EXPERIENCES OF CHILDREN LIVING IN HIV/AIDS-AFFECTED CHILD-HEADED FAMILIES AT RUFARO COMMUNITY TRIANGLE IN CHIREDZI DISTRICT OF MASVINGO PROVINCE, ZIMBABWE.

BY

MUGUMBA SUSAN

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Supervisor	Co-supervisor
Dr N.D Ndou	Dr N.S Mashau

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DECLARATION

I, Mugumba Susan, hereby declare that this mini-dissertation titled " **Experiences of children living in HIV/AIDS affected child-headed families at Rufaro Community Triangle in Chiredzi District of Masvingo Province, Zimbabwe**" hereby submitted to the University of Venda, has not been previously submitted by me at this university or any other university and that it is my own work. The resources that I have used or quoted have been acknowledged by means of complete references.

Signature…… Date ……

Dedication

I would like to dedicate this study to:

- My husband: Martin Canaan Mafunda
- My daughter: Tawananyasha Treasure Canaan

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List of Acronyms

AIDS	Acquired Immune deficiency syndrome
AMTO	Assisted Medical Treatment Order
ART	Antiretroviral Therapy
BEAM	Basic Education Assistance Module
HIV	Human Immunodeficiency Syndrome
NGO	NON-governmental Organisations
OVC	Orphans and Vulnerable Children
SA	South Africa
UNAIDS	United Nations Programme on HIV and AIDS
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Education

Abstract

Background: Human Immunodeficiency virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) is one of the major public health problems that has negatively impacted mostly orphans leaving in child-headed families in the world. A child- headed family is defined as a family, living under the same roof, which is headed by a person under the age of 18 years. Many of these children have become heads of households and they are obliged to look after themselves and siblings. As a result, some children drop out from school while looking for jobs to sustain the family.

Purpose: The purpose of the study is to explore and describe the experiences of children in HIV/AIDS-affected child-headed families in Zimbabwe.

Methodology: The researcher employed qualitative approach with explorative, descriptive, contextual and phenomenological designs. Nonprobability purposive sampling was used to select the participant. Children aged between 12-18 years were selected as they were able to narrate their life experiences. In-depth face to face individual interviews were used to collect data pertaining to experiences of children in HIV/AIDS child-headed families. Data was transcribed verbatim, and then translated from Shona to English. The data was then analysed following Tesch's eight steps model.

Findings: The findings of the study revealed that children in HIV/AIDS-affected child-headed families were lacking basic commodities such as food, clothing, shelter and clean water. The findings also revealed that children living in HIV/AIDS-affected child-headed families were being abused physically, sexually, emotionally and verbally. The findings of the study also revealed that children living in HIV/AIDS-affected child-headed families received support from the government, non-governmental organisations, community and relatives.

Key words: Children, Child-headed families, Community, Experiences, HIV/AIDS

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CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 Introduction and background

Human Immunodeficiency virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) is one of the major public health problems that have contributed to orphans, leading to child-headed families in the world (United Nations Programme on HIV and AIDS, 2016). A child-headed family is a household headed by a person under the age of 18 years (Foster, 2012). HIV and AIDS is a leading cause of adult mortality and it has led to many children becoming orphans and living in child-headed families. This has disturbed children's rights, obligations and social-roles, as children have become orphans and need to fend for themselves. There is often a premature shouldering of the burdens of adulthood without the rights, privileges and strength associated with adult status.

A United Nations Programme on HIV and AIDS (UNAIDS) (2016) reports reveal that 90% of the approximately 13.3 million orphans who have lost one or both parents to HIV/AIDS, reside in Sub-Saharan Africa. It further reveals that 8% of the 90% of children live in child-headed households. In Sub-Saharan Africa, the number of AIDS-orphaned children has been reported to have increased considerably during the last two decades from 3 million in 2000 to 13.3 million in 2016 (UNAIDS, 2016). From the statistics done by UNAIDS, many people are dying of HIV/AIDS; leaving behind some families without elders. Therefore, children have no other option than living in child-headed families.

Many of these children have become heads of the households and they are forced to look after themselves, and their siblings. As a result, many of them drop out of school to look for jobs to sustain the family (Bavier, 2011). In addition to the abuse experienced by children living in child-headed families, some of them are infected by HIV United Nations International Children's Emergency Fund (UNICEF, 2016). The continuous increase in the number of orphans, especially in the last decade, coupled

with the increase in poverty in the entire world, have overwhelmed the traditional extended families, leading to an upsurge in child-headed families (Bavier, 2012).

The study conducted by Bramlett and Blumberg (2012) in California on the health of children in child-headed families compared to those with two biological parents found that children in child-headed families needed special health care, as some of the children in child-headed families were infected with HIV/AIDS.

The findings of the study conducted in Canada on children living in child-headed households in Canada revealed that sexual abuse among children in child-headed families is higher, compared to those children who live with both parents (Elze, 2011). Social exploitation in South Africa (SA) is more frequent among children living without one or both parents, or whose primary caregiver is absent or unavailable as well as those placed in the care of more distant or unrelated person (Mabala, 2012).

Failure to acquire materials required at school, such as books, pens and failure to pay school fees contribute to children living in child-headed families' dropping out from school. Bavier et al, (2011) postulate that African-American children living in child-headed families were likely to be suspended from school or to repeat grade, compared to those living with both parents. Elze et al, (2015) further state that children in child-headed families have lower school engagement on average than what their peers in biological parents' care do and they also have low rates of educational attainment.

Health and nutrition statuses tend to decline as less money is available to properly feed the household. Children in child-headed families experience shortages in basic things such as food, shelter, clothing and education. Nutrition and food security are important to achieve good health, growth and development of every child. However, for many orphaned children in Sub-Saharan Africa, this is unattainable, as many of these children live in impoverished states after the family has spent most of their resources on medical care and other expenses during the parents' illnesses, due to HIV/AIDS and other diseases.

Studies in the rural parts of East Africa have shown that child-headed families experience severe food insecurity and that orphans in these areas are more likely to go to bed hungry than those who are not orphans (UNICEF, 2011). A food study

which was carried out in Congo revealed that child-headed families have lower levels of food security than those of the general population (Rodger, Fabrice and Amnata, 2011).

Zimbabwe is facing an increase in the number of children made vulnerable or orphaned by the pandemic. This has contributed to several children living in child-headed families, where they face different kinds of difficulties. Misinformation due to ignorance pertaining to HIV/AIDS has also limited the willingness of relatives and community members to look after orphans who have been left by their parents due to HIV/AIDS. This has contributed to the increase in child-headed households (Foster, 2012).

A recent study which was carried out by UNICEF, which shows that there are about 570,000 HIV/AIDS orphans in Zimbabwe. Of the 570,000 many are living in grandparents-headed families and child-headed families. About 13% of the orphaned children live in child-headed families (UNICEF, 2016). The children in HIV/AIDS-affected child-headed families internationally, nationally and locally are experiencing stigma, poverty, child labor and self-exploitation (Foster, 2012).

The stigma remains a serious problem for many people infected and/or affected by HIV/AIDS. It is especially an issue for orphans living in child-headed households, whose parents have died from AIDS. Furthermore, as a result of the stigma and discrimination, many of children in child-headed families end up losing self-confidence, leading to low self-esteem. In addition, many of the children end up dropping out of school because of fear of stigma and discrimination (Sun, 2013).

The living conditions of children in HIV/AIDS-affected child-headed families are very poor. Ibuke, Belkum and Maja (2014) state that children in child-headed households they access to basic facilities such as sanitation, water supply and food. Furthermore, very few may achieve secondary education. Children child-headed families experience psychological trauma as a result of the loss of their parents.

Some of the children observed their parents suffering and eventually dying from the devastating effects of HIV/AIDS and its complications. Children in HIV/AIDS-affected child-headed families also experience child labour. They find themselves with no other option but to work in harsh conditions. Tsegaye (2008) concurred that the dire

economic situation faced by many children in child-headed households leads them to engage in hazardous child labour.

Magoko and Dryer (2010) noted that children in child-headed families have no one to educate and protect them, often pass through different types of risk and exploitation, including exchanging sex for money, food, protection and shelter. These Children often become vulnerable to sexual and physical exploitation, as well as HIV infection, due to lack of sources of prevention and protection.

In Zimbabwe, many organisations, including government and non-government, have tried to come up with solutions to end the challenges faced by children in child-headed families. The government of Zimbabwe, through the Department of Social Services, in order to reduce the challenges of child-headed families, has come up with the National Action Plan for Orphans and Vulnerable Children (Government of Zimbabwe, 2010). It has some goals that are meant to cater for orphans and vulnerable children through systems such as cash transfers. These are meant to build a healthy and supportive family environment (Government of Zimbabwe, 2010). There are also several non-governmental organizations such as Regai Dzive Shiri and Plan International who are also playing a major role in helping child-head families by paying school fees and providing food and shelter to HIV affected children.

1.2 Problem statement

The present researcher once worked in the Rufaro community Triangle in Zimbabwe as a social worker and observed that the numbers of children living in child-headed families were increasing yearly. Furthermore, the researcher observed that these children were not receiving adequate support as they were lacking basic needs. Gomba (2018) reveals that the world needs to know that the children in child-headed families out there are burdened by the adult responsibilities of raising and supporting families. Hence, this motivated the researcher to conduct a study on the experiences of children in HIV/AIDS-affected child-headed families. Table 1 shows the number of children in HIV/AIDS-affected child-headed families.

Table 1: Children in HIV/AIDS-affected child-headed families at the Rufaro Community Triangle, Zimbabwe

Year	2013	2014	2015	2016	2017
Households	3	5	7	13	19
Children	6	7	11	21	36

Triangle Newsletter, (2016) Triangle

1.3 Rationale for the study

As the number of people dying due to HIV/AIDS increases daily, there is a need to look at the effects on the families, community, country and the entire world. People of all ages are dying, and statistics show that of the 29000 people who have died of AIDS-related illness in Zimbabwe, many of them were adults who were economically productive (UNAIDS 2016). Parents who are economically productive leave their children with no one to look after them; hence they become family heads (UNICEF, 2016). Therefore, further research needs to carry out a study on the experiences of children in HIV/AIDS-affected child-headed families. The number of child-headed families is increasing daily.

1.4 Significance of the study

The findings may influence policy makers in the Department of Social Welfare Services to implement policies pertaining to the experiences of children in HIV/AIDS-affected child-headed families. The findings of the research may also inform the relatives of the children in HIV/AIDS-affected child-headed families of the hardships encountered by the children to look for support from surrounding non-governmental organisations, the government and well-wishers within the community. The findings of the research may also be used as reference by some organisations that offer psycho-social support to psychologically affected children, such as Counseling of Children Centre, churches, Department of Social Development and the Department of Health.

1.5 Purpose of the study

The purpose of this study was to explore and describe the experiences of children in HIV/AIDS-affected child-headed families.

1.6 Objectives of the study

Objectives of the study were to:

- explore the experiences of children in HIV/AIDS affected, child-headed families
- describe the support systems received by children in HIV/AIDS affected, child-headed families

1.7 Definition of Terms

The following terms are defined differently in the literature, but for the purpose of this research, the following definitions are used.

1.7.1 Child

United Nations Convention on the Rights of the Child (2012) defines a child as any human being below the age of eighteen. In this study a child means a minor or person who is below 18 years of age and living in HIV/AIDS-affected child-headed families.

1.7.2 Child-headed families

These are families in which children take up the responsibilities of providing leadership, decision making, daily running and maintenance of their younger siblings after the death of their biological parents (Anderson, 2013). In this study, child-headed families refer to those households which are headed by children below the age of eighteen years.

1.7.3 Experience

Southgate (2013) defined an experience as an event or occurrence, which leaves an impression on someone. In this study, experience refers to the challenges, advantages, support and disadvantages encountered by children living in HIV/AIDS-affected child-headed families.

1.7.4 AIDS

AIDS is an abbreviation for Acquired Immune Deficiency Syndrome which is a disease caused by HIV virus. Mkhize (2006) argues that the AIDS pandemic is the major challenge that has threatens the family unit in the whole world. In this study, AIDS refers to the disease caused by HIV virus that contributed to the death of many parents leaving children without any to look after hence contributing to child-headed families.

1.7.5 Support System

These are network of people or organisations which provide an individual with practical or emotional support (Southgate, 2013). In this study support systems will mean individuals or organisations which are helping children in HIV/AIDS-affected child-headed families with cash or kind in order to deal with difficult situations in their day to day living.

1.8 Outline of chapters

Chapter 1: Introduction and background

This chapter gives a brief introduction and background to the study. The problem statement, rationale for the study, significance of the study, objectives are presented in this chapter.

Chapter 2: Literature review

The chapter gives a well detailed account of the previous research and literature used to motivate the study.

Chapter 3: Research methodology

In this chapter the methodology used to gather data is well presented.

