This is to certify that the

dissertation entitled

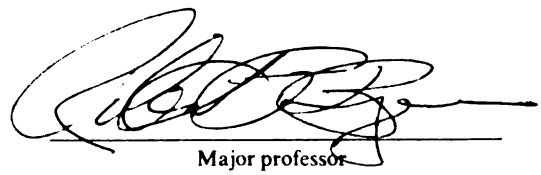
EXPLORING SELF-ESTEEM OF ORRPHANS WHOSE PARENTS DIED OF HIV/AIDS; EXAMINED THROUGH THE EXTENDED FAMILY/KINSHIP CAREGIVERS' ECONOMIC WELL-BEING, SOCIAL SUPPORT NETWORKS, AND CHILD-REARING PRACTICES IN ZIMBABWE

presented by

Mercy S. Tsiwo-Chigubu

has been accepted towards fulfillment
of the requirements for

Ph.D. degree in Family and Child Ecology



Major professor

Date November 8, 2000

EXPLORING SELF-ESTEEM OF ORPHANS WHOSE PARENTS DIED OF HIV/AIDS; EXAMINED THROUGH THE EXTENDED FAMILY/KINSHIP CAREGIVERS' ECONOMIC WELL-BEING, SOCIAL SUPPORT NETWORKS, AND CHILD-REARING PRACTICES IN ZIMBABWE

By

Mercy S. Tsiwo-Chigubu

A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Family and Child Ecology

2000

ABSTRACT

EXPLORING SELF-ESTEEM OF ORPHANS WHOSE PARENTS DIED OF HIV/AIDS; EXAMINED THROUGH THE EXTENDED FAMILY/KINSHIP CAREGIVERS' ECONOMIC WELL-BEING, SOCIAL SUPPORT NETWORKS AND CHILD-REARING PRACTICES IN ZIMBABWE

By

Mercy Susan Tsiwo-Chigubu

With the advent of the HIV and AIDS epidemic, it is critical to ask this question: "What is going on in these homes where suddenly the extended families find they have to take care of orphans who arrive uninvited, and without any financial support?" Recent research findings indicate that, in most cases, the kinship caregivers are not usually consulted before or when the orphans join them (Chigubu, 1998). Orphans suffer psychologically long before the deaths of parents, when they nurse them through a long period of wasting by disease, which may include incontinence, melancholia, and dementia. The orphans' grief and depression remain hidden and unrecognized. They do not receive death education, bereavement counseling, grief therapy, or emotional rehabilitation sessions. Later on, emotional and behavioral disorders start exhibiting.

This qualitative study explores the self-esteem of orphans whose parents died of HIV/AIDS, and is better understood by examining the kinship caregivers' economic well-being, social support networks, and child-rearing practices. This research advocates that orphanhood due to parents' deaths from HIV/AIDS, and the consequent kinship care giving of these orphans is a gigantic problem that needs to be documented and discussed both locally and globally.

Poverty, exacerbated by parental HIV/AIDS deaths, forces orphans in sub-Saharan Africa, particularly land-locked Zimbabwe, to migrate, and at times unceremoniously join relatives who are already facing severe economic hardships. The problems being experienced by Zimbabwe's orphans, as well as the extended families caring for these orphans, are due, to some extent, to the ramifications and implications that emanate from the vestiges of 20+ years of war, 15+ years of consistent drought, a decline in the global economy, the ongoing pervasive HIV/AIDS denial, HIV/AIDS stigmatization both locally and globally, and the Economical Structural Adjustment Program which has prompted employee down-sizing and the devaluing of Zimbabwe currency and consequently has lowered the standard of living among most families.

These mentioned social indicators, among others, directly or indirectly affect the orphans' kinship caregivers' economic well-being, social support networks, child rearing practices, and the ultimate orphans' self-esteem . Research reveals that poverty in Zimbabwe's extended families joined by orphans whose parents died of HIV/AIDS, is alarming. The sample reveals that 60% of kinship caregivers interviewed were widowed, impoverished, young/middle-aged women; 76% of kinship caregivers interviewed were self-employed earning about US$20 monthly and keeping 4 or more orphans; 60% of orphans interviewed were not attending school due to an inability to pay the tuition fees and levy costing approximately US$5 per child; 99.9% of orphans interviewed received no counseling; and 99.9% of orphans interviewed lacked basic food (Chigubu, 1998).

In February 2000, this study won US$100,000 from the World Bank Innovative competition as seed money for Zimbabwe projects that would help alleviate the horrendous poverty being experienced by both the kinship caregivers and the orphans.

Dedication from:

chigubumercy@hotmail.com
chigubum@msu.edu

To every human,

educated or uneducated,

young or old,

late or alive,

relative or not relative,

friend or not friend,

collaborator or non-collaborator,

educator or non-educator,

.....all of you,

share the "world perspective".

I have learned a thing or two,

from all of you good people,

and would not have come to be,

had it not been of your contributions,

directly or indirectly.

ACKNOWLEDGEMENTS

I thank Dr. Robert Boger, my major professor from the Department of Family & Child Ecology, College of Human Ecology, academic advisor, and dissertation director; Dr. Robert Griffore, professor from the Department of Family & Child Ecology, College of Human Ecology, my dissertation committee member, who taught me Human Development, and Quantitative Statistics, subjects useful for my Research Qualifying Examinations, the passport to this study; Dr. Holly Brophy-Herb, professor from the Department of Family & Child Ecology, College of Human Ecology, my dissertation committee member, who taught me Peace Education, Infant Studies, and assisted with unique resource materials for my doctoral comprehensive examinations and this study; and Dr. Philip Cusick, Chair & Professor: Educational Administration Department, College of Education, my dissertation committee member, and cognate supervisor, who taught me Qualitative Research pivotal in this study. I also thank Dr. Francisco A. Villarruel, professor in the Department of Family & Child Ecology, my academic advisor in the first phase of the Ph.D. program. Further, I thank Dr. Norma Bobbitt, professor in Family & Child Ecology, who taught me the Theory Construction Course, instrumental in the writing of this dissertation, and essential in securing the US$100,000 Award I won from World Bank (2000). I thank Dr. Vladmir Shlapentokh, professor from the Sociology Department, who taught me Advanced Research & Statistics. I acquired snowball-sampling skills for taboo topics of hard-to-locate groups, a technique I piloted in the USA (1997), and applied in Zimbabwe (1998). Finally, my special thanks to all professors at Michigan State University who taught me.

Funding: My research received funding through the MSU Graduate School Dissertation Incentive Award. Hats off to the Dean, Dr. Karen Klomparens. I thank her also for the Dissertation Completion Award. I thank the Rockefeller Foundation for the Africa Dissertation Proposal Writing Workshops; Dr. Jeanette Gassaway from the Psychology Department, for the research assistantship when I had one week left before my immigration visa expired; the American Association of University Women for a year's award; my Department Chair: Dr. Marjorie Kostelnik for a teaching assistantship and a number of Family & Child Ecology awards; the W. K. Kellogg Foundation, for the Master's Degree fellowship; the MSU International Center's Director Dr. David Horner, staff, and especially Ms. Margaret Arbanas for short-term loans, a number of awards, and moral support; the Dean, Dr. John Hudzik and Mr. Gregory Deppong, Finance Director for MSU International Studies & Scholars Program, for generously funding the Washington DC trip to the World Bank Competition where I won US$100,000. I thank the Director of MSU Institute for Children, Youth & Families: Dr. Marguerite Barratt; Ms. Lori Strom from Child Care Services; and Dr. Monica Goble, Cardiovascular Professor in Human Medicine for the graduate research assistantships.

