

**EXPERIENCES OF CAREGIVERS RAISING HIV/AIDS-ORPHANS IN BULILIMA
DISTRICT, ZIMBABWE**



Elias Maronganye

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EXPERIENCES OF CAREGIVERS RAISING HIV/AIDS-ORPHANS IN BULILIMA DISTRICT, ZIMBABWE

A Research Report submitted in partial fulfilment of a Master of Arts in Health Sociology by coursework and Research Report.

By Elias Maronganye

Supervisor

Dr Knowledge Rajohane Matshedisho

Department of Sociology

Faculty of Social Sciences and Humanities,

University of the Witwatersrand.

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DECLARATION

I Elias Maronganye, declare that this research is my original work. It has not been submitted before for any other degree, part of degree or examination at this or any other university. Where someone else's work has been used, due acknowledgement has been given and reference made accordingly.

Signature: _____

Date: 18 October 2017

DEDICATION

Chengetai, meeting you has been a blessing from above. Thank you for your constant support and encouragement through it all.

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My dearest daughter Vanessa Kundai, I will never be able to express how thankful and grateful I am to you. Thank you for your support, patience, and encouragement through this process.

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LIST OF ACRONYMS AND ABBREVIATIONS

AMTO	Assisted Medical Treatment Order
ART	Antiretroviral Treatment
BDSR	Bulilima District Situational Report
BEAM	Basic Education Assistance Module
CDG	Care Dependence Grant
CSG	Child Support Grant
DSD	Department of Social Services
FBOs	Faith Based Organisations
FCG	Foster Care Grant
HIV/AIDS	Human Immune Virus/Acquired Immune Deficiency Syndrome
MHCW	Ministry of Health and Child Welfare
NAC	National Aids Council
NAP for OVC	National Action Plan for Orphans and Vulnerable Children
NDP	National Development Plan
NGOs	Non-Governmental Organisations
SASSA	South African Social Security Agency
SSA	sub-Saharan Africa
UKCID	United Kingdom Consortium on AIDS and International Development
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Emergency Fund
WHO	World Health Organisation
ZimStat	Zimbabwe National Statistics Agency

ABSTRACT

In Zimbabwe, many studies on the care of HIV/ AIDS orphans mostly focus on how caregivers are selflessly enduring the burdens of raising HIV/AIDS orphans without external support because of the collapse of the traditional system of childcare. Although African children have long been acknowledged as making important contributions in the family livelihoods in rural settings, current studies tend to tone down orphans' agency and underline their dependency and care-seeking positions thus presenting orphans as burdens and caregivers as the bearers of the burden. The aim of this study was to understand the experiences of caregivers raising HIV/AIDS orphans within extended families in the rural area of Bulilima District, Matabeleland South province, Zimbabwe. The study argues that within the financial challenges and burdens of the HIV/AIDS epidemic, families in rural Zimbabwe are developing adaptive means to care for HIV/AIDS orphans. The study followed a qualitative approach by interviewing 15 caregivers using a semi-structured interview guide. The caregivers were selected using purposive sampling and the data was analysed using thematic analysis. Findings that emerged suggest the extended family orphan care support system is not breaking up, but rather actively ameliorating the structural challenges of the HIV/AIDS epidemic, harsh economic conditions, and persistent droughts. The capacity to care and caregivers' experiences should be viewed as a continuum because the family capacity to care is subject to change at any given time and place. The economic status of the family where the caregiver lives and economic status of the caregivers themselves influence experiences of the primary caregiver raising the HIV/AIDS orphans. Further, the study noted rural orphans with age become active household members who contribute significantly to the subsistence way of life in rural Zimbabwe.

Key words: Experiences; Caregivers; HIV/AIDS; orphans; Bulilima district

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CHAPTER 1: INTRODUCTION

1. Introduction

This chapter presents an overall background of the study, as well as stating the problem statement which created the researcher's interest in undertaking the study. The chapter outlines, the rationale of the study, the research objectives and research questions of the study. It briefly highlights the study significance and ends with a presentation of the study chapter outline.

Available studies on the care of HIV/AIDS orphans by extended families suggest caregivers are selflessly raising HIV/AIDS orphans without external support because of the weakening of the extended family, financial challenges and the general trend towards nuclear families (Mafumbate, 2013; Phetlhu & Watson, 2014). Other studies along similar lines present orphans as the burdens and caregivers as the burdened (Matshalaga, 2004; Mudavanhu, Segalo & Foure, 2008). However, there is a dearth of literature acknowledging caregivers live within the extended family. Therefore, caring responsibilities usually go beyond the primary caregiver, but extend to all members of the extended family.

Using two theoretical debates on orphan care; social rupture theory and social resilience theory, the argument put forward in this study is, within the financial challenges and burdens of the HIV/AIDS epidemic, rural families in Zimbabwe are developing adaptive means to care for HIV/AIDS orphans. This study focused on exploring and describing the experiences of caregivers who are raising HIV/AIDS orphans in the rural area of Bulilima District, Matabeleland South Province, Zimbabwe. Specifically, the researcher intends to: i) investigate the daily responsibilities of caregivers towards the orphans, ii) explore the caregivers concerns and, iii) to explore social support structures of caregivers who are raising HIV/AIDS orphans.

1.2 Background to the study

The HIV/AIDS epidemic has for a long-time been one of the primary causes of both child and adult mortality in HIV endemic settings within sub-Saharan Africa (SSA). The epidemic created an extraordinary orphan crisis in SSA, with Southern Africa

bearing the most burden. This has contributed to an enormous caregiving burden on society and particularly the extended family, which is the primary safety net for the orphans in Africa. Osafo, Knizek, Mugisha, and Kinyanda (2017) state that, the caring burden is felt by older persons who have a double burden of caring for their sick and dying adult children, as well as orphaned grandchildren.

Though HIV/AIDS is not the only cause of untimely parental deaths, studies concur from the beginning of the 1990s around half of all parental deaths in Africa were because of HIV/AIDS (see Ghosh & Kalipeni, 2004; Hunter 1990). For instance, United Nations Children's Fund (UNICEF) (2003) states that between the years 1990 and 2001, the number of orphans whose parents died of HIV/AIDS grew from 3.5 percent to 32 percent. Further, Ghosh and Kalipeni (2004) report that about 2 percent of the children in SSA had been orphans before the HIV/AIDS epidemic.

In addition, there is overwhelming evidence proving before the HIV/AIDS epidemic, the numbers of orphans in developing countries were decreasing because of improvements in life expectancy (United Nations Development Programme (UNDP), 2015). Scholars such as Mahati *et al.*, (2006), state that HIV/AIDS turned the situation upside-down by creating too many orphans that even family structures, as well as communities, can no longer cope with. The epidemic resulted in an estimated 13.3 million orphans globally, and with more than 80 percent of them (11.0 million) living in SSA (UNICEF, 2016). In SSA, HIV/AIDS have done immense harm to families, ruined lives of many people and affected individuals, families, and communities. Compared to the rest of the world, nations in SSA region, especially Southern Africa have witnessed a massive increase in the number of HIV/AIDS orphans (Joint United Nations Programme on HIV/AIDS (UNAIDS), 2008).

Even with the declines in new HIV/AIDS infections, the number of orphans will continue to grow in the years ahead. There are two main reasons, first according to Zagheni (2011:76) "there is a lag between the peak in adult HIV prevalence and the peak in AIDS-related orphanhood prevalence." Second, because of high numbers of adults already living with HIV/AIDS combined with continuing difficulties in expanding free life-prolonging Antiretroviral Treatment (ART) in some regions of SSA (UNAIDS, 2016).

The HIV/AIDS epidemic is both a health and development issue throughout Southern Africa, including Zimbabwe. Duri, Stray-Pedersen, and Muller (2013) mention the first HIV/AIDS case in Zimbabwe was reported in 1985. Since then, the HIV/AIDS prevalence rate rose sharply, reaching a peak of 27.7% in 1997 before declining to as low as 16.7% in 2014 (Duri, Stray-Pedersen & Muller, 2013; UNAIDS, 2016). Despite, the rate of new infections declining, the long incubation period of HIV/AIDS means the mortality rate will not plateau until 2020, meaning the proportion of orphans will remain unusually high (Foster & Williamson, 2000; Bongaarts, Pelletier & Garland, 2009).

Zimbabwe has a population of about 13 million people, of which 1.6 million are reported to be living with HIV/AIDS and about 39 000 die each year because of the disease (Zimbabwe National Statistics Agency (ZimStat), 2016; UNAIDS, 2016). Since 2014, because of HIV/AIDS, the number of orphans has risen to about 524 581 (UNAIDS, 2016). HIV/AIDS is the most serious burden faced by Zimbabwe since independence in 1980. The effects have been widespread deaths and massive suffering among the Zimbabwean citizenry. At independence, life expectancy was at 59, 2 years and it rose to 69, 9 years in 1985 (UNDP, 2015). However, according to UNDP (2015), HIV/AIDS lowered the life expectancy to as low as 50.3 in 1990. Life expectancy at birth has fallen below levels that existed at independence, wiping out the gains of a generation. Thus, the Ministry of Health and Child Welfare (MHCW) and National Aids Council (NAC) (2015) submit that HIV/AIDS is going to be a long, difficult struggle.

The HIV/AIDS epidemic changed the demographics of many societies as reported in the Help Age International Report of (2003) and later by Hosegood (2009). Further Mailula (2012: No page number) states that, "Typically, half of all people with HIV become infected before they are aged 25, developing AIDS and dying when they are 35, leaving behind a generation of children raised by their grandparents, other adult relatives or left on their own in child-headed households." Resultantly, scholars such as Mudavanhu *et al.*, (2008), write that resultantly, family patterns are the worst hit as HIV/AIDS is leaving behind vulnerable age groups, specifically the young and the old.

Thus, in the early years of the HIV/AIDS epidemic, researchers claimed the gradually growing numbers of HIV/AIDS orphans would collapse social fostering networks (Foster, 2000). Yet overtime, scholars such as Bray, (2003:54) realised that these “apocalyptic predictions” did not come to pass. Instead, kin-based networks, although strained by HIV/AIDS, are still the primary means for orphan care in Africa (Abebe & Aase, 2007; Mathambo & Gibbs 2008; Nyamukapa & Gregson, 2005; Verhoef, 2005). Further, Mathambo and Gibbs (2008) state that resilience of kinship networks is the primary reason upholding kin-based networks of orphan care.

Literature suggests that in many African communities the responsibility of orphan care mainly rests on the immediate families, with the main expectation placed on grandparents (Kiggundu & Oldewage-Theron, 2009; Kuo & Operario, 2009; 2011; Phetlhu & Watson, 2014). Further, studies suggest that elderly caregiving in Africa is carried out amid adverse conditions (Kiggundu & Oldewage-Theron, 2009; Kuo & Operario, 2009; 2011; Phetlhu & Watson, 2014). Further, caring for HIV/AIDS orphans involves unique responsibilities, which include but not limited to, financial, social, and emotional needs (Verhoef, 2005). Importantly, HIV/AIDS-affected children may have added needs that increase caregiving demands (Campbell *et al.*, 2016). For instance, some of them might be HIV/AIDS infected and therefore, experiencing HIV/AIDS-related stigma and emotional problems (Campbell *et al.*, 2016).

Also, studies have made known that many carers suffer from HIV/AIDS stigma and discrimination resulting in the isolation of carers and children from social networks (Ekstrand, 2006; Kuo & Operario, 2010). Powell and Hunt (2013) state that carers lack expertise in caring children living with HIV/AIDS. Moreover, researchers such as Kuo and Operario (2009) note that HIV/AIDS orphans caregivers have limited financial means to meet the basic needs of orphans, such as schooling, food, and medical care. These challenges are exuberated by the sheer volume of parental deaths which in turn leads to reduced household contributions which sometimes leads to poverty (Kuo & Operario, 2009).

Studies further note gendered and an unequal allotment of HIV/AIDS orphan caring responsibilities between women and men in rural areas. For instance, Powell and Hunt (2013) state, women carry out most of the household duties, while men focus

on duties that concern physical strength and finances. Along similar lines, Nkosingithi and Mtshali (2016) claim women are assigned to child caregiving because of the deeply entrenched gender and socio-cultural practices found in rural areas.

The Government of Zimbabwe committed itself to help vulnerable children, such as HIV/AIDS orphans, through developing legislations, sound policies, and helpful programme initiatives. However, practically the Government of Zimbabwe is not adequately supporting vulnerable children and their caregivers (Chitiyo, Chitiyo & Chitiyo, 2016). Zimbabwe has strained relations with the international community, especially developed countries because of differences in political and governing policies. This has resulted in failing to access funding from the international community necessary for economic development and social spending on even people made vulnerable by HIV/AIDS. Most of the programmes towards easing challenges faced by people made vulnerable by HIV/AIDS are funded by the donor community. Nyamukapa and Gregson (2005) further report that most of the approaches aimed at helping HIV/AIDS orphans and caregivers often remain largely poorly coordinated and underfunded. Therefore, leaving many caregivers and their HIV/AIDS orphaned children to be supported by the extended family.

Nyamukapa and Gregson (2005) put forward the claim that extended family remains true within the collective consciousness and is typically the first point of reference when a crisis arises to a family member. They further state that families come together in times of need and sorrow to support and work together on a way forward. This notion was earlier mentioned by MHCW and NAC (2004) which state that, in the Zimbabwean context, the extended family has the traditional responsibility to care for orphans. However, orphan caring within families is under strain as shown by the rise of child-headed families (MHCW & NAC, 2004; Magwa & Magwa 2016). Along similar lines, researchers argue the extended family system of orphan care has become saturated and it is also breaking up because of economic stress and the burden of HIV/AIDS, as a result, orphan care is not guaranteed (Abebe & Aase, 2007; Chirwa, 2002; Foster, 2000; Mathambo & Gibbs, 2009; Tanga, 2013). This is because of the increase in numbers of children that need protection and support and larger numbers of adults falling sick and dying because of HIV/AIDS (Magwa & Magwa, 2016).

In Bulilima district, Matabeleland South Zimbabwe, HIV/AIDS prevalence rate stands at 18, 9%, which is far higher than the 14% national prevalence rate (NAC, 2016; UNAIDS, 2016). Consequently, raising a cause for concern for the district. HIV/AIDS has caused suffering to the people in this rural community. Campbell (2003) state that, the disease usually infects people in the prime of their economic and child-rearing lives, leaving behind people with no sources of income responsible for caring for the orphans. According to the Bulilima District Situational Report (BDSR), of (2016), HIV/AIDS orphans in Bulilima are living in extended families' due to the HIV/AIDS epidemic and high migration to South Africa and Botswana. The children are left in the care of maternal or paternal relatives (BDSR, 2016). It is because of HIV/AIDS orphan crisis and the role of extended families that this study explores the experiences of caregivers who are raising HIV/AIDS orphans in the rural area of Bulilima.

1.3 Problem statement

So far much is known about the HIV/AIDS effects, but little attention has been devoted to the experiences of familial caregivers who invariably raise these HIV/AIDS orphans. There are not enough studies done on understanding the contextual roles and experiences of caregivers as they raise HIV/AIDS orphans. The available few studies on HIV/AIDS orphans caregiving assume that the extended family which is the traditional system of orphan care is stretched by the impact of the HIV/AIDS epidemic, and is actually collapsing and not able to care for HIV/AIDS. Studies further presume that caregivers are selflessly enduring the burden of raising HIV/AIDS orphans without external support. Other studies along similar lines, tone down orphans' agency and underline their dependency and care-seeking positions presenting orphans as burdens and caregivers as the bearers of the burden. To understand the context of HIV/AIDS orphan caregiving, it is important that a qualitative study is conducted to determine the context of caregiving by examining the experiences of caregivers raising HIV/AIDS orphans in a rural area.

There is a dearth of literature recognising that caregivers live within the extended family; and thus, caring responsibility usually goes beyond the carer alone but extend to all members of that family. Further, orphans as they grow up, they become active household members who contribute significantly to the rural agrarian life. This

study focused only on exploring and describing the lived experiences of caregivers who are raising HIV/AIDS orphans in the rural area of Bulilima District, Matabeleland south Zimbabwe. The researcher seeks to contribute towards literature on HIV/AIDS orphans caregiving, by arguing that within the financial challenges and burdens of the HIV/AIDS epidemic, families in rural Zimbabwe are developing adaptive means to care for HIV/AIDS orphans. Findings of the study would provide valuable information to the Government, faith-based organisations, non-governmental organizations and communities on the needs of, and relevant support needed by HIV/AIDS orphans caregivers, and further be used to improve strategies (which was not part of this study but could be done in future) on the care of the caregivers based on the experiences as expressed by them.

1.4 Rationale of the study

Although HIV/AIDS had been the centre of concern for the last three decades, the orphans' crisis only gained global attention towards the end of the nineties. When HIV/AIDS was discovered, the main concerns were in coming out with interventions and prevention initiatives to restrain the spread of the virus. Further, policymakers, international organisations, and national governments responded slowly to the impact of HIV/AIDS on orphans (Levine, 1995) believing that HIV/AIDS was more of a health rather than a developmental issue (Webb, 1997). Further, earlier studies such as Ulin (1992) focused much on cultural and behavioural determinants that promoted transmission of the HIV/AIDS virus. Later, researchers such as Abel, Barnett, Bell, and Cross (1988) and Hunter and Williamson (2002) focused on the social and economic impacts of the epidemic on various sections of the society since economically productive young adults were dying owing to HIV/AIDS.

Studies by Hunter (1990) as well as Barnett and Blaikie (1992), helped to draw attention to orphans made vulnerable by HIV/AIDS in Africa. Hunter's (1990) study in Uganda, showed the extent of lack of resources among the children and how education opportunities were reduced among the orphans of HIV/AIDS. In Uganda, Barnett and Blaikie (1992) lucidly express how families face the added strain of raising HIV/AIDS orphans coming from elsewhere within the extended families.

At present, the literature on how HIV/AIDS has destroyed family structures, affected roles of family members, including elderly caregivers in Sub-Saharan Africa has

been broadly examined (Abebe, 2010; Abebe & Aase, 2007, Osafo *et al.*, 2017). In Southern Africa, most research studies on the experiences or challenges faced by caregivers raising HIV/AIDS orphans were carried out in townships and rural areas of South Africa and Lesotho, for example (Block, 2014; 2016; Kiggundu & Oldewage-Theron, 2009; Rajcoomar, 2005; Phetlhu & Watson, 2014; Muhadisa, 2012; Mohale, 2013; Warwick, 2013; Gumede, 2003). South Africa still offers basic support such as child aid grants, foster grants, old age grants and even pensions. The Zimbabwean government, however, is failing to undertake the role of social provision (Chitiyo *et al.*, 2016). Therefore posing a question on how the caregivers raising HIV/AIDS orphans are managing, given the limited role of the government in taking care of its vulnerable members

Most of South African studies focus mainly on grandmothers' caregivers. These studies (for instance Kiggundu & Oldewage-Theron, 2009; Rajcoomar, 2005; Phetlhu & Watson, 2014; Muhadisa, 2012; Mohale, 2013; Warwick, 2013; Gumede, 2003) overlook that these grandmothers live within the extended family system, mostly caring responsibility usually goes beyond the carer alone but affects all members of that family. Further, the reality in Bulilima is that most of the HIV/AIDS orphans are living in extended families. The children are in the care of maternal or paternal relatives (BDSR, 2016).

In Zimbabwe, literature is replete with studies about the spread of HIV/AIDS and the behavioural characteristics associated with its transmission. Little is known about the macro-level sequelae of the epidemic that extend beyond biomedical outcomes. For instance, experiences of those providing care for orphans left behind because of HIV/AIDS. Within the limited body of literature on care structures, caregivers experiences, and the dimensions of caregiving, only a handful of studies explore experiences of caregivers raising HIV/AIDS orphans. Therefore, studies on experiences of caregivers raising HIV/AIDS orphans are few and far between. Further, it is yet to be comprehended how HIV/AIDS orphan care within the extended family has remained afloat considering this epidemic caregiving challenge. Such studies are important, around the issue of caring for an estimated 570,000 children orphaned by HIV/AIDS (UNAIDS, 2016).

Further, few studies such as Matshalaga (2004), Mudavanhu *et al.*, (2008), Skovdal, Campbell, Madanhire, Nyamukapa and Gregson (2011), Zagheni (2011) as well as Zvinavashe, Mukombwe, Mukona, and Haruzivishe (2015) being notable exceptions have so far conducted detailed studies, specifically on caregivers raising HIV/AIDS in Zimbabwe. Whilst these studies (Matshalaga, 2004, Mudavanhu *et al.*, 2008; Zagheni, 2011, as well as Zvinavashe *et al.*, 2015) have already explored the experiences of caregivers raising HIV/AIDS orphans, they emphasize how elderly grandmothers are selflessly bearing the burdens of caring for HIV/AIDS orphans without support. These studies problematize orphans by presenting them as “the burden” while the caregivers are the “the burdened”. While this may also be the case, the researcher believes such studies give a lopsided view by presenting orphans as passive beings in need of adult support and guidance. This study seeks to move beyond this conception, building on studies that have highlighted the reciprocity of care and support within such households (Abebe & Skovdal, 2010; Skovdal, 2010). Since the reality in the rural area of Bulilima is that HIV/AIDS orphans with age become active household members who contribute significantly to the rural agrarian life.

The chosen study area of Bulilima has high HIV/AIDS orphans compared to other districts (NAC, 2016b). This is a result of high HIV/AIDS rates, which surpasses the national figure, therefore, raising a cause for concern (NAC, 2016b). The district is described by NAC (2016a) as an HIV/AIDS hot spot. The rising numbers of HIV/AIDS orphans in Bulilima are caused by circumstances like single parenting and absent fathers (BDSR, 2016). Thus, if the only available parent dies because of HIV/AIDS; automatically the child or children become orphans (BDSR, 2016). According to the BDSR (2016) children end in the care of uncles or aunts, depending on the family set up. Some of these carers are poor, unemployed and rely solely on the donor community. Sometimes children are left without documentation like birth certificates which makes it harder for the carers to apply for basic support such as school fees and uniforms from the available donor support programmes (BDSR, 2016). Caregivers raising HIV/AIDS orphans sometimes find it difficult to offer guidance and basic needs to these orphans. The researcher realised there is a need to conduct research on the experiences of caregivers who are raising HIV/AIDS

orphans in a rural area of Bulilima since no similar study has been documented in Bulilima.

This study aims to fill this gap in the literature by focusing on experiences of caregivers who are raising HIV/AIDS orphans in a rural area. The study used the theory of social rupture and the theory of social resilience as theoretical lenses, to frame its argument on HIV/AIDS orphan care. Unlike studies by Matshalanga (2004), Mudavanhu *et al.*, (2008), Zagheni (2011) as well as Zvinavashe *et al.*, (2015) which argue that caregivers are on their own in raising HIV/AIDS orphans because of social rupture. This study argues that within the financial challenges and burdens of the HIV/AIDS epidemic, rural families in Zimbabwe are developing adaptive means to care for HIV/AIDS orphans. This study also goes beyond the 'orphan burden' by drawing attention to the ways in which care can be a two-way process. It demonstrates that orphans with age can reciprocate the resources of care in households.

1.5 Aims and objectives

This section sets out the aims and objectives developed for this research. Creswell (2014) believes aims, and objectives are important and can be signposts for the investigator in a research project. The overall aim of this study is to add and expand literature by sociologically researching the experiences of caregivers raising HIV/AIDS orphans in Bulilima District, Zimbabwe. The study achieved this aim by employing a descriptive and interpretive qualitative design as well as carrying out 15 semi-structured interviews with caregivers who are raising HIV/AIDS orphans in Bulilima District in Matabeleland South Province in Zimbabwe.

In pursuance of the broader aim, the study sets itself to address the following objectives:

1. To investigate the daily responsibilities of caregivers towards the orphans,
2. To explore the caregiver's concerns and
3. To explore social support structures of caregivers who are raising HIV/AIDS orphans.

1.6 Research questions

The research question guided the study all the way through. According to Mouton (1996), a research question is when the title is reformulated into a question. In this case, the main research question for this study is as follows: What are the experiences of caregivers raising HIV/AIDS orphans in a rural area? This research question is supported by the following three sub-questions:

1. What are the caregivers' daily responsibilities towards the HIV/AIDS orphans?
2. What are the caregivers' concerns in raising the HIV/AIDS orphans?
3. What are the social support structures available to caregivers raising HIV/AIDS orphans?

1.7 Significance of the study

Though the field of the proposed study is not new, little has been documented about the experiences of caregivers raising HIV/AIDS orphans in the rural area of Bulilima District Matabeleland South Province of Zimbabwe. This study expands the current knowledge base in four ways. First, it documents the experiences of caregivers raising HIV/AIDS orphans in the district of Bulilima in Matabeleland South Province of Zimbabwe. It complements some of the studies on this topic in rural Zimbabwe (Matshalanga 2004; Mudavanhu *et al.*, 2008; Skovdal *et al.*, 2011; Zagheni, 2011 and Zvinavashe *et al.*, 2015).

The significance of this study is that it fills the gap of understanding by acknowledging that, within the financial challenges and burdens of the HIV/AIDS epidemic, rural families in Zimbabwe are developing adaptive means to care for HIV/AIDS orphans. The study also adds the extended family orphan care support system in Bulilima is not breaking up, but rather actively ameliorating the negative impact of structural challenges of the HIV/ AIDS epidemic, harsh economic conditions, and persistent droughts.

Secondly, although research has been done on HIV/AIDS orphan caregiving in Zimbabwe, this study illuminates some of the 'blind spots' and gaps in the study of HIV/AIDS orphan care where orphans are always placed at the receiving end of the care continuum. The study moved beyond this conception by distinguishing between consuming orphans and contributing orphans (see chapter 4 section 4.8 of this

study). The study lucidly expresses that, care of HIV/AIDS orphans within extended families is characterised by complementary relationships in caregiving and care-receiving. The study notes orphans with age become active household members who contribute significantly to the agrarian, livelihood in rural Zimbabwe. This study, therefore, cautions against the misrepresentations of HIV/AIDS orphans as helpless victims, since like other children in the milieu of poverty, they too are contributors of household and agrarian labour.

Third, the study affirms the continued importance of extended families as is the primary safety net and appropriate form of HIV/AIDS orphan care. The research also notes that contrary to the theory of social rupture, which assumes that, “the traditional system of orphan care is overstretched and eroded by the strain of HIV/AIDS, and that its complete breakdown is imminent” (Abebe 2010:463). This study notes the traditional system of orphan care in Bulilima is not disintegrating, but it is rather adapting to structural challenges of HIV/AIDS epidemic, harsh economic conditions, and persistent droughts. The study suggests the capacity of families to raise HIV/AIDS orphans should be viewed in a continuum since the family capacity to care is subject to change at any given time and place.

Finally, towards policy, it is anticipated that this study can add to the understanding of the dynamics and contexts of HIV/AIDS orphan caregiving in rural Zimbabwe. Also, this might potentially guide developing of appropriate and sensitive caregiving and social protection intervention programmes in the country. Since documenting caregivers’ experiences will help institutions to identify gaps in care and support as well as deciding on the culturally specific context of the care and support needed. The study has the potential to encourage NGOs and other stakeholders to adopt a family-oriented approach when assisting orphans made vulnerable by HIV/AIDS. The reason being, orphans in rural areas are fostered by the extended families.

1.8 Outline of chapters

Chapter 1 provides an introduction and a broad overview of the study. Specific focus is on discussing the background, problem statement of the study, the rationale of the study, research questions, research aim and objectives, the significance of the study and the summary of the study’s outline.

Chapter 2 reviews related literature on impacts of HIV/AIDS as well as the experiences of caregivers raising HIV/AIDS orphans. The theoretical framework for this study in terms of the two theoretical debates on orphan care, namely the social rupture theory, and social resilience theory is also discussed. In addition, the chapter discusses the limitations of the social rupture theory that underscores the breakdown of family structures and social safety nets because of the impacts of HIV/AIDS and modernisation. The chapter also discusses the adaptive capacities of traditional families to deal with the HIV/AIDS orphan problem.

Chapter 3 will explain how qualitative research methods were utilised in the study to gather and interpret data. The population, sample, sampling method and the study setting were highlighted and discussed. The ethical standards adhered to throughout the research process are identified and discussed. This chapter wraps up by discussing the limitations of the research method.

In Chapter 4, the research findings are presented, discussed, compared with existing literature related to the topic. This chapter will draw on the daily lives of the caregivers who are raising HIV/AIDS orphans by discussing the following themes that emerged from the data: (1) caregivers' concerns (2) caregivers support structures (3) context of caregiving (4) caregiver's responsibilities (5) capacity to care, and (6) shared burdensomeness. The discussions of themes are enhanced by including direct quotations from participants.

Chapter 5 demonstrates the research argument, within the financial challenges and burdens of the HIV/AIDS epidemic, families in rural Zimbabwe are developing adaptive means to care for HIV/AIDS orphans. Chapter 6 concludes the study by presenting limitations inherent to the study as well as highlighting recommendations for further research, practice, and training.

1.9 Conclusion

The current chapter provided an overview of the research enquiry to orientate the reader with the study. This chapter provided an overall background of the study, stated the problem statement which generated the researcher's interest in undertaking the study. Further, the chapter outlined the rationale of the study, research objectives and the research questions of the study. Also, briefly highlighted

was the significance of the study. The chapter ended with a presentation of the study chapter outline.

In the next chapter, I present the literature review guiding this study. The chapter discusses the existing literature on impacts of HIV/AIDS, experiences of caregivers raising HIV/AIDS orphans and the theoretical debates on HIV/AIDS orphan care. The chapter also discusses the adaptive capacities of traditional families to deal with the HIV/AIDS orphan problem

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

In the previous chapter, I provided a background to the study, defined the problem statement and outlined aims, objective and the research questions. I also provided significance of the study and the outline of chapters of the project.

Because of the devastating effects brought by HIV/AIDS to families, studies pay attention to the weak social characteristics and poverty of grandmothers as heads of orphan-filled households (Kiggundu & Oldewage-Theron, 2009; Kuo & Operario, 2009; 2011; Phetlhu & Watson, 2014). Other scholars have examined the capacity of traditional systems of orphan support (Abebe & Aase, 2007; Chirwa, 2002; Mathambo & Gibbs 2008; Nyamukapa & Gregson, 2005). Within the profound impacts HIV/AIDS have on family systems, scholars are polarised regarding the capacity of extended families to support HIV/AIDS orphans. One school of thought states that the traditional support systems are overtaxed and probably too weak to function as expected (Chirwa, 2002). While the other contends the resilience and vitality of the traditional system can sustain more children if it receives more support (Abebe & Aase 2007).