Chapter 4: Presentation of the study findings

In this chapter data was well analysed using Tesch's eight step model. The research findings are presented, discussed, compared with existing literature related to the topic.

Chapter 5: Summary, Limitations, conclusions and recommendations

This chapter provides the summary, conclusion, limitations and makes recommendations to the topic.

1.8 Summary of the chapter

This chapter described background of the study, problem statement, rationale for the study, significant of the study, aim of the study, the objectives of the study and definition of terms. Chapter two detailed the literature searched for the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents literature review related to experiences of HIV/AIDS affected child-headed families. Literature on the causes of child-headed families, advantages, disadvantages and challenges of living in child headed families as well as support. Literature was searched from science-direct and ABSCOHOST databases.

2.2 Causes of child-headed families

UNICEF (2016) report reveals that approximately 13.3 million orphans have lost one or both parents in the world and further went on to say of the 13.3 million children, 90% of the children who have lost their parents to HIV/AIDS are in Africa. These children are often left in the care of close relatives but due to limited resources and unwillingness to take care of close relatives end up staying in child-headed families whereby siblings will be looking after each other. Lack of knowledge on how HIV/AIDS is transmitted many relatives they do not want to take children of their deceased relatives in their houses as they are afraid that they will contaminate them (Muchunguzi, 2012). The AIDS pandemic is having a profound impact on the health of the children in the entire world but more seriously in the Southern Africa. Although there has been progress and increased access to HIV treatment, demand remains greater than the availability of the antiretroviral therapy (ART) (World Health Organization, 2013)

2.3 Advantages of child-headed families

Children in HIV/AIDS affected child-headed families experience both good and bad experiences. Some of the children are experiencing better life styles in child-headed families than they used to live before the death of their parents. When their parents were alive, they were not receiving external support from different organisations,

such as the non-governmental organisations and government (Department of Development Studies, 2010). In South Africa orphans receive child support grants which they use to buy basic things for survival (Department of Development Studies, 2010). Research done in India found that some of the children in vulnerable families were having better lifestyles because of support from the government and other organisations (Indian HIV/AIDS Alliance for Tata Institute of Social Science, 2012). This is supported by the findings of the study which was done in Zimbabwe in the commercial farms which found that some of the people within the communities borrowed some material things such as mealie-meal and cooking oil from those children in child-headed families (Walker, 2012)

However, on the other note most of the children in child-headed families are left without birth certificates and relatives experience problems when they try to get birth certificates. Some of the children in child-headed HIV/AIDS affected families experience difficulties to get birth certificates because some of the relatives do not want to be involved in helping them (Ntozi, 2011). Some of the children in child-headed families may be entitled to other benefits but because of lack of birth certificates they end up not getting what they should have. Study which was done in America found that many children in child-headed families could claim their benefits they are entitled because of lack of birth certificates and identity documents (Sun, 2010). Also, the gap left by parents will never be filled by anyone despite having all the benefits from different organisations.

In Zimbabwe it is hard to register for an ordinary level and advanced level without birth certificates and identity card hence many people in child-headed families end up dropping out from school because they cannot write final exams because of lack of registration fees. A study which was done in Zimbabwe found that most of the children in child-headed especially those in Commercial farms Of Beatrice does not have birth certificate (Walker, 2012). Some of the girls in a bid to provide their siblings with food they end up indulging in prostitution and they experience hard life since they will be doing this not because they want but because of poverty.

2.4 Challenges experienced by children in child-headed families

Challenges are the difficulties which are experienced by children in HIV/AIDS affected child-headed families. The challenges which are faced in child-headed families comprises of poor performance at school, food insecurity, poor health and Stigmatisation.

2.4.1 Education (School drop outs and poor performance)

There are several challenges experienced by these children who are living in child-headed families. Several studies which were done in America, have found that lower education attainment is found among the children who are living in child-headed families or those under the care of grandparents (Sun, 2013). This is usually because they will be involved in some duties such looking after the young siblings and working in the fields in order to provide for the young ones, so it is difficult to be involved in children's school work; hence, many children in child-headed families end up dropping out of school. Having to play age-inappropriate roles might undermine children's feeling of self-worth and interfere with children's mastery of developmentally appropriate tasks that build self-concept to contribute to the development of their identity (Goldshall, 2014).

Blome (2011) states that compared with children living with at least one of their parents, children living in child-headed families are likely to drop out of school, less likely to take college preparatory courses and they are more likely to change schools. Children living in the absence of their parents usually exhibit behavioral problems in schools due to poor social guidance

Failure to acquire basic things that are needed at school such as books, pens and failing to pay school fees contributes to children living in child-headed families to drop out of school. Pillay (2012) notes that children in child-headed families are failing to keep up with their homework because they do not have textbooks. Lack of textbooks might have some negative impact on the children's performance. Children in child-headed families have low performance and low school attendance because of household duties that they perform before school.

Bavier et al (2011) postulates that African-American children living in child-headed families compared to those living with both parents were likely to be suspended from school or to repeat grade. Elze et al (2015) further states that children in child-headed families have lower school engagement on average than what their peers in biological parents' care do and they also have low rates of educational attainment.

According to international statistics many children who have lost their parents are in Sub-Saharan Africa, are characterized by economic instability, poor infrastructure and high inflation (UNAIDS 2012). HIV/AIDS has led to emergence of new family headed by children, single mothers, children, widowers and even grandparents, this change has brought with it increased need for support from the extended family but due to limited resources the kin support systems can no longer cope with the responsibilities hence leading to formation of child-headed families (UNICEF, 2016). A study which was done in KwaZulu Natal, have found that many children in child-headed families had dropped out of school either temporarily or permanently, in order to look after their young siblings (Masondo, 2012). Similar findings were reported in India, where two thirds of the children in child-headed households had dropped out of school (India HIV/AIDS Alliance and Tata Institute of social Science, 2012)

According United National Development Fund Programmes (2011) basic education for all is one of the important goals and central to preparing the young people their future roles in the society. However, households with ailing parents have high medical care costs and other expenses that leave the children with nothing after death of parents. The death of parents has a significant impact on children, and many of them drop out of school soon after death of parents they drop from school because of lack of school fees and some they need to take care of their siblings UNICEF (2013). Study which was done in Uganda, have found that most of the children who are elders in the child-headed families drop-out from school at an early age. A study which was carried out in Zimbabwe, have found that 40% of the school going age in child-headed families were not attending school (Walker, 2012). School enrollment for the children in child-headed families is lower than those living with their parents.

Children living under the care of their biological parents are more likely to be better cared and continue with their school even if they belong to poor families. Researches which were carried out in Zambia pertaining to children in child-headed families found that children who performed well when their parents were alive, after death of parents they perform poorly resulting from stress. They have got more tasks apart from school work

Children in Child-headed families are involved in different experiences of life. National Action Plan for Orphans and Vulnerable Children 3 (2015) notes that many orphans and vulnerable children are living in in extreme poverty and are less likely to access health care, attend school and other necessities than other from the same community living with their biological parents. UNICEF (2012) asserts that an orphans' education is not a priority due to lack of finances, causing a drop in School attendance and of ten high drop-out rates of orphans in schools. Losing a parent due to any disease is not easy for a child. Losing a parent to HIV/AIDS is even worse for most of children as they suffer from psychosocial effects and they even lose concentration from school.

Oghubvu (2010) conducted in Ghana on the attendance and academic performance of students in secondary schools and found out that children from child-headed families were more likely to display behavioral problems like truancy, late coming, inability to read and not consulting teachers. Continuous absenteeism will lead to poor performance hence will continue to repeat grade. Matseke (2011) observes that a person with a high intellectual potential may perform badly or poorly because of the non-intellectual factors emanating from home and the physical living condition.

However, on the other note education has a positive effect on the emotions and psychological self of children living HIV/AIDS-affected child-headed families. When the children are in school, they feel safe and happier and more confident (Pillay, 2012). Also, some children in child-headed families are motivated and are positive about their education because of the food and clothing they get from school, churches and non-governmental organisations at school.

2.4.2 Food Insecurity

Health and nutrition statuses tend to decline as less money is available to properly feed the household. Children in child-headed families experience shortages in basic things such as food, shelter, clothing and education. Nutrition and food security are important in achieving good health in growth and development of every child. However, for many orphaned children in Sub-Saharan this is far from reach since many of these children are living in a very impoverished state after family having spent most of their resources in medical care and other expenses during parents' illnesses due to HIV/AIDS and other diseases. Studies in Rural parts of East Africa have shown child-headed families reported from severe food insecurity and that orphans in these areas were more likely to go to bed hungry than those who are not orphans (UNICEF, 2011). Food study which was carried in Congo affirms that child-headed families have lower levels of food security than that of the general population (Rodger, Fabrice, Amnata, 2011).

Shortages of food leading to hunger as elder siblings are unable to provide enough food is also another challenge faced by children living in child-headed families. UNICEF (2012) noted that children in child-headed households are made to work under harsh conditions in return for food. Furthermore, the children in HIV/AIDS-affected child-headed families cannot afford a well-balanced diet since they are living in poverty. These children are living in extreme poverty; they have nothing to put on the table hence they take whatever is available in order to fill their empty stomachs.

2.4.3 Poor health status

Researches which were carried out by Bramlett and Blumberg (2012) in California pertaining to health of children in child-headed families compared to those from two biological parents found that children in child-headed families needed special health care needs. Some of the children in child-headed families were infected with HIV/AIDS and these children suffer more frequently from malnutrition. The research which was done by Kushel in UK on the health of children in child-headed families also reveals that children in child-headed families are living in severe poverty, having been admitted and discharged home with medication they end up missing doses due

to lack of proper diet and this contribute to increased morbidity and mortality in children

Many people in Africa are living in poverty and not financially viable to be able to afford the best treatment and many children living with HIV/AIDS are given the cheapest available antibiotics such as cotrimoxazole which is responsible for opportunistic status. Ayieko (2013) asserts that children from HIV/AIDS-affected child-headed families are prone to household accidents.

2.4.4 Stigmatisation

A stigma is a complex social phenomenon, and its effects on the children may vary in severity depending on individual and contextual factors (Evans, 2014). Stigma which is experienced by children in child-headed families may differ from individual to individual. Stein (2013) in his literature view on the psychosocial impact of HIV/AIDS on orphaned children in Sub-Saharan Africa states that stigma associated with HIV/AIDS is perhaps the greatest obstacle to their future wellbeing.

Stigmatisation is also another challenge that is faced by children living in child-headed families as a result of loss of parents due to HIV/AIDS. Children living in HIV/AIDS-affected child-headed families face stigmatisation and labeling in schools because they have lost their parents to HIV/AIDS. Some pupils in schools do not want to associate with children from child-headed families as they think that they might be infected as well. Also, relatives if they know that their late relative died from HIV/AIDS they no longer want to associate with the remaining children as they think that they may also have the disease because of lack knowledge on how HIV is spread (Ntozi and Mukiza, 2013). Study which was done in America on experiences of child-headed families, have found that when parents have died of AIDS social stigma acts as an additional stumbling block to the continued education of children in child-headed families.

Children in child-headed families in Africa are experiencing stigmatization. Ntozi and Mukiza (2013) postulates that lack of knowledge about HIV and AIDS and its transmission increases fears and prejudices to relatives after the death of biological parents due to HIV/AIDS. People lack knowledge on how the disease is spread and contaminated and they will also suspect the children to be infected by the disease

hence they tend to stigmatize and discriminate the orphans. Christina (2013) states that after death of parents due to AIDS, orphans suffer from intense discrimination on the unjustified fear of contamination.

Walker (2012) states that stigma and social exclusion are common experience children in child-headed families experience. Some children in HIV/AIDS-affected child-headed families because of HIV/AIDS are treated differently in their communities.

2.4.5 Sexual exploitation

The findings of the study conducted in Canada revealed that sexual abuse among children in child-headed families is more compared with those children who live with their parents (Elze, 2011). Social exploitation in South Africa is more frequent among children living without one or both of parents, whose primary caregiver is absent or unavailable and those placed in the care of more distant or unrelated person (Mabala, 2012). Magoko and Dryer (2010) note that children in child-headed families have no one to educate and protect them, often pass through different types of risk and exploitation including exchanging sex for money, food, protection and shelter. Children often become vulnerable to sexual and physical exploitation and HIV infection due to lack of having any source of prevention and protection. In addition to all the abuses that are encountered by children in child-headed families, they are also exposed to exploitation hence making them vulnerable to fall into poverty.

Mullen and Fleming cited in Mabala (2012) state that sexual abuse of children takes place in all demographic groups, not only among children in child-headed families. Moreover, research indicates that sexual abuse is more frequent among children living without one or both of their biological parents especially in child-headed families. The children in HIV/AIDS- affected child-headed families are being sexually abused, whether with their consent or not and they are abused by those people who are physically, emotionally and intellectually more mature than them.