Mentoring: Vice Chancellor, professor, and overseas mentor from the University of Zimbabwe: Dr. Peter Dzvimbo, you encouraged me with your words: "Fight on the intellectual battle, a warrior never gives up!" From UK: Commonwealth Secretariat, I thank Dr. Samuel Agere for being one of my overseas mentors. In the USA, I thank the Family & Child Ecology Dept. Office staff. I thank Dr. Mary Zabik, the former Associate Dean, Academic Affairs: College of Human Ecology for the academic support.

I thank the Dean of the Human Ecology College: Dr. Julia Miller for moral support and intellectual growth. I thank Dr. Won Song the Associate Dean, Academic Affairs: College of Human Ecology for the Dissertation Completion Fellowship. I thank Dr. Lee June the Vice President of Student Affairs and Assistant Provost, the Director of Student Affairs: Ms. Penny Wali, and all the related staff for the emergency assistance in putting the whole dissertation document together ready for distribution.

Networking: In Zimbabwe, I thank Mrs. Esnathy Kuyeli, Mrs. Joyce Karimupfumbi, and Mrs. Laina Choyemura, my three grassroots research assistants. From the USA, I thank Marcia Vandenberg, a Ph.D. student in the Family & Child Ecology Department. "You are an unassuming, and a valuable mentor, Marcia!" I thank the President of World Bank, Mr. James Wolfensohn, who raised US$5 million for the World Bank Innovative Competition.

Editor of this Dissertation: Ms. Rosemary Faiver "I salute your prowess."

My Immediate Family: I thank all immediate and extended family members, my parents, Mr. & Mrs. Maodzwa, and siblings. To my beloved 7-year-old daughter, Krystal, Nerudo you are a shining star in my life. You stood by me through thick and thin. To 18-month-old Kuda (Kukustar) Makayla, you gave me joy. Last but not least, I thank my husband Archie, for the great support especially during data collection.

Divine Power: God Almighty, You have been very good to me. You powerfully answer my prayers. *"Who can be against us, if the Lord is for us?"* Thank you God, Jehovah, Mwari!

TABLE OF CONTENTS

APPENDICES

TABLE LIST

LIST OF FIGURES

Chapter 1

INTRODUCTION

Muchatii, stigmatized from her full-blown AIDS status, worries about her children aged 5 to 14 years old who are out of school. "Soon they will be labeled orphans by parental HIV/AIDS and I do not know who shall give care to my children!" she ponders. Before her husband, Jo, died of AIDS, her children were in school and she was economically stable. While the invisible, voiceless children are orphaned by their parental HIV/AIDS, at times the popular news is: "child prostitution on the rise" (child is girl) or, "...women neglect child care..." or "...street-kids hit the cities..." As fictitious as this story might sound, the writer argues that with the advent of HIV/AIDS in Africa, the family institution has been battered and weakened in a way that has left many young children orphaned, impoverished, and forced by circumstances to migrate to join relatives.

Simultaneously, most kinship caregivers taking in these orphans assume increased unpaid care-giving roles, (Chigubu, 1998). In summary, there is a gigantic problem of orphans from parental AIDS, not only in Zimbabwe, but also in Africa in general.

Statement of the Problem

This study investigated the self-esteem of orphans whose parents died of HIV/AIDS in Zimbabwe. This was explored by examining the role of women as kinship caregivers of orphans, and manifested by differentials in the kinship caregiver's economic well-being, social support networks, and child-rearing practices. This process of

examining involved the researcher exploring the phenomenon ("case study"), and examining human experiences through the detailed descriptions of the people being studied. The desire to better understand the lived experiences of participants signifies phenomenology as a philosophy as much as it is a method of research. (Habermas, 1971; Nieswiadomy, 1998).

The problem in sub-Saharan Africa, particularly Zimbabwe, is a documented high level of unmet need for kinship care giving of orphans whose parents died of HIV/AIDS. The HIV/AIDS crisis is a highly stigmatized catastrophe. These realities are based, among other findings, on the Zimbabwe Demographic and Health Surveys (1994), and this research by Chigubu (1998).

Background of the Study

The steep rise in the numbers of orphans cannot be contemplated in isolation from the social and economic changes that have taken place in Zimbabwe. Parental HIV/AIDS death forces orphans in sub-Saharan Africa, particularly land-locked Zimbabwe, to migrate and unceremoniously join relatives already facing severe economic hardships from vestiges of 20+ years of guerilla war, 15+ years of consistent drought, global sporadic economy decline, the Economical Structural Adjustment Program, devaluing of local currency, retrenchments, and, among others, the stigmatized HIV/AIDS epidemic which impacts kinship child-rearing practices, social support networks, and brings about the "feminization of poverty" (Johnson,1988) and a diminishing of the orphans' self-esteem. This phenomenon has triggered the creation of an under-class, namely, orphans.

Research reveals that poverty in Zimbabwe's extended families that are unceremoniously joined by orphans from parental HIV/AIDS deaths is alarming (Chigubu, 1998). The target sample revealed that 60% were impoverished, young or middle-aged widowed women, 76% were self-employed earning less than US$20 monthly, and on average, and were keeping more than four orphans. Sixty percent of the orphans interviewed did not attend school due to the lack of ability to pay school fees or levy, 99.9% of the orphans interviewed had extremely low self-esteem, and 99.9% of orphans interviewed did not receive psychological nor emotional counseling during their parent(s)' ill health, parent(s)' funeral, nor after their parent(s)' funeral. Most orphans lacked basic food.

Recent research carried out by Chigubu (1998) to study among other factors, experiences and coping mechanisms of extended family kinship caregivers who take care of the orphaned young children due to parental HIV/AIDS, had interesting results. The findings of that study revealed why there continues to be a steep rise in orphans from parental HIV/AIDS deaths in Zimbabwe (Appendix B), which makes this study a rich base for future works on families, children and HIV/AIDS.

The HIV/AIDS epidemic has triggered excessive poverty and creation of an "under-class" among families. In some well-to-do families, wealth and individualism has greatly inhibited closeness and sharing in a manner that has never before happened. Alienation among families widens deeper as rich become richer, and poor become poorer.

An increasing number of orphans are being left on their own. Some are absorbed by the extended families, and some families offer more potential for the future than others. When orphans join extended families, a problem of overcrowding arises. Overcrowding

of young children may lead to diarrhea, eye and ear infections, communicable diseases, stress, alienation, irritation and other symptoms of stress.

Emotions felt by children who had been orphaned when their parents died of HIV/AIDS were like those experienced by youths that had witnessed parental suicide, rape or homicidal behavior (Dane & Miller, 1992). On examination, many of these children suffered from Post Traumatic Stress Disorder (Dane, 1994). The children experienced a "survivor guilt disorder syndrome" that prompted them to feel guilty for having survived while their parents had died of HIV/AIDS. Some orphans are institutionalized; while others end up in chaotic home environments, driving them ultimately into homelessness. In Zimbabwe they are termed "street kids." Some children and adolescents formerly raised in affluent homes in the cities end up joining some of their poor relatives, resulting in hardships of adjustment for the families to the children's downward mobility.