The themes presented in this literature review are concerned with understanding the experiences of caregivers who are raising HIV/AIDS orphans in rural areas within the theoretical debates of orphan care; the social rupture and social resilience theories. The argument will be presented that within the financial challenges and burdens of the HIV/AIDS epidemic, rural families in Zimbabwe are developing adaptive means to care for HIV/AIDS orphans.

This chapter situates the study within the broad scope of literature which detail and describes the experiences of caregivers raising HIV/AIDS orphans in rural areas. The chapter is organised as follows: The first section of this literature review will seek to present themes about the general impacts of HIV/AIDS. Afterward, there is a presentation of caregivers' experiences according to similar studies from SSA. Following is a discussion of social support available to caregivers raising HIV/AIDS orphans. Thereafter, two theoretical debates about orphan care guiding this study are discussed. Finally, the outline of the traditional caring arrangement among

African families, motives to provide care and support to HIV/AIDS orphans as well as the capacity of the extended family raising HIV/AIDS orphans.

2.2 The impacts of HIV/AIDS

In this section, the researcher provides the impacts of the HIV/AIDS epidemic on children, families, and communities. This section does not seek to present a comprehensive review of the literature on the effects of HIV/AIDS; rather it provides a synopsis on the impacts of the epidemic on children, families, and the community in general. The outline seeks to set the general setting which reveals the micro-context of this study, which is the experiences of caregivers raising HIV/AIDS orphaned children.

It is largely accepted that SSA, especially Southern Africa, is in the grips of an HIV/AIDS crisis. SSA has about 11 percent of the world's population and the region remains the most affected by the HIV/AIDS epidemic (Kharsany & Karim, 2016). World Health Organisation (WHO) (2016) states that in 2015 about 22.5 million people were living with HIV/AIDS in SSA, with most of them living in Southern Africa. The HIV/AIDS epidemic has resulted in an estimated 13.3 million orphans globally, with more than 80 percent of them (11.0 million) living in SSA (UNICEF, 2016). The growing orphan population is possibly the most disastrous and long-term legacy of the HIV/AIDS epidemic (Nyambedha, Wandibba & Aagaard-Hansen, 2003; Thurman, Jarabi & Rice, 2012). In Zimbabwe alone, as at 2014, there were about 570,000 orphans because of HIV/AIDS (UNIAIDS, 2016).

It is also widely documented the problems of HIV/AIDS to affected children, families and communities overlap with the problems associated with poverty (Abebe, 2010). However, HIV/AIDS exacerbates these problems, partly because of stigmatisation as well as multiple stressful events which are repeated in affected families and communities (Richter, Manegold & Pather, 2004). The epidemic comes in successive waves, with the first wave being HIV infection, followed by several years of opportunistic diseases, and later by a wave of AIDS illness then death (Barnett & Whiteside, 2002). The last wave affects societies at various levels, from the family and community to the national and international levels.

The epidemic is a development crisis, which deepens poverty and increases inequality at every level, from household to global (Barnett & Whiteside, 2002). Researchers such as, (Barnett & Whiteside, 2002; Campbell, 2003; Kiggundu & Oldewage-Theron, 2009; Meursing, 1997) have shown that, the impact of HIV/AIDS is most visible among the marginalised; particularly children and the elderly.

It could also be argued that HIV/AIDS has also exacerbated poverty (Leyenaar, 2005). The illness and death of income-earning members may impoverish households as well as reduce remittances. However, impoverishment is more than financial because illness and death of a family member lead to decreased social capital and social reproductive labour (Barnett & Whiteside, 2002).

The HIV/AIDS epidemic has represented a mammoth challenge for the disadvantaged families owing to its broad societal, economic and health consequences. The epidemic of HIV/AIDS is not limited to the illness and death of those directly affected; it also has secondary repercussions for surviving family and household populations. Researchers globally (see Ji, Li, Lin & Sun, 2007; Hunter & Williamson, 2002; Mathambo & Gibbs, 2009; Zhang *et al.*, 2009) document that HIV/AIDS illnesses and deaths mainly targets the economically active population which affects the coping capacities of households. This is because morbidity and mortality due to HIV/AIDS and interrelated diseases are concentrated between the ages of 25 and 50 years. People in this age bracket are often in the prime of their productive years, working and raising families. Consequently, long illness associated with HIV/AIDS and deaths of adult members are more likely to decrease the capacities of households to provide for themselves.

Because of HIV/AIDS, families are reconfigured, and end headed by grandparents, children or may perhaps collapse altogether as is the case when orphaned children are placed in foster care (Block, 2014; 2016; Phetlhu & Watson, 2014; Rajcoomar, 2005). Further, Poku (2005:62) states that “dependency ratios increase, as fewer adults care for children and the elderly, increasingly, older members of extended families assume a greater role in caring for and supporting remaining family members”. Similarly, Hunter and Williamson (2002) develop the claim that medical expenses represent a significant strain on household income as does their death. Along similar lines Ji *et al.*, (2007) also state that the locus of care for HIV/AIDS

patients in rural areas is the family because of poverty, lack of access to institutional care, personal preference, and cultural norms.

The presence of a family member suffering from HIV/AIDS necessitates a succession of caring responsibilities as well as normal domestic and care work (Akintola, 2005). Therefore, HIV/AIDS may have a severe effect on the stability of families since it brings new demands on family and reduces the time adults can spend on income-generating activities or subsistence agriculture (Ji *et al.*, 2007; Hunter & Williamson, 2002). Further, Baylies (2002) supposes the financial demands of HIV/AIDS impinge on the integrity and well-being of families, and their continued existence as a collective and cultural unit. Thus, apart from the impact HIV/AIDS has on individual family members, it poses special challenges for families to function according to their cultural expectations, making it difficult for HIV/AIDS-affected families to hold together as a unit (Ji *et al.*, 2007). As HIV/AIDS infection results in illness, adult family members are less able to care for children and the elderly.

The demands for children's labour for domestic chores, income-generating work, or care for an ailing parent increase, therefore reversing culturally expected roles (Hunter & Williamson, 2002). Households with family members suffering from HIV/AIDS usually spend income on treatment for opportunistic infections and funeral costs. Further, Hunter and Williamson (2002) suggest that families with little savings or reserves are impoverished by HIV/AIDS. Also, HIV/AIDS causes households to dissolve through death (Hunter & Williamson, 2002). Further, when HIV/AIDS appears in an already impoverished family, there are limited means of response, as such the impacts are severe and the pressures and pain of poverty are exacerbated (Ji *et al.*, 2007).

HIV/AIDS aggravates and is exacerbated by current economic conditions since it is not a stand-alone condition, but subsists within a broader socio-economic context that extends the vulnerability of households, communities, and nations. The costs associated with HIV/AIDS, the stigma attached to the disease that leads to prejudice and withdrawal to access social services combine to expand socio-economic inequalities in society (Ekstrand, 2006; Gilbert, 2016; Gilbert & Walker, 2010). HIV/AIDS is not only killing people, it is further dividing national societies.

The vulnerabilities of children, families, and communities are compounded by the geographic concentration of the pandemic (Hunter & Williamson, 2002). HIV/AIDS often causes urban-to-rural migration, the opposite of regular patterns. Illness forces some people to seek care or support from extended families in rural areas (Hunter & Williamson, 2002). Many communities that are severely affected by HIV/AIDS are already poor, with little or no access to even the most basic services (Hunter & Williamson, 2002). Hunter & Williamson, (2002:18) state that, HIV/AIDS stresses communities in different ways which include but not limited to, “reductions in the labour pool, particularly for agricultural and skilled labour, increased poverty, a reduced ability to maintain infrastructure, reduced access to health care and education, higher mortality, fewer resources to be marshalled for mutual aid, and a general loss of resilience.” Amidst all the impacts of HIV/AIDS in the communities, the rural extended family absorbs these orphans, despite limited financial resources (Madhavan, 2004; Richter, *et al.*, 2009).

Families remain an important social security for people affected and made vulnerable by HIV/AIDS (Abebe & Aase, 2007; Amoateng & Richter, 2003; Foster, 2000; Mathambo & Gibbs, 2009). However, challenged with strains from the effects of HIV/AIDS, families will not respond the same, some will collapse, whereas others will adapt owing to varied factors, predominantly those relating to social capital and material endowment (See chapter four section 4.7).

2.3 Theoretical debates on orphan care

A careful analysis of the available literature on care for HIV/AIDS orphans and the capacity of the extended family system, which culturally performs the role of HIV/AIDS orphan care, suggest two competing theories. The first, is the social rupture theory, which assumes the extended orphan care system is collapsing because of HIV/AIDS burdens coupled with economic challenges and progressing of families towards the nuclear family. By contrast, the second theory which is social resilience theory is built upon the premise that, the extended family is always under reconfiguration to cope with environmental challenges and changes in family structures. As such, it is still capable of absorbing and caring for HIV/AIDS orphans, though with difficulties. These dimensions are extended into two opposing theories, the theory of social rupture and the social resilience theory.

The choice to use these two theories is based on the fact caregiving of children in the extended family has historically been a common feature of African society (United Kingdom Consortium on AIDS and International Development (UKCID), 2012). Family caregivers have been at the heart of the community response to HIV/AIDS since the beginning of the epidemic (UKCID, 2012). According to Edwards-Jauch (2009:122), "When the child's parent or parents die because of HIV/AIDS the care burden may be assumed by the surviving parent, grandparents, aunts, uncles, older siblings or other members of the extended family." In the Zimbabwe context, the responsibility for orphan care, in rural communities lies in the extended family through social fostering (Foster, 2000; Nyamukapa & Gregson, 2005) Orphans can be fostered by grandparents, aunts (father's or mother's sisters), paternal cousins, older siblings and marital relatives on both sides (Chirwa, 2002).

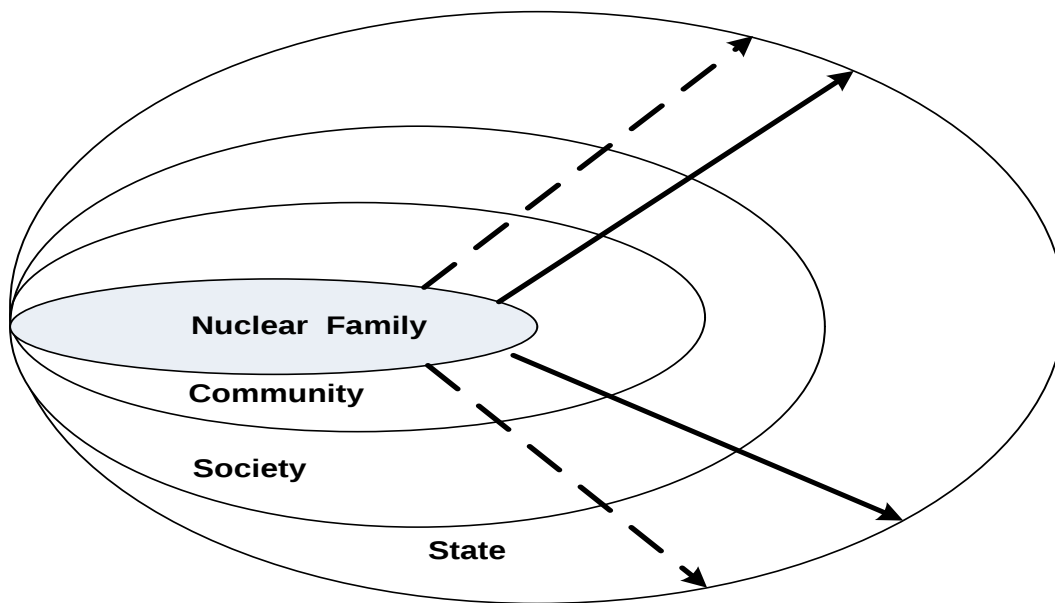
2.3.1 The theory of social rupture

The premise of the theory of social rupture is that, there is a collapse in a traditional family, social support and safety nets of orphan care (Abebe & Aase, 2007; Chirwa, 2002; Cross, 2001). Also, are overstretched and eroded therefore not able to cope with the burden of caring for orphans (Abebe & Aase, 2007; Chirwa, 2002; Cross, 2001). The support provided by the family and the communities are collapsing because of the strain imposed by the increasing numbers of HIV/AIDS. Social rupture occurs when HIV/AIDS attacks, weakens and destroys the inner circle, and the effects spread outwards until they affect society at large (Kalemba, 2000). Chirwa (2002) explains social rupture theory using a concentric circle of blood and other family relations. According to Chirwa (2002), the nuclear family is at the centre of the system followed by the extended family and the immediate community which comprises the neighbours, clan, tribe and the society at large. Chirwa (2002) further suggests the responsibility for orphan care mainly rests with the immediate nuclear family and lessens as the children grow up towards greater and independence from it.

When the nuclear family fails to offer care, the responsibility passes to the extended family through what Chirwa (2002) terms the economy of affection. Beyond the extended family, comes the community, which is comprised of individuals from the

same clan. Last is the state that offers orphan care through drafting legislation that promotes children's rights. Figure 1 below is a diagrammatic representation of the traditional childcare system according to the social rupture thesis.

Figure 1: The traditional childcare system Chirwa, 2002:99



The impact of HIV/AIDS goes beyond the real sufferer and affects all those close to him or her (Gow & Desmond, 2002). As HIV/AIDS infects the individual, the individual seldom lives as an island, rather lives in a family, which is within a community (Gono, 2015). Also, the caring responsibility usually goes beyond the carer alone but affects all those close to him or her, which is the family (Chirwa, 2002). According to studies, families, and communities are the first and remain the front-line for providing care and support to children made vulnerable by HIV/AIDS (see Chirwa, 2002, Gono, 2015, Mafumbate, 2013). Further, studies (see, for example, Block, 2014; 2016; Kuo & Operario, 2007; Phetlhu & Watson, 2014; Rajcooner, 2005) explain how orphans are raised by families that are poor and least able to cope with the burden of caregiving.

In this theory, orphans may find themselves excluded from kin and other family members and forced to form their own households (Chirwa, 2002). For example, the studies by (Gono, 2015; Mafumbate, 2013; Matshalaga & Powel, 2002; Mturi, Xaba & Sekokotla, 2005) underline that, there has been an increase in households formed by children only and those headed by young adults because of the impact of

HIV/AIDS. The previously mentioned studies underscore the failure of the extended family to absorb extra children and the likelihood of exclusion, of orphaned children from family and social relationships.

By proposing for the theory of social rupture, such studies overlook local historical and social contexts. Throughout these studies, no reference is made towards local understandings of 'family', 'care', and 'community'. Though valid in its rationalisation of the change of extended family childcare arrangements, the theory of social rupture is simplistic. The theory pays no attention to the diversity of households, and the varied nature of orphan care and fostering arrangements (Abebe & Aase, 2007; Chirwa, 2002). Moreover, this theory denies the capacity of the family to respond proactively to the demands placed on it, and significance of social relationships (Chirwa, 2002). For instance, studies by (Foster, 2000; Kuo & Operario, 2007; Madhavan, 2004; Nyamukapa & Gregson, 2005) argue the extended family has always been changing and adapting to broader social and economic shifts such as labour migration, urbanisation, famine, war and political change. They went on to argue the family is still capable of transforming itself to deal with the challenges of HIV/AIDS.

Similarly, Omwa and Titeca (2011) note that, the social rupture theory does not offer a clear picture of the key reasons that influence the process of inclusion or exclusion of orphans at various tiers of the existing family support. Nor does it take cognisance of the linkages between human agency and the structural conditions in a community. The theory supposes there is a straightforward system of care available to orphans that begin with the nuclear family, extends up to the community and that if one crumbles, the rest follow suit. This assumption is too one-dimensional and grossly overlooks that, orphan care system in Africa is much more complex and goes beyond looking at the nuclear, extended family and the community (Chirwa, 2002).

Literature that supports social rupture theory looks at the family and community as homogeneous units which are experiencing difficulties at the same time, in like manner, and with the same resource restraints (Chirwa, 2002). This assumption is challenged by scholars, for instance, Abebe and Aase (2007) who profiled Ethiopian extended families raising HIV/AIDS orphans into four categories, namely; rupturing, transient, adapting and capable. The profile of a family consequently points out the

diversities in the resilience of families in adjusting, resisting and coping with the disruptions caused by HIV/AIDS. The theory of social rupture, therefore, does not give a concrete account of how communities are responding to the challenges of orphan care. Moreover, the theory views families and communities as helpless victims and in need of outside help thus overlooking the local ingenious response initiatives in managing the challenges met by caregivers.

2.3.2 Social resilience theory-Families as dynamic entities

On the contrary, the second theory is grounded in the perspective of 'social resilience'. Resilience theory was developed from studies of children who could overcome dire, often life-threatening childhood circumstances. Early researchers sought to identify factors and develop frameworks to explain the behaviour and understand how resilience developed (Pearlin & Schooler, 1978, Zimmerman, 2013). Although originally developed in health circles, social resilience has been adopted in different studies including HIV/AIDS and caregiving (Abebe and Aase, 2007, Chirwa, 2002; Tanga 2013).

The theory assumes the extended family is neither breaking up nor faltering but rather is responding with innovative systems (Foster, 2002). Similarly, the social resilience theory postulates that families are flexible and constantly developing to meet the demands placed on them. Mathambo and Gibbs (2009:25) state that, "rather families are and have always been, restructuring and reshaping constantly in response to wider social and economic factors and the AIDS epidemic is just one of the many forces that are causing households and family caring arrangements to change". Chirwa (2002) affirms that rather than households and families rupturing, communities are coming out with inventive and complex approaches to orphan care within the existing extended family arrangement. He further argues that "alternative forms of social organisation and new social relationship patterns, with broad adaptive capacities, are emerging because of the HIV/AIDS crisis" Chirwa (2002:94).

Friedland, Arian, Kirschenbaum, Amit, and Fleischer (2005) state that irrespective of the destructive nature of HIV/AIDS, families respond with surprising resilience and the essential functions of the family often survive. According to this theory, internal arrangements continue to manage the 'orphan crisis' as they always have in

response to other crises (Ankrah, 1993; Hunter, 1990). Thus, the theory suggests the necessity of preserving the strength of traditional family responsibilities. Further, it advocates promoting of culturally appropriate orphan-care interventions to manage the problem (Abebe & Aase, 2007). Unpacking further, the theory of social resilience indicates two facets of resilience. The first facet connotes resistance while the other dimension denotes elasticity and flexibility (Omwa & Titeca, 2011). Arguing based on the aforesaid two facets, it could be put forward that social resilience is the expression of the extended families' ability to withstand hardships without necessarily altering their values (Omwa & Titeca, 2011). Additionally, social resilience can be regarded as a manifestation of a family's ability to manage the sometimes-hostile environment by changing and readjusting in new and innovative ways (Omwa & Titeca, 2011).

Along similar lines, according to Chirwa (2002:94), "To argue the orphan care system is developing adaptive strategies capacities is not the same as to argue that it is successful." Rather, it means the system is flexible, tension is present, structures and social relationships are being overstretched, but are not completely breaking up (Chirwa, 2002). Abebe and Aase (2007) for instance, note that within the communities there are multiple dimensions of care and multiple tiers of resilience. Likewise, Kuo and Operario (2007) drawing on their study in KwaZulu-Natal, South Africa, note the idea of the family needs to be reconfigured to include children's relatives from the mother and father. Thus, families' relatedness is being reconfigured to include a wider network of relationships and relatives.

About childcare arrangements, Kuo and Operario's (2007) study identified that even the neighbours were acting as caregivers for their neighbours' orphaned children. Chirwa (2002) put forward a similar view, rather than households and families rupturing under the burden of HIV/AIDS orphans care, new innovative and alternatives of childcare approaches are coming in response to the epidemic.

2.4 Experiences of caregivers raising HIV/AIDS orphans

Caregiving can entail positive as well as negative outcomes. In resource-constrained settings, the challenges of caring for HIV/AIDS orphans are exacerbated when compared to resource-abundant settings. Raising a child involves various activities

not limited to, attending to their medical, financial and emotional needs. Most of all, HIV/AIDS orphans often have special needs that intensify demands on the caregiver. For instance, researchers such as Campbell *et al.*, (2016), as well as Cluver and Gardner (2007) state that, caregivers might be HIV/AIDS seropositive, experiencing bereavement, suffering from HIV/AIDS-related stigma, have emotional and behavioural problems.

The experiences of caregivers raising HIV/AIDS orphans in sub-Saharan Africa has been extensively examined. For instance, studies in South Africa document that many orphans are raised by elderly caregivers, who are mainly women, poor, ill, and emotionally drained (Phetlhu & Watson, 2014; Kiggundu & Oldewage-Theron, 2009). Kiggundu and Oldewage-Theron (2009) who carried out a study in Alexandra Township in South Africa found that carers face enormous challenges like, lack of financial support and insufficient accommodation when it comes to caring for and supporting HIV/AIDS orphans. This is because at times communities are so disadvantaged in terms of access to resources; as a result, poor, old, unemployed guardians develop a sense of hopelessness. The study concluded that harnessing social support networks could be an effective strategy for helping caregivers to cope with the challenges of caring for these orphans in resource-constrained settings (Kiggundu & Oldewage-Theron, 2009).

Similarly, Phetlhu and Watson (2014) in their study in Koster, a small farming town located in the North West Province of South Africa report grandparents as caregivers of HIV/AIDS orphans. They further state the caregiver grandmothers face biophysical, socio-economic and psychosocial challenges with food as the main need for the caregivers and the orphans. Also, OXFAM (Rajcoomar, 2005) study in South Africa found that some of the challenges faced by the elderly women caregivers include, but not limited to, chronic poverty, decreased physical and emotional health, difficulties in coping, loss of support from family and finally, the barriers impeding access to social support and health care.

In Uganda, Williams (1998) notes that HIV/AIDS orphans caregiving is for grandmothers who are old and poor. Likewise, Osafo *et al.*, (2017) report that caregivers in Uganda are burdened with insecure provisions for food and difficulties in accessing health care. They went on to state that caregivers survived these

strains through managing their relationships, sharing the burden with care-recipients, social networks, and instrumental spirituality. Safman (2004) found the dominant concerns of caregivers to orphaned children in Thailand were the costs associated with child rearing in a dominant market-based society.

In Zimbabwe, studies by scholars such as Mudavanhu *et al.*, (2008); Zvinavashe *et al.*, (2015) report that HIV/AIDS orphans are fostered by elderly grandmothers who are expected to feed, house, clothe and educate them. The studies further report that grandmothers often raise HIV/AIDS orphans with limited social support from the extended family as well as the government. Similarly, Matshalanga, (2004) in her study in the rural area of Zvishavane in Zimbabwe states that, the burden of caring for HIV/AIDS orphans is particularly heavy on older persons who have a double burden of caring for their sick and dying adult children, as well as orphaned grandchildren. She further reports that caregivers experience psychological and emotional difficulties, and often neglected even to take care of their own health. Zagheni (2011) likewise notes that caring for orphans, whose ages range from infants to teenagers is physically challenging and exhausting. She further claims that caregivers are raising orphans with limited support from the government, NGO's and the extended family.

While the previously mentioned studies explore the care, and living arrangements of orphaned children and their caregivers, these studies underscore how the elderly caregivers selflessly carry the burden of caring for HIV/AIDS orphaned children (see, for instance, Matshalanga, 2004; Meursing's, 1997; Phetlhu & Watson, 2014; Rajcoomar, 2005, Zagheni, 2011). Whereas this may be the case for caregivers taking part in this study, such studies only give one side of the story. There is a need to be realistic about the capabilities of elderly guardians, particularly in rural areas, which usually survive from subsistence farming. Teenage orphans can be helpful in household duties, therefore presentations of HIV/AIDS orphans as a "burden" to "burdened" elderly caregivers are not realistic. Further, I also assume that such studies fail to recognise that orphans can provide older people with economic security, emotional and psychosocial support.

Studies such as Kiggundu & Oldewage-Theron (2009); Matshalanga (2004); Mudavanhu *et al.*, (2008) and Rajcoomar (2005) underline with great justification

how caregivers are selflessly raising HIV/AIDS orphans alone with limited external support. The diminishing external support is attributed to weakening of the extended family because of HIV/AIDS, economic challenges and families moving towards a nuclear family. The focus of this study is to advance that, despite the financial challenges and burdens of the HIV/AIDS epidemic, rural families in Zimbabwe are developing adaptive means to care for HIV/AIDS orphans. The economic status of the family where the caregiver lives, ages and gender of orphans and financial status of the caregivers themselves all have a bearing on the experiences of the primary caregiver raising the HIV/AIDS orphan or orphans.

Further, these studies give one side of the story (Madhavan, 2004), kin-based networks, though strained by HIV/AIDS, are still the primary mechanisms for orphan care in rural Zimbabwe (Zvinavashe *et al.*, 2015). More so, investigations on experiences of HIV/AIDS orphans caregivers are limited and it is yet to be understood, how rural kin-based orphan care has remained afloat despite the challenges brought by the HIV/AIDS epidemic (Kuo & Operario, 2009).

This study extends Matshalanga (2004), Mudavanhu *et al.*, (2008); Skovdal *et al.*, (2011); Zagheni, (2011); as well as Zvinavashe *et al.*, (2015). While their past works have already explored care and living arrangements of HIV/AIDS orphaned children and their elderly guardians, the present study extends the understanding of HIV/AIDS orphan caregiving. This study also seeks to present that, caregiving goes beyond the carer alone since he or she lives within the extended family. As such caring responsibilities are distributed among the entire family since rural people live a communal way of life. The study further extends that, the literature presentation of orphans as burdens to the caregivers is an inaccurate presentation of orphans. With age, orphans tend to be active household members as such, they contribute significantly to the subsistence communal life found in most rural areas of Zimbabwe.

2.4.1 Social exclusion and stigma

Goffman (1963:3) holds that stigma is "an undesirable or discrediting attribute that an individual possesses, thus reducing that individual's status in the eyes of society." From this definition, stigmatisation is a process that arises from the perception that, there has been a violation of shared societal expectations (Gilbert, 2016). Stigma is

one of the greatest challenges to all people affected by HIV/AIDS. Herek (1999: 1107) defines AIDS-related stigma as, “prejudice, discounting, discrediting, and discrimination directed at people perceived to have AIDS or HIV, and the individuals, groups, and communities with which they are associated.”

Gilbert (2016) states that even though there is convincing medical evidence about how the virus is passed on, the prejudices and stereotypes against HIV/AIDS positive people persist. HIV/AIDS-related stigma manifests itself in a whole variety of levels and contexts. People infected with HIV/AIDS often face shame, fear, and rejection from the people around them. HIV/AIDS caregivers also face stigmatisation and discrimination. According to Van Dyk (2010), they are often avoided and ostracised by community members, friends, family, and colleagues because of the care they provide for people affected by AIDS.

In her study on grandmothers and orphan care in Zimbabwe, Matshalaga (2004) noted that, caregivers were experiencing stigma and discrimination from the community members. Ogunmefun, Gilbert, and Schatz (2011) in their study in South Africa noted that caregivers caring for their HIV seropositive family members were suffering from secondary stigma¹. Their study suggested that caregivers were physically and socially isolated from family members. As such, most caregivers resorted to non-disclosure as a way of avoiding the impacts of disclosure (Ogunmefun *et al.*, 2011). Non-disclosure hinders caregivers from seeking and receiving much-needed support (Hlabiyago & Ogunbanjo, 2009). On the other hand, fear of stigma as reported by UNICEF (2003) resulted in extended families in Côte d'Ivoire to be reluctant to foster children orphaned by HIV/AIDS.

2.4.2 Gender and HIV/AIDS orphan caregiving

Gender is a social and cultural construct that differentiates male from female, and the social roles associated with being male or female within a given society (Gilbert, Terry-Ann & Walker, 2009). Typically, men are regarded as responsible for the duties outside the home while women are expected to be responsible for reproductive and

¹ This refers to the stigma associated with being a carer of an HIV-infected individual.

productive activities within the home. While the extent of this difference varies from one culture to the next, it always persists (Buvinic, 1995; Sivard, Brauer, & Cook, 1995). Sexuality is distinct from gender yet intimately linked to it. Sex refers to biologically determined and fixed set of characteristics for men and women (Gilbert *et al.*, 2009).

Shefer *et al.*, (2008) state that within African societies, men are commonly considered family heads, therefore, their responsibilities typically are outside the home. Scholars such as Block (2016) and Hunter (2006) suggest before African colonisation, men were regarded household's patriarchs, defenders, and providers. Scholars such as Block (2016) and Hunter (2006) suggest before African colonisation, men were regarded household's patriarchs, defenders, and providers. The societies were characterised by gendered social division of labour where everyday care duties for the sick, children and elderly were relegated to women. Currently, it seems like caregiving work is divided along gender fault lines as augmented by several studies (for instance, Kiggundu & Oldewage-Theron, 2009; Kuo & Operario, 2007; Phetlhu & Watson, 2014).

A review of existing literature reveals gendered patterns of care. For instance, Karimli, Ssewamala & Ismayilova (2012) note that, in Uganda, most of the caregivers for both single and double orphans are women. Also, the study reports, women are responsible for most of the caring duties. The results thus in Uganda are compatible with those from a study carried out in rural China by Hong *et al.*, (2015). Hong *et al.*, (2015) report that women are the most responsible for caring for HIV/AIDS orphans compared to their male counterparts. The study notes that orphans are fostered by husbands and their wives; though, it is wives who are responsible for their physical and personal well-being.

In South Africa, studies suggest the burden of HIV/AIDS orphan caregiving is carried by elderly women, especially maternal grandparents (Kiggundu & Oldewage-Theron, 2009; Kuo & Operario, 2007; Phetlhu & Watson, 2014). These findings are consistent with studies from Zimbabwe which demonstrate that the burden of caring for HIV/AIDS orphan's falls disproportionately on women, who constitute most of the caregivers (Matshalaga, 2004, Mudavanhu *et al.*, 2008; Nyamukapa & Gregson, 2005; Skovdal *et al.*, 2011).

In trying to explain the gendered nature of HIV/AIDS orphan caregiving, Matshalaga (2004) states that in Zimbabwean traditional social structures, women are viewed as the primary caretakers of families. Therefore, they are assigned to do most of the agricultural and domestic work necessary to sustain a household while the man is responsible for bringing in income (Matshalaga, 2004). On the other hand, Newman, Fogarty, Makoe, and Reavely (2011) believe caregiving is overlooked because of its unpaid status and is traditionally reserved for females since they are viewed as nurturers.