2.4.6 Psychological Challenges

Children living in HIV/AIDS-affected child-headed families encounter psychological problems due to death of their parents. Study which was conducted in Ethiopia by

Tsegaye (2010) found that child-headed families face tremendous emotional and psychological problems and live with the constant memory of their dead parents and prolonged agony. Usually children in child-headed families experience extremely disrupted life leading to higher degree of hurtful and unresolved emotions. Chilongwa (2014) observes that children in child-headed families suffer stress in the process of adapting to adult roles and responsibilities of carrying on with few resources of the needs of survival parenting and security. Children in child-headed families are at risk of neglect, violence, sexual abuses and other abuses which contribute to them having psychological challenges.

Moletsane (2014) pointed out that the lack of parental guidance, support and love leaves an indelible mark on the psychological wellbeing of children in child-headed families. More so teachers tend to discipline children for an example punishment of the child if he/she is late for school without knowing what will be taking place in the child's life. Therefore, for this reason children in child-headed families often prefer to keep their lives secret for this makes them feel safer but on the other side being affected psychologically. According to UNAIDS Report (2011) in one study carried out in rural Uganda, high levels of psychological distress were found in children who were living HIV/AIDS-affected child-headed families. Anxiety, depression and anger were found to be more common among these children.

A research which was done in Zimbabwe by UNICEF (2016) has shown that children orphaned by AIDS in rural Zimbabwe demonstrated greater anxiety, depression and anger as compared to children who are not orphaned. These problems will lead to low self-esteem hence contributing to children having low grades in classes. Van Breda (2016) states that psychological problems can only be reduced through psychosocial support services which may include a range of actions such as ensuring that the child's basic rights are realised, love and affirmation. Psychosocial support helps children in child-headed families to cope with the mental and emotional challenges related to the death of their parents. When a psycho-social intervention is successful, it brings back control and confidence in the lives of children in child-headed families. This results in increased participation in class, high grades in class and enhanced self-esteem.

2.4.7 Support System

There are support systems for children internationally, nationally and locally. Zimbabwe is a signatory to several international, regional and convention committing to the protection and care of all children in the country, such as the United Nations Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the child, therefore is committed to protect all children including those in child-headed families. United Nations on the Convention of the Rights of the Child (Article 5) and the African Charter on the Rights and Welfare of the Child (Articles 9 (3) and 18) also support good caring of all children. Zimbabwe is a signatory to the Convention of the Rights of the Child through the Children's Act (Chapter 5:06) despite having all these articles that supports children to be taken care in families AIDS pandemic defiles the concept of the analogy 'it takes a village to raise a child "as many children in communities are now living in child-headed families and they experience hardships.

Planning together with the government of Uganda, has formulated the Orphans and Vulnerable Children's national Policy in order to implement support programs for child- (Plan, 2011). A submission to the United nations High Commissioner for Human Rights has also been made by Plan regarding support of AIDS orphans in Child-headed households in Uganda. In some African countries like Zambia and South Africa children in child-headed households receive help and support from church-based support groups, local community-based organizations, governmental and non-governmental. According to National Aids Control Council of Kenya's report only 17% of orphaned and vulnerable children receive some free basic external support and these are mainly child-headed household in the urban areas (National AIDS Control Council, 2008. Greoten (2010) postulates that institutionalization has been advocated for by many as solution to orphan hood, but it was criticized as being expensive, creating dependency syndrome and being detrimental to children.

In South Africa there is also a child grant which is given to children in needy. The child grant can be applied by any primary caregiver of children under 18. The child grant was introduced some years ago and it is still working effectively, helping those children in need. The child support grant is having positive development outcomes

on children in promoting their education, promoting their education, promoting nutritional and health outcomes (DSD, SASSA and UNICEF, 2012).

In Zimbabwe, there are so many community-based initiatives that exists in order to support orphans and vulnerable children, such as community foster homes and projects that provide material and psychological support (National action Plan for Orphans and Vulnerable children 11, 2010-2015). Children who are orphans and vulnerable to their necessities and are living in child-headed families are given Assisted Treatment Orders (Children's Act Chapter 5:06). This is provided by government through Department of Social Services. The Assisted Treatment Order is only valid in public hospitals. There is also Basic Education Assistance Module which is given to orphans and vulnerable children in primary and secondary school.

The Department of Social Welfare is the government department responsible for child protection. It has developed National Orphan Care policy which cares for the children in institutions as a last resort and those in HIV/AIDS-affected child-headed families. It advocates for that children have rights to education despite their situation. The Department of Social welfare Service facilitates birth registration through mobile registration units. Moreover, they do resource mobilization at national and community level, research networking and advocacy.

2.5 Summary

In this chapter, the most relevant literature was reviewed in order to provide in-depth information to the topic titled "Experiences of children living in HIV/AIDS-affected child-headed families at Rufaro community, Triangle of Chiredzi district in Masvingo Province." The literature reviewed that the children in child-headed families are facing several challenges such sexual exploitation, health problems, dropping from school, abuses, just to mention but a few.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

Goddard and Melville (2014) define research as a process of expanding the boundaries of our ignorance. They further added that research is about answering unanswered questions or creating that which does not exist. Collies and Hussey (2013) define a research methodology as the overall approach that the researcher will take. Research methodology will comprise of a research approach and designs, population and the sampling methods, research instruments, method of data collection, data of analysis, ethical issues in relation to the study

3.2 Approach and design

A qualitative approach, with explorative, descriptive and contextual designs was employed in this study. Holloway and Wheeler (2013) define qualitative research as a form of social enquiry that focuses on the way people interpret and make sense of their experience and the world in which they live. The researcher selected the qualitative approach as it is best suited for exploring experiences of children in HIV/AIDS-affected, child-headed families in real life situation. A research design is a plan or strategy that moves from the underlying philosophical assumptions to specifying the selection of participants, the data gathering methods to be used (Maree, 2016). Qualitative research can also attend to the contextual richness of the setting, enables to study everyday lives of many kinds of people and what they think about, under many different circumstances (Yin, 2016). Qualitative research enables the researcher to understand how people cope in their real-world setting. Burns and Grove (2012) define a research design as a blueprint for conducting a study with maximum control over factors that may interfere with the trustworthiness of the findings.

Exploratory Design

An exploratory design is an investigation into a problem or situation which provides insights to the researcher (Creswell, 2013). It helps the researcher to gain insight into the situation, phenomenon, community or individuals. Saunders (2012) claims

that exploratory research does not aim to provide the final and conclusive answers to the research question, but merely explores the research topic with varying levels of depth. An explorative design allowed for in-depth exploration by probing, wherein the children explained their experiences of being in HIV/AIDS-affected child-headed families. An exploratory design helped in improving the researcher's knowledge of the topic. The study used an exploratory approach in order to gain more information on the experiences of children living in HIV/AIDS-affected child-headed families.

Descriptive design

A descriptive design is designed to depict the participants in an accurate way. Polit and Beck (2012) state that a descriptive design also has its main objective the accurate portrayal of the characteristics of individuals, situations or groups and frequency in which certain phenomena occurred. According to Maree et al, (2016) a descriptive design can serve a variety of research objectives, but descriptive studies tend to be primarily concerned with finding answers to what questions. The researcher gave the participants an opportunity to describe their experiences. Through descriptive design, the researcher was able to explore and describe intensely the experiences of children in HIV/AIDS-affected child-headed families.

Contextual design

A contextual design is a structured, well-defined user-centered design process that provides methods to collect data about users in the field interpret and consolidate that data in a structured way (Holloway & Wheeler, 2013). This study was contextually bound to the Rufaro Community in HIV/AIDS-affected child-headed families.

3.3 Research setting

The research was conducted on HIV/AIDS-affected, child-headed families, at Rufaro community Triangle in Chiredzi District of Masvingo Province, Zimbabwe. Zimbabwe is a landlocked country in Southern Africa known for its dramatic landscape and diverse wildlife. The country has a population of about 17.165 million. It is one of the highest HIV prevalence with 1.3 million living with HIV. The Republic of Zimbabwe has 10 provinces, which are divided into 59 districts and 1200 wards.

Chiredzi district is one of the largest districts in the country. The district also has high numbers of people who are living with HIV. A large chunk of the district is found in region four, although there are some parts that lie in region five.

The Rufaro community is in region 5 which is characterized by aridity and uncertain rainfall hence many parts are unfit for agriculture. This simply shows that children in child-headed families, with their level of poverty, do not get any yield from the farms as they cannot afford irrigation (Government of Zimbabwe, 2013). The Rufaro community depends on the harvest from the farms for survival and this makes life difficult for the children living in HIV/AIDS child-headed families. This is because they cannot farm because of their age and lack of equipment to use for farming (Triangle newsletter, 2016). The Rufaro community, compared to other surrounding communities, look dilapidated and overcrowded hence orphans in child-headed families are more vulnerable to diseases and hunger. Children in HIV/AIDS affected child-headed families in Rufaro community always suffer from poverty as they cannot meet their basic needs.

3.4 Study population and sampling

In the present study, the populations were all children living in HIV/AIDS-affected child-headed families in Rufaro community. Twelve people from HIV/AIDS-affected child-headed families were interviewed. Sample size was determined by data saturation which occurred after interviewing participants.

3.4.1 Population of the study

Polit and Beck (2012) define research population as an entire set of individuals or objects having some common characteristics. Burns and Grove (2011) define a target population as all elements (individuals, objects, events or substances that meet the sample criteria for inclusion in the study). In this study the population were all children in HIV/AIDS-affected, child-headed families in Rufaro Community.

3.4.2 Sampling

Punch (2012) defines sampling as the process of selecting a sample from the population, in order to obtain information regarding a phenomenon in a way that represents the entire population. In this study purposive sampling was used to select the participants. Purposive sampling is a method of sampling that is used in a special situation where the sampling is done with specific purpose in mind, for example children HIV/AIDS-affected. Purposive sampling is a non-probability sampling that is selected based on the characteristics of the population and the objective of the study. Purposive sampling is also known as judgmental, selective or subjective sampling. Purposive is the most appropriate method available if there are limited numbers of primary data sources who can contribute to the study (Saunders et al, 2012). In this case children living in HIV/AIDS-affected child-headed families were limited hence purposive sampling method was the most appropriate method. The researcher purposively selected children aged 12-18 years, because they were able to narrate their life experiences. Sample size was determined by data saturation which occurred after interviewing the participants.

Inclusion criteria

To be eligible for inclusion, participants complied with the following criteria:

- Residing in a HIV/AIDS-affected, child-headed family.
- Participants aged 12 to 18 years were included in the study
- Consent to participate in the interviews

3.5 Research Instrument

The researcher used an interview guide as a data collection instrument. The objectives of the study were used to design an interview guide. The interview guide enabled the researcher to probe more on the experiences of children living in HIV/AIDS-affected child-headed families. The researcher asked one central question to all the participants: "***May you please share with me your experiences of living***

in a household affected by HIV" This was followed by probing questions. The probing questions asked were determined by the participants' responses to the central question (See Interview guide Annexure C).

3.6 Pre-testing

Two children were requested to participate in the pretesting of the interview guide (See Annexure C). Flaws encountered during pretesting determined the changes which were made on the interview guide, the time allocated for the interview, and data collection process.

3.7 Trustworthiness of the study

Trustworthiness refers to ensuring that the study is worth paying attention to, worth taking account of, and that the findings are to be trusted (Curtin & Fossey, 2012). Speziale and Carpenter (2010) identified the following criteria for trustworthiness: credibility, dependability, confirmability and transferability.

Credibility

Lincoln and Guba (2010) state that one of the best ways to establish credibility is through prolonged engagement with the participants. Observations and extensive field notes were made during data collection. The researcher spent almost a months with the participants in the field, in order to ensure credibility. Creswell (2013) postulates that credibility can also be confirmed through participants recognizing the findings to be true to their experience. Maree (2016) points out that transferability does not involve genaralised claims but invites readers of research to make connections between elements of the study and their own experience or research. The researcher also ensured credibility through peer debriefing, whereby the researcher sought support from other professionals willing to provide scholarly outcome.

Dependability

This is the ability of a researcher to account for constant changing conditions of the phenomenon studied, for interaction with the study participants and the entire

research process carried out with an emergent design (Lincoln & Guba, 2010). Dependability can only be met once the researcher has determined the credibility of the findings. In this study data collection was monitored and recorded correctly in order to have deep answers all the times. The researcher availed the methodology and made everything pertaining to the research clear. The researcher ensured dependability through discussing the research process and findings with neutral peers, such as masters students, who were either doing qualitative research or have some experience in qualitative research.

Transferability

Transferability refers to the probability that the study findings have meaning to others in similar situations in other settings/groups (Lincoln & Guba, 2010). Transferability means the level to which the audience can generalize the results of a research to his or her own context. Transferability of the study is not the responsibility of the researcher, only the potential users can make an informed decision regarding the applicability of the findings in their context (Polit and Beck, 2012). In this study purposive sampling was used to select participants and this maximised the information which was collected. The expectation for determining whether the findings fit or are transferable rests with potential users of the findings and not with the researcher (Lincoln & Guba, 2010). The researcher ensured that the findings were transferable, by exposing the findings to colleagues for positive criticism and sharing the findings with other organisations that worked with children.