McLoyd (1990b), reviewing the impact of economic hardship on US Black families and children argues that poverty diminishes the capacity for supportive, participatory, and consistent parenting. She posits that negative life events, coupled by chronic sub-human living conditions or a disruption of marital bonds associated with the effects of poverty, lead to psychological distress, irritability, depression or anxiety. The numbers of orphans from parental HIV/AIDS deaths globally are estimated to be ten million. Most of these orphans are said to be in abject poverty, and the largest percentage of them come from Africa (World Health Organization, 1993).

These negative events of poverty impact the caregiver's coping mechanisms; and hamper the ability of children to adjust to their parental loss. In most cases, the care-

giving of the orphaned children is underpinned by the ecological conceptualizations of how gender, class and power relations differences, (e.g. patriarchy) in access to and control of the resources; interact to create multiple systems of oppression and inequalities that exist between men and women. Harding (1991) explains that gender relations in any particular situation are always constructed by the entire array of hierarchical social relations in which both men and women participate.

Women do most of the domestic work, and are the ultimate caregivers in Zimbabwe. "There's not a life nor death, that has a feather's weight or worth, without a woman in it" (Bowman and Howard, 1985). Constraints that exacerbate this unmet need are male migration for employment (Batezat & Mwalo, 1989), and cultural norms, which result in women carrying most household burdens. A study by Johnson (1988) reports that Zimbabwean males constitute 27% of farm labor, 38% of livestock care, 19% of fetching fuel, and four percent of cooking, collecting water, and child care.

In rural areas women take on tasks that were known to be men's work, due to men's rural-urban migration. Family ties are strong and extended family phenomena are culturally typical. The economy is agriculturally based. Rural areas are roughly 50% of the country's arable land in the worst natural regions and sustain lives of more than 60% of the ten million people. Most of these are women and children and are poor (Chipika & Getecha, 1995).

Culturally, Zimbabwean families always embraced the idea of the extended family. With the advent of HIV/AIDS, this culture seems to be overtly and covertly repulsed due to the magnitude of AIDS stigmatization, economic recession, and increasing numbers of orphans, a problem impacting care giving. Whereas relatives once welcomed orphans

without remorse, they now are negatively affected by the poverty and have a great deal of difficulty caring for additional family members.

The first incidences of AIDS cases in Zimbabwe were diagnosed in 1983, and in June 1992 Zimbabwe reported to the World Health Organization 14,023 AIDS cases (World Health Organization, 1993). Reports show that hospital patients infected with HIV-1 were almost tenfold higher in urban areas than rural areas (Denhe *et al.*, 1992). Consequently, this study was conducted in the peri-urban areas of Harare, the capital city of Zimbabwe.

HIV/AIDS has a social stigma within society that is associated with prostitution by society. This stigmatization is also perpetuated by most epidemiologists who loosely utilize the term "prostitute" in nearly every study of HIV/AIDS in Africa, while very rarely providing the definition. One question is: "What is a prostitute in the African context?" In HIV/AIDS prevention campaigns, studies show that males are asked: "Have you had sex with prostitutes?" (Wallinga, Paguio, & Skeen, 1987). Implications are that increased risk of HIV infection is prompted by being a prostitute and or having sex with a prostitute. Models used to explain HIV transmission and AIDS in Africa are predominantly linear and behaviorally deterministic (Mahommed, Houston, Neill, Ray, & Marowa, 1991, and 1995).

HIV/AIDS is linked with bad morals, contagion, an untimely death sentence, and stigma (Conrad, 1990; Alonzo & Reynolds, 1995). This stigma leads parents with HIV/AIDS into "denial," and causes them to become ashamed of disclosing their predicament to their children, a behavior commonly termed "courtesy stigma." It is

harmful to the children's self-esteem, reflected love, and emotional and psychological stability.

Consequently, stress paradigms resulting from societal HIV/AIDS stigmatization are outrageous, particularly in imparting kinship care giving resources to orphans of HIV/AIDS dead, and coping with the assumed negative changes (Henry, 1990; Korbin, 1992; Neighbors, Forehand, & McVicard, 1993; Samuelson, Foltz & Foxall, 1992).

The Zimbabwe situation cannot be evaluated in isolation of the prevalent socio-economic changes that have taken place. The HIV/AIDS plague came five years after a protracted war leading to the 1979 independence, and coupled by severe droughts, which adversely affected livelihood. Poverty levels of families have further deepened due to the effects of the Economic Structural Adjustment Program (ESAP), which included the devaluation of the local currency, removal of subsidies, and a hike in prices, thus creating an under class and a bourgeois class, where the rich get richer, as the poor get poorer. Wealthiness and individualism, versus abject poverty and helplessness, have cut traditional family ties, closeness, and sharing in a way that has never before happened.

Questions that remain unanswered are on the kinship care giving of orphans in a home setting. What are the joys and stresses? The unaddressed needs of children when parents die of HIV/AIDS in Africa is crucial (Mhloyi, 1995). In a study with Ugandans from four villages hit by HIV/AIDS, thirty guardians cited money, food, and health care as critical. African culture does not provide counseling to families taking on orphans whose parents died of AIDS, nor are the orphans given counseling, nor the choice to decide which relatives with which to live. Therefore, this too contributes to the strain imposed on the kinship caregivers of orphans in a home setting.

Extended family norms influence the roles of social support for children. However, the stigmatization and denial negatively impact the existence of social support from friends, relatives and society. Technological issues that might insinuate the unmet need in Zimbabwe and the sub-Saharan Africa are the absence of nationwide emotional therapy and empowerment zones for the bereaved orphans whose parents died of HIV/AIDS, programs on parenting education, and kinship care-giving education on orphaned children whose parents carried the HIV/AIDS stigmatization.

This researcher's expertise on families, children, and human ecological issues that were acquired in the U.S.A. prompted the need to carry out this important study. Most sub-Sahara African countries with high rates of HIV/AIDS would benefit from such a study. These countries have large segments of populations with little education, little employment, little wealth, poor nutrition, poor health, hazardous living conditions, and low income (Haan, 1982).

Relevance of the Study to African Development

No study exists in Zimbabwe on women's home-based kinship child-rearing practices for orphans from parental HIV/AIDS whose stigma might affect child self-esteem. Considering the magnitude of the AIDS orphans problem in sub-Saharan Africa, and the continual rise in parental AIDS mortality (World Health Organization, 1993, 1995), this study will connect the global community to the Zimbabwean strengths and failures in either sustaining or battering the orphans' self-esteem, and in educating the world community about the stresses and joys in the kinship care giving of orphans whose parents died of AIDS.

The long term goals of the study are to (a) promote orphans' self-esteem by providing support for kinship care givers, (b) promote the potential for training for developmentally appropriate parenting and parent education, as well as kinship child-rearing practices that instill self-esteem in orphans, and (c) empower women in their endeavors to promote sustainable development. This writer is laying the baseline for future studies on HIV/AIDS, families, and children, as well as how to start and run home-based, group-based, and family-based programs for orphans whose parents die of AIDS. Kinship caregivers training workshops, parenting education and orphans' counseling outlets will also be facilitated.