2.5 Social support for caregivers raising HIV/AIDS orphans

Households, caregivers raising HIV/AIDS orphans and communities have taken some initiatives to cope with the impacts of HIV/AIDS as they have done with other calamities such as drought; otherwise, they would simply cease to exist (Mutangadura, Mukurazita & Jackson, 1999). Some community coping mechanisms are initiated from within the communities, which Mutangadura *et al.*, (1999) refer to as indigenous or grass-roots responses. While others are initiated and financially supported by outside agencies such as NGOs, international development agencies, government and churches (Mutangadura *et al.*, 1999). Nixon (1997) states, the support needed by foster carers, in general, include but not limited to; financial, emotional, psychological, social, professional development and community support. Durand (2007) contends if caregivers can meet these needs, they are better equipped to meet the demands of caregiving. Further, Durand (2007) suggests that support for foster carers can come through the foster carer's own family, the foster child's biological family, professionals, other foster carers, and foster care associations.

2.5.1 Support from the extended family and community

Fauk, Mwakinyali, Putra, and Mwanri (2017) suggest that African culture is often communitarian. They went on to argue that it is an African communal way of life as well as social networking that binds families and other people together within a community. Similarly, Yarney, Mba, and Asampong (2015) from their study in Ashanti and Eastern regions of Ghana note that African communities, honour, mourn and perform certain rituals collectively. This communal way of life is believed to be

originating from the maxim of “ubuntu”- a person is a person through other persons- *Umuntu ngumuntu ngabantu* (Ndebele) (Mkabela & Lithuli 1997).

Afro-communitarian values are based on delicate networks of interdependent relations where an individual has the moral responsibility to care for the good of others within the community. The influence of what Fauk *et al.*, (2017) describe as “Afro-communitarian” culture is manifested in the way many African cultures, Bulilima included care and support one another. In addition, it is within the African culture for communities to offer different kinds of support in helping the bereaving families and children to mitigate the burden of the loss (Fauk *et al.*, 2017; Yarney *et al.*, 2015).

In traditional African societies, the community performs a significant role in the peoples' lives. Traditional African values are predicated on philosophies such as the value of the collective interest of the group, survival of the community or tribe, and the union with nature. Thus, according to Van Dyk, (2010:124), “the traditional African person cannot exist alone; his or her identity is embedded in the collective existence”. This collective existence of traditional Africans results in values such as communality, group orientation, cooperation, interdependence and collective responsibility.

Thus, traditionally, indigenous groups are a major source of support in communities that are experiencing the impact of the HIV/ AIDS epidemic. Literature from Tanzania, Zambia, and Zimbabwe indicate that many communities have traditional indigenous groups such as savings clubs, burial societies, grain-saving schemes and labour-sharing schemes which play a major role in helping households cope with the HIV/AIDS epidemic (Chirwa & Chizimbi, 2007; Foster, 2002; Mutangadura *et al.*, 1999). In Phetlhu and Watson (2014) caregivers use different coping strategies that include; but not limited to, support from relatives and home-based carers. Kiggundu and Oldewage-Theron (2009) state that guardians formed a support group with the assistance of an NGO where all interested grandmothers who have lost their children meet to comfort one another.

2.5.2 Support from NGOs and FBOs

NGOs and FBOs have always played an important role in mitigating the spread and socio-economic impacts of HIV/AIDS. Also, sometimes, they play an important

advocacy role in uplifting the rights of orphans (Rosenberg, Hartwig & Merson, 2008). Rosenberg *et al.*, (2008) noted that NGOs and FBOs in Botswana, Lesotho, Namibia, South Africa, and Swaziland collaborated with the government to ease the challenges faced by orphans and vulnerable children. NGOs and FBOs can fulfil an important role in the support and provision of resources of the extended family members, who are taking care of their orphaned relative (UNICEF, 2006). Available services provided by both NGOs and FBOs can be said to be contributing to preventing family breakdown. For example, NGOs and FBOs provide financial support to disadvantaged families, offer psycho-social support and counselling (Musavengana, Chibwana & Gumbo, 2014).

NGOs and FBOs in HIV/AIDS have provided care, support, and counselling for people living with HIV/AIDS, care for HIV/AIDS orphans, income generation projects for people living with HIV/AIDS and their dependents, and various HIV prevention activities. In Zimbabwe Matshalaga (2004) state that NGOs and FBOs started HIV/AIDS programs in the mid-1990s. In China, Hong *et al.*, (2015) state that NGOs have reached out to the communities by providing financial support. The financial assistance is a monthly allowance to foster parents so that, they can buy basic needs for the HIV/AIDS orphans (Hong *et al.*, 2015). In South Africa, studies suggest that NGOs reached to people infected and affected by HIV/AIDS by funding formed support groups (Kiggundu & Oldewage-Theron, 2009). The study further notes that NGOs support caregivers financially and assist them in starting income generating projects, engage in counselling and provide material support to destitute individuals and families.

However, one of the main challenges facing many NGOs and FBOs in HIV/AIDS programmes is to keep a balance between aiding poverty-stricken communities as well as making them more self-reliant. So, if the NGOs withdraw their support, the communities could continue with the developmental projects. On the other hand, the poverty in these communities erodes efforts towards self-sustenance (Matshalaga, 2004).

2.5.3 Support from the Government

To address the orphanhood crisis, the Government of Zimbabwe developed a plan for coordinated, expanded interventions to strengthen the existing child protection work of child rights organisations (Musavengana *et al.*, 2014). The result of this Government initiative was a broad-based intervention called the National Action Plan for Orphans and Vulnerable Children (NAP for OVC) which aimed at reaching out to all orphans and vulnerable children in Zimbabwe with basic services. Since its inception, in 2004, the NAP for OVC programme has failed to support most of the children in Zimbabwe who need care. Musavengana *et al.*, (2014) note that though limited in scope the Government of Zimbabwe came up with interventions such as cash transfers, Basic Education Assistance Module (BEAM)², public drought relief schemes and Assisted Medical Treatment Order (AMTO)³.

Zimbabwe like all African states shows a greater political will to support orphans made vulnerable by HIV/AIDS. Nonetheless, there is a limited effort in direct support towards caregivers raising HIV/AIDS orphans. Most support from the Government of Zimbabwe is in HIV/AIDS policy formulation to allow NGOs to implement the programmes. To this end, the Government of Zimbabwe has shown the political commitment to eradicate HIV/AIDS. The Government of Zimbabwe introduced the National AIDS Trust Fund (normally addressed as the AIDS Levy) as part of the nation's attempts to raise funds for the control and management of HIV/AIDS (Kerina, Babill & Muller, 2013).

Similarly, the Government of South Africa channels much of its support towards supporting children made vulnerable by HIV/AIDS than the caregivers. For instance, Chereni and Mahati (2014) note that in response to the problems faced by orphans

² "Basic Education Assistance Module (BEAM) is an Enhanced Social Protection Programme (ESPP) designed to provide quality education to children, including specific policies aimed at supporting orphans and vulnerable children (OVC). BEAM is a demand-side response to the cost barriers affecting the ability of OVC to access education due to increasing poverty levels in the country". Smith, Chiroro and Musker, (2012:8)

³ Non-contributory health insurance to enhance access to health care among vulnerable populations such as poor households; elderly people; people with disabilities; people who are severely ill; orphans and vulnerable children.

and their households, the Government of South Africa, as the leading partner, working with civil society, set up many structures at various levels, enacted new laws, developed new policies and made concerted efforts to roll out different programmes. Further, the Department of Social Services (DSD) also runs programmes that address material and related social protection needs of vulnerable children through monthly cash transfers that target needy children (Chereni & Mahati, 2014). These include the Child Support Grant (CSG), the Foster Care Grant (FCG) and the Care Dependence Grant (CDG) which are disbursed monthly by the South African Social Security Agency (SASSA).

In South Africa, provision of an assortment of grants for various categories of 'vulnerable' groups helps in providing support for HIV/AIDS affected households. Although there are no specific grants targeting households made vulnerable by HIV/AIDS, these grants represent the major, and often the only source of income for HIV/AIDS-affected families (Oni, Obi, Okorie, Thabede & Jordan, 2002; Steinberg, Johnson, Schierhout & Ndegwa, 2002). This support can have an immensely positive impact on the livelihoods of poor households.

2.6 Context of orphan care

This section examines traditional orphan care practices and traces how they have been affected by the advent of HIV/AIDS, and changes in the marriage institution. I then look at how orphan inheritance practices, changed from patrilineal patterns of care to accommodate matrilineal orphan care. I demonstrate the ways in which the care of HIV/AIDS orphans navigates through the cultural logic of bride price and patrilineal care to justify a range of configurations of care. Finally, I look at the concept of family from the traditional African perspective.

2.6.1 Socio-cultural context of child fostering practices that existed prior to the HIV/AIDS

To understand orphan care in Zimbabwe, it is essential to have a look at the historical and socio-cultural context of child fostering practices that existed before the HIV/AIDS pandemic. To begin with, when women married and a bride price paid, they move to their husband's family (Mangena & Ndlovu, 2013; May, 1983). Traditionally, bride price accorded the husband's rights to own, and be responsible

for the children (Meekers, 1992). Even at divorce children were more likely to remain with their father. Further, even when parents deceased, children were raised within their fathers' descent (Mangena & Ndlovu, 2013; Nyamukapa & Gregson, 2005). The extended family had an obligation to inherit the widow and the children by suggesting one of the deceased's brothers or cousins act as a provisional father-figure for the children (Nyamukapa & Gregson, 2005).

Similar rules applied if the wife died, the children stayed with their father who had the right to marry another wife. Another alternative involved provision of a replacement wife to raise the children provided the widower was not in a polygamous marriage. Young children went to live with the maternal aunt till they were old enough to return to their father (Nyamukapa & Gregson, 2005). Therefore, Foster (2000) argues, there was no orphan within the traditional society. Even if the family was poor it was the responsibility of the family to take care of the orphans (Nyamukapa & Gregson, 2005; see also Madhavan, 2004). Even before parents died, children in Zimbabwe were sent to live with relatives, especially grandmothers. These fostering arrangements did not need the death of a parent but were (and still are today) used by living parents.

According to Bourdillon (1993), though tradition is assumed stable overtime and unchanging, it is in fact ever changing. The culture of bride price has been greatly affected and this is central in altering marriages as well as caregiving practices (Block, 2014). According to Block (2014), changes in African marriage are difficult to measure because of its processual nature as well as many kinds of socially recognised marriages available nowadays (customary, religious, and state). Moreover, recently there has been a wave of the so-called "moving in together", a boyfriend and girlfriend can stay together produce recognised children from both families. Along similar lines in Zimbabwe, bride price was common, and marriage was based on bride price. However, there appears a decreased value of formal unions owing to various factors among them, high divorce rates, culture change and increased female access to wage labour. HIV/AIDS orphan care needs to be regarded as situated firmly within this changing landscape.

2.6.2 Influences of HIV/AIDS on the cultural context of child fostering

HIV/AIDS has led to what Madhavan (2004) call 'crisis fostering', whereby reciprocal obligations become less important. Likewise, a prior study by Nyambedha *et al.*, (2003a) state that customs placing children with family may be changing because of large numbers of orphans and a paucity of potential family carers. Likewise, the rise of matrilineal orphan care must be understood as entrenched in a setting constrained not only by HIV/AIDS and poverty but also by various historical, existing factors and political-economic shifts.

The role of the government in the care particularly to children orphaned or made vulnerable by HIV/AIDS in Zimbabwe is minimal. There are attempts by the current government to mitigate the social impacts of HIV/AIDS to orphans. However, the Zimbabwean economy is in depression, thereby probably hindering the state from providing social services. With help from NGOs and FBOs, there are few children homes where vulnerable children can be placed till they are 18 years. As a result, like many societies in Africa, the extended family networks in Zimbabwe continue to act as a social security system by absorbing these HIV/AIDS orphaned children. Zimbabwean extended family incorporates both paternal and maternal relatives. At times it may incorporate distant relatives tied to a given family based on marriage, lineage and social proximity.

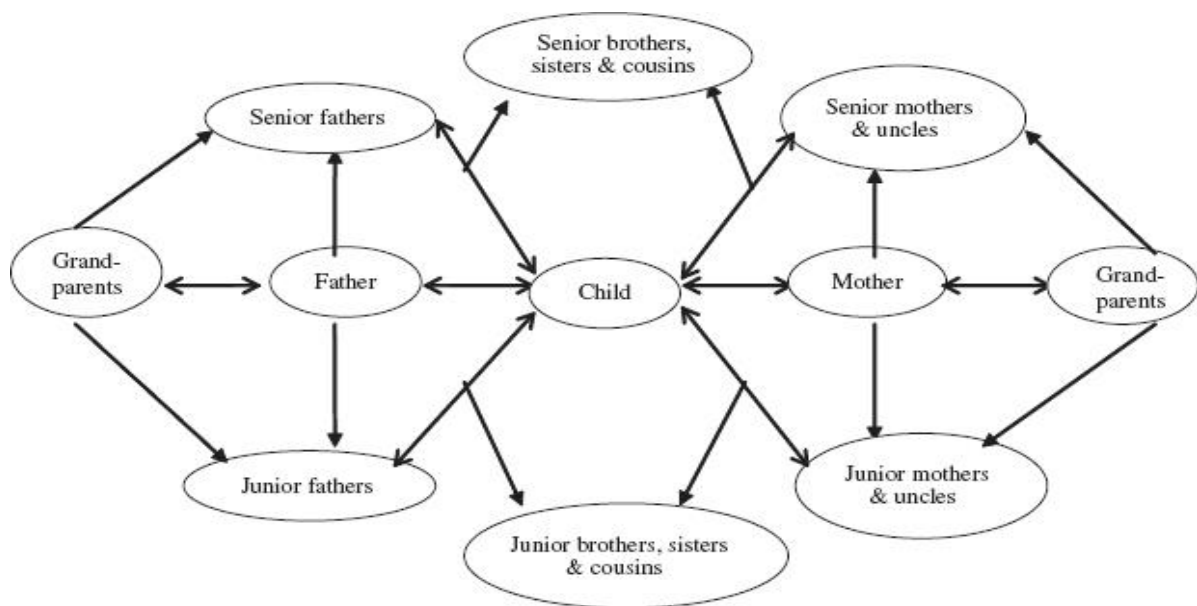
2.6.3 African family and orphan care

Kayongo-Male and Onyango (1984) state that African life is known for its notable characteristic of huge kin groups that goes beyond the nuclear family. Further Chirwa (2002) suggested in SSA, there is more to family than just a husband, wife and children. Foster and Williamson (2000:277) describe African families as involving, "a large network of connections among people extending through varying degrees of relationships, including multiple generations, over a wide geographic area and involving reciprocal obligations". Chirwa (2002:99), further suggest the "structure can be stretched by including aunts (father's sisters) and their children (paternal cousins) on the left side, affine (marital) relatives, and the siblings and marital relatives of the grandparents on both sides". Thus, in this system, children are assumed unified to both mother and father's families. Consequently, according to Chirwa (2002), the

responsibility for childcare when the death of either parent occurs is more likely to follow along with the prevailing kinship hierarchy. Chirwa's (2002: 99) diagrammatic presentation of an African family (see Figure 1 on page 21) plainly illustrates how childcare would customarily be organised if a father dies.

Likewise, Abebe and Aase (2007) note that fostering of orphans in Africa, despite HIV/AIDS is occurring within the extended family. In Ethiopia, Abebe and Aase (2007) note that orphan care was within the kinship structures, the main driving force is to keep the orphans within the family. Similarly, Oleke, Blystad, and Rekdal (2005) note that, in Uganda, the extended family system is caring for HIV/AIDS orphans. In South Africa, several studies suggest orphans and vulnerable children are cared within the extended family system with the main exception placed on the immediate grandmothers (Kiggundu & Oldewage-Theron, 2009; Phetlhu & Watson, 2014; Rajcoomar, 2005). A similar phenomenon exists in Lesotho where Tanga (2013), reports the extended family system is caring for most of the HIV/AIDS orphans.

Figure 2: Diagrammatic presentation of an African family (Chirwa, 2002:99)



In Bulilima district where the study was carried out, family relations are characterised similarly to the Malawian family (see Figure 2 above). A father is called *Baba*, a father's older brother is *babamdala* (which is the same to Chirwa's senior father), and a father's younger brother is *babamncane* (which is the same to Chirwa's junior father). A senior mother is *mamaomdala* and junior mother is *mamaomncane*. The mother's brother is *malume*. The family conception depicted in figure 2 demonstrates

how the African conception of families differs from the western context. The western family idea is based on individualism and independence, whereas the African family is based on collectivism and interdependence. In African societies, family refers to a much wider circle of people, which includes uncles and aunts (Sigwana-Ndulo, 1998).

2.6.4 Motivation to provide care and support to HIV/AIDS orphans

It can be argued that for generations Africans have preserved practices of orphan care. Strong kinship relationships and cultural ties commanded loyalty to family, also, clan created the basis for the extended family care system which defined orphan care (Mafumbate, 2013). Similarly, Kayongo-Male and Onyango (1984) note that early anthropologists' who studied African tribes noted the extended family, especially grandparents, have been a significant social support for people who are associated by kinship.

Historically, social fosterage, which means raising a child or children by someone other than the child's biological mother and father, has been a common traditional practice across much of Africa (Abebe & Aase, 2007). Children were a prized gift from God, and the whole family had the responsibility to bring up each child. The saying, "It takes a village to raise a child," has its roots in this perspective (Clinton, 1996). If children's biological parents were deceased, care was guaranteed from the extended family (Foster, 2000; McKerrow & Verbeek, 1995). Even if the family did not have sufficient resources to care for existing members; orphans were taken in by aunts and uncles (Gilborn, 2002). Similarly, Mudavanhu *et al.*, (2008) suggest that families accommodated orphans because life in traditional societies was defined by strong kinship ties and people lived communally,

Young and Ansell's (2003) research suggests that family roles and obligations are shifting in important ways because of the HIV/AIDS epidemic. Likewise, Raina, *et al.*, (2004) argue that because of HIV/AIDS orphan caregiving roles are born out of necessity. Also, Nyasani, Sterberg, and Smith (2009) found most of the HIV/AIDS orphans foster carers in rural areas were doing it out of obligation since they had no other choice. Along similar lines, Madhavan, (2004) states that some caring today is because of what he called 'crisis-led caring' caused by HIV/AIDS. His argument is

that members of the extended family find themselves caring for and supporting orphans and children made vulnerable by HIV/AIDS without any financial, physical or psychological support. Similar arguments are noted in a study by Matshalanga (2004) in the rural area of Zvishavane, Zimbabwe. She noted that grandmothers were caring for their grandchildren because they had no choice since no one was willing to foster the children.

Conversely, Nyambedha *et al.*, (2003b), found the elderly caregivers' decisions to raise the orphans made vulnerable by HIV/AIDS were influenced by affection. Thus, emotionally driven decisions obscured the caregiver's lack of financial resources to exercise their decisions, as well as their responsibilities or the stigma attached to HIV/AIDS.

On the other hand, Townsend and Dawes (2007) noted that some caregiver's decisions are influenced by the age of the orphan, HIV/AIDS status and whether the caregiver has the financial resources. This was earlier revealed by Freeman and Nkomo (2006) who noted that some caregivers were willing to foster HIV/AIDS orphans provided they are given financial help. For instance, in South Africa, there is an inconclusive debate on whether orphans are fostered for the sake of financial gains from social grants (Nyasani *et al.*, 2009).

2.7 Capacity of the extended family to care for HIV/AIDS orphans

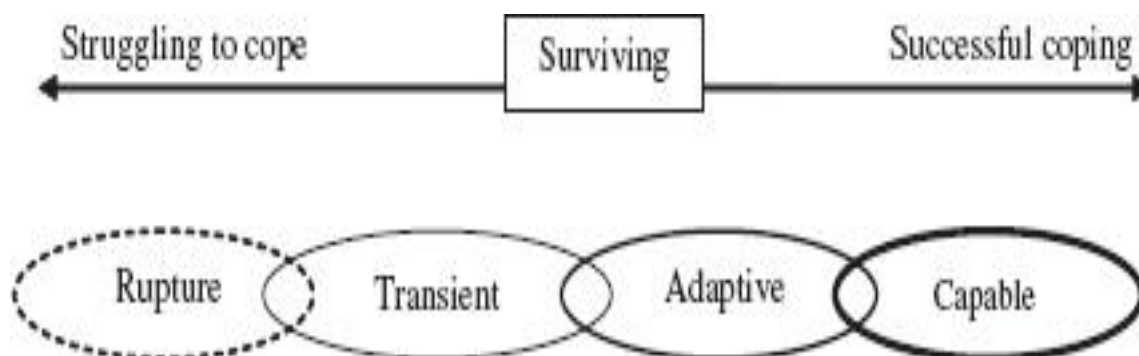
According to Seeley and Kajura (1993), in African communities, the extended family is commonly assumed as the first source of support to its members in times of need. Further, they suggested that African people usually dwell in intimate organised groupings and are more likely to accept communal obligations to mutually support one another. The authors concluded that even the poor in health, the aged and even the orphans made vulnerable by HIV/AIDS are all the responsibility of the extended family. However, regarding orphan care, some studies are painting a gloomy picture of the extended family capacity to provide care to HIV/AIDS orphans. For instance, Howard *et al.*, (2006); Kiggundu & Oldewage-Theron (2009) are some of the studies proposing that the extended family system is failing to take care of HIV/AIDS orphaned children.

Along similar lines, Foster (2000) admits that families face plentiful of problems such as social, political and economic challenges as such cannot manage to take in more children. Foster (2000) further suggests long before the HIV/AIDS epidemic, families have been breaking down because of modernisations and the moving closer towards the modern nuclear family. Similarly, Kiggundu and Oldewage-Theron (2009); Mafumbate, (2013); Matshalaga & Powel (2002) as well Mturi *et al.*, (2005), state the increase in numbers of grandmother caregivers and child-headed families are evidence of the incapacity of the extended families to care and support orphans made vulnerable by HIV/AIDS.

In contrast, Adams, Cekan, and Rainer (1998) contend, instead of referring the capacity of the extended family as universal across all families, it is significant to consider families' capacity to raise HIV/AIDS orphans along a continuum, ranging from failure (rupture) to successful coping (capable). They suggest that along the continuum, households muster resources that match the type and degree of challenges being experienced. Thus, according to Adams *et al.*, (1998) the capacity to cope with the challenges of HIV/AIDS orphan care depends upon various factors which include, but not limited to, family and household resilience, access to resources, the intensity and duration of the crisis.

The continuum approach was further developed and presented in a diagram by Abebe and Aase (2007)(see Figure 3 on page 41). They proposed that family's fortunes are more likely to change at regular intervals, thus placing families at different points in time along the continuum as shown in figure 3. Thus, a family unit can be bordering between transience and rupture or may be managing but not necessarily coping successfully. Hence the capacity to provide care can be described as overlapping between the four typologies of family capacity as illustrated in Figure 3.

Figure 3: Continuum of household survival (Abebe & Aase, 2007)



Abebe and Aase (2007) further developed the model of “capacity to care” for HIV/AIDS orphans by the extended family through deconstructing the concept of “capacity to care”. According to them, disaggregating, “capacity to care” can enable scholars to examine the potential sustainability of households to care for orphans in the face of the HIV/AIDS epidemic. They propose that rather than the “capacity to care” to be viewed solely in terms of the ability to provide necessities; they argue that it is important to incorporate multiple functions of families towards the orphans and the variability of families in response to the supposed ‘orphan burden’. Thus, they developed the subsequent three components of “capacity to care” which are, economic, social and emotional.

Abebe and Aase (2007:2062) suggest that “economic capacity includes the material capability of families to social foster orphans accompanied by the appropriate distribution and provision of resources needed for their well-being”. In this regard, HIV/AIDS leaves families and communities struggling to accommodate many orphans who are in dire need of food, clothing, shelter, education, medical facilities, and other material support. “This aspect of care can be placed within the wide discourses of poverty, vulnerability and lack of financial resources from social welfare organisations” (Abebe & Aase, 2007: 2063).

According to Abebe and Aase (2007), emotional capacity is not limited to the keenness and the ability of carers to render psychological as well as emotional support to the HIV/AIDS orphaned children. This dimension of care, which communities extend to members as part of deeply embedded socio-cultural

responsibilities, has a lasting implication for the psycho-social competencies and growth of children as productive members. Finally, social capacity was defined by Abebe and Aase (2007) as the ability and enthusiasm of members of the extended family to acclimatise orphans with social and cultural skills needed for present and future life. It is premised on the thought that social parenting is a collaborative and most suitable form of child-rearing in most African families.

2.8 Conclusion

In this chapter, I presented the literature that supports the nature of this study. The aim of this report is to understand the experiences of caregivers who are raising HIV/AIDS orphans in the rural area of Bulilima District, Matabeleland South Province, Zimbabwe within the theoretical debates of orphan care; the social rupture theory and social resilience theory. In this chapter, the main argument raised is that within the financial challenges and burdens of the HIV/AIDS epidemic, rural families in Zimbabwe are developing adaptive means to care for HIV/AIDS orphans. This chapter illustrated the limits of social rupture and how traditional families are reconfiguring themselves to adapt to the challenges brought by HIV/AIDS. Also discussed are the various support structures available to the caregivers who are raising HIV/AIDS in rural areas drawing examples from SSA and around the globe. In the next chapter, I take the reader through the research methods used in this study.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter discusses the research design and the qualitative research methods employed to gather and interpret data for this study. The chapter also discusses the rationale for adopting a qualitative methodology. Also discussed are the steps taken to address the research design are illustrated. Also, the chapter shall elucidate how the researcher conducted 15 semi-structured interviews with caregivers raising HIV/AIDS orphans in Bulilima District, Matabeleland South Province, Zimbabwe. Further, the data collection and analysis methods used to conduct the research study will be illustrated.

In the first section, the chapter describes the research site, Bulilima District in Zimbabwe's Matabeleland South Province. After that is a discussion of the research design and the rationale for choosing a qualitative and interpretive design. The research methodology is justified for its appropriateness and usefulness to achieve the basic research objectives for this study. The research population, research sample and sample distribution are explained. Next, the chapter explains and rationalises the sampling method utilised for this study. Then, the chapter discusses the data collection instrument and how data was analysed using thematic analysis. After that, the chapter recounts ethical issues that arose in the process of this study, and how the researcher dealt with them. Afterwards, a discussion of reflexivity, limitations of the study followed before concluding the chapter.

3.2 Research setting

Bulilima district is in Matabeleland South Province in South-western Zimbabwe and its administrative town is Plumtree. The district shares boundaries with Tsholotsho District to the north, Bulawayo to the North-East, Mangwe to the East and Botswana to the South-West. The district is made up of 22 wards, which are all rural (Bulilima District Profile Report, 2013). Bulilima residents belong to the Kalanga people who predominantly speak Tjikalanga language. There are however some Ndebele households dotted sparsely within some parts of the district. Matsa and Simphiwe (2014) put forward the view that Bulilima is an impoverished rural area, where most survive through subsistence farming and small remittances from relatives working in South Africa and Botswana. Moreover, they went on to state the district is one of

Zimbabwe's most marginal regions socially, economically and infrastructural (Matsa & Simphiwe, 2014).

Bulilima District has a population of 90561 people (ZimStat 2012 Census), and according to NAC (2016a), 7641 of the population are on ART. Further, in Bulilima HIV prevalence rate is at 18.9%, which is far higher than the national figure (14%) therefore raising a cause for concern (NAC, 2016a, NAC, 2016b). The district is described by NAC (2016a) as an HIV/AIDS hot spot. WHO as cited in NAC (2016b) defines an HIV/AIDS hot spot as a geographical area or location with evidence of high prevalence of HIV, STIs or behaviours that put people at risk for acquiring HIV.

Campbell (2003) asserts the disease targets people in the prime of their economic and child-rearing lives, leaving behind people with no sources of income responsible for caring for HIV/AIDS orphans. Based on the statistics, it can be implied that HIV/AIDS has destroyed families, the social and economic fabric of Bulilima district and made orphans of a whole new generation (Matshalanga & Powell, 2000). It is, therefore, important to understand the experiences of caregivers raising HIV/AIDS orphans in Bulilima District and to find out if there are support structures that mitigate the challenges faced in raising the orphans.

3.3 Research design

The study used a descriptive and interpretive qualitative design. Babbie and Mouton (2009: 72) define research design, "as the planning of scientific inquiry", that is to state as clearly as possible what one seeks to find out and to decide the most probable way of doing it. Further, Babbie (2016:119) adds that research design, "involves a set of decisions regarding what topic is to be studied among what population with what research methods for what purpose". In simple terms, Punch (1998:4) defines qualitative research as, "empirical research where the data is not in the form of numbers". Fortune and Reid (1999:94) define qualitative research as a method in which "the researcher attempts to gain a first-hand, holistic understanding of phenomena of interest by a flexible strategy of problem formulation and data collection, shaped as the study proceeds." Further, Terreblanche, Durrheim, and Painter (2006) state qualitative research methods generally seek to understand people within their context, to understand perceptions, as well as to explore how

people structure and give meaning to their daily lives. Further, they state the foundation of qualitative research rests in the interpretative approach to social reality and in the narratives of the lived experience of humans.

Scholars such as Babbie (2016) agree that qualitative research methods were developed in the social sciences to enable researchers to study social and cultural phenomena. Social scientists consider humans, not as individual's entities who subsist in a vacuum but explore their worlds within all their life context (Terre Blanche *et al.*, 2006). That is, social researchers seek to understand the socially constructed nature of the world and realise that values and interests become part of the research process. Likewise, Myers (2009) also adds that qualitative research is intended to assist researchers in comprehending people and the social and cultural environments within which they live. Data in qualitative studies is derived from sources such as direct observation of behaviours, interviews, written opinions, personal experience, public documents, life stories and observations (Denzin & Lincoln, 1994).

This study disagrees with the positivists' positions that would presume the experiences of caregivers and orphan care can be studied independently of the intersection of various factors and agencies. Similarly, Mason (1996) disagrees with the positivism approach for forcing respondents into predefined conceptual 'grid' or categories with the main concern of observing causal relationships. Denzin and Lincoln (1994) also agree with Mason (1996) by noting the positivist approach to research disconnects the researcher from the participants. This failure to engage with the research participants emanates from the argument that studies should be neutral, value-free and objective (Schurink, 2003).