Confirmability

Confirmability refers to the degree to which, the study results could be confirmed or corroborated by others (Williams, 2012). The present researcher documented the procedure for checking or rechecking the data throughout the study. The researcher also actively searched for and described negative instances that contradict prior observations. Confirmability was ascertained by examining the internal coherence of the research product, which is made up of the data, findings, the interpretations and the recommendations. Confirmability was ensured through keeping a reflexive journal which included all events that happened in the field and personal reflections in relation to the study.

3.8 Data collection procedure

The researcher first obtained an ethical clearance and then submitted letters for collection of data to the municipality and social welfare. After permission was granted, the social workers directed the researcher to the relatives of the children in HIV/AIDS-affected, child-headed families, so that she would ask for permission to interview the children. After getting the permission from the relatives, the researcher visited the children in order to get permission to interview them (Annexure F). The researcher explained the purpose of the research to the participants. The relatives of the children signed consent forms while the children signed assent forms.

Data was collected through an in-depth individual interview. An audio tape was also used after permission was granted by the interviewees; however, some of the children did not grant the researcher permission to use the audio tape because of their cultural beliefs. The Interviews were conducted in a quiet private place provided by the children in their own residence. The researcher carried out the interviews until data saturation was reached after interviewing 12 participants, with no new emerging information. However, the researcher continued to collect data from two more participants in order to make sure that there was no new information coming and therefore 14 participants were included in the study.

3.9 Data management and analysis

The collected data was transcribed verbatim then translated from Shona to English language by a language expert from the University of Venda. The transcribed and translated data was kept safe under lock and key. The data was stored without the names of participants but codes. Data was analysed following Tesch's eight steps as described by Creswell (2014) model as follows:

Step 1: Get a sense of the whole

The researcher read all transcriptions thoroughly and random ideas were jotted down. The transcriptions were read several times in order to understand them

Step 2: Review one document (one interview)

The shortest interview transcript was reviewed by the researcher.

Step 3: Make a list of Topics

The researcher developed a list of topics with similar ones in the same column. The researcher compared all the topics and group similar topics together.

Step 4: Abbreviate Topics into codes

This is where the checklist was developed as patterned against the data and emerging topics were abbreviated as codes.

Step 5: Categorize Topics

The researcher described topics and converted them into categories. A total list was categorized, and then reduced by grouping topics that relate to each other. Interrelationships were indicated by drawing lines between the categories

Step 6: Abbreviating the Topics as codes

Formulated topics were abbreviated as codes and closely arranged in appropriate segments of the text and reviewed to check if new categories or codes emerged.

Step 7: Assembling similar categories of data

Data belonging to each category was assembled and analyzed.

Step 8: Recording the existing data

At this stage, the existing data was recorded to ensure that all data would be considered.

3.10 Ethical considerations

Payne (2014) states that ethical practice is a moral stance that involves conducting research to achieve not just high professional standards of technical procedures, but also respect and protection of the people who would be participating. Ethical considerations relate to moral standards that the researcher should consider in all research methods in all stages of research design (Holloway & Wheeler, 2013). Informed consent, anonymity, privacy and confidentiality and rights of the participants will be described in detail.

3.10.1 Permission to Conduct Research

The research proposal was presented first at the Department of Public Health and at the School of Health Sciences for quality purpose. The proposal was then submitted to the University of Venda's Higher Degree Committee in order to obtain an ethical clearance. Ethical clearance and the research proposal were then submitted to Chiredzi Rural and permission to conduct the research was granted.

3.10.2 Informed Consent

Obtaining informed consent implies that all possible or adequate information on the goal of the investigation; the expected duration of the participant's involvement; the procedures which will be followed during the investigation; the possible advantages, disadvantages and dangers to which respondents may be exposed; as well as the credibility of the researcher, be rendered to potential subjects or their legal representatives (De Vos, 2014). Informed consent is an agreement by a prospective subject to participate voluntarily in a study after he/she has assimilated essential information about the study. A formal letter of informed consent was issued to participants before the commencement of interviews in order to ensure that the participants participate in the study knowing what they are involving themselves in. The relatives gave informed consent. Assent forms were signed by participants. The researcher explained how the children in HIV/AIDS-affected, child-headed families will benefit from the study.

3.10.3 Self-determination

The participants were given authority to be either part of the study or not and they could quit at any time, even after signing the consent forms. The researcher encouraged voluntary participation.

3.10.4 Anonymity

Based on the principle of anonymity, the participants have the right to anonymity and the information they gave during data collection should be confidential. The participants' identities were protected. Codes were used in order to protect the identities of the participants.

3.10.5 Privacy and confidentiality

Privacy implies that the element of personal privacy, while confidentiality indicates the handling of information in a confidential manner (De Vos, 2014). The principle of confidentiality was upheld through making sure that there were no names of participants which were attached to the tapes, transcriptions or notes. Also, the list of names and notes were kept in a locked safe place, in order to promote privacy and confidentiality. Furthermore, the participants were protected from adverse situations. Finally, participants were assured that information provided was not going to be used against them. Polit et al, (2012) state that the researcher-participant relationship should not be exploited.

3.10.6 Rights of the participants

The researcher ensured that no physical, emotional or psychological harm was inflicted on the participants. The researcher made sure that the questions were not in a judgemental manner in order to avoid anxiety and psychological discomfort to the participants. The researcher looked at other possible dangers and guarded against them.

3.11 Summary

This chapter looked on the methodology used in the study. The researcher opted for qualitative research because it sought to explore and describe the experiences of children living in HIV/AIDS-affected child-headed families at Rufaro community Triangle, in Chiredzi District. The chapter discussed on the techniques that were employed. The population of the study was identified, and the sampling method was clearly explained. The chapter was concluded by explaining the ethical consideration of the study.

CHAPTER FOUR

PRESENTATION OF THE STUDY FINDINGS

4.1 INTRODUCTION

The previous chapters focused on the introduction, background of the study, as well as literature review and research methodology used to collect data. This chapter focuses on data presentation, description of the study findings and data analysis. In-depth individual interviews were conducted with children living in HIV/AIDS-affected child-headed families.

Research objectives were:

- To explore and describe the experiences of children in HIV/AIDS affected child-headed families
- To explore the support systems received by children in HIV/AIDS affected child-headed families

4.2 Demographic data of participants

The researcher purposively selected 14 participants to take part in the study. Of the 14 participants, 6 participants were family heads and 9 were not family heads but were living in HIV/AIDS-affected child-headed families. Of all the participants, 5 had dropped out of school for various reasons, such as lack of school fees and dropping out in order to look after their siblings. Of the 14 participants, 2 were living with HIV/AIDS from infection from their parents. Lastly of the 14 participants, 8 were females and 6 were males.

Table 2: Demographic data of the participants

Participant	Age	Gender	highest level of education	Heading or not heading family
1	17	Female	Secondary	Yes
2	14	Female	Secondary	No
3	12	Male	Primary	No
4	17	Male	Secondary	Yes
5	15	Male	Primary	No
6	15	Female	Primary	Yes
7	18	Female	Secondary	No
8	14	Female	Primary	No
9	16	Male	Secondary	No
10	17	Female	Secondary	Yes
11	14	Male	Primary	No
12	18	Female	Primary	Yes
13	13	Female	Secondary	No
14	17	Male	Secondary	Yes

4.3 Presentation and discussion of the findings

The study findings revealed detailed experiences of children living in HIV/AIDS-affected, child-headed families. These experiences are grouped into themes and sub-themes, with a focus on the experiences of children living in HIV/AIDS-affected, child-headed families at Rufaro Community.

Table 3: Themes and sub-themes from the data

Themes	Sub-themes
4.3.1Financial constraints	4.3.1.1Lack of housing and proper shelter
	4.3.1.2 Lack of food
	4.3.1.3 Lack of education
	4.3.1.4 lack of clothing
	4.3.1.5 Lack of proper sanitation
4.3.2 Family responsibilities	4.3.2.1 Poor school attendance
	4.3.2.2 Poor social interaction with peers
4.3.3 Health problem	4.3.3.1 long distance walking to the clinic
4.3.4 Stigmatisation	4.3.4.1 Psychosocial stress
	4.3.4.2 fear of HIV transmission
	4.3.4.3 Experience low-self-esteem
	4.3.4.4 Discrimination
4.3.5 Abuse	4.3.6.1 sexual, physical, emotional and verbal abuses
	4.3.6.2 Incest
4.3.6 Support Systems	4.3.6.1 Support provided by government
	4.3.6.2 Support provided by Non-governmental organisations
	4.3.6.3 Support provided by community and family members

4.3.1 Financial constraints

Children heading families reported financial constraints as a major problem which affects them which is evidenced by difficulties in meeting their basic needs for survival. During the interviews with the participants, it was revealed that they were

experiencing lack of proper housing, lack of food, lack of clothes, lack of sanitation and lack of school expenses.

4.3.1.1 Lack of housing and proper shelter

The findings revealed lack of housing and proper shelter as one of their major challenges they were experiencing. The participants revealed that the problem with housing started after the deaths of parents, as the relatives claimed to be heirs, especially those from the maternal side. This in line with Van Dyk (2012) who asserts that children often lose their rights to the family land or property after the death of their biological parents. This made some of the participants homeless, while some had to move to places where they would pay rentals. UNICEF (2012) further argues that few people in poorer communities in Sub-Saharan Africa make official wills, increasing the risk that a deceased person's property will simply be grabbed by other family members or in some cases by other members of the community. The participants revealed that they were having difficulties with rental money and this made their lives difficult. The participants added that sometimes they were forced to indulge in some social ills in order to get rental money. One of the participants stated that:

"As soon as my mother died, my uncle chased us away from our house as he was claiming that the house belonged to his sister because my father had not paid anything for lobola. We are now renting but we are having difficulties with money for renting. Sometimes I end up sleeping with men unwilling so that I would be able to pay rentals." (Participant 07)

During the interviews with the participants, the researcher observed that they were living in the dilapidated houses with cracks, the roofs were leaking and some of the windows were broken, exposing them to rainfall and too much sunlight. These houses did not meet the needs of the children, as they needed to be living in a safe and well- built house. This correlates with Doyle (2011) who states that proper shelter/housing is a basic need for everyone, especially children, because of their vulnerability; they need to be brought up in a proper house that offers protection against hazards and extreme temperatures and it should be of the correct structure, so as to offer dignity to its inhabitants. This clearly shows the children in HIV/AIDS-affected, child-headed families have some challenges with proper accommodation,

and this has some effects on their wellbeing. Foster (2012) states that the impact of HIV/AIDS on children and their families is perpetual because of the fact they are living in poverty, with poor infrastructure and lack access to basic services.

The participants revealed that one or two members in their families were once admitted in hospital due to tuberculosis because of the poorly built houses which were not cleaned well and had poor ventilation. The researcher observed that some of the children were coughing, uncontrollably and this could have been caused by dusty houses which lacked proper ventilation.

During the interviews the participants explained that in the Rufaro community there were some children in child-headed families who were permanently staying on the streets. They couldn't afford to pay the rentals for the houses in which they were staying, and some had to move to the streets because the houses they were staying in were dilapidated and some had collapsed due to heavy rains. The findings revealed that moving to the street was the only option, as no one would accommodate them in their houses. Moving from homes to the streets contributed to innocent children indulging in social ills such as prostitution, burglary and theft, in order to earn a living. This is supported by the National AIDS Council (2013), which asserts that housing, shelter is the basic need which can never be negotiable, but children from child-headed families were denied the fundamental right by their plight; hence they ended up moving to the streets, where they got involved in prostitution for survival

The findings also revealed that poorly-built houses in which children lived have also given an easy leeway to the thieves to enter the houses. Many houses lived by children in child-headed families were not having security, some of the houses did not even have windows, as they were all broken and no one could repair them, as they had no money and the doors had no locks. One of the participants mentioned that:

'' We no longer have anything; all the things that our parents had left for us were stolen because our house is not lockable. Therefore, people would come and steal when we were at school. The only things left are heavy stuff, the like beds and tables that they could not carry.'' (Participant 04)

This sentiment clearly shows that even relatives and community members took advantage of those children by stealing from them, knowing that they do not have anywhere to report it. In Maslow's hierarchy of needs shelter is mentioned as a basic for every living being, the absence of it leads to unmet needs, which can be a source of ill-health and other socials ills. Children in child-headed families are deprived of one of their most important right, namely right to shelter; hence this affects them in many ways, including education and health. The study findings that some of the participants were not attending school all the days of the terms because of some sickness that are mainly caused by poor infrastructure.