The study will help future scientists to draw various hypotheses, theories and conclusions. It will benefit the global community, policy makers, families, educators, international or local donor agencies, religious groups, humanitarian agencies and all concerned with child survival, women's issues, HIV/AIDS victims, and families. This work will support efforts made by the Zimbabwe government, and non-governmental organizations, to promote the survival of the orphan children, as well as HIV/AIDS awareness campaigns.

This research was not an isolated effort, which lacked back-up support. It was designed to contribute to the works done by others like Mulenga (1993), whose study was carried out in Zambia, a neighboring country to the north of Zimbabwe. Mulenga cites that with the extreme poverty and rising mortality rates, it is of little surprise that 40% of Zambian households are caring for orphans. In a study of HIV/AIDS in Zambia, Haworth (1991) reported that 24% of orphans whose parents died of HIV/AIDS experienced stigmatization in the community. Similar patterns occurred in Ugandan family networks

taking care of AIDS orphans and are shown in Bledsoe's study (1993) in Sierra Leone. This work by Chigubu adds new dimensions specific to Zimbabwe. Aspects of how care giving of vulnerable children operates in Zimbabwe and the rest of Africa deserve attention. In 1990, the United Nations adopted a Convention on the Rights of the Child, stating details for upgrading the lives of children throughout the world (UNICEF, 1990).

In carrying out this study, the researcher did not set out to prove any particular theory, but to explore a taboo topic by way of a study that had not been carried out previously. In so doing, the researcher utilized diverse concepts, and frameworks were merged into a visual conceptual map (Figure 1.1). This process involved building a theory or model that could be later utilized by future researchers and scholars. Details of both the conceptual theoretical framework and conceptual operational model are discussed in Chapter Two.

CONCEPTUAL MODEL

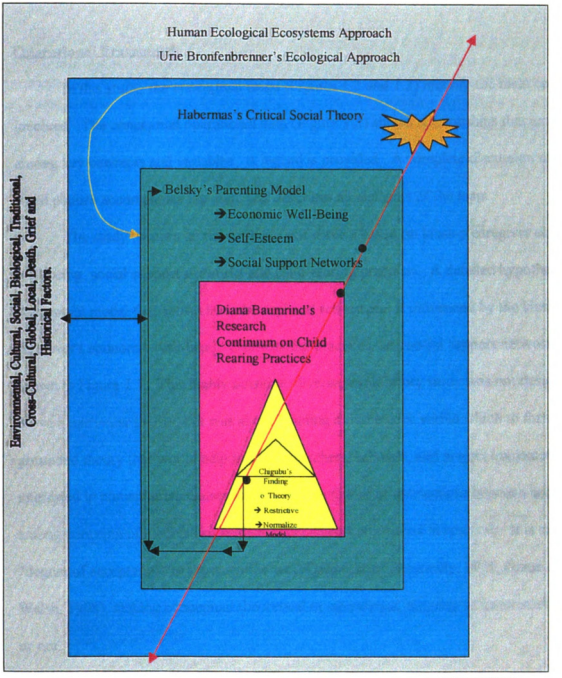
Theoretical Framework

Two categories of theories are applicable to this study, namely background and foreground (Figure 1.1), and are mapped into a theoretical framework. From the theoretical framework, the operational model (Figure 1.2) was constructed. The investigation was carried out from a critical science orientation, utilizing two process models of parenting, within a human ecological framework.

The intent of the research was to explore and foster an understanding of the effects of the kinships' child rearing practices, economic well-being, social support networks, and orphans' self-esteem after parental deaths.

The model posits an ecosystems framework supported by two parenting models and a critical theory. The map shows location of the model, informants' four coping mechanisms, and the discovery of four schools of thought by Chigubu (1998), that might be one of the answers why Africa, and Zimbabwe in particular, will continue to have a rise in the number of orphans whose parents died of HIV/AIDS, despite the numerous HIV/AIDS awareness campaigns by the Government of Zimbabwe, and various non-governmental organizations. The map also shows a holistic link relating to the project.

Figure 1.1 **Theoretical Map : Conceptual Model**



© Mercy Chigubu 2000

Legend

- Diana Baumrind's Child Rearing Continuum
- Habermas's Critical Theory
- Belsky's Parenting Model
- Chigubu's Finding
- Bronfenbrenner's Ecological Approach

Theory Cuts Across
Bi-directional relationship
Uni-directional relationship

CONCEPTUAL MODEL

Operational Framework

In this study, the conceptual maps (Figures 1.2 and 1.3) identify the main concepts involved. The conceptual operational map (Figure 1.2) shows relationships that exist among key concepts and variables. A legend is provided. A complete discussion of the word picture accompanies the map, and describes all elements of the map.

The study focuses on the orphan's self-esteem based on kinship caregiver economic well-being, social support networks and child-rearing practices. A detailed hypothetical conceptual model that shows how the orphans' self-esteem is influenced by the kinship caregiver's economic well-being, child-rearing practices, and social support networks is shown in Figure 1.3. This highly sensitive, diverse, exploratory study was not designed to prove a particular theory, but was about building a framework within which to formulate a grounded theory that would help future researchers, scholars, and project implementers interested in humanitarian causes in Africa. The nature of connections between and among concepts of models can neither be accepted nor rejected in research. It is the "degree of acceptance" to the scientific world that counts (Reynolds, 1971; Graue & Walsh, 1998), making conceptual theoretical or operational mapping of frameworks work or not.

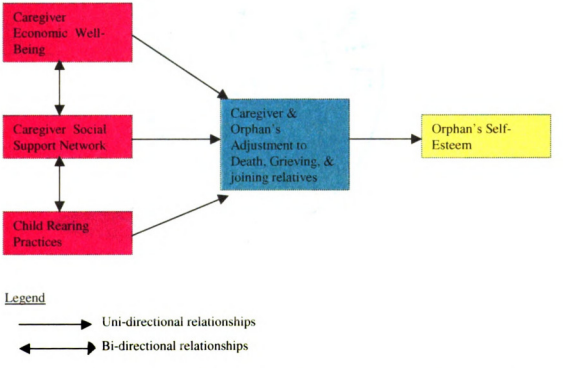
Figure 1.2 **CONCEPTUAL MODEL**

Dissertation Title:

Exploring self-esteem of orphans whose parents died of HIV/AIDS; examined through the extended family/kinship caregivers' economic well-being, social support networks, and child rearing practices in Zimbabwe.