As a rebuttal to this point, some scholars convincingly argue that such assumptions make people appear as if are automated and always respond rationally to situations and events. Babbie (2016:46) states that "people do not always act rationally". He went on to assert that each person acts, thinks and interprets subjectively to a certain extent. This subjectivity is unique to any individual, and the endeavour for objectivity could best be obtained through the discovery of intersubjective interests between individuals. Consequently, this is in the realm of the faculties of qualitative research approaches.

Quantitative studies are better suited for collecting cross-sectional data focusing on HIV/AIDS prevalence, basic material needs, and immediate experiences. Numeric data of this kind has much utility, for instance, can be used to predict the prevalence of caregivers in the context of HIV/AIDS. As well as the spatial distribution of the phenomenon within a particular area. Data from such studies can be useful in identifying areas that need policy intervention to address caregivers' basic needs.

Although quantitative studies are better for collecting cross-sectional data focusing on HIV/AIDS prevalence, the prevalence of HIV/AIDS orphans and are good at describing the general patterns, they do not necessarily explain why they occur and the experiences of the caregivers who are raising those orphans. Specifically, they do not tell, i) the daily responsibilities of caregivers towards the orphans, ii) caregiver's concerns, and iii) social support structures of caregivers who are raising HIV/AIDS orphans. It is for that reason Dear (1988:268) states that "it makes little sense to talk about 'facts', 'truths', the 'correctness' of a theory, or even 'science' itself, without further qualifications".

Thus, the researcher decided to make use of qualitative methods to explore experiences of caregivers who are raising HIV/AIDS orphans. Qualitative research can help in giving answers to questions such as why and how orphans are still cared for by the extended families, and what are the experiences of those who are raising these orphans. Thus, qualitative research was the most appropriate method to use in this study, borrowing from Denzin and Lincoln (1994) who state that qualitative methodologies view the social world as something that is dynamic and changing, always being constructed through the intersection of cultural, economic, social and political processes. Further, Fouche and Delport (2002:79), state that qualitative studies, "aim mainly to understand daily life and the meaning people give to their lives", and this speaks of the aims of this study making qualitative research methods relevant to the study.

In addition, the existences of caregivers raising orphans within the extended families which assumed to be collapsing because of HIV/AIDS suggest that there are agency and competency in dealing with HIV/AIDS orphan care. However, Chirwa (2002:92) cautions that, "to argue that, the orphan care system is developing adaptive strategies capacities is not the same as to argue that it is successful". While it may

be challenging for families to raise orphans, the fact that they do shows that they have some agency. Thus, it makes more sense for the study to investigate and explore using qualitative research methods. The researcher, therefore, had to go and give audience to the caregivers themselves. Epistemologically then, this study assumes a methodology that seeks to allow caregivers to speak for themselves to better understand experiences of caregivers as they are raising these HIV/AIDS orphaned children.

Moreover, qualitative research methods were preferred because they are characteristically more flexible and allow adaptation of the interaction between the researcher and the study participants (Mangal & Mangal, 2013). Participants had the opportunity to respond more elaborately and in greater detail. In turn, the researcher had the opportunity to respond immediately to what the participants said by tailoring subsequent questions according to information the participant had provided (Braun & Clarke, 2013; Christensen, 2001).

Denzin and Lincoln (1998:17) propose that one of the chief reasons for conducting qualitative research is that “not much has been written about the topic or population being studied; the research is exploratory, and the research seeks to pay attention to the ideas of informants and build a picture based on their ideas”. Denzin and Lincoln (1998) proposition speaks to the aims of this study. There is a deficiency of literature on the experiences of caregivers raising HIV/AIDS orphans in a rural set up under these extreme economic conditions prevailing in Zimbabwe.

The interpretivist researcher, according to Mason (1996) conducts research to advance knowledge by describing and interpreting phenomena of the world to establish shared meanings with others. An interpretivist approach was suitable for this study because of its concern with individual participants, their experiences, and the meaning that they assign to their experiences of caregiving. Interpretive approaches provide detailed, significant, wide descriptions of concerns by revealing and capturing not merely what people think or feel or do, but also the why and how of their social reality (Terre Blanche *et al.*, 2006).

Thus, qualitative research was selected ahead of quantitative since it had the potential of unearthing the grounds why familial orphan caregiving hasn't collapsed as predicted by the social rupture thesis. This is a merit of using interpretivist

approach since elements of this nature are difficult to study when using quantitative research (Denzin & Lincoln, 2003). Moreover, experiences cannot be quantified in numbers as such a qualitative approach was appropriate to capture experiences of caregivers raising HIV/AIDS in the rural area of Bulilima.

Qualitative research is a situated activity that locates the observer in the world (Terre Blanche, *et al.*, 2006). It consists of a set of interpretive, material practices that make the world visible. Terre Blanche, *et al.*, (2006) went on to state that it the approach involves an interpretive, naturalistic approach to the world. Therefore, qualitative researchers investigate humans within their natural environments, seek to construct a sense of, or to interpret, phenomena in terms of the meanings people bring to them (Denzin & Lincoln 2000). Likewise, the researcher was in Bulilima district moving from ward to ward conducting interviews with caregivers raising HIV/AIDS orphans as well observing the duties involved in caregiving.

Though the researcher chose to use a qualitative research design instead of a quantitative, neither of these designs is inherently superior to the other; the suitability of the method needs to be decided by the context, purpose, and nature of the study in question. For instance, in this context, a qualitative design was used because though a quantitative design, in all variations, is useful and valuable, was limited since it neglects the participants' perspectives within the context of their lives. Further, the aim was not to generate statistical answers as would be done in a quantitative study, but on understanding the experiences of caregivers who are raising HIV/AIDS orphans within in a rural area.

3.4 Population and sample

Caregivers raising HIV/AIDS orphans in Bulilima District of Matabeleland South, Zimbabwe forms the study population for this study. Bless and Higson-Smith (2006) define research population as the set of elements the researcher is going to focus on and to which results are going to be obtained and generalised. There are several ways to gather information about people. One way is to contact every person or nearly every person and ask them questions about what the researcher needs to know. Gathering data from everyone is costly and time-consuming. Generally, because of budget and time constraints, researchers cannot collect data from every

individual in the population; instead, they collect data from a subset of individuals – a sample – and use that data to make generalisations about the entire population. According to Bless and Higson-Smith (2006), a sample refers to the subset of a population selected for any given study. Ideally, the sample has the same characteristics as the population of interest. Thus, the study's conclusions from the sample are most likely to be applicable to the entire population. Thus, the sample for this study was 15 caregivers raising HIV/AIDS orphans in Bulilima District, Matabeleland South Province in Zimbabwe. According to literature, women are the main caregivers for the HIV/AIDS orphans (Kuo & Operario 2007). These gendered care patterns hold true for Bulilima District where all 15 interviewed caregivers were women.

3.4.1 The sampling method

Babbie (2016), Neuman (2014), Singleton, Straits, Straits and McAllister (1988) and Strydom and Delport (2011) all highlight the importance of sampling in any given study. This is because it is difficult to question every individual concerned in the research. Patton (2002:230) states that “qualitative inquiry typically focuses in depth on relatively small samples, selected purposefully”. Further, he went on to argue that in qualitative studies, sample sizes are of less significance since the size of the sample is typically dependent on what the study seeks to accomplish, the purpose of the inquiry, what will be useful and what can be done with available time and resources (Patton, 2002). The researcher utilised a successive combination of purposive and snowball sampling. Purposive sampling hinges exclusively on the decision of the researcher, in that a sample is composed of elements that contain the most characteristic, representative or typical attributes of the population (Strydom & Venter, 2002).

The research participants for this study were selected using purposive sampling. Neuman (2014), Singleton *et al.*, (1988) as well as Strydom and Delport (2011) describe purposive sampling as selecting participants based completely on the judgement of the researcher and the sample is comprised of elements that have the most attributes representative, of the population. As recommended by Neuman (2014) this sampling method was preferred because it focuses on the characteristics of a population that are of interest to the researcher, enabling answering the

research questions. Likewise, Palinkas, Horwitz, Green, Wisdom, Duan, and Hoagwood (2015) further affirm the purposive sampling aids in identifying and selecting of individuals or groups of individuals that are especially knowledgeable about or experienced with a phenomenon of interest.

The primary step when using purposive sampling is to decide the selection standard (Merriam, 2009). For the purpose of this study, the following inclusion criteria were used when gathering data :1) orphan(s) being looked after have lost one or both parents because of HIV/AIDS: 2) caregivers were at least 20 years and above, and not the grandmother of the orphan(s); 3) caregivers raising one or more children orphaned by HIV/AIDS (staying at the same homestead with the children and providing total caring duties); 4) orphan(s) were not in the care of the remaining biological parent; 5) The caregiver was supposed to be a permanent resident of Bulilima District.

The second stage when using purposive sampling is to decide which type of purposive sampling to employ (Merriam, 2009). Merriam (2009:78) states that “Common purposive sampling types include: typical, unique, maximum variation, convenience, and snowball or chain sampling”. This study used snowball sampling which Voigt (1999:368) defines as, “a technique for finding research subjects, one subject gives the researcher the name of another subject, who in turn provides the name of a third, and so on”. This sampling technique basically involves approaching a single case that is involved in the phenomenon to be investigated, to gain information on other similar persons. In turn, this person is requested to identify further people who could make up the sample. According to Berg, (as cited in Atkinson and Flint, 2001:1) the process assumes that a ‘bond’ or ‘link’ exists between the initial sample and others in the same target population, allowing a series of referrals to be made within a circle of acquaintances”.

Purposive and snowball sampling methods were chosen because of the sensitive nature of the subject under study. The stigmatisation of HIV/AIDS makes it difficult for people affected and infected to come out and disclose any information about family members. Further people are generally reticent to share information about their families, particularly to an outsider. Another reason for this choice is the study was conducted in a culturally sensitive area. Therefore, the researcher was obliged

to follow certain rules of etiquette when approaching people who could provide information.

Study participants were recruited with the help of ward councillors and village headmen since they are the custodians of Bulilima District. Councillors and village headmen assisted with identifying the first participants who later gave reference to subsequent participants. Below is a table giving a breakdown of the participants according to their gender, age and type and number of care-recipients.

Table 1: Distribution of respondents according to their gender, age, and number of care-recipients

Participant ID	Sex	Age	Number of orphans being raised
Participant 1	Female	21	3
Participant 2	Female	51	11
Participant 3	Female	40	1
Participant 4	Female	27	2
Participant 5	Female	22	3
Participant 6	Female	48	1
Participant 7	Female	28	1
Participant 8	Female	54	2
Participant 9	Female	40	1
Participant 10	Female	32	2
Participant 11	Female	41	1
Participant 12	Female	35	6
Participant 13	Female	31	3
Participant 14	Female	30	2
Participant 15	Female	36	2

3.5 Data collection procedure

To access the experiences of caregivers raising HIV/AIDS orphans, the use of semi-structured interviews and participant observations, instead of other types (such as experiments and survey questionnaires) was most appropriate for this study. As supported by Esterberg (2001), semi-structured interviews allowed the researcher to explore the topic of interest more openly, while allowing participants to express their opinions and ideas in their own words. In addition, semi-structured interviews were a better option to use because the researcher could follow up interesting avenues that emerged during the interview process, and the informants could give a fuller picture. Likewise, the interviewer could explain questions which the respondent did not comprehend. Finally, Denscombe (2010) states that when using semi-structured interviews, informants are more likely to be asked the same questions, and this allows comparison of responses.

The researcher spent two continuous days in two separate caregivers' homes. Participant observation offered the researcher a distinct way of collecting data since it draws on the direct evidence of the eye witnessing events first-hand (Descombe, 2010). It is based on the premise that, for certain purposes, it is best to observe what happens (Descombe 2010). Participant observation allowed the researcher to observe day-to-day responsibilities of the caregivers towards the orphans. Similarly, Descombe (2010:211) states that "In participant observation, things are examined in relation to their context; as such it scores highly in terms of the validity of the data".

3.5.1 Data analysis

According to Babbie (2016), data analysis means categorising, ordering and summarising of data to obtain answers to research questions. Similarly, Cohen Manion and Morrison (2007:147) describe data analysis as, "making sense of the data in terms of the participants' definitions of the situation, noting patterns, themes, categories, and regularities". Likewise, DeVos, Strydom, Fouché, & Delport (2005) state that qualitative data analysis transforms data into findings, this involves reducing the volume of raw information, sifting significance patterns and constructing a framework for, communicating the essence of what the data reveals. Analysis of the qualitative data for this study was approached through the process of making

sense of the raw data by observing patterns, interpreting such patterns to discover concepts and relationships, and then organising them to arrive at the formulation of substantive findings.

For the purposes of this study, Braun and Clarke (2006) thematic analysis method was used for data analysis. Braun and Clarke (2006:6) define thematic analysis, “as a method for identifying, analysing, and reporting patterns (themes) within data”. They further went on to state that, “the process starts when the analyst begins to notice, and look for, patterns of meaning and issues of potential interest in the data – this may be during data collection” (p15). Thematic analysis method was selected because it was found to be organised, flexible, clear, and suitable for answering the research question.

Thematic analysis was done in six phases described as follows: step one the researcher familiarised himself with the data by transcribing the audio recorded interviews into texts. In this stage, the researcher immersed himself in the data by working with field notes, the diary and interview transcripts with the aim of stimulating the formation of potential ideas and patterns. The procedure involved reading the texts many times intending to mark ideas for coding, plus searching for meanings and identifying emergent themes as proposed by Braun and Clarke (2006). Step two involved producing first codes from the data by identifying and grouping data relevant to each code. After coding and collating of data a list of different codes was identified across the data set. Step three comprised searching for themes. This step involved re-focussing the analysis at the broader level of themes, rather than codes. The different codes were sorted into potential themes, and all the relevant coded data was collated within the identified themes as suggested by Braun and Clarke (2006).

Braun and Clarke (2006:10), define a theme as a “coherent and meaningful pattern in the data relevant to the research question and represents some level of patterned response or meaning within the data set”. This step comprised refocusing the analysis and codes were sorted into potential themes. After construction of themes sets, the process moved to step four which comprised reviewing and refinement of the identified themes. The researcher reflected on whether the themes tell a convincing and compelling story about the data. Subsequently begun to define the nature of each individual theme, and the relationship between the themes after which

step five of naming and defining themes followed. In step five, the researcher wrote a detailed analysis of each theme as well as identifying the substance of each theme and constructing a brief and informative name for each theme. Finally, in step six, the researcher had to do what Clarke and Braun (2013: no page number) explain as “weaving together the analytic narrative and data extracts to tell the reader a coherent and persuasive story about the data and contextualising it in relation to existing literature”. At this step, the researcher compiled together the findings in the form of a report using the identified themes as headings and subheadings.

3.6 Ethical considerations

The fact that human beings are the objects of study in the social sciences brings in ethical problems to the fore. Strydom (2011:113) states that “For researchers in the social sciences, the ethical issues are pervasive and complex since data should never be obtained at the expense of human beings”. Consequently, Gravetter and Forzano (2011) argue that researchers have two basic categories of ethical responsibility: responsibility to the humans who participate in a project; and responsibility to the discipline of science, that is, to be accurate and honest in reporting of their research.

3.6.1 Informed consent and voluntary participation

Schinke and Gilchrist (as cited in Kumar, 2014:220) state that, “... all informed consent procedures must meet three criteria: participants must be competent to give consent; sufficient information must be provided to allow for a reasoned decision, and consent must be voluntary and uncoerced”. For that reason, participants were made adequately aware of the (purpose, procedures, risks, benefits), of the study. Also, they were afforded sufficient time of at least two days to consider whether to participate in the study. Participants were informed that partaking in the study was voluntary and they could withdraw at any stage of the research process. The caregivers signed a consent form so that consent could be verified. Moreover, the researcher obtained consent to audio record the interviews using a digital audio recorder.

3.6.2 Privacy, confidentiality and anonymity

In this study, the researcher managed the principles of privacy, confidentiality, and anonymity by discussing them with participants before the interviews were done. Confidentiality is ensuring the informant's information is not shared with anyone who is not part of the study without their consent (Gravetter & Forzano, 2011). Anonymity is making sure that the participants are not personally identified by information they provide (Gravetter & Forzano, 2011). Participants were informed that their privacy would be protected during the course of data collection and afterwards. Participants were promised that anything discussed would be kept strictly confidential and the findings would be in the form of a research report that may be made available to them upon request. The participants were also assured that neither their real names nor those of the respective sites would be made explicit in the report and likewise no real names are revealed in this study.

Confidentiality was guaranteed by saving recorded interviews and transcripts on a password protected device. The translator who formed part of the research team signed a confidentiality agreement form. The researcher guaranteed anonymity by using anonymisation procedure. Sieber (1992:52) describes anonymisation as a procedure of removing "personal identifiers or employing other methods to mask individual identities". The researcher removed all personally identifiable information and assigned pseudonyms to safeguard participant's privacy and identity as provided by Kaiser (2009). Pseudonyms were used in reporting the findings to conceal the individuals' from being identified by members of the public.

3.6.3 Protection from harm

Leedy and Ormrod (in Maree, 2007:298) state that, "the researcher should ensure the participants are not exposed to any undue physical or psychological harm". The researcher strived to be honest, respectful, avoided harm (physical or emotional) and was sympathetic towards the caregivers who partook in this study. The researcher took every reasonable step in this study to ensure the safety and protection of all participants from any physical, mental or emotional discomfort.

Interviewing participants on their experiences at times can raise false hope that the researcher had the solution to addressing their challenges. As such to minimise this,

participants were informed there was no direct or indirect benefit resulting from participation in the study. Also, participants were informed the study is not directly linked to any NGO or organisation and it was for academic purposes only.

3.7 Reflexivity

Reflexivity pertains to the “analytic attention to the researcher’s role in qualitative research” (Gouldner, 1971:16, in Dowling, 2006). Reflexivity entails self-awareness (Lambert, Jomeen, & McSherry, 2010), which means being actively involved in the research process. Gerrish and Lacey (in Lambert, *et al.*, 2010:322) note that, “reflexivity is perceived as an integral process in qualitative research whereby the researcher reflects continuously on how their own actions, values and perceptions impact upon the research setting and can affect data collection and analysis”.

Along similar lines, Parker (1999) presents the view that, from an individual position, being reflexive involves reflecting upon one’s own views, beliefs and experiences while considering how these might affect research through any political and social identities one may hold. In qualitative research, the researcher plays a dual role by being a researcher and a participant as such can therefore not be separated from the phenomenon under study (Palaganas, Sanchez, Molintas, & Caricativo, 2017). Additionally, the researcher has more power, as they determine the entire research project as well as ultimately deciding on how best to analyse the data (for example what is to be included and excluded).

To mitigate the issues of reflexivity, I kept a research diary describing step-by-step the details of interviews and observations made during the entire data collection process. The researcher wrote down any feelings, preconceptions, conflicts, and assumptions he had about the study. This enabled self-monitoring to prevent bias and increase objectivity. The researcher always attempted to keep track of and situate conversations within the confines of the study. Whenever an interview was conducted a new entry was made on a new page. Each new entry started with the date and brief biographic details of the caregiver. Reflections on the interview experiences were noted, which focused both on practical issues as well as how the researcher experienced the interview as a social encounter. The notes from the diary were also used to inform the transcription process of the individual interviews. This process has the support of Henning, van Rensburg and Smit (2004) who suggest

that verbatim transcripts be buttressed with the diary notes of the researcher's experience during the interviewing process.

In the face of challenges faced by some caregivers and the sensitivity issue which surrounds HIV/AIDS, it was very important that the researcher suspends his emotions. This study was neither directly nor indirectly funded by any organisation and the findings of this research project were not manipulated to achieve any goal, but to reflect the experiences of caregivers raising HIV/AIDS in Bulilima District. Finally, caregivers in Bulilima District are predominantly women. For this reason, the researcher undertook to approach the research with an open mind and was quite gender sensitive.

3.8 Limitations

The study was limited by time and resources, given that this is a Masters' Research report which combined coursework and a research report. Further, observing only two caregivers might not provide a deeper understanding of their responsibilities. I assume that doing participant observations of more than two caregivers was going to yield more detailed data. While the methodology chosen seems appropriate for the study, I am aware of the inherent limitations of using a qualitative approach since results cannot be generalised to other rural areas beyond Bulilima District of Matabeleland South Province Zimbabwe.

Likewise, McEnery and Wilson (2001:76) state that, "the findings from qualitative research designs cannot be extended to wider populations with the same degree of certainty that quantitative analyses can". This is because the findings of qualitative research studies are not tested to discover whether they are statistically significant or due to chance (McEnery & Wilson, 2001). In another sense, this project was exclusively seeking to explore experiences of caregivers raising HIV/AIDS orphans. The major criticism labelled against qualitative data is that it is difficult to apply conventional standards of reliability and validity because of the subjective nature of qualitative data and its origin of single contexts.

Babbie (2016) suggests that one of the major limitations of qualitative research is the time required for data collection, analysis, and interpretation. Like in this context that researcher had to spend 37 days collecting data. Finally given that interviews were

contacted in person, some respondents were not comfortable in answering questions about their family situations. This is also one of the major weaknesses of qualitative research methods as advocated by Terre Blanche *et al.*, (2006) who state the researcher's presence has a profound effect on the subjects under study.

3.9 Conclusion

In this chapter, the qualitative research methods utilised in this study was discussed in detail. Justification of the methodological choices in terms of discussing the merits and demerits of the methods employed were done. Further discussed were ethical considerations and reflexivity. The subsequent chapter of this study will present the findings and discussions of the data. The findings shall be situated within the relevant literature on this topic in accordance with the conceptual framework which provided guidance to the study.

CHAPTER 4: RESEARCH FINDINGS AND DISCUSSIONS

4.1 Introduction

This chapter reports on findings from a qualitative exploratory study of the experiences of caregivers raising HIV/AIDS orphans in the rural area of Bulilima District in Matabeleland South Province, Zimbabwe. The study-specific objectives included: (1) To investigate the daily responsibilities of caregivers towards the orphans, (2) To explore the caregiver's concerns and (3) To explore social support structures of caregivers who are raising HIV/AIDS orphans. The study asks, what are the experiences of caregivers raising HIV/AIDS orphans in a rural area? A case study of Bulilima District in Matabeleland South Province Zimbabwe.

This chapter will draw on the daily lives of caregivers who are raising HIV/AIDS orphans by discussing the following themes that emerged from the data: (1) caregivers' concerns (2) caregivers support structures (3) context of caregiving (4) caregiver's responsibilities (5) capacity to care, and (6) shared burdensomeness.

Each theme that emerged from the data is discussed and described. Where necessary, the researcher used direct quotations from the caregivers to substantiate the themes identified from the caregivers' responses. Please note the study also used secondary data to substantiate the caregiver's responses.

4.2 Presentation of findings

The initial themes arising from the analysis of the raw data were clustered into five main groups with their related subthemes: (1) caregivers concerns (2) caregivers support structures (3) context of caregiving (4) caregivers responsibilities (5) capacity to care, and (6) shared burdensomeness. The aforementioned six themes identified by the researcher after reviewing data demonstrate the experiences of caregivers raising HIV/AIDS in the rural area. Further, they demonstrate the resilience and resourcefulness of the extended family to deal with the burdens of orphan care.

The themes and subthemes are presented in Table 4.1 and explored in detail thereafter. It is important to note that some of the themes overlap, and they are presented as such.

Table 2: Themes and subthemes on caregivers' experiences living with HIV/AIDS orphans

Theme	Subthemes
Caregivers concerns	Resource and basic needs constraints
	Securing birth registrations
	Fearing disclosure- bullying, and stigma
	Dealing with treatment compliance
Caregivers support structures	Support from the family
	Support from NGOs and FBOs
	Support from the Government
	Religion and spirituality
Context of caregiving	Motivation for caregiving
	Absence of men caregivers - where in rural areas have you seen a man doing those duties?
Caregivers responsibilities	Caring responsibilities
	Multiple dimensions of care
	Competition between caregiving and other demands
Capacity to care	Capacity to care
Shared burdensomeness	Shared burdensomeness

4.3 Caregivers concerns

Participants described raising HIV/AIDS orphans as a demanding process, experienced in both positive and negative ways. HIV/AIDS-related caregiving, particularly to children, places unprecedented demands on the carers since the intensity of problems they deal with are peculiar. When respondents were asked to identify the main challenges encountered in caregiving, four subthemes emerged. These four subthemes are; resource and basic needs constraints, securing birth registrations, fearing disclosure- bullying, and stigma and dealing with treatment compliance

4.3.1 Resource and basic needs constraints

Caregivers reported that looking after orphans under the tough economic conditions experienced in Zimbabwe was daunting and stressful. The participants reflected on the impact of limited resources on their ability to care for children orphaned by HIV/AIDS. Given the economic challenges in Zimbabwe, most caregivers care for HIV/AIDS orphans under conditions of severe poverty. Caregivers thus have difficulties in meeting children's most basic needs, such as food, clothing, and access to private health care and education.

One caregiver, in her forties, recounted a story of caring for paternal kin:

"It is hard... though she receives free treatment at the government hospital and clinics; I still need to buy medication because it is not available at government pharmacies."

Though most orphans are receiving funding from the Government, NGO's and FBO's, the caregivers were to pay for the extra lessons, stationery, school uniforms and many other supplies. Further, support from NGO's, FBO and the Government was for the most basic needs. Though the support is helpful, it is not enough. Another caregiver, who is raising a teenager girl, highlighted her problems of struggling to buy monthly sanitary pads for the orphan. She stated that:

"Life is not all about food, a roof over your head, and clothes. Sometimes these small issues are as valuable as food. Like in my case, I have a teenager daughter, who needs sanitary pads and some lotions. Where will I get the money to buy her all those things? They might appear as if they are useless, but they are necessities, especially to women."

Caregivers recounted how they are failing to properly look after orphans because of lack of necessities. For this reason, some caregivers indicated that their inability to assist was causing them much stress. One caregiver summarised her challenges as follows:

"I spend so many sleepless nights wondering how I am going to feed these children and to provide them with other basic things in life. I feel so helpless. The situation is

made worse because they are not used to this rural life you know... Here in rural areas, we do not worry about many things as long as there is isitswala⁴ and relish.”

Respondents from this study expressed concern over meeting basic material needs of HIV/AIDS orphans, such as food, clothing, health, and education. Their major sources of income, the family, donors and the government are insufficient. This has been reported by several studies which note that although extended family networks continue to assume the primary role in orphan care and support, they are struggling to provide the orphans with basic needs such as school fees, food and medical care (Nyambedha *et al.*, 2003b; Oleke *et al.*, 2005; Oni, 1995; Ssengonzi, 2009). Similarly, Phetlhu and Watson (2014) noted that caregivers could not meet basic needs like food and clothes for orphans and were also failing to provide adequately for day-to-day basic needs.

Coupled with the harmful effects of HIV/AIDS and the persistent steep decline of the Zimbabwean economy, caregivers' capacities to provide material, emotional and psycho-social well-being to HIV/AIDS orphaned children under their care are severely strained. Zimbabwe is home to approximately 14 million people of whom 72 percent live in the rural areas, and in chronic poverty of less than US\$1. 25 a day (ZimStat 2016; UNICEF; 2016). Therefore, most rural households struggle to meet the most basic needs. Food insecurity in rural Zimbabwe remains a challenge and the South-Western districts where Bulilima is located is particularly vulnerable because of its hot and dry climate. UNICEF (2016), states that over the past five years the food insecurity prevalence was around 18.4 percent of the rural population.

The scarcity of basic needs is a serious issue for caregivers. A significant number of studies on experiences of caregivers raising HIV/AIDS orphans have highlighted that, most caregivers live below the poverty line (Fuller-Thomson & Minkler, 2000; Smith, Beltran, Butts & Kingson, 2000). Besides their scarcity of basic needs, Kelley and Whitley (2003) observe that caregivers at times lack social support. According to Backhouse (2006) not having enough necessities to provide the household may produce other challenges such as anxiety and stress. Such struggles point out the strain which many caregivers undergo and underline that neither the public sector

⁴ Soft porridge made from mealie-meal

nor communities are currently providing adequate support to the growing number of HIV/AIDS orphans. However, Foster (2002) states that extended families if supported by community initiatives, can be able to meet most of these children's basic needs

Finally, amidst the challenges caregivers are facing, the extended orphan care is not rupturing as predicted by the social rupture thesis. Instead, most of the caregivers in this study are within the transient phase. If the economic outlook does not change rupture will occur. However, if support is provided like at present, most families raising HIV/AIDS orphans can be able to cope with the challenges of raising orphans.

4.3.2 Securing birth registrations

From the 15 interviewed caregivers, five caregivers had encountered great difficulties in securing birth registration certificates for their orphans. A compounding problem is an unsympathetic approach adopted by the Registrar-General's office responsible for producing such certificates. The office makes the process of applying for birth registration certificates difficult and sometimes impossible. The processes for application of birth certificates in Zimbabwe are rigid, requiring documents like birth or death certificates for the parents. Lack of such documents from their deceased parents prevents most of rural HIV/SIDS orphans from proceeding to secondary education as a birth certificate is a pre-requisite.

One of the caregivers was deeply concerned about one of her orphans. She narrated that:

"I am worried about the future of Nkosinothando (pseudonym). Next year she will be writing grade seven examinations, how will she advance to form 1 without a birth certificate?"

The Zimbabwe secondary education system requires that one produce a birth certificate to enrol for secondary education. Without a birth certificate, Nkosinothando may not be able to proceed to secondary education.

One participant, none of her fostered orphans had birth certificates because the children were born in South Africa. Further, the surviving family members could not

secure death certificates for the deceased orphan's parents. The deceased had changed their identities when they migrated to South Africa. As such, it was difficult for the surviving relatives to prove the existence of a relationship between them and the deceased. One participant summarised her challenge in acquiring birth registration for her orphans as follows:

"It is difficult to get birth certificates for them... Both parents changed their identities when they moved to South Africa, the children were also born in South Africa... it is like we are raising stolen children."

A birth certificate is a vital document that every child is entitled to, and important evidence of one's nationality. The major underlying cause of non-registration in Bulilima District is that children are born outside Zimbabwe to parents who had assumed new identities. Sometimes, it is a result of single parenting, if the mother dies, and the father of the children is not known in the family, registering such children is a daunting task. Also, the bureaucracy at the Registrar's offices coupled with the rigorous systems of getting birth certificates are other causes hindering caregivers from acquiring birth certificates for the orphans.