Many of the participants were sharing rooms, which clearly shows that there is a big problem of accommodation among child-headed families. The participants explained that they could not afford more rooms because they do not have money for rentals. Health problems are very common in overcrowded areas, hence the spread of communicable diseases such as tuberculosis, crime, incest and all forms of abuse are found in child-headed families (Barrett, 2010).

The findings of the study also revealed that in many of the participants' families, was one or two children who were HIV-positive due to infection from the parents. In some families there were children who had died shortly after the deaths of their parents because of low CD4 and high viral loads caused by poor accommodation and lack of knowledge on the siblings on how to look after HIV positive siblings. This correlates with Monasta et al (2008), who stated that housing is the availability of safe house; lack of proper housing contributes to low CD4 and high viral loads, less adherence to antiretroviral treatments and high rates of child mortality. These indicators were confirmed by a study conducted on HIV positive homeless children of Chicago, whose viral load had dropped to undetectable levels in 12 months of placement in safe stable house, and this was an 80% reduction in child mortality rates. This review was expanded by another participant who remarked that

"My little sister died soon after my parents passed on because of tuberculosis due to poor ventilation, not giving her medication at the right time and lack of correct diet because we did not have any knowledge on how we were supposed to do things." (Participant 01)

The participants explained that they did not have enough money and knowledge on how they should make the houses more spacious and poorly-ventilated as there were children without any source of income. However, there were some participants who confirmed that the Department of Social Welfare Services had built houses for them. The houses were more spacious and ventilated. The participants in these few families seemed to be experiencing a better life. One participant mentioned that:

"I am so much grateful to the Department of Social Welfare Services for what it has done to us; it has built houses, rendered support to us in the form of food hampers, school fees and school uniforms. My life is even much better than when my parents were alive." (Participant 05)

4.3.1.2 Lack of food

The study findings also revealed that financial constraints contributed to lack food to the children living in HIV/AIDS-affected child-headed families. Many participants explained that they did not have any source of income for their living, which made it hard for them to access proper food. Money and food, work hand in hand: if one does not have money, it means that person does not have enough food. The current researcher also observed that the area dependent on irrigation for their crops and children in child-headed families could not farm because of lack equipment for farming and most of them would be at school. One of the participants indicated that:

'' It is difficult for us to be involved in farming, as we don't have the right equipment to use for farming and to make matters worse, we spend most of our time at school, when we come back." (Participant 02)

The study findings revealed that many participants were living below the poverty datum line and they were surviving on one plate of food per day, while some had to share one plate of food per day. This correlates with Grove (2011), who found that children in HIV/AIDS-affected child-headed families experienced hardships when it comes to food security. This is because they may be unable to meet their minimum food requirements over sustained periods of time. The participants added that on weekends they helped in people's homes, so that they could earn money for food. The participants helped with washing, cooking, cleaning, to mention but a few so that they could be given food or money in return.

Some of the participants revealed that, due to their health conditions, they were given special diets by doctors but due to lack of money, they ended up not taking the prescribed diet. This had complications on their health, which led to health deterioration. The participants further revealed that they experienced a high cost in seeking special diets, medical care and many other things. All these have negative impact on the children as their health, nutrition and physical wellbeing deteriorates. This correlate with UNICEF (2012) which contends that lack of income, puts extra pressure on the children in child-headed families to contribute financially to the household. In some cases, driving them to the streets to steal, work, seek food, beg, and practice prostitution. One of the participants stated that:

"Although the doctors said I must eat healthy foods, like fruits, vegetables and meat, I cannot because I do not have money to buy such luxurious foods because the burden is too heavy for me. The little money that I get from the part-time/ casual jobs I use to buy mealie-meal and matemba (small dried fish), so that the whole family can eat." (Participant 10)

The study findings revealed that the participants were living in extreme poverty and could not eat balanced diets in correct proportions because of lack of money. UNAIDS (2016) asserts that children in HIV/AIDS-affected, child-headed families have absolutely nothing to put on the table; hence, they take whatever is available whether nutritious or not, in order to fill their empty stomachs.

Some of the participants who were infected with HIV by their parents reported that there were certain types of food that they were supposed to eat, but because of poverty they could not buy that food. This led to a deterioration of their health. The participants mentioned that having been admitted to the hospital and discharged with some medication was a problem because of lack food. The issue of balanced meal before taking medication was a problem because they could not afford that special meal. This led to missed doses and increased morbidity and mortality in children. This correlates with Kushel at el (2012) which showed that for vulnerable groups' children, the elderly, people living with HIV/AIDS and poverty-stricken communities, one of the strongest predictors of adherence to treatment is a proper diet.

The participants especially those on treatment reported that there were certain types of food that they were supposed to eat in order to boost their CD4 count but those

foods are beyond their reach; hence they ended up eating any type of food they found. This view was elaborated by another participant who reported that:

"Sometimes just think that I will die anytime soon because the food that the nurses encouraged me to eat, I cannot afford, I just eat any food in order to chase away hunger" (Participant 09)

This clearly shows that children in HIV/AIDS-affected, child-headed families know the foods that boost their immune system, but the prices are beyond their reach, and this makes them believe that they will die soon. The researcher observed that many children who were infected with HIV/AIDS frequently suffered from malnutrition. Greenberg (2012) asserts that children in child-headed families are at greater risk of malnutrition than any other children. The participants revealed that compared to other children with biological parents; they were by far the worst as these kids have glowing skin because they eat balanced foods at home, while they did not.

The study findings revealed that some of the participants were blaming this situation on their parents' illness and finally death as the reason why they were suffering. One of the participant also revealed that they had many asserts, but they were left with nothing to sustain their living because they sold all the inheritance in order to pay the parents' hospital bills and all the funeral costs. One of the participants remarked that:

"We used to eat whatever we wanted when my parents were still alive, but now we are suffering to such an extent that we can go hungry for the whole day. This always makes me think of my parents." (Participant 12).

4.3.1.3 Education

Education disturbances due to lack of finance were also mentioned as one of the biggest challenges experienced by children living in HIV/AIDS-affected child-headed families. Education is defined by WHO (2012) as a comprising consciously constructed opportunity for learning, involving some forms of communication designed to improve health literacy including improving knowledge and developing life skills which are conducive to individual and community health. The findings of the study revealed that education of children in HIV/AIDS-affected, child-headed families was being affected, as many children were dropping out of school because of lack of money for school fees, stationery and uniforms This had great negative effect on the

future of the children because they would continue to suffer in the ruthless cycle of poverty.

The study findings also revealed that education of the participants was interrupted by their situation. The findings further revealed that school expenses, such as tuition, stationery and uniforms, were the stumbling blocks to their success. This view was elaborated by another participant, who remarked that

‘*’The headmaster from our school told me to stop coming to school until I have school fees, he further told me that the days of free education ended during Rhodesian Government.”* (Participant 08*)*

Despite the policy implemented by the government (of no expulsion of pupils in school due to of lack of school fees) many participants reported that they were being chased away from school because they could not pay their school fees. Though education is important to children living in HIV/AIDS-affected, child-headed families, the possibilities of completing their education are minimal (Foster, 2012). Children living in HIV/AIDS-affected, child-headed families are exposed to a life of poverty, pain and suffering; hence, schooling can help them to restore some lost confidence and develop a renewed sense of efficacy. However, due to some circumstances beyond the participants’ control, their education is hindered at the early stages. Studies by Smart (2013) show that dropping out of school may have serious impacts on the children’s future, as school offers an environment to develop socially and emotionally gain knowledge and skills that will enable children to progress through adolescence to adult life.

“Sometimes I just wish if I was not the first born because this has made me suffer a lot. I am no longer going to school because I couldn’t pay school fees for myself and my little sisters. I used to think that when I grow up, I would become a lawyer but now all my dreams have been shattered” (tears rolling down the cheeks), participant 12)

The participants also revealed that lack of stationery was another obstacle to their success. The new curriculum which was introduced in Zimbabwe in 2015 came with its own demands. The demands include buying more prescribed books and notebooks. On the other hand, it was compulsory that each learner should have a

laptop or a phone. During examinations, each learner was expected to own dust coat that one wore during practicals for the chemistry, biology, integrated and physical sciences. These required more money; hence, children in child-headed families with no source of income ended up dropping out of school because they could not afford all that was needed. Many participants revealed that they ended up dropping out of school as they could not afford all the requirements.

The study findings also revealed that sometimes some participants managed to get some assistance in the form of school fees and stationery and continued with their school, but at the end of the day, they had problems with money to register for their final examinations. The findings further revealed that they ended up dropping out of school as they could not afford to register and write their final examinations. Eventually, children living in HIV/AIDS-affected, child-headed families missed out on their basic education and they would be faced with economic, health and social problems as they grow up (UNICEF, 2012).

It is the present researcher's point of view; the death of both biological parents during childhood can represent one of the most profound losses experienced in life, with serious negative implications on children's educational, behavioural and social interaction patterns. The above statement is in line with the assertion by Cluver and Gardener (2013) who asserts that parental bereavement has been shown to have understandable negative impacts on the children's wellbeing, connected to grief, loss of attachment figures, and uncertainly causing these children to under achieve academically.

4.3.1.4 Inadequate clothing

The findings revealed lack of proper clothing as one of the problems that they were experiencing. The findings revealed that they did not have money to buy nice uniforms, like other learners, and this made them feel shy when in the company of peers living with both parents. Hence this contributed to them performing poorly. This view was expanded by another participant who remarked that:

'' *Many people in my situation would agree with me, no matter how intelligent you are if you have torn uniforms sometimes this may lead to low performance in class*

because the moment you try to give some answers, everyone will look at you and this makes you feel shy because of the torn uniforms." Participant (08)

The findings revealed that participants were laughed at by other learners because of their torn uniforms. Some of the learners did not even want to interact with them because they associated them with poverty and all other bad things. The findings further revealed that the participants could not afford nice uniforms and school shoes for special occasions hence their teachers always told them not to come to school. This affected the participants, as they were discriminated due to poverty.

The researcher observed that when the participants were talking about the issue of their torn uniforms, how the teachers and their peers treated them, they showed great sadness and some would burst into tears, meaning that this greatly affected them. This does not only contribute to low performance but also to low self-esteem, whereby children would end up thinking that they are not worth living.

The study findings revealed that in the community where the participants lived, they could not dress like other children. This made them worry and feel less important. A study in Zimbabwe found that children in child-headed families could not associate with other kids in their communities because they were too shy due to their torn clothes (Walker, 2012). The participants revealed that some of the community members made fun of them pertaining to how they dressed. The participants further revealed that they had stopped going to church because they did not have nice clothes, like other church members. One participant stated that:

*"All my clothes are old fashioned and torn so I no longer go to church nowadays because if I meet my classmates there, they will laugh at me, they will even tell others at school that I am always wearing torn clothes" (*participant 06)

All the participants revealed that they usually felt the impact of not having nice clothes on special days or functions, like Christmas, whereby those kids living with their parents would be having new clothes. The participants further revealed that this made them think of their dead parents. The findings of the study also revealed that on special days like Christmas and Easter the participants' neighbors and relatives often invited them to their houses, so that they would eat with them. The participants added that they usually did not respond to the invitations, even though they wanted

to go there, but due to lack of nice clothes, they could not. The participants also explained that lack of nice clothes made them to feel out of place. This review was expanded by another participant who remarked that:

"This year if our neighbours invite me to have Christmas with them, I will not go there again because when they invited me last year I felt out of place because I was the only one with old clothes. That made me feel so embarrassed and felt out of place." (Participant 01*)*

However, some of the participants revealed that they were receiving assistance in the form of clothes from different people, churches and non-governmental organisations. This in line with what UNICEF (2012), which asserts that when family, cannot adequately provide for the basic needs of the children, the community is the next safety for essential support. The participants also revealed that their relatives sometimes brought clothes as presents during the festive season, so that they would also feel loved and remembered. One of the participants stated that:

"My uncle always bring us clothes and food during Christmas. Sometimes he comes all the way from Harare in order to pick me and my siblings so that we would go and have Christmas holiday with them." (Participant 14)

4.3.1.5 Lack of proper sanitation

During the interviews, the participants mentioned lack of proper sanitation as another challenge that they were experiencing. The participants mentioned that they were having difficulties in accessing clean water. The participants added that the water they used for domestic purposes was not purified; hence they were afraid of cholera, diarrhea and typhoid. The participants also revealed that in their place there was some outbreak of cholera and typhoid, which led to many deaths. One of the participants revealed that:

"It is really hard to access clean water all the time in our community so sometimes we end up walking long distances in order to get clean water from the boreholes" (participant 11)

The study findings also revealed that participants were not using rubbish bins at their homes because they did not see the importance. This is because they could just

throw the rubbish away. Their homesteads were too dirty and there was rubbish everywhere. This rubbish could lead to some outbreaks of diseases such as tetanus, cholera and malaria.