Operational Map:

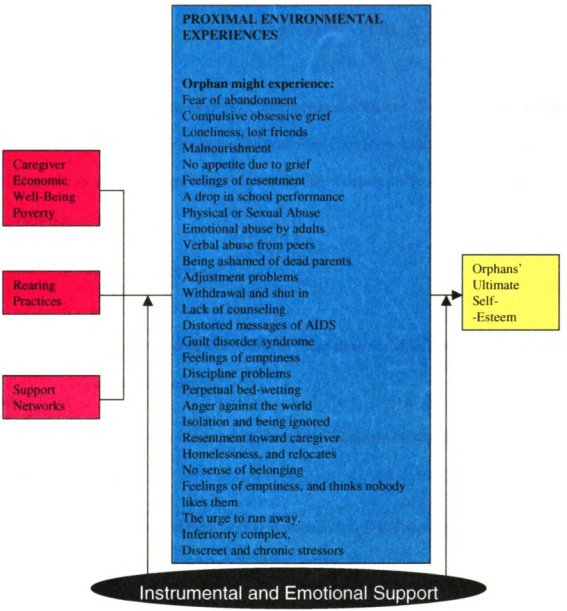
This is not a model that will be tested quantitatively in this study.



Designed by Chigubu, M. (2000) Michigan State University, College of Human Ecology, Dept. of Family & Child Ecology.

Figure 1.3 A HYPOTHETICAL CONCEPTUAL MODEL

Figure below presents a hypothetical conceptual model:



A hypothetical conceptual model of how orphan's self-esteem is influenced by kinship care-giver economic well-being, social support networks, and child rearing practices.

Designed by Chigubu, M. (2000) Michigan State University, College of Human Ecology, Dept. of Family & Child Ecology, USA. This is a result of the research done by Chigubu, M. (1998), in Zimbabwe.

Chapter 2

REVIEW OF LITERATURE

This chapter on the review of literature is divided into two major sections that contain several subsections. The section entitled Operational Model: Conceptual Mapping reviews literature on the association between the three kinship caregiver variables, namely:

1. economic well-being,
2. social support network,
3. child-rearing practices, and how these three variables assist in examining the orphans' self-esteem.

The second section is entitled Theoretical Framework, and it reviews literature on the following:

1. U. Bronfenbrenner's (1979) Human Ecological Perspective,
2. J. Habermas' (1971) Critical Social Theory,
3. J. Belsky's (1984c) Determinants of Parenting, and
4. D. Baumrind's (1995) Child-Rearing Practices Continuum.

OPERATIONAL MODEL

Kinship Caregiver's Economic Well-Being

The situation of increasing numbers of orphans of parents who died of HIV/AIDS in Zimbabwe is problematic. When these orphans join extended families, in some cases a shortage of adequate resources for the kinship caregivers to support these orphans arises (Chigubu, 1998). Consequently, overcrowding occurs when orphans join in. Overcrowding of young children and adolescents often leads to frequent diarrhea, eye infections, stress, alienation, irritation and others.

Of the world's population, 80% lies within the developing world, where about 13 to 18 million, mostly children, die yearly of hunger, malnutrition, dangerous environments, and poverty-related causes (Speth, 1995). The fragile living conditions of orphans in Zimbabwe have required a high proportion of orphans to relocate and has forced a great number of children between the ages five and seventeen years to join their extended families, uninvited. In most cases, these relatives are already experiencing severe economic hardships even before these orphans join them due to the effects of the devaluation of the local currency, drought, global economic decline and Zimbabwe's Economical Structural Adjustment Program, which has left the poor poorer than ever before. Simultaneously, HIV/AIDS deaths that keep occurring deplete resources within immediate neighborhoods and surrounding communities, placing a strain on the kinship caregivers' economic well-being (Chigubu, 1998).

The effects of poverty inhibit parents in their parenting role, manifesting stresses and frustrations that constrain parents and kinship caregivers from providing the stimulating and nurturant care they desire for their children (McAdoo, 1988). There is

documented evidence which shows that poverty exposes caregivers, children and families to a variety of chronic stressors that negatively impact how individuals function (Taylor, 1997). Research consistently shows differences in developmental status, health, quality of the home environment, and self-esteem for non-poor versus poor children, favoring those from homes with higher incomes (Kronenberger & Thompson, 1992; Mertens, Tondorf, Siebolds *et al.*, 1992). However, poverty does not uniformly impact children (Escalona, 1982). Describing a group of resilient children, Boyce and Jemerin (1990) indicate that, despite environmental risks, some children yet develop into well-functioning individuals, free from notable developmental problems. Psychological factors associated with resiliency can exist among young adults who experienced risky circumstances during the first two years of life (McLoyd, 1990b).

Chronic stressors experienced by some poor Zimbabwean parents and kinship caregivers, who also happen to be black, might undermine their parenting or child-rearing practices because economically poor parent/kinship caregivers are psychologically and emotionally distressed. Why black Africans only, when Zimbabwe is a heterogeneous country? Developmental history reveals that the factors that account for the structural and functional differences that exist in the Zimbabwean families are based on race, gender, and class. Hence, it comes as no surprise that the majority of the Zimbabwean population consists of poor African families, the great majority of whom are black, and that they are the ones taking in orphans whose parents died of HIV/AIDS. Most of them live in neighborhoods lacking in social and financial resources (Chigubu, 1998).

In Figure 1.3, the Conceptual Model depicts how stressors such as financial hardship or neighborhood AIDS stigmatization have an effect on both the kinship

caregivers' and orphans' adjustment to the current situation, through their impact on the extended families'/kinship caregivers' economic well-being and child-rearing practices. Kinship caregivers living in the context of financial hardship and neighborhood HIV/AIDS stigmatization due to the orphans who joined them, may be more emotionally drained, psychologically distressed, and hence, less able or inclined to effectively engage in developmentally appropriate child-rearing practices.

Results from the research done by Chigubu (1998) reveal that up to 80% of the kinship caregivers of these orphans are facing extensive economic hardships. Findings from a number of investigations have indicated that economic strain is associated with a variety of socio-emotional problems and negative self-esteem challenges both in children and adults. Indeed, poverty has been associated with problems in peer relations (Langner, Herson, Greene, Jameson, & Goff, 1970), depression (Gibbs, 1986), somatic symptoms (McLoyd, 1990b), conduct disorders, social-maladaptation and psychological disorders (Kellam, Ensminger, & Turner, 1977; Myers & King, 1983). Specific findings have indicated that family income is associated with the quality of caregiver-peer relations, and consequently orphan-peer relations.

Family scholars' research (Elder, 1974; Elder, van Nguyen, & Caspi, 1985) on families experiencing the Great Depression, revealed that mothers in families experiencing deprivation were likely to report that their children, especially adolescents, had emotional problems. Further, Conger and his colleagues (Conger, Conger, Elder, Lorenz, Simons, & Whitbeck, 1992) have shown that family income is linked to children's school performance and self-confidence.

A substantial body of literature argues that economic hardship has a negative influence on individuals' psychological functioning and on the quality of family relationships (Ge, Conger, Lorenz & Simons, 1994; Conger *et al.*, 1992; Lempers, Clark-Lempers, & Simons, 1989; McLoyd, 1990b; McLoyd, Jayaratne, Ceballo, & Borquez, 1994). HIV/AIDS drains all of the socio-economic resources available to parents in their endeavor to seek medical treatment. At the time death occurs, families are already facing economic hardships. Thus, losing parents to HIV/AIDS for most of these children means facing immediate abject poverty.

Recent work has also investigated the impact of parental/caregiver employment on family functioning (Flanagan & Eccles, 1993). This work indicates a positive association between unstable employment and disruptive behavior by young children, especially middle scholars and adolescents, and a low rating of competence by teachers. This further demonstrates to us how the orphan's self-esteem can be further battered when he/she joins the extended family where the economic well-being of the caregiver is handicapped.