Caregivers suggested that they are facing great challenges in securing the birth documents for the orphans they are raising. These results are consistent with other studies from Namibia. For instance, Taukeni (2013) reports that most orphans who are from single mothers who died because of HIV/AIDS-related sickness had no birth certificates as such caregivers could not apply for social grants from the government. Similarly, in South Africa, Kuo and Operario (2007) note that obtaining identity documents for orphans had significant difficulties, particularly to non-parental caregivers. Without government intervention, all these children will not have a nationality, citizenship rights, nor will they be able to proceed to high school. Caregivers are appealing to the Government of Zimbabwe to come out with solutions to assist orphans to acquire birth registrations.

4.3.3 Fearing disclosure- bullying, and stigma

Stigma remains a major challenge irrespective of how long HIV/AIDS has been in existence and how much education has been done. A general lack of knowledge of HIV/AIDS is obvious in the myths surrounding transmission, prevention, and cure.

Caregivers faced enormous challenges of disclosing the HIV/AIDS status of the orphans as narrated by one caregiver:

“Themba is on ART, luckily these days we have a single dose, he doesn’t know that he is positive, and I don’t know how to tell him. How will I explain HIV to a five-year-old boy? How will the community treat him?... People in this community still don’t have enough understanding about AIDS”

Caregivers avoided disclosing the HIV/AIDS diagnosis and treatment to the child, lest the child might reveal his or her status to someone or at school and be discriminated against. They also feared that the child could have difficulties in accepting his/her HIV/AIDS status. Therefore, the caregivers chose to be silent about HIV/AIDS status and treatment, of the child.

Caregivers who fostered HIV/AIDS positive orphans preferred to keep the HIV/AIDS seropositivity of their orphans to themselves. The results thus obtained are compatible with (Kuo & Operario, 2010) who found that social stigma around HIV/AIDS prevents people from being open as such this increases the isolation of people in families affected by HIV/AIDS. Moreover, non-disclosure of one’s status can result in individuals not getting social support.

One respondent mentioned that even though people know about HIV/AIDS, stigma and discrimination was still a challenge. These stereotypes were experienced by a participant who stated that:

“I had to transfer him to another school...His mother was an HIV/AIDS activist and at one time gave a speech on living positively at that school. That is when it started... even teachers who have knowledge about AIDS were isolating him”

These findings resonate with a study conducted in Thailand by Wattradul and Sriyaporn (2014) who note that caregivers raising HIV/AIDS infected children experienced difficulties in accessing education and the children were less likely to get support from educators. Also, they experienced stigma and social exclusion. Consequently, they had to resort to non-disclosure when sending HIV/AIDS seropositive children to school. The participants’ response points out that HIV/AIDS is still a stigmatised disease. The experiences of participant correspond to (Gilbert, 2016) who found that HIV/AIDS transmission is still poorly understood by some

people in the general population, causing them to feel threatened by the mere presence of someone supposed to be having the disease.

One caregiver mentioned that she accepts her fostered child as she is, but people out there are making it difficult for her. She spoke at length about how people in the village were reticent in allowing their children to play with her orphan. Experiences of stigma and discrimination to young children can bring isolation and psychological problems as reported Biru, Lunqvist, Molla, Jerene, & Hallström, (2017).

The stigma surrounding HIV/AIDS relates not only to a blame of sexual promiscuity but also to the paradoxical location of infected peoples in a domain betwixt-and-between the bracket of life-and-death. This perception is a result of the earlier assertion of HIV/AIDS-death link in the public where HIV/AIDS was presented as an incurable fatal condition. The claim that a person was afflicted with a virus that would lead to death, generates a fatalistic attitude and raises questions about whom they might infect. It has been documented in various studies on HIV/AIDS-related stigma that infected and affected people often experience different forms of stigma from kin, friends and community members (Mahajan *et al.*, 2008; Biru *et al.*, 2017).

Respondents from this study reported that they had similar experiences of being stigmatised because of the HIV/AIDS orphans they are raising. Narratives from the respondents correlate with a study done in rural South Africa by Ogunmefun *et al.*, (2011) that notes that caregivers caring HIV/AIDS infected were suffering from a secondary type of stigma. Similarly, Gilbert and Walker (2010) note that people living with HIV/AIDS were stigmatised on the basis that they might have contracted the diseases because of immoral behaviour.

The data appear to suggest that caregivers experienced physical stigma, by being isolated by certain family and community members. Moreover, respondents narrated that they also experienced social isolation and verbal stigma in the form of being gossiped about, finger-pointing and being jeered at. These situations lead to some caregivers not to reveal the HIV/AIDS status of their orphans, as disclosing could entail jeopardising their emotional well-being. In view of the stigma and discrimination associated with HIV/AIDS, caregivers may feel embarrassed and consequently, they might end up being isolated and withdrawn.

This research suggests that stigma and discrimination can exacerbate the material and psychological problems caregivers already face in the context of the HIV/AIDS pandemic. Stigma, discrimination and courtesy stigma directed towards orphans affected the ability of caregivers to provide appropriate psychosocial and material support for children orphaned by HIV/AIDS. Fearing such stigmatisation, caregivers decided to hide the HIV/AIDS status of their orphans from colleagues, friends and even some family members. Non-disclosure led to caregivers to administer ART to their orphans secretly.

4.3.4 Dealing with treatment compliance

Caregivers raising HIV/AIDS infected orphans indicated that it is a very difficult task to adhere to the requirements of ART. ART is a permanent process and medication must be taken every day, forever and religiously. To achieve success, ART requires perfect and constant adherence rates of at least 95% to prevent treatment failure and the generation of drug-resistant strains of HIV/AIDS (Ekstrand *et al.*, 2011; Skovdal, Campbell, Nhongo, Nyamukapa & Gregson, 2011). One of the caregivers narrated that she cannot go anywhere leaving the child behind. She is so fearful that if she leaves her child under the custody of someone they might administer ART irregularly hence creating drug-resistant HIV for her orphan. Moreover, caregivers who fostered HIV/AIDS positive orphans were burdened by the day-to-day administration of ART.

HIV/AIDS infected children under the care of caregivers may face some barriers to optimal ARV adherence that is unique to their care arrangements. ART is exceptional in requiring adherence rates of at least 95% to prevent treatment failure or drug resistance (Ekstrand *et al.*, 2011). Lack of adherence to ART often leads to treatment failure and is likely to bring drug-resistant strains of HIV/AIDS. Nonetheless, findings presented in this study highlight perseverance of caregivers in ensuring that orphans under their care comply with the rigid treatment regimens associated with ART, an asset previously identified in Cambodia (Williams, Knodel, Kim, Puch, & Saengtienchai, 2008) and Thailand (Knodel, KespiChayawattana, Saengtienchai, & Wiwathwanich, 2009). Moreover, carers repeatedly stated the strength of their commitment to ensuring that children attended their monthly hospital review on the appropriate date.

However, data gathered in the study suggests that caregivers who fostered HIV/AIDS infected orphans were not receiving enough support from their family. The data obtained agrees with the Skovdal; Campbell, Nhongo *et al.*, (2011) who state that at times caregivers raising orphans infected by HIV/AIDS and enrolled on ART programmes experience limited support from family members. Lack of family support can result in challenges in adhering to ART because once the caregiver is absent chances are high the child might miss their medication.

4.4 Support structures

Consistent with studies from other regions, caregivers in Bulilima District are receiving social support from the Government of Zimbabwe, faith-based organisations, non-governmental organisations and family members. Social support is defined by Thoits (1986) as helpful functions performed by significant others to enhance the individual's physical and psychological well-being. Current research appears to confirm the view that caregivers in Bulilima District are receiving emotional and instrumental support.

4.4.1 Support from the family

Similar to findings from within Sub-Saharan countries in many of the cases, extended family takes on the primary responsibility for the care of HIV/AIDS-orphaned children (Kuo & Operario, 2010; 2011). Moreover, family relationships provide the most instant source of support to caregivers raising HIV/AIDS orphans. Of the 15 interviewed caregivers, most of them were receiving support from their kin. However, most of the caregivers receiving support have relatives working outside Zimbabwe. Support was in the form of groceries, clothes, and cash sent through *umalayitsha*⁵. The following interview transcript from one participant reveals the kind of support the caregivers are receiving.

“Yes, I am receiving support from family members...They are young brothers of my husband who are in South Africa and Botswana.”

⁵ Zimbabwean cross boarder goods transporter from South Africa or Botswana to Zimbabwe.

When questioned to explain further the support she is receiving from the family members, the caregiver stated that:

“Every December they buy Christmas clothes and groceries for the children. They also give me money for uniforms and stationery. I am grateful for the support I am getting from my in-laws”

Similarly, one of the participants stated that she is receiving support from the uncle and aunt who are working in South Africa and Botswana respectively. She responded that:

“I receive support from Babamcane and Babakazi, if the other buys groceries, the other will send money. Anyway, I prefer grocery to money because groceries are cheaper in South Africa.”

Some of the respondents also explained that they prefer grocery and clothes compared to money because of the low exchange rates between the South African Rand against the United States Dollar.

Extended family is central in supporting the caregivers who are raising HIV/AIDS orphans in Bulilima District. It acted as a social insurance scheme in which caregivers could draw support from. Of the interviewed caregivers, two were only receiving emotional support from the extended family members. One of the participants raising two orphans was not receiving any financial support from the extended family members. However, according to her, she is receiving emotional support from family members.

Such response indicates that though these participants are not receiving any financial or any other form of tangible support as expected by the researcher, they were receiving emotional support from their extended family members.

Based on the evidence currently available, it seems fair to suggest the extended family system remains the primary support structure for the care, protection, and development of HIV/AIDS orphaned children in Bulilima District. These findings provide insights into local understandings of care and challenge the assumption put forward by the social rupture thesis, which assumes that family caregiving is collapsing because of HIV/AIDS. Similar support from the immediate family members is augmented by Jacobs, Shung-King, and Smith (2005) who state that in South

Africa many of orphaned children live with relatives without intervention or incentives from the State. The results thus obtained are compatible with Chirwa and Chizimbi (2007) who found that in Malawi, family support is a normal practice. They went on to suggest that family members working in town have an obligation to support their family in rural areas. This study, therefore, demonstrated how families are finding strategies to manage the burden of caring for HIV/AIDS orphans by supporting the caregivers.

4.4.2 Support from NGOs and FBOs

In addition to the efforts of the extended families, some caregivers in Bulilima district are receiving assistance from NGOs and FBOs. Several NGOs and FBOs have implemented projects in Bulilima. These projects aim at strengthening the community programmes in response to the HIV/AIDS epidemic. The activities carried out in these projects include, giving out food parcels, cash transfers, and helping in forming community projects. The distribution of cash and material goods is mainly done through the Government's Department of Social Services. While the initiative of distributing the material goods to orphans and their families is good, the major problem is the sustainability of such programmes. At the time of this study, about 20 organisations were operating in Bulilima District.

However, NGOs and FBOs in Bulilima mainly target the labour constrained caregivers. That is, support mainly targets caregivers who because of old age, physical disabilities or illness cannot work for themselves. However, there can be exceptions where few caregivers, not labour constrained can be beneficiaries. Thus, from about 20 organisations operating in Bulilima, only Restless Development, Caritas, Higher Life Foundation and Hope for a Child in Christ are mentioned in this study because of the stingiest "Labour Constraint" criteria adopted by these organisations.

Restless Development is one of the NGO's operating in Bulilima. The organisation supports the vulnerable, including children orphaned by HIV/AIDS, through income generating projects. The proceeds from the incoming-generating projects are meant to support education and well-being, of both orphans and caregivers' families. Restless Development has supported some schools in Bulilima District to run sewing

and poultry projects, with teachers and government officials working to assist orphans and vulnerable members of the community. Some schools were given irrigation equipment to mobilise resources for orphan care through growing vegetables for selling.

Respondents also highlighted the organisation seeks to balance between assisting communities and at the same time making them more self-sustaining so that in the case Restless Development withdraws its support, the communities will continue with the development projects. The organisation also seeks to empower vulnerable children in poor communities with lifelong skills for future survival.

The following responses suggest how the organisation is supporting caregivers raising HIV/AIDS orphans:

“Yes, I am receiving support from Restless Development. However, they do not provide support in the form of cash and goods like other organisations, but through “food for work” also known as income generating projects. They sunk us a borehole for the garden, and from the proceeds of the garden, we are able to pay fees and buy stationery.”

Another respondent stated the following:

“I am benefitting yes, but indirectly. Restless Development is assisting us with projects at the secondary school. The projects are a joint venture between the school and the orphans. It is helping me a lot because now I do not need to worry about school fees, school uniform, stationery and even lunch.”

Higher Life Foundation is assisting with school fees and stationery for HIV/AIDS orphans and the needy children. Further, the organisation is lauded for paying both school fees and providing stationery as summed up by one of the respondents who stated that:

“The good thing about the Higher Life Foundation is that they pay fees and provides stationery.”

However, the organisation only assists academically well-performing students as stated by one participant who mentioned that her orphans, though most deserving

failed to meet the minimum requirements since their school grades were below average.

Caritas supports caregivers by providing food parcels after members of the community had performed community services as expressed by this participant:

“Caritas assisted us through the food for asset programme. I received 10kgs mealie-meal, 2 kg cowpeas, 750ml cooking oil every month from April to August 2016. The programme shall resume again early next year.”

Hope for a Child in Christ (HOCIC) one of the FBO's operating in Bulilima supports the poor members of the community by giving out cash transfers monthly as articulated by this participant:

“I am a beneficiary of Hope for a Child in Christ; I receive \$84-00 monthly.”

Similarly, another participant expressed that:

“I am receiving \$49-00 each month from Hope for a Child in Christ”

HOCIC is assisting some of the caregivers with cash transfers on a bi-monthly basis where each household member receives USD7.00.

In response to the plight of the caregivers raising HIV/AIDS orphans, NGOs, and FBOs with support from international donor agencies, provide various forms of support that include education, skills development and economic empowerment to a limited number of HIV/AIDS orphans in Bulilima District. Such support is often largely directed at responding to short-term assistance to orphans and vulnerable children. Previous studies in Zimbabwe suggest that NGOs and FBOs have historically played and continue to play an important role in providing care and support to the poor and the vulnerable (Mahati *et al.*, 2006). Many of these initiatives are small but are helpful to caregivers raising HIV/AIDS orphans. Research in Bulilima, Mangwe and Chimanimani districts in Zimbabwe by Mahati *et al.*, (2006) suggest that local faith-based initiatives are providing a significant amount of help that is derived from the community itself, demonstrating the resiliency of communities and the innate sustainability of such actions.

The results thus obtained are compatible with Skovdal *et al.*, (2011) who reported that NGOs responded to caregivers struggles by providing them with food aid and

engaging them in income and food generating work. Likewise, Chirwa & Chizimbi (2007) note that FBOs in Malawi are embarking on several projects on HIV/AIDS that have both direct and indirect references to orphans' care and support. In South Africa, studies have found that NGOs are supporting caregivers by forming support groups where caregivers could meet and share ideas on how they can cope with the challenges of caregiving (Hearle & Ruwanpura, 2009). The study by Kiggundu & Oldewage-Theron (2009) in the township of Alexandra found that NGOs support caregivers financially, and assist them in starting income generating projects.

So far, the focus of NGO's and FBOs is to target orphans only, with most programmes attempting to provide services and support directly to children (Ritcher & Desmond, 2008). Seldom have they seen their caregivers and families, despite their great need for assistance. It is recommended that these organisations espouse a family-centred approach to support. Therefore, assistance geared towards HIV/AIDS orphans should be directed at supporting the caregivers and their families since they are the ones supporting these orphans.

4.4.3 Support from the government

During periods of drought, the Government of Zimbabwe always gives out grains to households. Households with more vulnerable children, receiving more grain in proportion to numbers of dependents. Of the 15 interviewed caregivers, 11 were receiving drought relief maize from the government monthly. For instance, one participant who is a beneficiary of the drought relief programme stated:

"I am receiving a 50kg bag of grain every month and in December I also received 10 kilograms of rice as a complimentary gift from the president."

Maize is very important since *sadza* is the staple food of Zimbabwe. Besides the grains, the Government of Zimbabwe assists vulnerable children like HIV/AIDS orphans with school fees under BEAM as suggested by the following participant:

"She is on BEAM as such, we do not pay any school fees for her"

BEAM is non-discriminatory since the intended beneficiaries, such as orphans, are always selected for the programme. Selection is based on necessity than academic performance. For one to be a beneficiary of BEAM, they just need a

recommendation from both teachers and community selection committees. Respondents were appreciative of BEAM since it provides for both tuition and examination fees.

Governments in SSA have so far been sluggish to respond particularly to the HIV/AIDS orphan crisis. Perhaps most significantly, governmental action has been slow to emerge because families and communities have shouldered most of the strain or it is because a host of immediate challenges competes for their attention and for scarce public funds. Moreover, complicating matters further, the orphan crisis is not observable, as the millions of orphaned children are dispersed over many families, in rural areas and far from sight.

The data yielded by this study suggests that although the Government of Zimbabwe is playing a role in providing basic social services, especially in the areas of education, health, and social welfare that try to meet the needs of orphans. This support is insufficient as very few families are benefitting. For instance, providing ART for a child is not enough because the caregiver will still need transport money monthly to go and collect medication from the collection or distribution centre.

These results of this study thus are consistent with other studies which have shown the minimal role of the government in aiding caregivers raising HIV/AIDS orphans. For instance, the Government of South Africa provides foster care grants and childcare grants, monthly (Kuo & Operario, 2007). The aim of the grants, according to National Development Plan (NDP), vision 2030, is to ensure that primary caregivers living in poverty can finance the basic needs of children (National Planning Commission, 2011). Moreover, the Governments of South Africa, Namibia and Botswana introduced fee waivers for primary and secondary education for HIV/AIDS orphans (Taukeni, 2013). In Zimbabwe, at present, there are no government interventions aimed directly at assisting HIV/AIDS orphans and their caregivers.

4.4.4 Religion and spirituality

According to some caregivers, the church was a social parent who brought spiritual, physical as well as moral support. It is at the church where they meet and share their concerns about caregiving. Most caregivers mentioned that they join the church for

spiritual purposes and to strengthen their social support networks. They mentioned that the church at times provides them with support in times of need and distress. The following response from one of the participants reveals the significance of religion to the caregiver's concerns:

"I take everything to God in prayer. No one gave me these orphans, but Him. As such, I told myself that through Him I shall manage this burden."

"For me, I give all the credit to my prayers, God is the one who took away their parents and he is still the one who is providing for them by making sure that we always benefit from most programmes implemented in our ward."

From the participant's response, it can be inferred that beyond the central spiritual mission, the church is a major factor in providing psychological and social support. Also, it functions almost as a community support centre that promotes social cohesion and mutual support in times of despair, tragedy, and illness. Sometimes, churches paid school fees for the orphans and the vulnerable. Two of the caregivers suggested that they received food parcels and clothes from a local church earlier in November.

One of the participants believes in her ancestors, and she thanks them for always providing for her. She thanks them for always making sure that she benefits from most of the programmes operating in the district. She narrated her belief in ancestors as follows:

"How I am surviving I do not know, I thank the ancestors of these children and mine for always helping us to benefit from these programmes. They always look after us, none of these children are sick... all are fit and well."

Such statements allude to the fact the caregiver believes in her ancestors who always provide for, and take care of her family.

Zimbabwe is a religious nation, much of the public, when asked about religion, profess a faith in God and affirm that religion is at least "most important" in their everyday lives. Consequently, 14 of the interviewed caregivers were Christian believers. Findings suggest that caregivers' religious beliefs enable them to deal with the challenging situations they face in their lives. Moreover, religion informed many

participants' accounts of how they responded to their caring duties. Carers of HIV/AIDS orphans frequently cited that God would reward their commitment. During the data collection, the researcher observed the church was the only available organisation where caregivers could get social and emotional support either from sermons or through fellowship with other church members. Religion is an important tool that brings people together in this age where communal ties are gradually disintegrating. In some circles, the church has been referred to as a social parent that offers both spiritual as well as moral support to its members (Munthali & Ali, 2000).

The results thus obtained are compatible with Büssing, Fischer, Ostermann, and Matthiessen (2008), as well as Musick (1996) who report that religion can be a strong source of support for the caregivers by providing them with a sense of strength, encouragement, comfort, and hope in challenging situations. For caregivers who take recourse to faith, God and the religious beliefs that they hold on to can serve as a highly important support system (Blinderman & Cherny, 2005). By listening to the comforting words of compassion from church, caregivers may get the inner strength to bear with their demanding circumstances.

4.5 Context of caregiving

The supposition in international children's rights organisations is that families are the best place for children's rights and well-being. In Zimbabwe, government policy discourages inter-country adoption of children favouring fostering. This policy recommends that children are better off if raised within their culture. The first developed subtheme within this theme, state of HIV/AIDS orphan caregiving relates to the reasons provided by participants for choosing to raise the orphan or orphans. This subtheme was followed by the subtheme: dominance of females in HIV/AIDS orphan caregiving duties.

4.5.1 Motivation for caregiving

This subtheme explores the reasons given by caregivers on what motivated them to raise the HIV/AIDS orphan(s). Among the 15 caregivers interviewed, various explanations were given on why they are raising those orphaned children. One caregiver indicated that she felt compelled to raise orphans because she grew up as

one and was raised well by both maternal and paternal relatives. Her foster parents even sent her to study at a boarding school.

“I grew up as an orphan and was raised by relatives; I made a vow that one day in life I should return the favour...here I am raising 11 orphaned children... I owe it to the families who raised me well. I went to a boarding school... I have a sense of responsibility to take care of these orphans despite my situation... You know it gives me peace of mind seeing these children around me calling me mama”.

The preceding narration reveals the caregiver decided to raise 11 HIV/AIDS orphaned children since she was raised as an orphan. When asked further about how she came to raise a total number of 11 orphans, she responded that five orphans belonged to the husband's late sisters, four belonged to the husband's late brother and the last two belonged to her two separate late sisters.

Other participants said that they fostered the orphans because either there was no one willing to take care of the children

“The elders, who came for the funeral, never discussed anything on who should look after the children. They just said I should look after my sister's children and they will assist whenever possible”.

Another participant response suggests the decision was made by the elder family members as highlighted by the forthcoming response:

“After the burial, both families sat down to discuss on how the wealth of my sister including children should be shared... From that family meeting, it was agreed that I should take care of her children...Everything here is in my care from the children to all the livestock”.

The preceding responses suggest that family plays an important role in deciding the primary caregiver for orphan care. This agrees with what was earlier on noted by Oleke *et al.*, (2005) who confirm the customary role of the family in childcare if a parent dies. Further noted from participants, is the broader definition of the traditional family to include, older and younger sisters of the mother and older and younger brother from the father's side. This proves the resilience and resourcefulness of the African families to deal with the burdens of HIV/AIDS orphan care. Instead of

orphans to be cared and raised within or along the patrilineal lineage, they are cared for by what Chirwa (2002) term senior mothers and uncles; junior mothers and uncles from the mother's family lineage.

Moreover, the researcher noted that some caregivers were raising orphans because of tradition. For instance, one of the participants stated the husband opted to foster the orphans because he is the oldest male figure in the family. Therefore, he was given the responsibility by other family members to raise the orphans as noted by the response below:

"My husband chose to raise these children out of tradition. He is the eldest in the family, as such he is the one who has the responsibility of raising these children. Other family members can only support, but the children will be here. This is their home until they are old enough to look after themselves".

The researcher also noted that some caregivers decided to raise the orphans because they were overwhelmed by emotions as noted from one of the participants who stated that she decided to foster one of the orphans because she felt that it was the right decision as indicated by the following narration:

"When my younger sister passed away, her child was left under the care of the child's paternal grandmother. As such when I heard the child is on ART, I was overwhelmed with emotions and decided to foster the orphan herself".

When the respondent was probed further by the interviewer to clarify what she meant by saying she was overwhelmed by emotions, the respondent stated that:

"To cut the long story short during my teaching days I attended several HIV/AIDS courses and training as such I have a better understanding of ART. ART is so complicated to be administered by an elderly grandmother. As such, I felt that it was the right thing to do. I am so happy that my husband supported me too...I can say that is how I ended up raising my sister's child... and I have no regrets at all".

Caring for orphans before arriving of HIV/AIDS was customary and governed by cultural norms. The senior member of the family on the fathers' side was obligated to foster the deceased children. Studies suggest the most important motivation was to keep the orphaned children within the family (Abebe & Aase, 2007; Foster, 2000).

Norms placing orphans in families might be changing because of large numbers of orphans and at times lack of potential family carers (Nyambedha *et al.*, 2003a). For example, the study conducted in Richards Bay by Nyasani *et al.*, (2009) found most of the rural foster carers care for orphans out of obligation because they have no other choice. Madhavan (2004) called it 'crisis-led caring', a situation where members of the extended family find themselves supporting orphaned children without any financial, physical and psychological capacity.

Despite the arguments that kinship care is collapsing and thus families are reluctant to take in orphans. Findings from this study point to the persistent role of extended family in taking care of the HIV/AIDS orphans in Zimbabwe. In this study, orphans are fostered by either the father's family or the mother's family. It is uncles and aunts fostering orphans, thus suggesting the traditional family is readjusting itself to help orphans made vulnerable by HIV/AIDS. These caring arrangements are a testimony that, traditional African family has redefined itself by broadly spreading the responsibilities of care within family members. Therefore, the theoretical assumptions that kinship care is collapsing because of too many orphans produced by HIV/AIDS-related deaths are questioned. This is because, despite the economic hardships and poverty, the extended family is the most likely safety net of orphans since it is embedded in the social space where caring for orphans is expected (Kuo & Operario, 2007).

Further, respondents in this study suggested that caring for HIV/AIDS orphans is informed by structural constraints and local context. As such, most of the caregivers responded that they found themselves in the HIV/AIDS orphan caregiving role because of what Raina *et al.*, (2004) term necessity. At times, the family members were fostering the orphans because they were driven by sympathy and socio-cultural norms. The results thus obtained are compatible with Kimane (2004) who note that at times family members often feel obliged to care for orphans lest they offend ancestors, thereby inviting the ancestors' wrath.

4.5.2 Absence of men caregivers - where in rural areas have you seen a man doing those duties?

According to previous studies, women are the main caregivers for the HIV/AIDS orphans (Kuo & Operario 2007). Also, Matshalaga (2004) went on to further suggest that it is because women are viewed as the primary caretakers of families under the traditional social structures. These gendered care patterns hold true for Bulilima where all fifteen interviewed caregivers are women. This is because the social division of duties in rural areas remains central to the socially constructed gender roles that characterise men's and women's place in society as augmented by the following participant responses:

*“*Laughing* how can you ask such a question? Where have you seen a man looking after children? That is my responsibility as his wife, the mother of the house... His responsibility is to work and bring in money. Raising a child involves washing, feeding, and cooking for the child. Where in rural areas have you seen a man doing those duties?”*

The preceding narration cements further the reality that society is still socially constructing duties between men and women. This phenomenon is most present in rural areas as suggested by the previous participant responses. Women are responsible for family and household well-being, including a greatly expanded caregiving burden related to taking care of HIV/AIDS orphans. One caregiver in her early fifties who recounted a story of caring for paternal kin:

“It is hard because many things occur in life. Like now my husband's sister got sick for some time, and she passed on, so I am now responsible for my children and her children because, in the family, the only surviving person is their uncle my husband”.

In many responses, references to women as caregivers were implicit rather than explicit but carried the clear understanding that it is her responsibility as a woman to take care of these children she fostered through her husband. The data yielded by this study provides evidence that caregiving in rural areas is considered a women's job. Zimbabwean rural areas still accept women's caregiving as the natural order of culture. Males are supposed to be the providers while women take care of the

household duties. The results thus obtained are in agreement with findings from other regions. For instance, a study in China by Hong *et al.*, (2015) demonstrate that fostering might be the decision made by both husbands and wives, wives were more likely to spend more time than husbands in providing personal care and offering emotional support to the fostered HIV/AIDS orphans.

These findings agree with a study carried out in Tanzania by Fauk *et al.*, (2017) which affirms that more females are taking care of HIV/AIDS-orphaned children compared to males. These gendered care patterns are also found in South Africa, where most orphans are cared for by women (Kuo & Operario, 2007; Kiggundu & Oldewage-Theron, 2009). Similarly, in their attempt to understand the grounds for the low representation of males in HIV/AIDS caregiving activities in Lesotho, Newman *et al.*, (2011) found that caregiving is overlooked because of its unpaid status and is traditionally reserved for females since they are viewed as nurturers. These gendered care patterns are also true for Zimbabwe as reported by Matshalaga (2004) as well as Skovdal *et al.*, (2011).

4.6 Caregivers responsibilities

An HIV/AIDS orphan caregiver's responsibilities may vary depending on how much support that child may need. This section discusses the theme, caregiver's responsibilities. The theme was further subdivided into the following subthemes, daily responsibilities, multiple dimensions of care and competition between caregiving and other demands

4.6.1 Daily responsibilities

Caregivers raising HIV/AIDS orphans between the ages of one and eight years were likely to be more responsible for all the caring duties. Caregivers reported that they will start their duties early in the morning till they go to sleep. During school days, they will wake up early in the morning; make a fire, prepare food and warm water to wash. In some areas, some of the caregivers had to walk the children to school because of the long distances. During the day, the caregivers will prepare lunch so that when the children come back from school they will find something to eat. At night, they will prepare supper for the orphans and prepare a place for them to sleep. The following respondents highlight their experience:

“When its schooldays, I wake up early to prepare them and make sure that they are okay”.

Another participant stated the following:

“Raising a five-year-old means you have to do everything for her, I bath her, wash clothes for her, and cook for her. She just plays with the child when I am busy with household duties. I do everything in this house you know. All the household duties you can think of, it is me who do them.”

The daily responsibilities of caregivers vary significantly depending on the age of the orphans they are raising as suggested by one of the participants'. The caregiver mentioned that her daily responsibilities are characterised by making sure that all household duties are done. Her response was:

“These orphans are old enough to do everything for themselves during schooldays I wake them up so they can warm bathing water and prepare something to eat depending on what is available. As for me, I just supervise them”

4.4.2 Multiple dimensions of care

Caregivers, under stressful financial conditions, provided homes in which the orphans could grow under parental guidance. Some of the fostered orphans were living in urban areas while others were living outside Zimbabwe, but caregivers managed to acclimatise them to the new rural life. Despite the challenges and stress of managing their own households under extreme economic conditions, the caregivers provided these HIV/AIDS orphans with the identity of a home and family love. For instance, one participant who taught all the orphans under her care to call her mum.

“You know it gives me peace of mind seeing these children around me calling me mama.”

