary period



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