There is documented evidence in the research, which examines the impact of low-income families living in stressful neighborhoods and communities on young children's functioning, and linking this to middle school and adolescent problem behaviors. For instance, Hogan and Kitagwa (1985) argue that living in a neighborhood with a high proportion of poor families increases a youngster's likelihood of becoming pregnant.

Evidently, HIV/AIDS stigmatization of the infected or affected has become common phenomena in many neighborhoods and communities in Zimbabwe. To the victims of HIV/AIDS, this can be very stressful indeed. It is important to understand how stressful experiences linked to poverty, AIDS stigmatization, or declining neighborhoods

influence individuals' functioning. For example, poor families may face unremitting stressful events such as a high rate of frequent deaths of relatives due to AIDS, numerous orphans from different relatives joining in, poor health, and many others. These stressful life experiences may, indeed, mediate the relationship between economic resources, neighborhood quality, child-rearing practices and orphans' self esteem.

Stressful experiences have been linked to mental health problems for both children and caregivers, trouble with the law, and children's school adjustment problems (Masten, Nemann, & Andenas, 1994), as well as psychological distress (Taylor & Roberts, 1995). Taylor and colleagues (1993) found that among poor families, stressful events in the areas of interpersonal relations (marital problems, family conflict) and family disruption (frequent moves, death in the family) are associated with psychological distress.

During field research in Zimbabwe, Chigubu (1998) found that there were a number of orphans who displayed mental health problems after joining their poor relatives. Recent research (Roberts & Taylor, 1994a) examined the association between family stress, parenting practices, parental adjustment, and adolescent adjustment in families living below the poverty threshold. Findings showed that mothers' health problems and marital problems are negatively associated with adolescents' sense of autonomy and self-reliance. These findings can be directly applied to the situation of orphans in Zimbabwe today.

Despite the negative impact of caregiver economic well-being, there is documented evidence that reveals that economically disadvantaged families and kinship caregivers employ a variety of strategies and living arrangements designed to moderate the impact of poverty. Some of the strategies may include the sharing or pooling of resources across

extended families, the sharing of blankets, food, child-rearing, or co-residence, and others (McLoyd, 1990b).

Kinship Caregivers' Social Support Networks

There is extensive literature arguing for the importance of kinship support as a culturally distinctive feature of family life (Aschennbrener, 1973; Billingsley, 1968; Hill, 1978; McAdoo, 1982). Empirical studies show that adults and children benefit from the availability of an extended kin network (Dressler, 1985; Kellam, Adams, Brown, & Ensminger, 1982). Dressler found that although economic strain is linked to increased support from kin, kin support is associated with lower levels of depression.

In the USA, research has shown that African-American teenage mothers display more adequate parenting and better adjustment when assistance from kin is present (Colletta, 1981; Furstenberg & Crawford, 1978). In studies on the impact of kinship social and emotional support on adolescent psychological well-being, Taylor, Casten, & Flickinger, (1993); and Taylor & Roberts, (1995); found a positive link between support and several indices of adjustment.

According to Vaux (1988), social support network vulnerability may indirectly or directly affect the degree of cohesion among families and communities. Vaux emphasizes that the value of network resources depends on their capacity and willingness to provide appropriate assistance to the focal person in need. Vaux indicates that the capacity to function positively is assumed based primarily on the network size, composition, and quality of component relationships. Vaux cites two related kinds of vulnerabilities that might impact networking, and these are stressor and support-need homogeneity.

According to Vaux (1988) stressor homogeneity relates to members of networks who might be occupying a similar ecological niche and suffering the same trials and tribulations. They could be vulnerable to the same stressors. This is typical of what was found in Zimbabwe during field research (Chigubu, 1998).

Networks of widowed caregivers taking care of orphans whose parents died of HIV/AIDS were found in Zimbabwe. They had shared experiences, and at times all these networks lived in the same deteriorating neighborhoods. Most of the time, the shared experiences of these kinship caregivers made their networks vulnerable, thus diminishing their capacities to provide essential support. In most cases, the network members found themselves in competition for alternative resources, for example clients to buy their back yard vegetables and fruits for sale.

Vaux (1988) states that a related form of vulnerability might occur if network members experience needs that are similar to those of the focal person. This was a phenomenon found in Zimbabwe (Chigubu, 1998). Orphans that joined extended families uninvited were extremely economically disadvantaged in most cases. For those kinship caregivers who were extremely poor and had orphans joining them uninvited, they ultimately formed a network of members with the same kind of vulnerability. The vulnerability even trebled when the kinship caregiver tried to keep pace with the external networks that also lacked financial resources, wisdom to discuss HIV/AIDS with orphans, transportation if the orphan or they themselves fell ill, information on child-rearing practices that promote self-esteem to orphans whose parents died of HIV/AIDS, time to counsel the grieving orphans, time to relax, and ways of dealing with the downward spiraling self-esteem of both orphans and caregivers.

Vaux (1988) winds up his argument by stressing that when the demand for social support networks exceeds the supply available, then the network resources are highly likely to be drained over time, and consequently the needs will not be met. This is typical of what is going on currently in Zimbabwe to those extended families joined by orphans, and the networks that formerly provided help and assistance, are becoming excessively vulnerable.

Vaux (1988) cautions that a social support network might be thought of as having "sustainable yield", defined as a level of supportive behavior that it could provide without difficulty. At this level, yield could be pushed beyond this ability to provide. Vulnerability becomes imminent when the desperate network member bothers, or charms, or horrifies other network members enough to elicit more assistance.

However, there comes a point when the network cannot be pushed beyond a certain threshold without serious damage being done, damage that might destroy it as a support resource - within its confines of sustainable yield, thus failing to elicit successful supportive behavior, but which can nonetheless, often deepen relationships and result in enhancement of support network resources. According to Vaux (1988), an ecological aspect of support is thereby formed. For instance in Zimbabwe, according to Chigubu (1998), most kinship caregivers interviewed indicated that their social support networks had decreased immensely after the orphans joined in, evidently a good example of the disadvantaged ecological aspects of support Vaux (1988) is discussing.

While social support will enhance the orphans' well-being through its positive effects on kinship-caregiver well being and parenting behavior, it is unfortunate that at times, social support may also undermine the positive cause that is intended. For instance,

the support networks of the kinship caregiver might not be knowledgeable about developmentally appropriate practices that are sensitive to the needs of orphans whose parents died of HIV/AIDS, and self-esteem realities that might be highly vulnerable, or negative due to AIDS stigmatization.

Kinship Child-Rearing Practices

The state of kinship caregiver child-rearing practices can directly impinge upon an orphan's growth and development. It is crucial for kinship caregivers to know appropriate kinship care-giving for children who may have increased vulnerability. Inadequate parenting and the impact of caregiver economic well-being differ across families or cultures in poverty (U.S. Department of Health and Human Services 1991b). There is documented evidence that among children living in poverty, there exists a cycle of failure which leads to increased morbidity. On the other hand, literature also reveals that there indeed is a cycle of success, which elevates some from succumbing to stress (Morgan, 1988).