The participants also revealed that they were using clothes as sanitary towels during their menstrual periods. It was so sad when the researcher, discovered that the girls were now comfortable using old clothes during their menstrual periods. One of the participants proudly said:

"During my menstrual period I use white clothes that I was given by my aunt, she encouraged me to wash it thoroughly, so that it will not smell.'' (Participant 13)

The female participants revealed that they were so much comfortable using clothes during their menstrual periods. The participants further revealed that instead of buying pads when they got money, they bought food. One of the participants reported that they were once given pads at school by Restless Development Organisation, which encourages Health Reproductive Education and exchanged with food with other girls who came from better families who were well informed on the importance of sanitary pads. This was confirmed by another participant who indicated that:

"I gave my classmate my sanitary pads in exchange of food. It is better to have food than those sanitary pads that I will throw away after use" (Participant 13)

This clearly showed that the participants were not well informed about the importance of sanitary pads. This even showed that in school, children have little education pertaining to a healthy reproductive system. The findings revealed that the participants were not aware of the infections which could be caused by using clothes during menstrual periods. The findings of the study further revealed that participants changed their sanitary pads once per day. One of the participants articulated that:

"My sister gives me five pads per months, so if I change many times per day, I will end up having shortage; hence I only change it once a day." (Participant 13)

4.3.2 Family responsibilities

The study findings revealed that family responsibilities such cooking, and washing were affecting the school attendance of children living in HIV/AIDS-affected, child-

headed families. This made them drop out of school or sometimes fail because they did not have enough time to study. The study findings further revealed that family responsibilities affected the participants' social interaction with peers.

4.3.2.1 Poor school attendance

The findings further revealed that family responsibilities affected school attendance. The findings revealed that they were not attending school normally like others living with their parents because they had many responsibilities resulting in high rate of absenteeism from school. This is supported by the study which was done in Zimbabwe which; found out that 40% of children living in child-headed families were not attending school due to family responsibilities (Walker, 2012).

The participants further revealed that in the morning, before they left for school, they did some household chores, like cooking, washing plates and gardening. The participants further revealed that when they finished these chores, they would be tired and would be late, so they ended up deciding not to go to school. The participants added that after some heavy household chores, and if they decided to go to school, they would find some of the subjects already done. This greatly contributes to the poor attendance, low performance and failure of children because a tired child can never benefit from a normal school because the concentration span is very low (UNICEF, 2012). One of the participants stated that:

"I was called to a hearing in the headmaster's office because my teacher had reported that I am always absent or late for my classes. When the headmaster asked me the reasons that made me late or absent, I told him that I was the one responsible for my family, so every day before I come to school, I first do some household chores, and this makes me tired and I end up not coming to school." (Participant 2)

The participants further added that sometimes they missed out important exams while home-based caring for their siblings. This made the participants to repeat a grade, as they would have missed an examination that is supposed to take them to the next level. This view was affirmed by one of the participants who elaborated that:

"It is so unfortunate that I had to repeat Form three for almost two times because I would miss important examinations while looking after my sick sibling, I wonder if I will be able to write my final examinations." (Participant 14)

The participant showed so much worry when they were explaining their plights. They reported that the government should intervene in the plights of children in child-headed families, so that they do not continue to suffer in poverty.

The study findings also revealed that poor school attendance due to family responsibilities as another challenge that led to low performance and failure of children living in child-headed families. The findings revealed that they had low attendance at school, as they had some other chores to do such as looking after their sick and accompanying their siblings to the hospitals to collect their medicines. Some children were infected with their mothers through the mother-to-child transmission, as they are on Antiretroviral Treatment. Thus, they frequently needed to go to the hospitals to collect their medications. It is the duty of the eldest child/head in the family to accompany their siblings to the clinic or hospital while absenting them from school.

Poverty contributes to poor school attendance of the children living in HIV/AIDS-affected child-headed families, as they were to look for jobs, in order to sustain the family (Chidziva, 2014). The participants reported that the eldest child was mostly affected, as he/she has more responsibilities than other children. When there was insufficient food in the family, he/she has the responsibility to supply the family with food. India HIV/AIDS Alliance and Tata Institute of Social Sciences (2012) revealed that the role of heading the family is not only difficult; rather interferes with schooling. This view was elaborated more by another participant who articulated that:

"I had to finally drop out of school so that I would fully look after my siblings because I used to spend most of my time out of school engaging in family issue and this created problems with teachers." (Participant 10)

This is supported by George and Lane (2012) who assert that there is a large association between poverty in early years of childhood and poor academics. This type of lifestyle is one of the characteristics of third world countries, which are still living below the poverty datum line.

4.3.2.2 Poor interaction with peers

Findings revealed that family responsibilities contributed to them having poor interaction with their peers. The participant further went on to explain that they also wished to have some time to play with other children of their age but due to family responsibilities they could not enjoy that precious time. The findings of the study also revealed that due to family responsibilities, the participants' play was compromised, which meant that the participants had missed an important component of childhood. According to Goldshall et al (2014) children generally grow and learn through play

The findings of the study also revealed that the participants did not have time to play with other children of their age. Sigmund Freud in his psychosocial theory asserts that a child who undergoes deprivation in life will end up fixating. This implies that children in child-headed families were expected to perform adult people's roles. When they are old, they would be doing children's roles because they had jumped the childhood stages.

The participants also revealed that in a bid to look after their siblings, sometimes they ended up doing age-inappropriate roles, carrying heavy buckets of water. The above statement is supported by Goldshall et al (2014) who explained that having to play age-inappropriate roles may undermine children's feeling of self-worth and interfere with the children's mastery of developmentally appropriate tasks that build self-concept to contribute to the development of their identity. This has a negative effect on the growth of a child and contributes to a child having low self-esteem. The participants also revealed that in the community there are no longer treated as children like other children of their age but adults who should look after their siblings. One of the participants stated that:

"My neighbours told me that I should continue to work hard in order to look after my siblings because if I stop working hard the whole family would die of hunger." (Participant 01)

The findings of the study further revealed that due to their situations, participants were no longer comfortable to socialise with their peers.

4.3.3 Health related challenges

Health problems were also mentioned by the participants as some of the challenges that they were experiencing every day. Access to health care refers to the situation in which children can obtain the needed medical /health services. Access to health is basic for all Zimbabweans citizens. However, due to many reasons, children living in HIV/AIDS-affected child-headed families were walking long distance to the hospital.

4.3.3.2 Long distance walking to the health institutions

The study revealed that they were walking long distances from their homes to the nearby clinic. The participants added that most of the time when they visited the hospital, they end up not going school. This is because they would be tired or sometimes, they would have come late from the clinic, which made it impossible for them to proceed with their journey to school again. Foster (2012) asserts that children take on adult roles; some of them, especially girls, must give up school in order to fully take care of the family. The findings revealed that they were visiting the hospital almost every month in order to collect their medication. This had some negative effects on their school performance because the more they were absent from school the more they remained behind in their school work.

The findings revealed that sometimes when they visited the hospitals, they found long queues, to such an extent that they would be forced to walk at night, putting their lives in danger. One of the participants added that she was once followed by two men who showed that they had some evil intentions and she had to run to a nearby homestead and ask for a place to sleep. The participant explained that:

"We kindly ask the government to build the clinics in our community because if things continue as they are, we might end losing many children; especially girls are the most targeted." (Participant 07)

The findings revealed that the participants sometimes spent a day without being attended at the clinic. Even though they would have spent the whole day unattended, sometimes they would be told to return the following day. The participants further revealed that sometimes even if you were seriously sick and had walked a long distance, they received their services late; sometimes they just left for home, without getting help, as there would be no medicines.

The country is not financially viable and cannot afford the best treatment for children living with HIV/AIDS, and they are only given the cheapest available antibiotics, cotrimoxazole, which is responsible for opportunistic infections. This is in line with what was articulated by Meera (2016), who asserts that the government needs company that produces the Anti-retroviral drugs at cheaper price, to provide children and all other citizens with the right drugs that help the progression of HIV and AIDS.

The findings also revealed that during emergencies whereby a member of the family gets seriously ill during the night, they faced problems as the clinic was too far and neighbours with cars needed money for fuel. The participants added that the only option was to wait until the next morning, to walk to the clinic. One of the participants reported an incident when she lost a sibling because they could not find a car to transport them to the clinic when she got seriously sick during the night. She stated that:

"My brother just got seriously sick at midnight and within a few minutes he could not talk, we ran to all our neighbours seeking for help and it was so unfortunate that we could not get any help. Around 3:45am my brother passed on, my brother died a pathetic death." (Participant 01)

The above statement is in line with what Ayieko (2013) states about children from child-headed families who are prone to emergency and household emergency, as they partake in some household chores which are age-inappropriate. This is because some of the chores there are too heavy for them; hence they end up getting involved in accidents. However, on the other note there are community projects aimed at assisting children living in child-headed families and living with HIV. The projects are meant to fight the scourge of HIV/AIDS and to improve health care services.

4.3.4 Stigmatisation

The findings revealed that they were experiencing stigmatisation in their daily life. They were stigmatised at schools, churches, communities and hospitals. The participants revealed that stigmatisation by friends and relatives made them to experience psychosocial stress, low self-esteem, feel unwanted and to feel not worth living.

4.3.4.1 Psychosocial stress

The findings revealed that participants were experiencing psychosocial stress due to loss of their parents through HIV/AIDS. The Psychosocial stress was mainly caused by lack of pre and post- counseling. Pre-counseling is the counseling that should have been provided to children when they were nursing their sick parents. Post-counseling is the counseling that should have been provided to the children after losing their parents to HIV/AIDS. A well-balanced psychosocial image of a person is an indicator that the person is healthy and that there is a balance between the stressors and coping mechanisms. Once the equilibrium is disturbed, the person is not healthy. Phillips (2011) asserts that disturbance of the health continuum is evidenced by many cycles of illness that may or may not be accounted for, ranging from a general feeling of being unwell, to specific symptoms relevant to a specific condition.

The researcher observed that many participants had hidden worries that they could not explain but rather kept to themselves. It was only after thorough probing that the researcher could conclude that the children were suffering from psychosocial stress. Psychosocial needs, such as counseling after double losses of parents and siblings, were mentioned and from the findings these were not met at all. The participants revealed that after losing their parents they were never counseled but relatives were rather concerned with how they would distribute the inheritance. To make matters worse, within a few days after burial, all the relatives left them in their parents' homes alone. This is supported by a research done by Moffet (2007) which argues that a child heads experienced various psychological stressor, of which several would be related to the illness or death of their parents, whilst the impact of the other will be directly related to be the head of the family. The participants added that these brought back memories when they used to be with their parents and all the suffering that their parents had gone through. One of the participants elaborated that:

"All the memories on how my parents suffered during their sickness came back when I was left all alone to take care of my sibling after the burial of my mother. My mother suffered most to an extent that I even prayed for her soul to be put at rest." (Participant 14)

The findings revealed that sometimes children found themselves angry or feeling low, even if there was nothing bad that had happened. This view was well explained by another participant, who explained that sometimes she just found herself trying to think of the unusual and these made her even more worried, to such an extent that she begins to cry for no apparent reason. This is in line with the UNAIDS Report (2016) in a study carried out in rural Uganda. High levels of psychological stress were in children living in HIV/AIDS-affected child-headed families, anger, anxiety and depression were common among these children.

The participants further revealed that being forced to move away from their siblings had made them to experience some problems that they could not explain. Separation with siblings had led to many participants experiencing emotional stress. This correlates with a UNAIDS report (2016) on the study done in Uganda on psychological distress in children, found out that children in HIV/AIDS-affected, child-headed families experienced psychological stress and later these became more severe due to forced separation with their siblings.

4.3.4.2 Fear of HIV transmission

The findings of the study also revealed that the participants were afraid of contracting HIV from their siblings. This contributed to stigmatisation. The findings further revealed that participants were not aware of how HIV is transmitted from one person to another; hence they ended up not providing care to their siblings who were living with HIV/AIDS. Some of the participants stated that they even believed that they were already HIV-positive from sharing a house with their HIV-positive siblings. One of the participants stated that:

“I don’t want to get tested because I know that I am already HIV positive because I have been looking after my brother who is HIV positive since 2016. My aunts even told me that they did not even want to see me and my brother in their houses because we are both HIV positive.” (Participant 04)

The findings also revealed that some of their relatives and other community members were not associating with them because they were afraid of contracting HIV. Even though many of the participants revealed that they were HIV negative, people accused them of being positive as their parents died of the diseases. They

added that in their communities they were deprived of some their rights simply because their parents died of HIV. This is in line with what was asserted by De Witt and Lessing (2010), that community members feared that orphans who were HIV-positive would transmit the HIV or believed that their families had brought shame to their communities and discriminated against the children by denied them social, emotional, educational and economic support. This view was expatiated by one participant who elaborated that:

"Our uncle told us that he is not going to help us with anything and made it clear that we are not supposed to go anywhere near his house because we'd bring bad luck to the family"

The findings revealed that at school their class-mates were not comfortable sharing chairs, food and books, as they were afraid that they might contract the disease. The researcher observed that the way the participants explained this, showed that they were so touched by how their peers stigmatised them. The participants further explained that not all children in child-headed families are HIV-positive but that their parents had unfortunately died of the disease and everyone believed that they were also HIV positive. From the way the participants were explaining this, the researcher noted that many people in the community seemed ignorant about how HIV is spread; hence they just believed that if a child lost parents from HIV, he/she might as well have the disease, leading to stigmatisation.