When asked further by the researcher the reason behind the orphans calling her mama, the caregiver mentioned that they are her children and will raise them equally to her real children. Moreover, she stated that she did not want the orphans she is raising to feel that they are not part of the family. She narrated the following:

“Yes, they know that their parents passed away... like I said previously, I taught them to call me mama. Because I am the only mother they have now. Also, I want them to grow up with oneness and I do not want to create a gap between them and my real children.”

Some of the caregivers stated that children orphaned by HIV/AIDS suffer from psychological trauma from the parent's illness and sometimes the stigma of HIV/AIDS. As such, they have an even greater need for love, affection and a sense of belonging. Caregivers mentioned that they provide care and affection to these orphans since they want them to be part of the new family's family. As this participant explained:

“I provide them all the love I have...I raise them as my own children, I am their mother and they call me as such...these children went through a lot in their life. They witnessed the illness of their mother and father... Yeah, we know that AIDS these days can be managed with ART, but to be honest, ART is not enough on its own. One needs money for proper nutrition, medication for opportunistic infections.”

During the interviews conducted for this study, it became evident the caregivers at times fulfilled a role beyond the limits of the caregiver but also assumed what Mohangi (2008) refers to as a pseudo-parental role.

Further, this is compatible with the social and emotional capacity of care as termed by Abebe and Aase (2007), who defined social capacity as the ability and enthusiasm of members of the extended family to acclimatise orphans with social and cultural skills needed for present and future life. Emotional capacity was defined as the desire and capability of carers to render psychological as well as emotional support to the HIV/AIDS orphaned children. Thus, rather than just a mere provision of economic resources, this study demonstrated that caregiving goes beyond intensive daily physical care, but involves providing a home, guidance and family love. Traditionally, parents provide love, subsistence and an encouraging environment for the socialisation of children. These caregivers are all providing a home environment where the orphans are growing up together with their children. The fact that some of the caregivers even instructed their orphans to call them mother indicates that they are more than caregivers, but pseudo-parents.

4.6.3 Competition between caregiving and other demands

With competing demands, caregiving takes priority for some of the caregivers. They suggested that it is difficult to leave HIV/AIDS orphaned children with other people since they are more vulnerable to abuse. Moreover, some caregivers pointed out that because of the orphan's seropositivity status it is difficult for them to delegate their caring duties. This might be because they either want to keep the status of orphan a secret or they are afraid the child's medication might not be administered correctly. For these reasons, when caregiving duties clashed with other programmes, caregivers prioritise the former. They at times, often delay, reschedule or make alternative plans as augmented by the following participant's response:

"My plans have to wait and I put her first. She is on ART and I do not want people from outside the family to find out because people talk too much. Last year, in this village a teenager committed suicide after some children mocked his HIV/AIDS status...I cannot take that risk. That is a family secret. Many people in the community do not understand this AIDS thing. You can only understand when it happens to you."

Orphans are the most vulnerable to abuse; anyone can take advantage of them in the absence of their caregivers. The following interview transcript from a participant illustrates this:

"I cannot travel leaving her alone here, they will abuse him, to make matters worse, he is my younger sisters' child, and to them, he is a foreign child."

These findings agree with Morantz *et al.*, (2013) who report that orphans in sub-Saharan Africa are vulnerable to abuse and neglect. It transpires from the participants' responses that caregivers raising HIV/AIDS are prioritising caring to protect their foster orphans from any form of abuse.

4.7 Capacity to care

Like other studies, this study noted three categories of extended families, which mirrors rupturing, transitory and adapting. These families should be viewed as part of a fluid continuum and reflecting the capacity of extended families to care for HIV/AIDS orphans. The three categories of families highlight that, though families

are burdened by the HIV/AIDS epidemic, HIV/AIDS orphan care, and economic instabilities, they are exercising agency and resilience to cope. Further noted, is the heterogeneity in the resilience of families in coping with the disruptions brought by HIV/AIDS. Finally, the families mirror the economic and socio-cultural dynamics of care in rural settings.

Figure 4: Classifications of HIV/AIDS orphan caregiving families in Bulilima District



Type One (rupturing): These types of caregivers are experiencing absolute poverty and rely solely on the food parcels which are donated mainly by NGOs and FBOs, and partly by the government. For instance, one of the participants who is raising six orphans from different families whose parents all died from HIV/AIDS. In another sense, assistance which is meant to ease the burdens of caring and to assist the orphans now supports the entire family. She narrated her situation as follows:

“I spend so many sleepless nights wondering how I am going to feed these children and to provide them with other basic things in life. I feel so helpless. The situation is made worse because they are not used to this rural life you know... here in rural areas, we do not worry about many things, we only worry about isisitswala and relish.”

Along similar lines, another participant narrated that:

“I only think about food, where and how to find food for this family. We just need help with food to feed these children. You know when children are hungry, they will never go to a man, but they will always come to me and cry, mama we are hungry. What can I do? We are only receiving maize from the government and is not enough,

because that maize needs to be taken to the grinding mill where I am supposed to pay a dollar per 20kgs.”

The preceding narrations demonstrate how these two families are in absolute poverty as they are even struggling to provide the necessities to the orphans they are raising. Further, the researcher observed the poverty is exuberated by the fact there are no family members who are gainfully employed within these families. As such, their only and main sources of support are the donations from the government, FBOs, and NGOs. Thus, if this support stops, these families are more likely to sink even beyond rupture. If they are supported, they are more likely to move towards transient category.

Type two (transient): As opposed to rupturing families, which are characterised by chronic poverty and destitution, 10 of the families were found to be living in relative poverty and semi-deteriorating living conditions. These transient families are not presently living in a situation of extreme poverty but may easily sink into deprivation or can move into adapting category. A common feature of these families is fluidity and sporadic support from family members. The following are narrations from participants whom I classified as falling within the transient category.

“We are living the most basic life you can think of. It is only isitswala that matters the rest are luxuries...As you know, this region is very hot, characterised by low rainfalls. The region is most suitable for cattle ranching. The food, we usually produce from the gardens is not enough to meet our demands. Mostly we survive from selling some of our livestock. But these days it is challenging selling cattle considering the cash shortages currently being experienced in the country.”

“Life is difficult as you can see. Without support from NGOs, we are nothing. Yeah, their babamncane at times send money and groceries, but it is not enough considering the challenges we are experiencing here in Zimbabwe. Thus, the little which is remitted for the sake of the children, I end up sharing with others. I cannot have relish with cooking oil while others do not have. It will appear as if I am benefitting because of these children.”

Along similar lines, another participant narrated that:

“We have nothing here; I cannot say we are solely struggling because of these children, but everyone elsewhere is struggling. Our lives are dependent on God, it is really God’s grace that we are seeing each day. I am so grateful to these donors without them life was going to be very challenging.”

Families in the transient category are said to be having the necessities for everyday survival. The researcher observed that families in the transient category appear fluid, any stop in support from the government, NGO’s, FBO’s and families, they are more likely to sink in the rupture phase. Most of these families are more likely to be receiving much of their support from relatives who are mainly working in South Africa and Botswana. The relatives usually send remittances in the form of groceries and cash. Therefore, furthering the supposition that African people are more likely to accept communal obligations to mutually support one another in times of need

The third category of caregiving families are well-functioning households and I describe them as adapting. These families (2 cases) are typical of common households in terms of possession of household resources and livelihood assets. The families have economic security and are surviving from a family member or members gainfully employed. Consequently, they have enough economic capacity as defined by Abebe and Aase (2007) who suggest that HIV/AIDS orphans under their care are more likely to be well taken care of.

For instance, the participant’s responses can be categorised in the adapting and these caregivers themselves are gainfully employed. Further, they are even taking care of the entire families.

“I am a teacher by profession as such I am a little bit better than the rest of the caregivers. Moreover, I am teaching here in rural areas where the cost of living is very cheap. I think I cannot whine that much about taking care of these children since the entire family survives from my own salary.”

Along similar lines, another participant narrated that

“Yeah, I can say they are challenges here and there, you know as a human being I will never say I have enough resources. But I personally think we have all the basic needs which a person might need in life.”

From the participant's responses, it is noted not all caregivers' families are rupturing nor all are resilient, but most of the caregivers and their families fall into the transient category. Thus, if support is not availed, they may sink into rupturing and if support is availed these families are more likely to be adaptive. With regards to the two theoretical debates of orphan care, the rupture thesis and the social resilient, this study demonstrates the extended family is not rupturing because most of the orphans in Bulilima are cared within the extended family system.

The study noted the extended family support system in Bulilima has not yet disintegrated, but it is relatively revealing pointers of weaknesses basing on the challenges being experienced by the caregivers. Further observed is the economic status of the family where the caregiver lives and the economic status of the caregivers themselves all have a bearing on the experiences of the primary caregiver raising the HIV/AIDS orphan(s).

The researcher observed that families are devising strategies to mitigate collapse and to deal with the challenges of HIV/AIDS orphan care. One of the strategies adopted in Bulilima is orphan transfer within members of the extended family. For instance, one participant is caring for 11 orphans where some were brought from Botswana. This strategy was earlier noted by Mathambo and Gibbs (2009) who stated that orphans can be transferred between a fixed set of relatives within the extended family.

The findings agree with other studies which note that extended families in Africa are trying to adapt to the growing number of children orphaned by HIV/AIDS. For instance, Chirwa (2002) who argues that within the African context, a family of a child goes beyond just mother and father. Thus, he expands the family to include both relatives from the mother and father's side of the child. For that reason, Chirwa (2002) cautions against conclusions supposing the capacity of the extended family to care for orphans as collapsing. He rather suggests that families are reconfiguring themselves to adopt the orphans made vulnerable by HIV/AIDS.

The study also note that though families are the main source of orphan care, their "economic capacity" is somehow limited because of economic challenges currently being experienced in Zimbabwe. This was earlier noted by Abebe and Aase (2007) study on the capacity of the extended family to care for HIV/AIDS orphans. Their

study too demonstrated that though families were fostering HIV/AIDS orphans, most of them were characterised by “economic capacity” deficiency.

Family members working from Botswana and South Africa are sending either money or groceries to Zimbabwe to alleviate the economic challenges currently in Zimbabwe. These remittances go a long way in also alleviating the burdens of caregivers who are raising HIV/AIDS orphans. This phenomenon is also occurring in Malawi as reported by Chirwa and Chizimbi (2007) who noted that, the family member working in urban areas had an obligation of supporting members in the rural areas.

Families in Bulilima are upholding communalism by supporting the caregiving families by sending remittances. This notion has the support of Seeley and Kajura (1993) who state that, in African communities, the extended family is commonly assumed as the first source of support to its members in times of need. They went on to suggest that, even the frail, the old and the orphans are all the responsibility of the family members. Further, to bypass the cash shortages being experienced in Zimbabwe, the researcher noted that expatriates are sending groceries, clothing, uniforms, and money from Botswana and South Africa using *umalayitsha*. Though not secure compared with services such as offered by Western Union and International banks, it is very convenient in dealing with the cash shortages.

4.8 Shared burdensomeness

Caregivers raising HIV/AIDS orphans of at least nine years were less involved in providing daily care. The orphans were providing valuable assistance that was lessening the burden on the caring duties. The following respondents are a testimony of how helpful orphans can be in rural households:

“The old boy will look after the other children; he is too responsible for his age. I am so proud of him; very proud...The boy is the only one who helps me with household duties. He fetches water with a wheelbarrow, looks for firewood.”

“They are old enough to do it themselves; I only do household chores during midweek, weekend they are the ones who do all the chores of cooking, cleaning, and washing of clothes.”

Such responses suggest that caregivers raising older orphans are less involved in daycare as the orphans are active participants in the household duties. There is a symbiotic relationship between the caregiver and the orphans. Caregivers were involved only in managing and organising their orphans while the orphans performed all the domestic household duties for the family.

In households comprised of girls and boys, domestic chores were allocated along traditional gender lines. The boys did work such as caring for livestock, fetching water in wheelbarrows, or drawing firewood with a scorch cart. The girls helped with all the household tasks such as cooking, washing dishes, cleaning the house.

In one of the Participants' household, her orphans aged 10 and 14 years were doing most of the household duties. The orphans would wake up early in the morning to clean the yard, make fire and warm water for the elders to wash their faces. Her responsibility is only to wake them up early in the morning. The boy will go and milk cows for breakfast milk while the girl helps the caregiver in preparing breakfast. After breakfast, the boy will go herd family livestock while the girl remained at home doing household duties with the caregiver.

Reflecting on dominant understandings of childhood, many researchers describe HIV/AIDS orphans as an emotional and financial cost to the households in which they live (Hlabiyago & Ogunbanjo, 2009; Mudavanhu *et al.*, 2008; Phetlhu & Watson, 2014). This has created a representation of orphans as a burden, not only to their fostering household but also to the society. Findings from this study reveal that such studies only give one side of the story. They overlook the reciprocal nature between caregivers and HIV/AIDS orphans. This study found that HIV/AIDS orphans are not always passive care-recipients, but also active household members since they can provide important assistance in household duties. Orphans need to be categorised into two groups which are consuming orphans and contributing orphans.

Consuming orphans are what Abebe and Aase (2007) describe as less 'resourceful' and rely on caregivers to meet their basic and life needs, thus are more likely to be dependent on their caregivers. Contributing orphans are active household members who take part in everyday reproductive activities in the household. For instance, from

previously above cases, orphans would do all the household duties either alone or with the caregivers.

Similar results are reported by Skovdal *et al.*, (2011) who note that orphans are not only helping with household chores but also contribute income to their fostered households. Thus questioning studies which highlight that most orphans are fostered by grandmothers who selflessly take on the burden of caring for orphaned and AIDS-affected children.

Along similar lines, Skovdal *et al.*, (2011) state that though caregivers provide HIV/AIDS orphaned children with a home; their old age may limit their contribution towards income and food generation. Therefore, they at times can depend on the contributions and active participation of these orphans in sustaining their livelihoods. This theme, therefore, cements the claim that caregivers at times rely on the orphans when it comes to household duties and working in the fields. This study, therefore, argues studies that view orphans as helpless and burdensome only tell one side of the story.

4.9 Summary of the findings of this study

Rather than just a mere provision of economic resources, this study demonstrated there are multiple dimensions of care. Caregiving involves material assistance, social, emotional, routinised care, such as the daily administering of ART, and intensive daily physical care. Findings from this study validate the view that extended families are still holding up as an important source of care and support for HIV/AIDS orphaned children in Bulilima District.

The study noted the extended family support system in Bulilima has not yet disintegrated, but it is revealing pointers of weaknesses. This points to patterns of families that do not fit into the theory of social rupture theory. Thus suggesting that though assumptions of the theory of social rupture might be historically or contextually bound, they might have limited relevance to families and HIV/AIDS orphan caregiving circumstances in rural areas of Zimbabwe.

The findings demonstrate the division of care along gender dimensions. Moreover, the study revealed that orphans are not always a burden as sometimes there is a

symbiotic relationship between the caregiver and the orphans. Within the context of this study, caregivers' concerns included challenges to meet basic needs, securing birth registrations for the orphans, stigma, and non-disclosure and dealing with ART treatment compliance. It appears the challenges, coupled with the dire economic outlook in Zimbabwe at large, are sometimes so overwhelming that some caregivers are left with a feeling of emotional exhaustion.

4.10 Conclusion

In this chapter, the findings were discussed in the format of themes and subthemes and integrated with the research literature and the participants' narrations. It is evident from the findings and the discussion in this chapter, that in the Zimbabwean context, orphan care is not an exclusive responsibility of caregivers but the entire family.

The extended family support system in Bulilima has not yet disintegrated, but it is rather relatively revealing pointers of weaknesses. Thus, rebuffing the social rupture thesis as well as the social resilience. The following chapter presents the research argument using the six major themes that emerged from the data.

CHAPTER 5: THE ARGUMENT

5.1 Introduction

Chapter 4 described and discussed the experiences of caregivers who are raising HIV/AIDS orphans by deliberating on themes that emerged from the data. This chapter explains the research argument using the six major themes that emerged from the data. These themes are: (1) caregivers concerns (2) caregivers support structures (3) context of caregiving (4) caregivers responsibilities (5) capacity to care, and (6) shared burdensomeness. The argument put forward in this study is, within the financial challenges and burdens of the HIV/AIDS epidemic, families in rural Zimbabwe are developing adaptive means to care for HIV/AIDS orphans.

Two theoretical debates on orphan care guided this study. The first theory is grounded in the social rupture thesis (Chirwa, 2002) which proposes that because of the increase of orphans because of HIV/AIDS, the extended family can no longer cope (Cross, 2001). The theory assumes there is a breakdown in family structures, social support systems and traditional safety nets of orphan care (Chirwa, 2002). Further, it states that families are overstretched and eroded therefore not able to cope with the burden and caring for HIV/AIDS orphans (Abebe & Aase, 2007; Chirwa, 2002; Cross, 2001). By contrast, the second theory counter-suggests, by stating the extended family is neither breaking up nor faltering, but rather is responding with innovative systems to the burdens of orphan care brought by HIV/AIDS (Foster, 2002). The theory further suggests that if families are supported by appropriate interventions, can still support many orphans.

Based on a qualitative research fieldwork involving observations and semi-structured interviews with caregivers raising HIV/AIDS in Bulilima District, this chapter demonstrates the social dynamics of HIV/AIDS orphan care by the extended family. The chapter also offers a critical and alternative look at how families in Bulilima experience and cope with the burdens posed by HIV/AIDS.

In Bulilima District Matabeleland South Province Zimbabwe, there seems to be a significant variance in the capacities and resources of extended families that are raising HIV/AIDS orphans. Therefore, contradicting the theory of social rupture.

Findings from this study suggest the theory of social rupture does not fully capture both the crisis and adaptations within extended family structures.

The following section highlights the caregiver's concerns, presents caregivers social structures, discusses caregiver's responsibilities to, towards the orphans, presents the capacity of the caregivers to care for HIV/AIDS orphans and discusses as well demonstrates that HIV/AIDS orphans are not always a burden.

5.2 Caregivers concerns

This theme seeks to demonstrate that, to affirm that families are developing adaptive capacities to care for HIV/AIDS orphans, is not the same as asserting there are no structural challenges encountered in the caring process. Rather, it means that families are resilient. Indeed, challenges are encountered, family structures and social relationships are over-stretched, but the system is not totally breaking down as proposed by the theory of social rupture. Rather families are going through a process of what Chirwa (2002:94) terms "social reconfiguration" in which some approaches to orphan care are discarded while others are adopted.

Consistent with other studies, most of the caregivers raising HIV/AIDS seropositive orphans were experiencing stigma and resorted to non-disclosure. While the importance of stigmatising aspects of HIV/AIDS has been widely acknowledged, little consideration has been given to how social stigma interacts with caring experiences. In this study, women caregivers used a selective approach to disclosure of HIV/AIDS and only disclosed to people that they trusted such as family members and key community leaders such as the village headmen. Further, they only relied on public health institutions for the health care needs of the orphans. Despite these challenges, caregivers showed a spirit of resilience as they continued providing the care despite acute shortage of necessary resources required for effective and good caring.

Caregivers concerns were not uniform, some were living in relative poverty some in absolute poverty and some were adapting well. This suggests that economic status of the family where the caregiver resides and economic status of the caregivers themselves influences the experiences of the primary caregiver raising the HIV/AIDS

orphan(s). This resulted in some caregivers failing to maintain their social networks, therefore, ending isolated and withdrawn.

Further caregivers experienced several challenges related to caring for these HIV/AIDS orphans in very limited resource setting of rural Bulilima. Concerns included challenges to meet basic needs, securing birth registrations for the orphans, stigma, and non-disclosure and dealing with ART treatment compliance. It appears the challenges coupled with the dire economic outlook in Zimbabwe at large, are so overwhelming that some caregivers are left with a feeling of emotional exhaustion.

The extended family support system in Bulilima has not yet disintegrated, but it is relatively revealing pointers of weaknesses basing on the challenges being experienced by the caregivers. Whereas the extended family and orphan care arrangements are resilient, flexible and fluid, and capable of responding to structural challenges, this is unsuccessful at times. However, rather than total collapse as assumed by the theory of social rupture, families in Bulilima are still responsible for orphan care. Most caregivers and their families are floating within the transient category which is characterised by relative poverty, emotional capacity, social capacity and limited economic capacity. Therefore, pointing to patterns of families that do not fit into the social rupture thesis.

5.3 Support structures

Caregivers in Bulilima district survive on multiple sources of support to mitigate the structural challenges of the HIV/AIDS epidemic, harsh economic conditions, and persistent droughts. Further noted is that participants in this study were receiving minimal support from NGOs, FBOs, and government because many of them are classified as the able-bodied. Support for HIV/AIDS orphans in Zimbabwe mainly targets caregivers who are regarded as “labour constraint”, that, is those because of old age, physical disabilities or illness cannot work to support themselves or the orphans they are raising.

Religion and the church are playing a significant role in lessening the emotional burdens experienced by the caregivers. Family members were the most and immediate social support to the caregivers raising HIV/AIDS orphans in Bulilima.

Thus, in contrast with studies such as Matshalaga (2004) and Rajcooner (2005) which note that caregivers were selflessly raising HIV/AIDS orphans without any form of support from members of the extended families.

Further observed from the study is what Fauk *et al.*, (2017) terms communalism, whereby members of the extended family are culturally obliged to be the first source of support to other members in need. In this study, communalism was practised where members who had migrated to neighbouring countries were sending remittances home. This source of support further extends the ability of the caregivers to withstand the burdens of care thus mitigating the breaking down of families as assumed by the social rupture thesis. Though the support from the family might not be enough, it helps to keep the orphans within families.

Another form of support was from NGOs, FBOs, and the government. NGOs, FBOs and the government all adopted a child-centered approach where they support orphans only. The agencies adopted a child-centered approach where aid was availed specifically targeting the orphaned children. Rather than limiting conceptions of the family to the nuclear family model, it is important that programmes aiming to strengthen families affected by HIV/AIDS take cognisance of notions of the family (and household) grounded in people's lived experiences. Such notions may ascribe a more collective understanding of the family than a conjugal unit, which tends to be the case in the West. African orphans mostly reside and are cared for and supported by the extended families. Therefore this study recommends that, the Government, NGOs, and FBOs embrace a family-centered approach.

5.4 Context of caregiving

Bulilima community still believes in the ideals of patrilineal lineages of children as suggested by most caregivers interviewed in this study. They suggested that culturally it is children's father's side that is responsible for orphans, with the eldest son in the family being given the responsibility. Nonetheless, in response to changes of the marriage institute as highlighted in Chapter 2 and the rise of orphans as a result HIV/AIDS, configurations of orphan care that are not in line with patrilineal lineages are occurring in Bulilima District.

To mitigate social rupture, alternative forms of social organisation and with increasingly broad adaptive capacities, are emerging because of the HIV/AIDS crisis. Family relations are being reconfigured and sometimes overstretched to accommodate orphans made vulnerable by HIV/AIDS. Studies across Africa note the same phenomenon of a shift from cultural norm (patrilineal) of orphan care to include affinal as well as matrilineal orphan care for instance Block (2014; 2016) in Lesotho Kasedde, Doyle, Seeley and Ross, (2014) in Uganda; Matshalaga (2004) in Zimbabwe; Nyambetha *et al.*, (2003) in Kenya. While studies describing the care of orphans before HIV/AIDS arrived in Zimbabwe are sparse, there is a reason to believe that matrilineal and affinal orphan care is occurring with increasing frequency as families are becoming more flexible as highlighted in chapter 2 and chapter 4.

The findings obtained are broadly consistent with the major trends which note that within cultures where the traditional way of living is still preserved, orphans are more likely to be fostered within kinship relations. In Zimbabwe, traditional values are still maintained in most rural areas. As such extended family safety nets remain preserved and orphans made vulnerable by HIV/AIDS are fostered within extended families. The study found the extended family is still responsible for orphan care in Bulilima District. Further noted is that though HIV/AIDS orphan care might be a collective and shared responsibility within the extended family network, there is evidence of a shift from purposive fostering to crisis fostering as suggested by some caregivers.

Similar to other studies, about kinship orphan care, women were the primary caregivers for the HIV/AIDS orphans in Bulilima district. The extensive caring responsibilities of the women caregivers reflect the findings from other studies conducted in different countries (for example Balew, Worku, Tilaye, Huruy & Fetene, 2010 in Uganda, Kuo & Operario, 2007; Kiggundu & Oldewage-Theron, 2009 in South Africa). Caregiving work is delegated to women in most societies around the world because men are traditionally in paid work (Glaser, 1987). Scholars such as Fishman (1978) and Glazer (1987) state that child caring is particularly the work of women in many societies around the world because men do not show interest to take part even if they are not in a paid work, as it is low-status work. Women caregivers in this study were providing care to children that were known to them.

Further, data collected suggest that social and cultural contexts of the extended family are central to understand orphan care in Bulilima District. The preference of families to take HIV/AIDS orphans within their households is influenced by not only the vulnerability conditions of the orphans but also the emotional imperatives of those who are raising them.

5.5 Caregiver responsibilities

To understand the caregiver's responsibilities towards the HIV/AIDS orphans they are raising, it is important to establish what care means in the context of HIV/AIDS. According to Block (2014:6), "There are three basic means of contributing to orphan care that permeate the social landscape: material assistance, routinised care that oversees established regimens (such as monitoring ART adherence), and intensive daily physical care, often in response to emergencies such as parental death".

Narrations from informants suggest the economic hardship currently being experienced in Zimbabwe do not necessarily diminish the social and emotional capacity of families to share the non-material resources of care and solace, nor does it damage deeply embedded emotional exchanges with which poor people share in times of need. Thus, contrasting the presumptions of the social rupture thesis which assumes that because of modernisation, financial challenges and burdens of HIV/AIDS the capacity of the extended family to care for orphans made vulnerable by HIV/AIDS is breaking up.

Caregivers' responsibilities included physical and psychological care and support for the HIV/AIDS orphans. Further noted, is the emotional capacity of families to raise orphans as their own children. Consistent with other studies (see for instance Abebe & Aase, 2007; Mohangi 2008), rather than just a mere provision of economic resources, this study demonstrated that caregiving goes beyond the physical work towards the HIV/AIDS orphans. Caregiving is more than the provision of necessities and the daily responsibilities towards the child but involves emotional, social and social parenting.

5.6 Capacity to care

Though families are flexible and fluid and capable of responding to challenges such as the burden of HIV/AIDS, this is unsuccessful at times as noted from the two cases of rupturing families. Along similar lines, instead of total collapse or rupture, as suggested by the rupture thesis, the findings of this study suggest that amidst structural challenges of the HIV/AIDS epidemic harsh economic conditions and persistent droughts rural families are responding with innovative means to adopt children orphaned by HIV/AIDS. Orphans in Bulilima are fostered within a wider network of kin, thus suggesting the concept of family and family relations are productively reconfigured to include a wider network of kin.

From the participants' responses, there are differences in the capacities and resources of extended family households to cater for orphans, thus contradicting the social rupture thesis as well as social resilience theory. Thus, instead of bunching extended families as breaking up because of the HIV/AIDS the epidemic and related structural challenges. It is important to recognise that some households may be emotionally and socially capable of caring for children while not being able to meet the material needs of children. Along similar lines, some families might have the material needs, but without having the emotional and social capabilities to raise orphans. Rather the capacity of families to raise HIV/AIDS orphans should be viewed as a continuum since the family capacity to care is subject to change at any given time and place.

Most caregiving families can be categorised into the transient category. A category characterised by only having the necessities for everyday survival. Thus, if support is not availed, they may sink into rupturing and if support is availed these families are more likely to be adaptive. Further, the study demonstrated that, rather than to look at capacity to care in economic terms as suggested by the social rupture theory, capacity needs to include both social and emotional capacities since these two are significant when raising children.

Pertaining the two theoretical debates on orphan care, contrary to social the rupture thesis, this study demonstrates that the extended family is not rupturing since most of the orphans in Bulilima are cared within the extended family system. However, the

study also acknowledges that families are facing structural challenges of HIV/AIDS epidemic harsh economic conditions and persistent droughts.

5.7 Shared burdensomeness

The orphans in Bulilima District could be categorised into two types, the consuming and contributing orphans. Consuming orphans are what Abebe and Aase (2007) described as less 'resourceful' and rely on caregivers to meet their basic and life needs. Consuming orphans are more likely to be dependent on their caregivers. Unlike the consuming orphans, contributing orphans are active household members who participate in everyday reproductive activities in the household.

The latter category of orphans should not be viewed only as care-recipients, but they can also provide emotional and practical care which is helpful to their caregivers (Barnett and Whiteside, 2002). It seems obvious to argue that, the extent of care that HIV/AIDS orphans can receive from their caregivers is subject to their age and health status. HIV/AIDS-orphaned children need more attention and physical care when they are still young, and over time they can provide caregivers with some crucial assistance.

Further, the researcher argues that rural life is mostly agrarian and subsistence in nature and households survive on what they produce. Orphans too can be active household members by age, where they actively participate in the everyday household production of goods and services for everyday survival. Thus, older orphans need to be acknowledged as contributing agents to household survival. Such an acknowledgement of orphans' agency helps us to move beyond inaccurate understandings of all orphans as a "burden" to "burdened" caregivers, but gives a true image of rural orphans.

5.8 Conclusion

The six themes, generated from Chapter 4 were used to show that within the financial challenges and burdens of the HIV/AIDS epidemic, rural families in Zimbabwe are developing adaptive means to care for HIV/AIDS orphans. In rural areas, the extended family remains a critical safety net of orphan made vulnerable by HIV/AIDS. This study suggests that the extended family system should be viewed realistically, given the structural challenges of HIV/AIDS, harsh economic conditions,

and persistent droughts. Though the extended orphan care is revealing pointers of weaknesses because of structural challenges, the system is not crumbling as reported by the caregivers' emotional and social capacity to raise HIV/AIDS orphans. The researcher, therefore, states that capacity to care and caregivers' experiences be viewed as a continuum rather than being bunched as either rupturing or resilient.

Further noted is, the economic status of the family where the caregiver resides and economic status of the caregivers themselves influence experiences of the primary caregiver raising the HIV/AIDS orphan(s). Thus, augmenting that, orphan care in the Zimbabwean context, is not an exclusive responsibility of caregivers but the entire family. As such, the burdens of supporting orphans lie on the entire family. The next chapter provides an overall conclusion, recommendations and the limitations inherent in this research study.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter presents an outline of the previous chapters. Afterwards, it presents an overview of research findings in relation to the theory of social rupture and social resilience, by it, summarising the research argument made in Chapter 5. The chapter also presents limitations inherent to the study and ends by recommending and highlighting implications for future research.