When it comes to child-rearing practices, it is documented that in most cases, foster children suffer all kinds of discrimination compared to the family's natural-born children. Further, there is growing evidence that in terms of child-rearing practices; a child's achievement is often a function of the way in which he/she was raised (Barton, Dielman, & Cattell, 1974). In a study conducted in the United States on 169 sixth graders and 142 seventh graders tested on standardized achievement tests, in social studies, science, mathematics, and reading, the parents/caregivers of these children completed a Child Rearing Practices Questionnaire (CRPQ). Scores obtained from the CRPQ were

used as predictor variables, and results showed that rearing practices variables were significant predictors of both standardized achievement scores and grades attained (Barton, Dielman, & Cattell, 1974).

If we look at Figure 1.2 (p.13), the operational model depicts parents and kinship caregivers living in the context of stressors such as economic hardship, community and neighborhood AIDS stigmatization, and diminished social support networks are likely to exhibit less adequate parenting and poorer psychological adjustment for orphans joining in, which in turn can be detrimental to the orphans' self-esteem. Recent work suggests that there is a link between parents' distress caused by economic difficulties and parents'/kinship caregivers' child-rearing practices (Conger *et al.*, 1984; Conger *et al.*, 1992; Ge, Conger, Lorenz, & Simons, 1994). Further, it is proposed that stressors, such as financial problems, negatively affect parents/kinship caregivers' psychological distress, and parents'/kinship caregivers' distress, in turn, is associated with less adequate parenting, which in turn has significant bearing on the child's self-esteem.

Support for the model has shown that stressors including financial problems are associated with parents' mood swings and depressed moods, which are positively linked to harsh, inconsistent parenting (Ge *et al,* 1994) and restrictive caregiver-child communication (Chigubu, 1998). Links between financial difficulties, parental distress, and less adequate parenting have been most clearly demonstrated with rural white families (McLoyd *et al.*, 1994b).

In research among African-American two-parent families, findings reveal that families with more resources report greater optimism and lower depression. Higher optimism and lower incidences of depression are associated with greater mutual support

among parents, and lower conflict regarding caregiving (Brody, Stoneman, Flo, McCrary, Hastings, & Conyer, 1994). There is a limited pool of research linking neighborhood or community context and kinship parenting practices. Little of the work on neighborhood effects has directly examined the impact of characteristics of a family's neighborhood (safety, availability of resources, integration versus isolation) on parents'/caregivers' economic well-being and child-rearing practices. Furstenberg's (1993) work assesses the direct links between parents' behavior and the quality of the community.

This research has shown that families that live in a "cohesive" urban neighborhood - that is, with extensive social and financial resources, and financial resources, and with shared values and social trust among residents - are likely to utilize a variety of agents in the community to facilitate youths' socialization. Parents/kinship caregivers in these neighborhoods look to other residents to report on their child's behavior when away from their supervision, and they also rely on resources within the community to expose their youngsters to social and educational growth and stimulating activities.

On the contrary, families living in *anomic communities*, in which social and financial resources are impoverished, find that shared values and social trust are also depleted. These are some of the problems in Zimbabwe as observed by this researcher (1998), that are facing orphans whose parents died of HIV/AIDS. What the study reveals is that among the extended families living in the anomic neighborhoods and communities, there exists a perception that the caregiving environment is unsafe and the risk of AIDS stigmatization, exploitation, and HIV/AIDS denial to orphans under care is perceived to be high. Consequently, the kinship caregivers tended to restrict the orphans' contact with

others in the community to protect the orphans from being stigmatized and verbally abused.

Furstenberg (1993) states that indeed, parents/kinship caregivers may seek for outside neighbors to develop their youngsters' social networks. However, it is expected that parents' well-being is enhanced in cohesive neighborhoods and that they are, thus more likely to display better parenting practices. This is a challenge for the low-income neighborhoods where the research was conducted. For as long as people are in denial of HIV/AIDS, neighborhood "cohesion" which used to be the order of the day before the coming of HIV/AIDS, will continue to erode the quality of life everyday.

Garbarino and Sherman (1980) illustrate that the neighborhoods of families at high and low risk of child abuse differ in important ways. High-risk neighborhoods are said to be less stable, suffer from greater physical deterioration, and have more crime and sources of nuisance (problem bars, vandalized buildings). These areas are said to have higher rates of social problems including alcoholism, mental health problems, poor nutrition, and a higher infant mortality.

In their most recent work on examining parents' perception of their neighborhood and its relationship to their parenting practices, Roberts and Taylor (1994b) complement the findings of Furstenberg (1993) and Garbarino and Sherman (1980). Findings obtained from families living in disadvantaged neighborhoods again reveal that the more mothers perceive their neighborhood to be physically deteriorated and unsafe, the more depressed they become, the less accepting they also become, and the less they encourage mature behavior in their parenting practices.

In this study's operational model, kinship caregiver child-rearing practices and kinship caregiver psychological well-being (economic well-being + social support networks + community attributes) are the variables that mediate the association of stressors with positive functioning of the orphan and are thereby linked to the orphans' positive self-esteem. Thus, if my model is appropriate, this author must be able to show that kinship caregiver child-rearing practices and the kinship caregiver's own adjustment to the sudden influx of orphans who carry a stigma from their dead AIDS parents are indeed linked to the orphan's adjustment to grieving, and competence to sustain positive self-esteem.

A growing number of research studies have investigated the association that exists between parenting styles and child-rearing practices with indices of middle school children and adolescent adjustment. In the case of parenting styles, the impact of authoritative parenting on measures of adjustment has been investigated. Steinberg, Mounts, Lamborn, and Dornbusch (1991) looked at the effects of authoritative parenting on middle school children and adolescents' grades, psychological distress, self-reliance, and delinquency. The findings showed that African-American middle school children and adolescents in working class and middle class homes are more likely to report feelings of self-reliance and independence, and are less likely to engage in delinquent activities, to the effect that their homes were authoritative.

In similar studies conducted by Taylor *et al.* (1993), they noticed that among female-headed, working class, African-American families, authoritative parenting is also associated with self-reliance and an absence of problem behavior. Notably, it has been also indicated that among poor African-American families, parental acceptance and firm

behavioral control (two components of authoritative parenting) are significantly linked to adolescent adjustment (Taylor & Roberts, 1995)

Literature, however, documents that although authoritative parenting has been linked to adjustment among African-American middle school children and adolescents, authoritativeness is not a prevalent style among African-American families. This scholarly evidence is found in the works of Steinberg *et al.* (1991) who documents that only 12% of African American families were authoritative.

Scholars interested in the study of children and families suggest that African-American parents may employ a more restrictive, authoritarian style of parenting aimed at protecting their children from the dangers of urban life. This same reasoning is also echoed by Chigubu (1998) based upon her findings in Zimbabwe where 30% of the interviewed kinship caregivers of orphans whose parents died of HIV/AIDS employed restrictive parenting styles to orphans who were not informed that their parents had died of HIV/AIDS. The kinship caregivers pointed that they were restrictive particularly on information in-flow to the orphan in order to protect the orphans from the dangers of stigmatization due to parental HIV/AIDS deaths. This more restrictive style was thought to enhance the orphan's adjustment to the new environment.