On the other hand, many participants who used to nurse their parents before they died revealed that they never got tested. The researcher encouraged the participants to get tested, so that they know their status. There are many studies which show that many children who have nursed their HIV positive end up contracting the disease too. Hunter and Williams (2012) assert that some children are sick themselves, having contracted the disease whilst tendering to their sick parents. It is of paramount of importance that each person who looks after a sick person should always get tested and also should take precautionary measures such as wearing gloves when bathing them, especially if they have wounds or sores.

4.3.4.3 Experiencing low-self-esteem

The participants revealed were ridiculed at school because of the way they dressed (tattered uniforms and bare footed) and because they could not bring food to school like any other children. The findings also revealed that during break time, they were no longer joining other children with lunch boxes, but they would go and hide in the trenches near the school, so that their peers would not see that they did not have any food. The findings of the study further revealed that some of the participants had dropped out of school because they could not stand being teased daily because of their tattered uniforms and torn shoes. The participants further explained that the way their peers treated them contributed to low-self-esteem. They had no friends at school because no one loved them due to poverty. This view was elaborated by another participant who explained that:

"I do not have any friend at school because they all said I was too poor to be their friend and cannot afford food; they even said I was after their food." (Participant 03)

The findings also revealed that due to how the teachers treated them, they were afraid of expressing themselves in class. The participants revealed that they were given funny names that they did not understand. They further added that whenever the teachers wanted to give bad examples in class, they used them. The participant further revealed that teachers showed no interest in them when they asked for clarity in class. As a result of this many, children from child-headed families had, high rate of truancy and failure. This contributed to children living in HIV/AIDS-affected child-headed families having low self-esteem and displaying low performance in class.

4.3.4.4 Discrimination

The participants revealed that they were being discriminated against by their friends, relatives and community members. The participants revealed that they were not interested in playing with other children in the community because they discriminated against them. However, all the participants explained that they were not concerned about the discrimination that they experienced at home and in their communities, because they had siblings to play with and knew families experienced the same situation.

All the participants explained that they were stigmatised by people in the community. They were labeled as being cursed in the communities because there had been so many deaths in their families. The participants also revealed that community members were no longer treating them as children, even though they treated other children of the same age with parents as children. This is supported by a Rwandan study; 86% of children living in HIV/AIDS-affected child-headed families indicated that they felt “discriminated by the community”. The participant further explained that community members were seeing them as “women and men” and expected them to work hard and care for their siblings. As the result, many children in child-headed families had no friends, except for those who were in the same situation.

The findings revealed that the discrimination experienced by children living in HIV/AIDS-affected, child-headed families was strongly exacerbated by shame, fear and rejection. Children who have lost parents to HIV/AIDS were assumed to be HIV positive themselves, adding to the likelihood that they will face stigmatisation, labeling and discrimination that may even damage their prospects. Moffet (2007) states that discrimination attached to parents having died of HIV and AIDS become a major barrier to the children in HIV/AIDS-affected, child-headed. The children are able to speak openly and without restraint about the multitude of feelings, fears and concerns of the disease. The view was expanded by one of the participant who remarked that:

“I do not even see myself being someone better in life because the way people reject and discriminate me wherever I go shows that I am a curse and a complete failure.” (Participant 10)

This clearly shows that the discrimination experienced by the children in child-headed families made them feel unwanted and unworthy. This also contributed to some of them dropping out of school and some are longer associating with peers because of fear of discrimination.

4.3.5 Abuse

Many children are prone to different kinds of abuses. Furthermore, children in child-headed families are sexually, physically, emotionally and verbally abused. The findings of the study revealed that children in child-headed families were more

vulnerable to the risk of abuses because many people, including the relatives were aware that these children did not have parents to protect them. Some of the children ended up seeing abuse as something that is right, due to poverty. The participants reported that they were experiencing many forms of abuse, including incest.

4.3.5.1 Sexual, Physical, Verbal and Emotional Abuse

The participants revealed that they were abused on daily basis by their relatives, friends, teachers and community. They added that they were going through physical abuse daily. The findings of the study revealed that many people in the community were aware that the participants were living in poverty and in need of basic commodities such as food and clothes hence, they would call them to do some work in exchange for food and money. The participants further revealed that the work that they were given was too much and inappropriate for their age. This clearly shows that children in child-headed families were being abused physically and forced by poverty to do age-inappropriate work. The findings of the study further revealed that the participants were being taken advantage of by the community as they were aware of their situation, they gave them heavy work and paid them little. One of the participants reported that

"My neighbours always give me heavy work to do and when I am done, they give me a packet of mealie-meal and dried vegetables, despite the fact that we would have agreed on monetary basis" (Participant 08)

Sexual abuse was also revealed as another form of abuse that the participants were experiencing. The findings revealed that the participants were sexually abused, either with their consent or for the purpose of sexual erotic gratification. The findings revealed that the perpetrators were the extended family members, community people or other persons who were emotionally, physically, sexually and intellectually more mature than the participants. The findings of the study further revealed that the participants were forced to indulge in sexual activities, in order to provide for the family. This correlates with Kelso (2007) who reports that in some parts of Africa, children in child-headed families are turning to commercial sex work to generate an income, to help their families survive. Ironically this exposes them to HIV/AIDS, the very same disease that led to their vulnerability in the first place.

The findings of the study revealed that incest is another form of abuse that participants were experiencing. Incest is sexual intercourse between members of the close families; for an example, an uncle, brother, father and a cousin. In one of the families, the participant reported that two boys and two girls were sleeping in one room. The girls were sleeping on the bed while the boys were sleeping under the bed. This was problematic concern regarding to incest and sexual abuse. The findings of the study also revealed that there was a sister who was impregnated by her own brother and the brother ran away upon realising that the sister was pregnant. The doctors could not terminate the pregnancy because it was full term. This view was elaborated by the participant (victim) who remarked that

"The doctors wanted to terminate the pregnancy because they were saying that there is a high probability that the child would have disabilities, but they couldn't because it was already full term." (Participant 01)

It is the present researcher's point of view that some of the problems that the children in child-headed families are experiencing are caused by lack of parental guidance. Incest makes the whole become a laughing stock and further makes the victims life enemies. In addition, Incest creates a generation of no identity. Furthermore, Incest can contribute to children being born disabled and this creates a generation of disabilities.

The participants revealed verbal and emotional abuses were other forms of abuse that they were experiencing in their daily lives. The participants reported that in their communities' people were calling them names and some of the names really disturbed them. The participants further explained that even at school some of the learners, whenever they had some arguments; they would end up telling them that they would die soon because of HIV. This view was explained well by another participant who remarked that

"My classmate scolded me in front of everyone in class when I had taken her pen. She told me that she doesn't want her things to be touched by someone who was going to die anytime soon because of HIV." (Participant 03)

Abuse contributed to the participants dropping out of school even if they did not drop out of school, their performance declined. The participants also revealed that they

were afraid of expressing themselves in front of others because of fear of being laughed at.

4.3.6 Support systems

Children from child-headed families were receiving various forms of supports from different organisations, although the support was not enough. The organisations that were providing support to the children in HIV/AIDS-affected child-headed families included the government, non-governmental organisations, community people, churches, relatives and friends. The participants revealed that they were being provided with clothes, food and school fees.

4.3.6.1 Support provided by the government

The findings revealed that they were getting support from mainly the Department of Social Welfare. The Department of Social Welfare is responsible for child protection. The findings revealed that the participants were being helped with tuition, through the Basic Education Assisting Model. Basic Education Assisting Model is responsible for paying school fees for orphans in primary schools. The participants also revealed that through the Department of Social Welfare they were getting health assistance. Assisted Medical Treatment Orders are given to orphans, so that they can get free treatment in government hospitals. The participant explained further that through the Department of Social Welfare Services, they managed to get better houses. One participant stated that:

*"I am so grateful to the Department of Social Welfare for building houses for us" (*participant 04*)*

The Department of Social Welfare has developed a national AIDS policy as a co-coordinating body, to issues related to issue related to children and child protection. These have been decentralised to provisional, district, ward and village levels, in order to facilitate the implementation, monitoring and co-ordination of child-related activities in the respective localities.

Some of the participants revealed that through the Department of Social Welfare they had managed to get their birth certificates through mobile registration units. However, this initiative had not reached all the children in need due to lack of funds.

The participants also revealed that through the Department of Social Welfare they were receiving awareness raisings on child rights and responsibilities in their communities.

4.3.6.2 Support provided by non-governmental organisations

All the participants also revealed that they were getting support from non-governmental organisations in the form of school fees, food and books. The participants also revealed that the non-governmental organisations helped them initiate income-generating activities, to supplement the income of these families. The non-governmental organisations were also helping through community mobilisation and capacity-building, aimed at enabling communities to act upon children affected by HIV/AIDS.

The findings of the study also revealed that the non-governmental organisations were also rendering support to children in HIV/AIDS-affected, child-headed families through psycho-social support. Some of the participants reported that when their parents died, there were some peer educators who were sent to them to do bereavement counseling by non-governmental organisations, although the counselling sessions were limited. The participants reported that through the counseling sessions, they dealt with death of their parents in a better way. The non-governmental organisations addressed the importance of preparation of death of parents and provided guidance on how to write wills, ensuring that important documents for the children are in order to gain access to the necessary social services.

4.3.6.3 Support provided by community and family members

The participants also revealed that the surrounding churches, well-wishers, community people, friends and some relatives were playing significant roles in their lives. The participants revealed that during the festive season, the churches in the community provided them with different gifts, so that they would also feel loved and forget about their dead parents. The researchers observed that when the participants were describing the assistance, they were getting from various organisations; their eyes started glowing with gratitude and happiness.

4.4 Summary

This chapter dealt with data presentation and analysis. An interview guide was used to collect data among the families of children in HIV/AIDS-affected, child-headed families. Data was categorized into themes and sub-themes. The findings revealed that children in child-headed families lacked basic commodities and dropped from school for various reasons. However, these children were getting support from different people and organisations, although the support was not sufficient.

CHAPTER FIVE

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

5.1 INTRODUCTION

The previous chapter presented the findings of the study in accordance with the themes and sub-themes that emerged during data analysis. The findings were complemented by literature control. In other words, the findings were compared with the existing body of knowledge. In chapter five the researcher deliberates on the conclusion, limitations and makes recommendations pertaining to the study. This chapter also demonstrates how the objectives of the study were successfully achieved. The strengths and limitations of the study are also discussed in this chapter.

5.2 Conclusions drawn from the study findings

The findings of this study revealed that child-headed families are a reality in Zimbabwe due to HIV/AIDS. These families will forever be child-headed as children continue to lose parents due HIV/AIDS. The impact of children growing up in child-headed families cannot be understated, as this has some negative consequences on the growth and development of children.

The study revealed that children living in HIV/AIDS-affected, child-headed families, due to financial constraints, lacked commodities such as food, education, shelter and sanitation. Furthermore, many participants dropped out of school due to lack of school fees and requirements. The participants who were mostly affected were who were heading families.

The study revealed that participants who were heading families were dropping out of school in order to look for jobs and generate an income to help their families survive. These family heads were bread winners, and if the siblings got sick, the family heads were the ones taking them to the hospital.

The findings of this study revealed that children living in HIV/AIDS-affected child-headed families had problems with accommodation. Many participants were living in dilapidated houses, with broken windows, cracked walls and doors which did not have locks. Many of the participants were living in less than two rooms. This made diseases like tuberculosis and cholera to be easily passed from one person to another.

The participants in this study were having difficulties with accessing clean water. This is because they had to walk long distances in order to get clean water for domestic purposes. In the community, where the participants were living, there were outbreaks of cholera and typhoid due to lack of clean water.

The study revealed that the children living in HIV/AIDS-affected, child-headed families were involved in work which was age-inappropriate. The work that the children were doing always kept them busy always and this made them lack time to socialise with their peers. Children living in HIV/AIDS-affected, child-headed families were also not attending school regularly like any other children living with biological parents.

The findings of this study revealed that the participants had difficulties to access medical services. The participants were walking long distances to collect their medicines from the clinics. Sometimes the participants walked for long distances to the clinic, only to find that they were no medicines. The study further revealed that the participants would also drop their medicines due to lack of proper diet.

The study revealed that some of the children living in HIV/AIDS-affected child-headed families were infected by their mothers. Participants who were infected were relying on their siblings for help. These participants had difficulties accessing a proper diet, which contributed to them being sick all the time.