6.2 Overview of previous chapters

Chapter 1 of this study provided the researcher's view of the problem, which described issues on raising HIV/AIDS orphans by caregivers and provided a justification for the study. The main objective of this study was to answer the question, what are the experiences of caregivers raising HIV/AIDS orphans in a rural area? To answer this question, three research sub-questions were created; 'What are the caregivers' daily responsibilities towards the orphans, 'what are the caregiver' concerns in raising the orphans' and 'what are the social support structures available to caregivers raising HIV/AIDS orphans?'

The significance of the study to the current debates on HIV/AIDS orphan caregiving was explained in chapter 1. The study fills the gap in the literature on caregivers raising HIV/AIDS orphans, in rural areas. Theoretically, the study noted the extended family support system has not yet disintegrated, but it is revealing pointers of weaknesses. Therefore contradicting the pessimistic social rupture thesis as well as the optimistic theory rooted in social resilience. Instead of bunching extended families as breaking up because of the HIV/AIDS epidemic and related structural challenges. It is important to recognise some households may be emotionally and socially capable of caring for children while not able to meet the material needs of children. Thus, the capacity of families to raise HIV/AIDS orphans need to be viewed as a continuum. Since the family capacity to care is subject to change at any given time and place as suggested in Figure 3.

The practical contribution of this study rests in illuminating some of the 'blind spots'; gaps in the study of HIV/AIDS orphans caregiving by noting that orphans are not always consuming. In rural communities, orphans can be active household members who engage in everyday reproductive activities.

Towards policy, the study has the potential to encourage NGO's and other stakeholders to adopt a family-oriented approach when assisting orphans made vulnerable by HIV/AIDS. The reason being, these orphans live and are cared for within the extended families.

Chapter 2 provided insights into the existing literature on HIV/AIDS orphan care. The first section presented a synopsis of the general impacts of HIV/AIDS on children, families, and communities. This section highlighted the macro-context of the HIV/AIDS pandemic and serves as the general setting which reveals a specific aspect, namely the micro-context of this study. The micro-context at issue is the experiences of caregivers raising HIV/AIDS orphaned children. The section that followed dealt with the experiences faced by caregivers raising HIV/AIDS orphans. Within this section, concepts like stigma were explained on how they affect the caregivers. Further discussed was the subject of gender and caregiving. The section also delved into the discussion that studies give only one side of the story when it comes to HIV/AIDS orphan caregiving. In rural areas which are communal, HIV/AIDS orphan caregiving is the family responsibility. Further discussed is the subject, orphans are not all the time burdens as presented in the literature. Further, a discussion on social support structures available to caregivers who are raising the HIV/AIDS orphans was presented. The chapter presented the theoretical framework which informs orphan care in Zimbabwe. An overview of orphan care in Zimbabwe was also discussed in relation to what other scholars have noted about HIV/AIDS. The chapter concluded by looking at the capacity of the extended families raising HIV/AIDS orphans. In this section, the concept of capacity was deconstructed to include aspects such as emotional and social capacity.

Chapter 3 outlined the research methodology employed by this study. The chapter discussed qualitative research design employed in the study as well as how purposive and snowballing sampling methods were employed to recruit the 15 caregivers who partook in this project. The ethical standards that were adhered

throughout the research process were identified and discussed. Moreover, the chapter provided a reflection of the researcher's experience as well as limitations encountered during collecting and analysing data, and how these challenges were managed. The chapter wrapped up with a discussion on the limitations of the research method.

In Chapter 4, the research findings were presented, discussed and compared with existing literature associated with the topic. The findings were presented with reference to the specific themes and subthemes that emerged from the data. The six main themes that were identified are:

1. Caregivers' concerns
2. Caregivers support structures
3. Context of caregiving
4. Caregiver responsibilities
5. Capacity to care
6. Shared burdensomeness

Chapter 5, using the data accumulated from chapter 4 with the literature presented in Chapter 2, showed how the study arrived at the conclusion that, the extended family support system has not yet disintegrated, but it is fairly revealing pointers of weaknesses, therefore contradicting the pessimistic social rupture thesis. The economic status of the family where the caregiver lives, the economic status of the caregivers themselves all influences the experiences of the primary caregiver raising the HIV/AIDS orphan(s).

6.3 Overview of research findings in relation to the theoretical framework

Researchers base their work on certain philosophical perspectives; it may be based on single or more paradigms, depending on the kind of work they are doing. Accordingly, the philosophical assumptions underlying this study come mainly from two opposing concepts of orphan care, the "social rupture thesis" and the "theory of social resilience". The social rupture thesis echoes what the researcher calls "moral panic" surrounding orphanhood, with predictions of the impending collapse of the extended family. The main argument of the social rupture thesis is the extended family is collapsing under the additional strain of HIV/AIDS, thus orphans end into

child-headed households or even in the streets (Chirwa, 2002; Mathambo & Gibbs, 2009). The social resilience theory postulates that families are flexible and constantly developing to meet the demands placed upon them as such social rupture is not apparent (Abebe & Aase, 2007). The premise for using the concepts as theoretical lenses is, in the Zimbabwean context, orphan care is not a sole responsibility of caregivers, but the entire family.

Regardless of the economic challenges being experienced in Zimbabwe, the extended family system is not rupturing as assumed by the social rupture thesis. Since most of the orphans in Bulilima are being cared within the extended family system. However, caregiving families are absorbing and raising HIV/AIDS orphans under difficult circumstances, considering the economic challenges prevailing in Zimbabwe. The study noted the extended family support system in Bulilima has not yet disintegrated but is revealing pointers of weaknesses, thus contradicting the pessimistic social rupture thesis. However, the study also acknowledges that families are facing structural challenges of HIV/AIDS epidemic, harsh economic conditions, and persistent droughts.

6.4 Limitations of this study

This study has its limitations. Firstly, the study utilised purposive sampling. In purposive sampling, the sample size is more of the function of available resources, time constraints, and objectives of a researcher's study. As such, it may not be affirmed the selected participants are representative of the general population of Bulilima District. Equally, the findings of the study may not be generalised to the general population of caregivers at large. However, the study findings can be transferable to caregivers with similar characteristics to the sample.

One of the probable limitations of the study pertains to sample size. The sample size was small since only 15 caregivers were interviewed; thus, the findings have limited generalizability to the entire population of caregivers raising HIV/AIDS orphans. However, in qualitative research, the aim is to gain a deeper understanding of a problem within a specific context. For this reason, the sample size served its purpose and participants yielded an in-depth understanding of caregiver's experiences.

In this study, only caregivers were interviewed, and not the HIV/AIDS orphans. It could have been more informative; if NGO's, FBO's, Government, orphans and other family members had been interviewed too. This could prove an interesting future research.

Since the research is based on a specific case study of Bulilima District, it is important to note the results cannot be representative or generalisable to other rural areas in Matabeleland South and across Zimbabwe. The findings are context specific and they are only applicable to Bulilima District. However, some of the findings may be helpful in uncovering the experiences of HIV/AIDS caregivers as well as revealing the child-centered approach currently adopted by the government and international donors is not the best approach, considering that it is family structures which are caring for orphans.

In qualitative studies, the researcher is the instrument for data analysis. This may be a limitation since the data gathered may be interpreted differently according to other researchers. To guard against subjective interpretation, the researcher relied on reflexivity as discussed in chapter 3.

6.5 Recommendations

From the findings of the study, the following recommendations seek to contribute to a solid foundation for addressing the experiences of caregivers who are raising HIV/AIDS orphans in rural areas. The recommendations are situated within broad categories of policy, research and practice.

It is worrying to note that no support groups exist in Bulilima District, where the research was conducted. Studies (Kiggundu Oldewage-Theron, 2009; Kuo & Operario, 2007) have shown that support groups' play a supportive role when it comes to HIV/AIDS. The study, therefore, recommends that organisations involved in HIV/AIDS programmes assist caregivers in forming support groups in rural areas.

Towards policy, the study recommends that NGOs and FBOs do awareness campaigns on HIV/AIDS in rural areas. It appears that most of the HIV/AIDS awareness campaigns are mainly done in urban areas. Awareness campaigns can be helpful in educating people about the facts of HIV/AIDS. Moreover, this can also go a long way in eradicating the belief in people that HIV/AIDS is a death sentence.

Campaigns should aim at reducing stigma and helping caregivers on how they can inform the HIV/AIDS status of their orphans. Campaigns should also aim at informing the public about the roles and responsibilities of caregivers and how members of the community can assist.

This study notes that, the government and international community organisations assisting children made vulnerable by HIV/AIDS focus their support on affected children only. Seldom have they noted the caregiving families that carry the burdens of caring, supporting and protecting the HIV/AIDS orphaned children. Therefore, this study recommends that organisations involved in assisting orphans made vulnerable by HIV/AIDS adopted a family-centered approach.

The extended family remains a critical safety net for HIV/AIDS orphans in rural areas. This study suggests the extended family orphan care system ought to be viewed realistically given the structural challenges of HIV/AIDS, harsh economic conditions, and persistent droughts. Given the important role of these structural challenges in shaping families' capacities to respond effectively to HIV/AIDS orphan care, economic strengthening is important, as this will improve economic capacity to care.

It appears that caregiving is a female responsibility and a notion rooted in the socially constructed division of labour, a characteristic of rural communities. This study recommends that organisations involved in HIV/AIDS programmes do some awareness campaigns that can encourage men in caregiving. These programmes should aim at deconstructing the social division of labour in rural areas.

Future research that draws on the perspectives of the orphans, and challenges the supposed assumptions that HIV/AIDS orphans are burdens, not resources, is crucial. Further investigations are needed to explain how caregiving challenges impact upon the quality of care. This may even be expanded to encompass the quality of care received to orphans and children of the family. Future research could further assess caregivers' experiences by interviewing all related parties involved in caregiving. That is, interviewing the orphans for the sake of substantiating claims from caregivers, as well as interviewing the NGOs, FBOs and the government departments that are involved in assisting orphans and children made vulnerable by HIV/AIDS.

REFERENCES

- Abebe, T. (2010). Beyond the 'Orphan Burden': Understanding Care for and by AIDS-affected Children in Africa. *Geography Compass*, 4(5): 460–474, 10.1111/j.1749-8198.2009.00301.x 4. 460 - 474. 10.1111/j.1749-81
- Abebe, T., & Aase, A. (2007). Children, AIDS and the politics of orphan care in Ethiopia: The extended family revisited. *Social Science & Medicine*, 64, 2058-2069.
- Abel, N., Barnett, N., Bell, S., & Cross, S. (1998). The impact of AIDS on food production system in East and Central Africa over the next ten years: a programmatic paper. In Fleming, A.F.; Carballo, M; FitzSomons, D.W. et al., (eds). *The global impact of AIDS*, Alan, R. Liss, New York, 145-154.
- Adams, A. M., Cekan, J., & Sauerborn, R. (1998). Towards a conceptual framework of household coping: reflections from rural West Africa. *Journal of the International African Institute*.68 (2):263-283
- Akintola, O. (2005). *Community Responses to HIV/AIDS: The Role of Volunteers in Home based Care for People Living with HIV/AIDS in South Africa*. Research Report for Centre for Civil Society, University of KwaZulu-Natal, Durban, South Africa.
- Amoateng, A.Y., & Richter, L. (2003). *The state of families in South Africa*. In: Daniel, J., Habib, A. & Southall, R. (eds) *State of the nation: South Africa 2003-2004*. Cape Town: HSRC Press.
- Ankrah, E.M. (1993). The impact of HIV/AIDS on the family and other significant relationships: the African clan revisited. *AIDS Care*, 5:5-22.
- Atkinson, R., & Flint, J. (2001). *Accessing hidden and hard-to-reach populations: Snowball research strategies*. *Social Research Update*, 33. Available at <http://sru.soc.surrey.ac.uk/SRU33.pdf> (Assessed on the 15th of May 2016)
- Babbie, E. R. (2016). *The Basics of Social Research*. USA: Cengage Learning.

- Babbie, E., & Mouton, J. (2009). *The practice of social research*. Cape Town: Oxford University Press.
- Backhouse, J. (2006). *Grandparents-as-parents: Social change and its impact on grandparents who are raising their grandchildren*. In Social Change in the 21st Century Conference 2006, 27 October 2006. Carseldine QUT, Brisbane.
- Balew, G., Worku N., Tilaye T., Huruy K., & Fetene T. (2010) Assesment of the household burden of orphaning and coping strategies by guardians and families with orphans and vulnerable children in Hossana Town, SNNPR. *Ethiopian Medical Journal*. 48(3):219-28
- Barnett, T., & Blaikie, B. (1992). *AIDS in Africa – Its present and future impact*. New York: Guilford Press.
- Barnett, T., & Whiteside, A. (2002). *AIDS in the twenty-first century: disease and globalisation*. New York: Palgrave Macmillan.
- Baylies, C. (2002). HIV/AIDS and older women in Zambia: concern for self worry over daughters, towers of strength. *Third World Quarterly-Journal of Emerging Areas*.23 (2), 351-375.
- Biru, M., Lunqvist, P., Molla, M., Jerene, D., & Hallström, I. (2017). Hope for the Future But Fear the Risk of Stigma: Ethiopian Family Caregivers' Lived Experience of Caring for Their HIV Positive Child Two Years After Starting Antiretroviral Treatment. *Comprehensive child and adolescent nursing*, 1-17
- Bless, C., & Higson-Smith, C. (2006). *Fundamentals of social research methods an African perspective*. Cape Town: Juta & Co
- Blinderman, C., & Cherny, N. (2005). Existential issues do not necessarily result in existential suffering: Lessons from cancer patients in Israel. *Palliative Medicine*, 19, 371–380.

- Block, E. (2014). Flexible kinship: caring for AIDS orphans in rural Lesotho. *The Journal of the Royal Anthropological Institute*, 20(4), 711–727. <http://doi.org/10.1111/1467-9655.12131>
- Block, E. (2016). Reconsidering the orphan problem: the emergence of male caregivers in Lesotho, *AIDS Care*, 28:sup4, 30-40, DOI: 10.1080/09540121.2016.1195480
- Bongaarts, J., Pelletier, F., & Garland, P. (2009). *Poverty, gender, and youth. Global trends in AIDS mortality* (Working Paper No. 16). New York: Population Council
- Bourdillon, M.F.C. (1993). *Where are the ancestors: changing culture in Zimbabwe?* Harare: University of Zimbabwe Publications.
- Braun, V. & Clarke, V. (2013). *Successful Qualitative Research: A Practical Guide for Beginners*. India: Sage Publications.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.
- Bray, R. (2003). Predicting the social consequences of orphan hood in South Africa *African Journal of AIDS Research*, 2(1): 39–55
- Bulilima District Situational Report*. (2016). Unpublished document. Department of Social Services Bulilima Office.
- Büssing, A., Fischer, J., Ostermann, T. & Matthiessen, P. (2008). Reliance on God's help: Depression and fatigue in female cancer patients. *International Journal of Psychiatry in Medicine*, 38(3), 357–372.
- Buvinic, M. (1995). *Investing in Women*. Washington, DC: ICRW
- Campbell, C. (2003). *'Letting them die': why HIV/AIDS intervention programmes fail*. Cape Town: Juta.
- Campbell, C., Andersen, L., Mutsikiwa, A., Madanhire, C., Nyamukapa, C., & Gregson, S. (2016). Can Schools Support HIV/AIDS-Affected Children? Exploring the “Ethic of Care” amongst Rural Zimbabwean Teachers. *PLoS ONE*, 11(1), e0146322. <http://doi.org/10.1371/journal.pone.0146322>

- Campbell, C., Skovdal, M., Mupambireyi, Z., Madanhire, C., Nyamukapa, C., & Gregson, S. (2012). Building adherence-competent communities: Factors promoting children's adherence to antiretroviral HIV/AIDS treatment in rural Zimbabwe. *Health & Place*, 18(2), 123–131. <http://doi.org/10.1016/j.healthplace.2011.07.008>
- Chereni, A. & Mahati, S. T. (2014). *South Africa's response to orphans and vulnerable children: A literature review*. Available at <http://hivhealthclearinghouse.unesco.org/library/documents/south-africas-response-orphans-and-vulnerable-children-literature-review> (Assessed on the 1st of December 2016)
- Chirwa, W. C. & Chizimbi, S. (2007). *Supporting care providers to improve lives of children orphaned or made vulnerable by HIV/AIDS*. 1-76, Report to Plan Malawi.
- Chirwa, W. C. (2002). Social exclusion and inclusion: Challenges to orphan care in Malawi. *Nordic Journal of African Studies* 11(1): 93-113
- Chitiyo, J., Chitiyo, A., & Chitiyo, M. (2016). Psychosocial Support for Children Orphaned by HIV/AIDS in Zimbabwe Childhood Education, 92(6), 465-469
- Christensen, L.B. (2001). *Experimental methodology*. (8th ed) Boston: Allyn & Bacon
- Clarke, V. and Braun, V. (2013). Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist*, 26 (2), 120-123.
- Clinton, H. (1996). *It takes a village: And other lessons children teach us*. New York, NY: Simon & Schuster.
- Cluver, L., & Gardner, F. (2007). The mental health of children orphaned by AIDS: A review of international and southern African research. *Journal of Child Adolescent Mental Health*, 19(1), 1-17.
- Cohen, L., Manion, L., & Morrison, K. (2007). *Research methods in education*. (7thed.). London: Routledge.

- Creswell, J.W. (2014). *Research design: qualitative, quantitative and mixed method approaches*. Thousand Oaks, SAGE Publications.
- Cross, C. (2001). "Sinking deeper down": HIV/AIDS as an economic shock to rural households. *Society in Transition*, 32(1): 133-147.
- De Vos, A.S., Strydom, H., Fouché, C.B., & Delport, C.S.L. (2005). *Research at Grassroots for the Social Sciences and Human Service Professions*. (3rd ed). South Africa: Van Schaik Publishers.
- Dear, M. (1988): The postmodern challenge: reconstructing human geography. *Transactions of the Institute of British Geographers*. NS 13, 262-74.
- Denscombe, M. (2010). *The good research guide*. (4th ed). New York: McGraw-Hill.
- Denzin, N. & Lincoln, Y. (Eds) (2nd ed) (2000). *Handbook of Qualitative Research*. London: Sage Publications.
- Denzin, N. K. & Lincoln, Y.S. (Eds) (2003). *The Landscape of qualitative research: Theories and issues*. California: London, Thousand Oaks: Sage.
- Denzin, N., & Lincoln, Y. (Eds) (1994). *Handbook of Qualitative Research*, London: Sage.
- Dowling, M. (2006). Approaches to reflexivity in qualitative research. *Nurse Researcher*, 13(3), 7-21.
- Durand, B. (2007). *The Support and Training of Foster Parents*. Unpublished MA dissertation. The University of Stellenbosch.
- Duri, K., Stray-Pedersen, B., & Muller, F. (2013). HIV/AIDS: The Zimbabwean Situation and Trends. *American Journal of Clinical Medicine Research*. 1(1), 15-22.
- Edwards-Jauch, L. (2009). *The effects of HIV/AIDS-related mortality on family structures in Namibia: selected case studies from Namibian AIDS service organisations*. Unpublished Doctor of Philosophy Dissertation. Windhoek University of Namibia

- Ekstrand, M. (2006). *How does stigma affect HIV prevention and treatment?* University of California, San Francisco: Center for AIDS Prevention Studies (CAPS) and the AIDS Research Institute.
- Ekstrand, M. L., Shet, A., Chandy, S., Singh, G., Shamsundar, R., Madhavan, V., ... Kumarasamy, N. (2011). Suboptimal adherence associated with virological failure and resistance mutations to first-line highly active antiretroviral therapy (HAART) in Bangalore, India. *International Health*, 3(1), 27–34. <http://doi.org/10.1016/j.inhe.2010.11.003>
- Esterberg, K. G. (2001). *Qualitative methods in social research*. Boston: McGraw-Hill.
- Fauk, N. K., Mwakinyali, S. E., Putra, S., & Mwanri, L. (2017). Understanding the strategies employed to cope with increased numbers of AIDS-orphaned children in families in rural settings: a case of Mbeya Rural District, Tanzania. *Infectious Diseases of Poverty*, 6, 21. <http://doi.org/10.1186/s40249-016-0233-7>
- Fishman, P. M. (1978): Interaction: the work women do. *Social Problems*, 25,397-406.
- Fortune, A.E., & Reid W.J. (1999). *Research in Social Work* (3rd ed.). New York: Columbia University Press
- Foster, G. (2000). The capacity of the extended family safety net for orphans in Africa. *Psychology Health and Medicine*, 5(1), 56–62.
- Foster, G. (2002). Supporting community efforts to assist orphans in Africa. *New England Journal of Medicine*, 346, 1907–1910.
- Foster, G., & Williamson, J. (2000). A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa. *AIDS*;14 Suppl 3: S275-84
- Fouche, C.B. & Delport, C.S.L. (2002). Introduction to the research process. In De Vos, A.S., Strydom, H., Fouché, C.B., & Delport, C.S.L. (2002) *Research at*

Grass Roots: For the Social Sciences and Human Services Professions (2nd Edition, pp 77-91). Pretoria: Van Schaik Publishers.

Freeman, M., & Nkomo, N. (2006). Assistance needed for the integration of orphaned and vulnerable children –views of South African family and community members *SAHARA-J*.3(3):504–509.

Friedland, N., Amit, K., Arian, A., Fleischer, N., & Kirschenbaum, A. (2005). *The concept of social resilience*. USA: Samuel Neaman Institute

Fuller-Thomson, E. & Minkler, M. (2000). ‘America’s grandparent caregivers: Who are they?’ In Hayslip, B. & Goldberg-Glen, R. (eds.) *Grandparents raising grandchildren: Theoretical, empirical, and clinical perspectives*. New York: Springer Publishing Co, 3-21.

Ghosh, J. and Kalipeni, E. (2004). *Rising tide of AIDS orphans in Southern Africa*. In Kalipeni, E., Craddock, S., Oppong, J.R. and Ghosh, J. (eds) *HIV/AIDS in Africa: beyond epidemiology*. USA: Blackwell Publishing, 304-315.

Gilbert L., Selikow T.A. & Walker E. (2009). *Society, Health, and Disease in a time of HIV/AIDS*. Johannesburg: Macmillan

Gilbert, L. (2016). The mercurial piece of the puzzle’: Understanding stigma and HIV/AIDS in South Africa *SAHARA-J: Journal of Social Aspects of HIV/AIDS*, 13:1,8-16, DOI: 10.1080/17290376.2015.1130644

Gilbert, L., & Walker, L. (2010). “My biggest fear was that people would reject me once they knew my status...”—Stigma as experienced by patients in an HIV/AIDS clinic in Johannesburg, South Africa. *Health & Social Care in the Community*. 18:139–146. doi: 10.1111/j.1365-2524.2009.00881. x.

Gilbert, L., & Walker, L. (2010). “My biggest fear was that people would reject me once they knew my status...”—Stigma as experienced by patients in an HIV/AIDS clinic in Johannesburg, South Africa. *Health & Social Care in the Community*. 18:139–146. doi: 10.1111/j.1365-2524.2009.00881. x.

- Gilborn, L. Z. (2002). In the public eye beyond our borders the effects of HIV infection and AIDS on children in Africa. *West J Med*; 176:12-14
- Glaser, N. Y. (1987). Servants to capital: unpaid domestic labour and paid work. In Gerstel N and Gross, H (ed.) (1987): *Families and Work*. Philadelphia: Temple University Press.
- Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. New Jersey: Prentice Hall.
- Gono, M. (2015). *The experiences, challenges and coping resources of AIDS-orphans heading households in an urban area in the Free State*. Unpublished Master of Social Work Dissertation. Pretoria: University of South Africa
- Gow, J. & Desmond, C. (eds.). (2002). *Impacts and interventions: The HIV and AIDS epidemic and the children of South Africa*. Pietermaritzburg: University of Natal Press.
- Gravetter, F.J. & Forzano, L. B. (2011). *Research methods for the behavioural sciences*. Belmont: Wadsworth Thomson Learning.
- Grinyer, A. (2002). The anonymity of research participants: Assumptions, ethics, and practicalities. *Social Research Update*; 36:1–4.
- Gumede, N.V. (2003). *The attitudes of primary caregivers towards caring for HIV/AIDS orphans in the Ingwavuma district*. Unpublished Master of Arts in Community Work Dissertation. Durban: University of Zululand
- Hearle, C., & Ruwanpura, K.N. (2009). Contentious Care: Foster Care Grants and the Caregiver-Orphan Relationship in KwaZulu-Natal Province, South Africa. *Oxford Development Studies*, 37(4), 423-436.
- Help Age International. (2003). *Forgotten families Older people as carers of orphans and vulnerable children*. Available at <http://www.bettercarenetwork.org/sites/default/files/Forgotten%20Families%200%20Older%20People%20as%20Carers%20of%20Orphans%20and%20Vulnerable%20Children.pdf> (Assessed on the 12th of March 2016).

- Henning, E., van Rensburg, W., & Smit, B. (2008). *Finding your way in qualitative research*. Pretoria: Van Schaik Publishers.
- Herek, G.M. (1999). AIDS and stigma. *American Behavioral Scientist*.42(7):1106–1116.
- Hlabiyago, K., E & Ogunbanjo, G., A (2009). The experiences of family caregivers concerning their care of HIV/AIDS orphans. *SA Fam Pract*.51(6):506-511.
- Hong, Y., Chi, P., Li, X., Zhao, G., Zhao, J., Stanton, B., & Li, L. (2015). Community-based family-style group homes for children orphaned by AIDS in rural China: an ethnographic investigation. *Health Policy and Planning*, 30(7), 928–937. <http://doi.org/10.1093/heapol/czu093>
- Hosegood, V. (2009). The demographic impact of HIV and AIDS across the family and household life-cycle: implications for efforts to strengthen families in sub-Saharan Africa. *AIDS Care*, 21(Suppl 1), 13–21. <http://doi.org/10.1080/09540120902923063>
- Howard, B. H., Phillips, C. V., Matinhure, N., Goodman, K. J., McCurdy, S. A., & Johnson, C. A. (2006). Barriers and incentives to orphan care in a time of AIDS and economic crisis: a cross-sectional survey of caregivers in rural Zimbabwe. *BMC Public Health*, 6, 27. <http://doi.org/10.1186/1471-2458-6-27>
- Hunter, M. (2006). Fathers without amandla: Zulu-speaking men and fatherhood. In L. Richter, & R. Morrell (Eds.), *Baba: Men and fatherhood in South Africa* (pp. 99–107). Cape Town: HSRC Press.
- Hunter, S. & Williamson, J. (2002). *Children on the brink. Strategies to support children isolated by HIV/AIDS*. Washington, DC: USAID.
- Hunter, S. (1990) Orphans as a window on the AIDS epidemic in sub-Saharan Africa: initial results and implications of a study in Uganda. *Social Science and Medicine*, 31(3), 681-690
- Jacobs, M., Shung-King, M., & Smith, C. (eds). (2005). *South African Child Gauge 2005*. Cape Town: Children’s Institute, University of Cape Town

- Ji, G., Li, L., Lin, C., & Sun, S. (2007). The impact of HIV/AIDS on families and children -a study in China. *AIDS (London, England)*, 21(Suppl 8), S157. <http://doi.org/10.1097/01.aids.0000304712.87164.42>
- Joint United Nations Programme on HIV & AIDS (UNAIDS). (2008). *Report on the Global Aids Epidemic: The impact of AIDS on people and societies*. Available at http://data.unaids.org/pub/GlobalReport/2006/2006_GR_CH04_en.pdf (Assessed on the 02nd of April 2016).
- Joint United Nations Programme on HIV & AIDS (UNAIDS). (2016). *Global AIDS Response Progress Report 2015*. Available at http://www.unaids.org/sites/default/files/country/documents/ZWE_narrative_report_2015.pdf (Assessed on the 29th of February 2016).
- Kaiser, K. (2009). Protecting Respondent Confidentiality in Qualitative Research. *Qual Health Res*. November; 19(11): 1632–1641.
- Kalembe, E. (2000). *The Challenge of Increasing Numbers of Orphaned Children in Africa: What needs to be done?* Seminar Paper, Chancellor College, Department of Sociology.
- Karimli, L., Ssewamala, F. M., & Ismayilova, L. (2012). Extended families and perceived caregiver support to AIDS orphans in Rakai district of Uganda. *Children and Youth Services Review*, 34(7), 1351–1358. <http://doi.org/10.1016/j.childyouth.2012.03.015>
- Kasedde, S., Doyle, A. M., Seeley, J. A., & Ross, D. A. (2014). They are not always a burden: Older people and child fostering in Uganda during the HIV epidemic. *Social Science & Medicine* (1982), 113(100), 161–168. <http://doi.org/10.1016/j.socscimed.2014.05.002>
- Kayongo-Male, H., & Onyango, P. (1984). *The sociology of the African family*. London. Longman Publishing Group.
- Kelley, S. & Whitley, D. (2003). Psychological distress and physical health problems in grandparents raising grandchildren: Development of an empirically based

- intervention model. " In Hayslip, B. & Patrick, J. H. (eds.) *Working with Custodial Grandparents*. New York: Springer Publishing Co, 127-144.
- Kerina, D., Babill, S., & Muller F, M. (2013). HIV/AIDS: The Zimbabwean Situation and Trends. *American Journal of Clinical Medicine Research*, 1(1), 15-22.
- Kharsany, A. B. M., & Karim, Q. A. (2016). HIV Infection and AIDS in Sub-Saharan Africa: Current status, challenges, and opportunities. *The Open AIDS Journal*, 10, 34–48. <http://doi.org/10.2174/1874613601610010034>
- Kiggundu, E., & Oldewage-Theron, W. (2009). Coping: a challenge for guardians of children orphaned by HIV/AIDS in a South African Township. *Development Southern Africa*. Vol. 26(3), 383-397.
- Kimane I. (2005). *Protecting orphaned children through legislation: The case of Lesotho*. A paper presented at the 4th World Congress on Family Law and Children's Rights, 20–23 March 2005, Cape Town, South Africa.
- Knodel, J., Kespichayawattana, J., Saengtienchai, C., & Wiwathwanich, S. (2009). Older-age parents and the AIDS epidemic in Thailand: Changing impacts in the era of antiretroviral therapy. UNESCAP. Available at <http://www.unescap.org/ESID/psis/Ageing/publications/> (Assessed on the 6th of June 2016)
- Kumar, R. (2014). *Research Methodology: A Step-by-Step Guide for Beginners*. New Delhi: Sage
- Kuo, C., & Operario, D. (2007). *Challenging dominant policy paradigms of care for children orphaned by AIDS: Dynamic patterns of care in KwaZulu-Natal Republic of South Africa*. South Africa, Centre for Social Science Research, AIDS and Society Research Unit, 1-32, Working paper No. 205.
- Kuo, C., & Operario, D. (2009). Caring for AIDS-orphaned children: A systematic review of studies on caregivers. *Vulnerable Children and Youth Studies*, 4(1), 1–12.

- Kuo, C., & Operario, D. (2010). Caring for AIDS-orphaned children: an exploratory study of challenges faced by carers in KwaZulu-Natal, South Africa. *Vulnerable Children and Youth Studies*, 5(4), 344–352. <http://doi.org/10.1080/17450128.2010.516372>
- Kuo, C., & Operario, D. (2011). Health of adults caring for orphaned children in an HIV endemic community in South Africa. *AIDS Care*, 23(9), 1128–1135.
- Lambert, C; Jomeen, J & McSherry, W. (2010). Reflexivity: a review of the literature in the context of midwifery research. *British Journal of Midwifery*, 18(5), 321–326.
- Levine, C. (1995). Today's challenges, tomorrow's dilemmas. In Geballe, S, Gruendel, J., and Adiman, W. (eds) (1995). *Forgotten children of the AIDS epidemic*. USA: Yale University Press, New Haven.
- Leyenaar, J. K. (2005). HIV/AIDS and Africa's orphan crisis. *Paediatrics & Child Health*, 10(5), 259–260.
- Lyons, M. (2008). *Impact of HIV and AIDS on Children, Families, and Communities: Risks and Realities of Childhood during the HIV Epidemic*. HIV and development programme Issues Paper No. 30. Available at <http://www.undp.org/hiv/publications/issues/english/issue30e.html> (Assessed on the 18th of April 2016)
- Madhavan, S. (2004). Fosterage patterns in the age of AIDS: Continuity and change. *Social Science & Medicine*, 58, 1443-1454.
- Madhavan, S. (2004). Fosterage patterns in the age of AIDS: Continuity and change. *Social Science & Medicine*, 58, 1443-1454.
- Mafumbate, R. (2013) Sustainability of the Role of Extended Families on Orphan Care in the Era of HIV and AIDS in the Zimbabwean Society. *Journal of Emerging Trends in Educational Research and Policy Studies* 5(1): 91-99

- Mafumbate, R. (2013) Sustainability of the Role of Extended Families on Orphan Care in the Era of HIV and AIDS in the Zimbabwean Society. *Journal of Emerging Trends in Educational Research and Policy Studies* 5(1): 91-99
- Magwa, S., & Magwa, W. (2016). Challenges Affecting Schooling Faced By Child-Head Families: A Study of perceptions by teachers, parents, and learners in Masvingo District. *European Journal of Research and Reflection in Educational Sciences*. 4(10):19-27
- Mahajan, A. P., Sayles, J. N., Patel, V. A., Remien, R. H., Ortiz, D., Szekeres, G., & Coates, T. J. (2008). Stigma in the HIV/AIDS epidemic: A review of the literature and recommendations for the way forward. *AIDS (London, England)*, 22(Suppl 2), S67–S79. <http://doi.org/10.1097/01.aids.0000327438.13291.62>
- Mahati, S.T., Chandiwana, B., Munyati, S., Chitiyo, G., Mashange, W., Chibatamoto, P., & Mupambireyi, P., F. (2006). *A qualitative assessment of orphans and vulnerable children in two Zimbabwean Districts South Africa*. Cape Town: HSRC Press.
- Mailula, G., S. (2012). *Listening to stories of AIDS Orphans: Cry in the ghetto: The narratives of children affected by HIV and AIDS*. United Kingdom: LAP LAMBERT Academic Publishing.
- Mangal S. K., & Mangal, S. (2013). *Research Methodology in Behavioral Sciences*. India: Prentice-Hall.
- Mangena, T. and Ndlovu, S. (2013). Implications and complications of bride price payment among the Shona and Ndebele of Zimbabwe. *International Journal of Asian Social Science*.3 (2): 472-481
- Maree, K. (ed). (2007). *First Steps in Research*. Pretoria: Van Schaik
- Mason, J. (1996). *Qualitative researching*. Thousand Oaks, CA: Sage.
- Mathambo, V., & Gibbs, A. (2008). *Qualitative accounts of family and households' changes in response to the effects of HIV and AIDS: A review with pointers to action*. Joint Learning Initiative on Children and HIV/AIDS. Available at www.jlica.org on the (Assessed on the 21st of May 2016)

- Mathambo, V., & Gibbs, A. (2009). Extended family childcare arrangements in a context of AIDS: collapse or adaptation? *AIDS Care*, 21(S1), 22–27. <http://doi.org/10.1080/09540120902942949>
- Matsa, M., & Simphiwe, M. (2014). Grappling climate change in southern Zimbabwe: The experience of bakalanga minority farmers. *Sacha Journal of Environmental Studies*, 4(1) 34-52
- Matshalanga, N. (2004). *Grandmother and orphans care in Zimbabwe*. Harare: SAFAIDS.
- Matshalanga, N., & Powell, G. (2000). *Community-based Orphan Care Program: Zimbabwe's Approach Theca*. New York: Institute for African Development, Cornell University.
- Matshalanga, N., & Powell, G. (2002). Mass orphanhood in the era of HIV/AIDS Bold support for alleviation of poverty and education may avert a social disaster *BMJ*.324:185–186
- May, J. (1983). *Zimbabwean women in colonial and customary law*. Gweru: Mambo Press
- McEnery, T., & Wilson, A. (2001). *Corpus Linguistics; An Introduction*. Edinburgh: Edinburgh University Press
- McKerrow, N.H., & Verbeek, A., E. (1995). *Models of care for children in distress*. Pietermaritzburg: KwaZulu-Natal
- Meekers, D. (1992). The Process of Marriage in African Societies: A Multiple Indicator Approach. *Population and Development Review*.18 (1):61-78.
- Merriam, S. (2009). *Qualitative Research: A Guide to Design and Implementation*. San Francisco, CA: John Wiley & Sons.
- Meursing, K. J. (1997). *A world of silence: living with HIV in Matabeleland, Zimbabwe*. Amsterdam: Royal Tropical Institute.
- Ministry of Health and Child Welfare (MHCW) & National Aids Council (NAC), (2004). *The HIV and AIDS Epidemic in Zimbabwe Where Are We Now?*

Where Are We Going? Available at <http://www.sarpn.org/documents/d0000989/P1107-PNADA504.pdf> (Assessed on the 15th of March 2016).

Mkabela, N. Q. & Lithuli, P.C. (1997). *Towards an African Philosophy of Education*. Durban: Kagiso Publishers.

Mohale, N.F. (2013). *The Burden of Grandparenting: Caring for Aids-Orphaned Grandchildren in Lephalale, South Africa*. Unpublished Master of Arts in Psychology Dissertation. Limpopo: University of Limpopo

Mohangi, K. (2008). *Finding roses amongst thorns: How institutionalised children negotiate pathways to well-being while affected by HIV/AIDS*. Unpublished Doctoral thesis. University of Pretoria.

Morantz, G., Cole, D., Vreeman, R., Ayaya, S., Ayuku, D., & Braitstein, P. (2013). Child abuse and neglect among orphaned children and youth living in extended families in sub-Saharan Africa: What have we learned from qualitative inquiry? *Vulnerable Children and Youth Studies*, 8(4), 338–352.

Mouton, J. (1996). *Understanding Social Research*. Pretoria: Van Schaik Publishers

Mturi, A.K., Xaba, T., & Sekokotla, D. (2005). *Assessment of circumstances facing contemporary families in South Africa*. Durban, South Africa: School of Development Studies, University of KwaZulu-Natal.

Mudavanhu, D., Segalo, P. & Fourie, E. (2008). *Grandmothers caring for their grandchildren orphaned by HIV and AIDS* available at: http://www.unisa.ac.za/contents/faculties/humanities/psy/docs/2008%20vol%204_1/Mudavanhu.pdf on (Accessed on the 1st April 2016)

Muhadisa, T.C. (2012). *Psychosocial effects of parental loss on children orphaned by HIV and AIDS: perspectives from caregivers*. Unpublished Master of Arts in Clinical Psychology Dissertation. Pretoria: University of South Africa

- Munthali, A. & Ali, S.J. (2000). *Adaptive strategies and coping mechanisms: the effect of HIV/AIDS on the informal social security system in Malawi*. Lilongwe: National Economic Council.
- Musavengana W.T., Chibwana M.W.T., & Gumbo, N. (2014). *Assessment report of the alternative care system of children in Zimbabwe*. Austria: SOS Children's Villages International available at https://www.google.com/search?q=Musavengana+Chibwana+%26+Gumbo,+2014&ie=utf-8&oe=utf-8&client=firefox-b&gfe_rd=cr&ei=eGzaWMzFDoKp8wfmrbHQBA (Accessed on the 29th of July 2016)
- Musick, M. A. (1996) Religion and subjective health among black and white elders. *Journal of Health and Social Behavior*. 37,221–237
- Mutangadura, G., Mukurazita, G., & Jackson, H. (1999). *A review of household and community responses to the HIV/AIDS epidemic in the rural area of Sub-Saharan Africa*. Geneva: UNAIDS.
- Myers, M. D. (2009). *Qualitative Research in Business & Management*. London: Sage.
- National Aids Council (NAC) (2016a) *Bulilima-Mangwe HIV/AIDS statistics*. Unpublished document. NAC Bulilima-Mangwe Office
- National Aids Council (NAC). (2016b). *Zimbabwe AIDS Response Country Progress Report 2015* available at <http://www.nac.org.zw/sites/default/files/Final%202015%20GARPR%20Report%20-%2031%20March%202015%20fc.pdf> (Assessed on 29th of February 2016)
- National Planning Commission. (2011). *National development plan: Vision 2030*. Pretoria: NPC.
- Neuman, W.L. (2014). *Social research methods: qualitative and quantitative approaches*, (7th ed.). Boston: Pearson Education Inc.

- Newman, C. J., Fogarty, L., Makoe, L. N., & Reavely, E. (2011). Occupational segregation, gender essentialism, and male primacy as major barriers to equity in HIV/AIDS caregiving: Findings from Lesotho. *International Journal for Equity in Health*, 10(24): 1-13.
- Nixon, S. (1997). The limits of support in foster care. *British Journal of Social Work*, 27(6), 913-930.
- Nkosinathi, M., & Mtshali, G. (2016). Role Reversal of Rural Black Grandparents in South Africa. *Journal of Comparative Family Studies*.47(3)369-377.
- Nyambedha, E., Wandibba, S., & Aagaard-Hansen, J. (2003a). Changing patterns of orphan care due to the HIV epidemic in Western Kenya. *Social Science & Medicine*, 57(2), 301-311.
- Nyambedha, E.O., Wandibba, S., & Aagaard-Hansen, J.(2003b). "Retirement Lost"—The New Role of the Elderly as Caretakers for Orphans in Western Kenya. *Journal of Cross-Cultural Gerontology* 18: 33. doi:10.1023/A:1024826528476
- Nyamukapa, C., & Gregson, S. (2005). Extended family and women's roles in safeguarding orphans' education in AIDS-afflicted rural Zimbabwe. *Social Science and Medicine*, 60, 2155-2167.
- Nyasani, E., Sterberg, E., & Smith, H. (2009). Fostering children affected by AIDS in Richards Bay, South Africa: A qualitative study of grandparents' experiences. *African Journal of AIDS Research*, 8(2), 181-192.
- Ogunmefun, C., Gilbert, L., & Schatz, E. (2011). Older Female Caregivers and HIV/AIDS-Related Secondary Stigma in Rural South Africa. *Journal of Cross-Cultural Gerontology*, 26(1), 85–102. <http://doi.org/10.1007/s10823-010-9129-3>
- Oleke, C., Blystad, A., & Rekdal, O. B. (2005). "When the obvious brother is not there": Political and cultural contexts of the orphan challenge in northern Uganda. *Social Science & Medicine*, 61(12), 2628-2638.

- Omwa, S.S., & Titeca, K. (2011). *Community-based Initiatives In response to the OVC crisis in North Central Uganda*. Belgium: Belgium Institute for Development Policy and Management
- Oni, J. (1995). Fostered children's perception of their health care and illness treatment in Ekiti Yoruba households, *N. Health Transition Review*, 5, 21-34.
- Oni, S., Obi, C., Okorie, A., Thabede, D., & Jordan, D. (2002). 'Economic Impact of HIV/AIDS on Rural Households, Small Holder Agricultural Production and Orphans in the Limpopo Province of South Africa,' *South African Journal of Economics: Special Issue on the Economics of HIV/AIDS* 70 (7): 1173-1192.
- Osafo, J., Knizek, B. L., Mugisha, J., & Kinyanda, E. (2017). The experiences of caregivers of children living with HIV and AIDS in Uganda: a qualitative study. *Globalization and Health*, 13, 72. <http://doi.org/10.1186/s12992-017-0294-9>
- Palaganas, E. C., Caricativo, R. D., Sanchez, M. C., & Molintas, M. V. P. (2017). Reflexivity in qualitative research: A journey of learning. *The Qualitative Report*, 22(2), 426-438. Retrieved from <http://nsuworks.nova.edu/tqr/vol22/iss2/5>
- Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health*, 42(5), 533–544.
- Parker, I. (1999). Critical reflexive humanism and critical constructionist psychology. In: Nightingale D, Cromby J, eds. *Social constructionist psychology a critical analysis of theory and practice* (23–36). Buckingham: Open University Press,
- Patton, M. Q. (2002). *Qualitative Research & Evaluation Methods*. (3rd ed). California: Sage Publications, Inc.
- Pearlin, L., Scholler, C. (1978). The Structure of Coping. *Journal of Health and Social Behavior*. 19:2-21.
- Phetlhu, D. R., & Watson, M. (2014). Challenges faced by grandparents caring for AIDS orphans in Koster, North West Province of South Africa. *African Journal*

for Physical, Health Education, Recreation and Dance (AJPHERD)
Supplement 1:2.348-359.

Poku, N. K. (2005). *AIDS in Africa: How the poor are dying*. Cambridge UK: Polity

Powell R.A., & Hunt, J. (2013). Family caregiving in the context of HIV/AIDS in Africa. *Progress in Palliative Care*, 21, 13–21.

Punch, K. (1998). *Introduction to Social Research: Quantitative and Qualitative Approaches*. London: Sage.

Raina, P., O'Donnell, M., Schwellnus, H., Rosenbaum, P., King, G., Brehaut, J., Wood, E. (2004). Caregiving process and caregiver burden: Conceptual models to guide research and practice. *BMC Pediatrics*, 4, 1. <http://doi.org/10.1186/1471-2431-4-1>

Rajcoomar, U. (2005). *Has the impact of HIV and AIDS affected the lives of rural 'gogos'?* Available at www.oxfam.org.au/world/africa/south_africa/lawyershumanrights.pdf (Assessed on the 29th of March 2016)

Richter, L. M., & Desmond, C. (2008). Targeting AIDS orphans and child-headed households? A perspective from national surveys in South Africa, 1995–2005. *AIDS Care*, 20(9), 1019–1028.

Richter, L. M., Sherr, L., Adato, M., Belsey, M., Chandan, U., Desmond, C., Wakhweya, A. (2009). Strengthening families to support children affected by HIV and AIDS. *AIDS Care*, 21(S1), 3–12. <http://doi.org/10.1080/09540120902923121>

Richter, L., Manegold, J & Pather, R. (2004). *Family and Community Interventions for children affected by AIDS*. Cape Town: HSRC

Rosenberg, A., Hartwig, K., & Merson, M. (2008). Government–NGO collaboration and sustainability of orphans and vulnerable children projects in southern Africa. *Evaluation and program planning*, 31, 51-60. doi: 10.1016/j.evalprogplan.2007.08.005

- Safman, R. M. (2004). Assessing the impact of orphanhood on Thai children affected by AIDS and their caregivers. *AIDS Care*, 16(1), 11–19.
- Schurink, W. (2003). Qualitative research in management and organisational studies with reference to recent South African research. *SA Journal of Human Resource Management*, 1 (3), 2-14.
- Seeley, J. & Kajura, E. (1993). The extended family and support for people with AIDS in rural populations in south-west Uganda. A safety net with holes? *AIDS Care*, 5, 17-23.
- Shefer, T., Crawford, M., Strebel, A., Simbayi, L. C., Dwadwa- Henda, N., Cloete, A., Sherman, Robert R., & Webb, Rodman B. (Eds.). (1988) *Qualitative Research in Education: Focus and Methods*. London: Palmer Press.
- Sieber J. (1992). *Planning ethically responsible research: A guide for students and internal review boards*. Newbury Park: Sage.
- Sigwana-Ndulo, N. (1998). Rural African family structure in the Eastern Cape Province, South Africa. *Journal of Comparative Family Studies*, 29,407-417
- Singleton, R., Straits, B. C., Straits, M. M., & McAllister, R. J. (1988). *Approaches to social research*. New York: Oxford University Press.
- Sivard, R.L., Brauer, A & Cook, R. (1995). *Women... a World Survey*. Washington, DC: World Priorities.
- Skovdal, M., Campbell, C., Madanhire, C., Nyamukapa, C., & Gregson, S. (2011). Challenges faced by elderly guardians in sustaining the adherence to antiretroviral therapy in HIV-infected children in Zimbabwe, *AIDS Care*, 23(8), 957-964. Doi:10.1080/09540121.2010.542298
- Skovdal, M; Campbell, C; Nhongo, K; Nyamukapa, and Gregson, S. (2011). Contextual and psychosocial influences on antiretroviral therapy adherence in rural Zimbabwe: towards a systematic framework for programme planners. *Int J Health Plann Mgmt*. 26: 296–318.

- Smith, C. J., Beltran, A., Butts, D. M. & Kingson, E. R. (2000). Grandparents raising grandchildren: Emerging program and policy issues for the 21st century. *Journal of Gerontological Social Work*, 34(1): 81-94.
- Smith, H., Chiroro, P., & Musker P (2012) Process And Impact Evaluation Of The Basic Education Assistance Module (BEAM) In Zimbabwe Final Evaluation Report. Available at www.unicef.org/evaldatabase/index_69966. (Assessed 18th of January 2016)
- Ssengonzi, R. (2009). The impact of HIV/AIDS on the living arrangements and well-being of elderly caregivers in rural Uganda. *AIDS Care*, 21(3), 309-314.
- Steinberg, M, Johnson, S, Schierhout, G, Ndegwa, D. (2002). *Hitting Home. How Households cope With the Impact of The HIV and AIDS Epidemic. A Survey of Households Affected by HIV and AIDS in South Africa*. Washington DC: Henry J. Kaiser Family Foundation
- Strydom, H. & Venter, L. (2002). *Sampling and sampling methods*. In De Vos, A.S. (2002). *Research at Grass Roots: For the Social Sciences and Human Services Professions*. (p. 197-209). 2nd ed. Pretoria: Van Schaik Publishers.
- Strydom, H. (2011). *Single-system design*. In De Vos, A.S. et al. (2011). *Research at grass roots: for the social sciences and human service professions*. (pp. 159-170). Pretoria: Van Schaik Publishers.
- Strydom, H., & Delport, C. (2011). Sampling and pilot study in qualitative research. In A.S. de Vos, H. Strydom, C. Fouche & C. Delport, (Eds.), *Research at grass roots: For the social sciences and human service professions* (4th ed., pp. 390–396). Pretoria: Van Schaik Publisher.
- Tanga, P., T. (2013). The impact of the declining extended family support system on the education of orphans in Lesotho. *African Journal of AIDS Research*, 12(3): 173–183
- Taukeni, S., G. (2013). Accessing Child Welfare Grants to Meet Orphan Children School Needs: Namibia and South Africa Perspective. *US-China Education Review*, 3(9), 716-721.

- Terre Blanche, M., Durrheim, K. & Painter, D (Eds) (2006). *Research in Practice: Applied Methods for the Social Sciences*. Cape Town: University of Cape Town Press
- Thoits, P.A. (1986). "Social support as coping assistance". *Journal of Consulting and Clinical Psychology*. 54: 416–423. doi:10.1037/0022-006x.54.4.416.
- Thurman, T., Jarabi, B., & Rice, J. (2012). Caring for the caregiver: Evaluation of support groups for guardians of orphans and vulnerable children in Kenya. *AIDS Care*, 24(7), 811–819.
- Townsend, L., & Dawes, A. (2007). Intentions to care for children orphaned by HIV/AIDS: A test of the theory of planned behaviour. *Journal of Applied Social Psychology*, 37(4), 822-843.
- Ulin, P. (1992). African women and AIDS: negotiating behavioural change. *Social Science and Medicine*, 34, 63-73.
- United Kingdom Consortium on AIDS and International Development (UKCID). (2012). *Past due: remuneration and social protection for caregivers in the context of HIV and AIDS*. London: United Kingdom Consortium on AIDS and International Development:
- United Nations Children's Emergency Fund (UNICEF). (2003). *Africa's Orphaned Generations*. Available at http://www.unicef.org/sowc06/pdfs/africas_orphans.pdf (Assessed on the 31st of March 2016)
- United Nations Children's Emergency Fund (UNICEF). (2006). *Africa's orphaned and vulnerable generations: Children affected by AIDS*. New York: United Nations Children's Fund. Available at http://www.unicef.org/publications/files/Africas_Orphaned_and_Vulnerable_Generations_Children_Affected_by_AIDS.pdf (Assessed on the 16th of June 2016)

- United Nations Children's Emergency Fund (UNICEF). (2016). *Orphan*. Available at http://www.unicef.org/media/media_45279.html (Assessed on the 3rd of April 2016)
- United Nations Children's Emergency Fund (UNICEF). (2016). *Zimbabwe Humanitarian Situation Report No 2 29 February 2016*. Available at https://www.unicef.org/zimbabwe/UNICEF_Zimbabwe_Humanitarian_SitRep2_-_29_Feb_2016.pdf.(Assessed 23 March 2017)
- United Nations Development Programme (UNDP). (2015). *Human Development Report, Work for Human Development*. Available at http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/ZWE.pdf (Assessed on the 24th of April 2016)
- Van Dyk, A.C. (2010). *HIV/AIDS Care & Counselling: A multidisciplinary approach* (4th Ed.). Cape Town: Pearson Education.
- Verhoef, H. (2005). A child has many mothers': Views of child fostering in northwestern Cameroon. *Childhood*.12 (3):369–390.
- Vogt, W.P., (1999). *Dictionary of statistics and methodology—A Nontechnical Guide for the Social Sciences*. London: Sage.
- Warwick, J. (2013). *An explorative study of the experiences and needs of foster carers of HIV-positive children in the Western Cape, South Africa*. Unpublished BSocSc (Hons) in Social Work Dissertation. Cape Town: University of Cape Town
- Wattradul, D., & Sriyaporn, A. (2014). Experiences of Caregivers in Healthcare for and Social Support of HIV Positive Children Attending Schools in Bangkok. *Asian Nursing Research*. 8 (3), 226–231.
- Webb, D. (1997). *HIV and AIDS in Africa*. London: Pluto Press.
- Williams, N., Knodel, J., Kim, S., Puch, S., & Saengtienchai, C. (2008). Overlooked potential: Older-age parents in the era of ART. *AIDS Care*, 20(10), 1169-1176.

- World Health Organization (WHO) (2017). *HIV/AIDS Factsheet*. Available at <http://www.who.int/mediacentre/factsheets/fs360/en/> (Assessed 1st of July 2017)
- Yarney, L., Mba, C., & Asampong, E. (2015). Qualitative study on the socio-cultural determinants of care of children orphaned by AIDS in the Ashanti and Eastern regions of Ghana. *BMC Public Health*, 15, 6. <http://doi.org/10.1186/s12889-014-1332-7>
- Young, L & Ansell, N. (2003). Fluid households, complex families: the impact of children's migration as a response to HIV/AIDS in southern Africa. *The Professional Geographer*, 554 (4), 464-479
- Zagheni, E. (2011). The impact of the HIV/AIDS epidemic on kinship resources for orphans in Zimbabwe. *Popul Dev Rev* 37: 761–783.
- Zhang, L., Li, X., Kaljee, L., Fang, X., Lin, X., Zhao, G., Zhao, J., & Hong, Y. (2009). I felt I have grown up as an adult': caregiving experience of children affected by HIV/AIDS in China. *Child: Care, Health and Development* 35(4):542-550. doi: 10.1111/j.1365-22 14.2009.00973.x.
- Zimbabwe National Statistics Agency (ZimStat). (2016). *Zimbabwe Population Census 2012* retrieved from the World Wide Web http://www.zimstat.co.zw/sites/default/files/img/National_Report.pdf on 5th of March 2016
- Zimmerman, M.A. (2013). Resiliency theory: a strengths-based approach to research and practice for adolescent health. *Health, Education, and Behaviour*, 40(4):381-383.
- Zvinavashe, M., Mukombwe, O., Mukona, D., & Haruzivishe, C. (2015). Coping Strategies of Caregivers of HIV/AIDS Orphans in Ward 15 Bikita District, Masvingo Province, Zimbabwe. *Nova J Med Biol Sci*. Volume 4, Issue 4

APPENDICES

Appendix A: Consent Form

Consent to participate in the research study as well as to audio-record the interview.

I, _____ hereby consent to participate in Elias Maronganye research study entitled, “Experiences of caregivers raising HIV/AIDS-orphans in Bulilima District Matabeleland South Province Zimbabwe”. I understand that there will be neither direct nor indirect benefits for participating in this study and that there are no any likely risks involved. I understand that participation is voluntary, and I am free to withdraw from the study at any time.

I have been given sufficient information about this research project. The purpose of my participation as an interviewee in this project has been explained to me.

I have been guaranteed that the researcher will not identify me by name.

I have understood the contents of the Participant Information Sheet, my questions about participation in this study have been answered satisfactorily, and I am aware of the risks and benefits of participating in the study.

Signed: _____ Date: _____

Consent for audio recording the Interview

I _____ hereby give the researcher Elias Maronganye permission to audio-record the interview of the study entitled. “Sharing care: Experiences of caregivers raising HIV/AIDS-orphans in Bulilima District Matabeleland South Province Zimbabwe”.

I am aware that anonymity will be ensured.

Signed: _____ Date: _____

Appendix B: INTERVIEW GUIDE

My name is Elias Maronganye a Masters student in the Department of Sociology at the University of Witwatersrand in South Africa. I am carrying out a research project on: Experiences of caregivers raising HIV/AIDS orphans in Bulilima District. The study is part of the requirements for the fulfilment of my qualification. As such it is neither indirectly nor directly linked to any organisation. Additionally, there will be no direct or indirect benefit resulting from participation in the study.

You were identified as one person who could enlighten me on the subject as such I am kindly requesting you to share with me your experiences as the caregiver. Though I would like to know as much as possible you have the right to decide what information you wish to share with me. All information shall be treated with confidentiality and anonymity shall be ensured always. This shall be ensured by removing all personally identifiable information and assigning pseudonyms to safeguard your privacy and identity when reporting the findings. The researcher shall password protect the memory card which shall be used in recording this interview. Moreover, once the information had been transcribed into texts, the audio recorded data shall be deleted. Only the interviewee, the interpreter and possibly the supervisor shall have access to the information you shall provide.

I am not making any promises that I shall come back to give you a written summary of the study nor the electronic copy of the final study. The results shall be compiled in the form of a research report which shall become University of Witwatersrand property. Moreover, the university shall publish an online copy which shall be available to the public. The findings of this study shall be used for this study only.

Participation in this study is voluntary and you are free to refuse to participate or withdraw your consent and discontinue participation at any time.

SIGNED.....DATE.....

TIME.....PLACE.....

A. BACKGROUND QUESTIONS

1. Name.....
2. Age.....
3. Sex.....
4. Occupation.....
5. Religion.....
6. Ward.....
7. Marital status.....
8. How many children are you looking after?
9. How many are your own?
10. How many have you fostered?
11. How old are the children?
12. What happened to the fostered children's parent(s)?
13. How are you related to the child/children you have fostered?
14. Why did you choose to foster these children?
15. For how long have you been looking after these fostered children?
16. Do the children know they are orphans?
17. Do the children know who you are?
18. If yes, how do think they accept you? Why?
19. Do you know the HIV status of these children?
20. If HIV positive, what help have you sought?
21. If HIV positive and have not informed the child, why have you not told them?
22. Until when do you think you will continue to raise these children?
23. If you were to be sick, who will look after these children?

B. DAILY CARE

24. What time do you wake up?
25. Who prepares food for the children?
26. Who does laundry for the children?
27. Who helps them with their homework if any?
28. What other duties do you do for the fostered children?

B. THE VALUE OF THE ORPHANS TO THE HOUSEHOLD

- 29. Do you get any help with household duties from your fostered children?
- 30. If yes what type of help do you receive?
- 31. What else can you tell me about the benefits of caring for these children if any?

C. NEEDS FOR THE ORPHANS

- 32. What, in your opinion, are the needs of the orphans you are raising?
- 33. How can you describe the capacity of your family, to cope with these orphan needs?
- 34. How can you describe the capacity of your family to provide in these needs?

D. SOURCES OF INCOME

- 35. Who pays for the living expenses of these children?
- 36. Are the expenses manageable?
- 37. If yes/no, why?
- 38. Who buys clothing for the fostered children?
- 39. Who takes care of their health costs?
- 40. Who pays school fees?
- 41. Who buys food?
- 42. Do you have any other sources of income?
- 43. If yes, can you please name them?

E. FAMILY SUPPORT

- 44. Are you getting any support from other family members?
- 45. If yes, how are you and the children related to the family members?
- 46. If so, what kind of support are you getting?

F. SUPPORT FROM NON-GOVERNMENTAL ORGANISATIONS (NGOs)/ FAITH-BASED ORGANISATIONS (FBOS)

- 47. Are you getting any support from FBO or NGOs?
- 48. If yes, what kind of support are you getting?

49. Are you getting any assistance from the government?

50. If yes, what sort of assistance?

51. Have you ever faced any challenges in accessing FBO, NGO and government assistance?

52. If yes what were the challenges?

G. CHALLENGES AND RECOMMENDATIONS

53. Are there any other challenges you are facing in caregiving for these children?

54. In your view what can be done to ease the burden of caregiving?

THANK YOU FOR YOUR COOPERATION

TIME.....