Children living in HIV/AIDS-affected child-headed families were abused sexually, physically, emotionally and verbally. The children were also taken advantage of because they did not have parents to protect them. Sometimes poverty contributes to the children to indulging in sexual activities in order to generate incomes to sustain the family.

Stigmatisation was also found to be the most common stumbling block to the education of children in child-headed families. Many children had to drop out of school because of it, while some children's performance dropped. Stigmatisation also contributed to participants having low-self- esteem.

The study revealed that the children were receiving support from different people and organisations, although the support was not enough. They were receiving support in form of clothing, food, shelter and school fees.

5.4 Recommendations

Based on the findings, the following recommendations are made:

- The Department of Social Welfare must keep updating the database of children living in child-headed families separate from orphans and vulnerable children (OVCs) so that this phenomenon can be closely monitored by relevant stakeholders.
- The service providers, such as the government, non-governmental organisations, well-wishers and friends must not only target those children who are already receiving support, but must dig deeper, so that they also render their support to the neediest groups.
- The organisations working with children should have a dedicated day for child-headed families, to allow the needs of the children in HIV/AIDS-affected child-headed families to be addressed effectively and ethically under the constant supervision of the funding body. This is since many NGOs working with children are quitting due to lack of funds.
- Children from child-headed families should be exempted from paying school fees so as to reduce the rate of children from HIV/AIDS-affected child-headed families from dropping out of because of lack school fees.
- More social workers should be employed and allocated to work with children in child-headed families. The social workers should advocate for the children's rights and link them with relevant organisations for further assistance.

5.4.1 Recommendations for further researchers

The researcher's recommendation for future and further researchers is that more similar studies should be carried in other parts of Zimbabwe, as this research only covered the Rufaro community. The researcher recommends that quantitative research on the same study should be carried out in a broader area. This will enable more children in HIV/AIDS-affected, child-headed families to be included.

5.5 Limitations

Some of the participants did not give the researcher consent to use the audio recorder so the researcher ended up spending more time writing notes. The study focused on children living in HIV/AIDS-affected, child-headed families at Rufaro community in Chiredzi District, which could affect the generalizability of findings. However, the researcher gave a thick description of the account, which gives the readers a choice on the generalizability of the study findings.

5.6 Summary `

In this chapter, the researcher presented conclusions reached in gaining in-depth understanding of the experiences of children in HIV/AIDS-affected child-headed families. The conclusion of the study showed that the children living in HIV/AIDS-affected child-headed families had financial constraints, and this made it hard for them to access basic commodities, such as food, shelter and clothing. The limitations to the study were also articulated. Recommendations pertaining to the research findings, further and future were presented accordingly.

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ANNEXURE A: ETHICS

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Mrs S Mugumba

Student No:
17017034

PROJECT TITLE: Experiences of children living in HIV/AIDS- Affected child-headed families at Rufaro community Triangle in Chiredzi District of Masvingo Province, Zimbabwe.

PROJECT NO: SHS/18/PH/26/0110

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Dr ND Ndou	University of Venda	Supervisor
Dr NS Mashau	University of Venda	Co - Supervisor
Mrs S Mugumba	University of Venda	Investigator – Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: October 2018
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Senior Prof. G.E. Ekosse

UNIVERSITY OF VENDA
DIRECTOR
RESEARCH AND INNOVATION
2018 -10- 03
Private Bag X5050
Thohoyandou 0950

University of Venda
PRIVATE BAG X5050, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 FAX (015) 962 9060
"A quality driven financially sustainable, rural-based Comprehensive University"

ANNEXURE B: LETTER FROM CHIREDZI COUNCIL

CHIREDZI RURAL DISTRICT COUNCIL

CHIREDZI RURAL DISTRICT COUNCIL
P O BOX 128
CHIREDZI

Phone:031-2647/2765
Fax:031-2696
Email: ceo@chiredzirdc.org

COUNCIL OFFICES
69 INYATHI ROAD

All correspondences are addressed to the Chief Executive Officer

24 October 2018

The Research Director
University of Venda
P Bag X5050
Thoyohandou 0950
South Africa

RE: REQUEST FOR PERMISSION TO CARRY OUT A RESEARCH: SUSAN MUGUMBA – STUDENT NO: 17017034

The above subject matter is certainly paramount:

This letter serves to inform you that Chiredzi Rural District Council has no objection to your application to carry out a research in its area of jurisdiction.

You are therefore granted permission to proceed with the process of conducting the intended research

We also request a copy of the research after the process for council information.

Your usual co-operation would be profoundly appreciated.

Yours faithfully

V. Magumbe
For: Chief Executive Officer
Chiredzi Rural District Council

VM/pc

ANNEXURE C: INTERVIEW GUIDE

The main objective is to explore the experiences of children living in HIV/AIDS-affected child-headed families.

Demographic information of children in child-headed families

Child age (tick the appropriate age on the dotted line)

12-14**.....**

15-16**.....**

17-18**.....**

Qualification (tick the appropriate qualification on the dotted line)

Primary level**.....**

Secondary level**.....**

College**.....**

Research questions to guide interviews (themes)

2.1 Central Question

"Share with your experiences of living in a HIV/AIDS-affected, child-headed family?"

2.2 Possible Probing Question

- Tell me about the challenges you are facing
- Tell me about the support system available to children living in HIV/AIDS-affected child-headed families
- Despite of all these experiences, is there anything else that you want to share with me?

ANNEXURE D: LETTER TO CHIREDZI RURAL DISTRICT COUNCIL

P.O BOX 802
TRIANGLE
ZIMBABWE

CHIREDZI RURAL DISTRICT COUNCIL
P.O BOX 3120
CHIREDZI
ZIMBABWE

Dear Sir/Madam

I Susan Mugumba registered social worker and currently a Public Health Masters student at the University of Venda in the School of Health Sciences, I am conducting research entitled **'Experiences of children living in HIV/AIDS-affected, child-headed families at Rufaro Community in Triangle, in Chiredzi District, Masvingo Province, Zimbabwe.'**

The study is conducted under the supervision of Doctor Ndou ND and Doctor Mashau NS from the School of Health Sciences at the University of Venda. The aim of this study is to explore the experiences of children in HIV/AIDS-affected, child-headed families in Rufaro community. In Order to fruitfully complete this study, I need to do in-depth interviews with children in child-headed families in Rufaro Community. The results of the study will help children in child-headed families to get help from the government and non-governmental organisations. For more information contact the researcher on +27613 258 513(SA), +277 842 046 991(SA)

Thank you
Mugumba S.

…… …….. ……
Signature student no Date

…… ……
Signature of supervisor Date

…… ……
Co-supervisor's signature Date

ANNEXURE E: CONSENT FORM

RESEARCH ETHICS COMMITTEE

UNIVEN INFORMED CONSENT

LETTER OF INFORMATION

Title of the Research Study: Experiences of children living in HIV/AIDS affected child-headed families at Rufaro Community Triangle in Chiredzi District of Masvingo Province, Zimbabwe.

Principal Investigator/s/ researcher : Mugumba Susan

Co-Investigator/s/supervisor/s : Dr N.D Ndou and DR Mashau NS.

Brief Introduction and Purpose of the Study: Human Immunodeficiency virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) is one of the major public health problems that have contributed mostly to orphans leading child-headed families in the world. Many of these children have become heads of households and they are obliged to look after themselves, their siblings and some drop from school while looking for jobs to sustain the family.

The purpose of the study is to determine the experiences of children in HIV/AIDS affected child-headed families in Zimbabwe.

Outline of the Procedures: The researcher will make appointments with individual participants in advance to set the date, time and venue for the interview. Prior to the commencement of the interview, the researcher will explain the ethical issues regarding their participation in the research, then the participants will choose to sign or not to sign the consent form. The researcher will also ask the interviewees for permission to record the interview proceedings. Once permission is granted, an

audio tape will be used. The researcher will collect data through an in-depth face to face interview. An interview guide with one central question will be used for all participants. Then probing questions will be asked, determined by the response from the participants. An interview session will last for 45-60minutes. This study will focus only on children living in HIV/AIDS affected child-headed families.

Risks or Discomforts to the Participant: if the participant shows discomfort while interviewed, he/she will be properly told not to continue with the interviews. The interview may also change interviewing place.

Benefits: Through the study the participants may get support from the government, non-governmental organisations and well-wishers. This may also benefit police makers who work hand in hand with children.

Reason/s why the Participant May Be Withdrawn from the Study: The participant has the right to withdraw at any stage of the research if you wish to do so. There is no harm or threats expected in participating in the study or to withdraw from the study.

Remuneration: No remunerations will be offered.

Costs of the Study: Participants will not be expected to pay anything towards the study.

Confidentiality: To ensure confidentiality, Interview will take place in a quiet private place. Your anonymity will also be safeguarded by using pseudo names throughout the study.

No information will be linked to your name.

Research-related Injury: In case of research related injury, the researcher will withdraw the participant from the study, refer to the Doctor and report the event to the managers of the institution and to my supervisors at Univen for assistants. No compensation is available.

Persons to Contact in the Event of Any Problems or Queries:

Please contact the researcher Mugumba Susan at (0613258513) my supervisor DR N.D Ndou at (tel no.060 613 5281) or the University Research Ethics Committee Secretariat on 015 962 9058. Complaints can be reported to the Director: Research and Innovation, Prof GE Ekosse on 015 962 8313 or Georges Ivo.Ekosse@univen.ac.za

General:

Potential participants must be assured that participation is voluntary and the approximate number of participants to be included should be disclosed. A copy of the information letter should be issued to participants. The information letter and consent form must be translated and provided in the primary spoken language of the research population

CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, (*name of researcher*), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _,
- I have also received, read and understood the above written information (*Participant Letter of Information*) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during this research which may relate to my participation will be made available to me.

Full Name of Participant Date Time Signature

I..... ....

(*Name of researcher*) herewith confirm that the above participant has been fully Informed about the nature, conduct and risks of the above study.

Full Name of Researcher

..... Date.....

Signature.....

Full Name of Witness (If applicable)

..... Date .....

Signature.....

Full Name of Legal Guardian (If applicable)

..... Date.....

Signature.....

ANNEXURE F: CHILD ASSENT FORM

Child Assent Form

I am doing a research on the experiences of children living in HIV/AIDS-affected child-headed families at Rufaro community Triangle in Chiredzi District of Masvingo Province, Zimbabwe. I am asking you to help because I want to know more on the experiences and challenges faced by children in child-headed families.

If you agree to be in my study, I am going to ask you some questions on the challenges and support of children in HIV/AIDS-affected child-headed families. For example, I will ask when last you received support from the government and other well wishers

You can ask questions about this study at any time. If you decide at any time not to finish, you can ask me to stop.

The questions I will ask are only in line with my research topic. There are no right or wrong answers because this is not a test.

If you sign this paper, it means that you have read this and that you want to be in the study. If you don't want to be in the study, don't sign this paper. Being in the study is up to you, and no one will be upset if you don't sign this paper or if you change your mind later.

Researcher name and signature: _____ Date_____

Signature of the child _____ Date_____

ANNEXURE H: INTERVIEW TRANSCRIPT

Transcript from an in-depth individual interview

Researcher: Hello, how are you today?

Participant: I am fine

Researcher: We can start our interviews

Central question: What are your experiences of living in a HIV/AIDS-affected, child-headed family?

Participant1*: it is not easy to be living in a child-headed family, especially when you are the family head. In a child-headed family, you are always experiencing a life of suffer and lacking.*

Participant 2: *my life will never be ok; this type of family is not good to stay in. We are always lacking basic things because we do not have money to access them.*

Participant 3: *I have been experiencing stigmatisation since the day that my mother died. No one wants to associate with me and my siblings because they believe that they will contract HIV from us since our parents died of AIDS.*

Participant 4: *I have been experiencing shortages since we started staying alone, we used to eat whatever we wanted when my parents were still alive, but now we are suffering to such an extent that we can go hungry for the whole day. This always makes me think of my parents.*

Participant 5: mmmmmm my sister hupenyu hwekugara sevana vega hunorwadza.zvinhu zvese zvakashata ndimi munongopomerwa. Hapana kana chakanaka chamunombonzi maita (My sister life of staying as children alone is not easy, all the bad things that happens in the community people always blame you for that even though you won't be responsible for that. Community people will never see anything good from you, simply because you are staying in a HIV/AIDS-affected, child-headed family).

Participant 9: haa hupenyu hwekufirwa nevabereki mosiwa murivana mega hwakaoma zvahwo. Unoita kusuwa nyama chaiyo. Ndava nemwedzi mitatu chaiyo ndisati ndamboona chinonzi nyama. (It is hard to be staying in a child-headed family. You go to the extent of missing meat; it's now three months since I ate meat.

Participant 10: you are always taken advantage of either by relatives or community members. All the properties that we had were taken while we were at school. To make matter worse, the only farm that we relied on for our survival, it was taken by my mother's sister.

Participant 14: I am no longer going to school because I had to drop out of school so that I would look for a job that would give me money, so that I will be able to look after my siblings.