There seem to be limited findings to support the argument for the beneficial effects of authoritarian parenting. Baumrind (1991a)states that authoritarian parenting is associated with independence and assertiveness for girls, but not related to school achievement. Fletcher (1994) found that authoritarian parenting is, however, associated with boys' school achievement.

Other research relevant to the impact of parenting styles on middle school children and adolescent adjustment has shown that maternal/caregiver affection and communication of mothers'/caregivers' goals for children are associated with children's school success (Slaughter, 1977).

Further, harsh corporal and physical punishment is positively linked with middle schoolers' and adolescent depression and cognitive distress - for instance, having difficulty both in making decisions and in remembering things (McLoyd *et al.*, 1994b) and conduct problems (Dodge, Pettit, & Bates, 1994). Studies carried out among white American working and middle-class adolescents, reveal that inconsistent and punitive discipline is also associated with delinquency and drug use (Lempers, Clark Lempers, & Simons, 1989). Brody *et al.*, (1994) noticed that mutual caregiving support for mothers and fathers is closely associated with adolescents' self-regulation (concentration, patience, and planned behavior tasks). On the other hand, adolescents' self-regulation is linked with higher academic performance, fewer conduct problems, and lower depression.

In terms of parents' racial socialization, a new twist was found regarding parenting behaviors relevant to parenting styles. A family scholar namely Peters (1985) argues that African-American parents, in preparing their children for the likely experience of racism, actively seek to inoculate them by enhancing their racial self-perceptions and self-esteem. Bowman and Howard (1985) discovered that to the extent that parents socialize their youngsters to be aware of racism and racial barriers, the middle school children and adolescents perform better in school.

Other documented evidence on child-rearing practices suggests that kinship caregivers/parents' family management practices may be associated with young children's

adjustment to the new environment. For instance, Clark (1983) in an ethnographic study of the factors that distinguish the homes of high versus low-achieving, low income African-American middle school children and adolescents, found that parents/kinship caregivers of the former work to structure and monitor adolescents' time and activities by establishing daily and weekly routines and schedules. These parents/kinship caregivers also actively monitor the adolescents' schooling through help with homework and attendance at school functions.

In a related research on the impact of African-American family management practices on middle school and adolescent behavior, Taylor (1994) found out that family organization as well as parental involvement in schooling are significantly associated with child adjustment (self-reliance and problem behavior) competence (school grades), and positive self-esteem. These scholarly research findings clearly show that many of the child-rearing practices and parenting behaviors that may be compromised by family stress (parental/caregiver warmth, family organization, parental/ caregiver accessibility) are also behaviors and practices linked to the orphans' well-being and positive self-esteem.

Young children, middle school, and adolescents exposed to less adequate parenting are at-risk for a number of psychological and behavioral problems (Aber & Cicchetti, 1984; Egeland & Sroufe, 1981; McLoyd, Jayaratne, Ceballo, & Borquez, 1994). Scholars in family and children's studies argue that a diminished quality of parenting may have adverse effects on children.

ORPHANS

Self-Esteem

Young children endure negative self-esteem and stress from their parents' crumbling relationship once both or one of them is diagnosed HIV positive. A study done in the USA on 59 adolescents from 40 families where the primary caregiver had died of HIV/AIDS showed that for these adolescents, alienation, dejection, anger and loss were crucial issues in their lives (Mann, 1991).

Few teens continued to stay in their homes, and many were negatively involved with law enforcement, played school truancy, declined in grades, had problems with teachers, and dropped out of school. Chronic adverse conditions have risk factors for low self-esteem, mental, physical and social ills (Mann, 1991). Adversities in early life and adolescence, impact negatively on the government's future spending on health care, high crime rate, and numerous social insults that do not sustain the nation's economic development.

Emotions felt by children who had been orphaned by their parental HIV/AIDS were like those experienced by youths that had witnessed parental suicide, rape or homicidal behavior (Dane, B. 1994). On examination, many of these children suffered from Post Traumatic Stress Disorder (Dane, & Miller, 1992). It was found that these children experienced a survivor guilt disorder that prompted them to feel guilty for having survived while their parents had died of HIV/AIDS.

Some children are institutionalized; others end up in chaotic home environments driving them into homelessness. In Zimbabwe they are termed street kids. Some children and adolescents formerly raised in affluent homes in the cities end up joining some of their

poor, extended families resulting in hardships in adjusting to downward mobility for these children. The esteem-elevating experiences of social support networks, developmentally appropriate child-rearing practices, and the ability of social support to promote a resilient self-conceptualized identity are viewed as central mechanisms of the effectiveness of support as a stress buffer (Cobb, 1976; Cohen & Wills, 1985; Thoits, 1986). Certainly for children, especially vulnerable ones like orphaned children from parental HIV/AIDS, the immediate family or extended family is a prime source of information in determining that one is a person of value who is esteemed by others (Sandler, Miller, Short, & Wolchik, 1989).

There is documented evidence that family social support is related to self-esteem and self-concept. The esteem-enhancing aspects of parental or kinship caregiver support (Greenberg *et al.*, 1992) are found in both mothers' and fathers' provisions of support to their young and adolescent children (Barrera, Chassin & Li, 1993; Hoffman, Ushpiz, & Levy-Schiff, 1988). Popular are the theory and measures that conceptualize self-concept as consisting of distinct components which correspond to domains such as scholastic competence, social competence with peers, and physical abilities (Harter, 1982).

Orphanhood, however, results in constant criticism of the self, which constantly lowers the self-esteem of orphans. Most orphans are said to suffer from guilt disorder syndrome, where they constantly blame and criticize themselves for the deaths of their parents, hence believing that they are "bad" children, and a cause of their family problems. The experience of low self-esteem in orphans is worsened by stigmatization from peers and/or neighbors. When orphans experience low self-esteem, they become non-assertive,

fear failure, appear incompetent, fear rejection, isolate from others, hold a negative self-image, and always strive to be perfect (Friends in Recovery, 1987, 1989).

When orphans relocate to join relatives, this frequently means a change in the school environment, which often impacts the orphans' self-esteem negatively. Indeed, scholars like Simmons, Rosenberg, and Rosenberg (1973) found that changes in the school context might influence personality and self-esteem. In a study of almost 2000 children and adolescents, ages 12 and 13, greater self-consciousness, instability of self-image, and slightly lower self-esteem was evident.

In terms of poverty among orphans, it is documented that economic inequality and decline creates the perception of a subject's own limitations to influence one's own fate:

> If the individual is successful, internal control attributions and self-esteem are enhanced, and vice-versa. The subject assumes that success was due to his or her effort and achievement, and efforts are more likely to be continued in the future (Gurney, 1981).

One thing is certain, that after the death of the parent(s) from HIV/AIDS, stressful life experiences affect the lives of a great number of orphans. For many of these orphans, poverty will become a persistent experience; research reveals that about 24% of children who are poor early in life will experience poverty when they are 10-14 years old, (Duncan & Rodgers, 1992), which will persistently damage the orphans' self-esteem directly or indirectly. Parental loss results in young children's delinquency, survivor guilt disorder syndrome, negative self-esteem, social isolation, poverty, hunger, and malnutrition (Hill, 1978).

However, on a more positive tone, if children who have lost their parents to AIDS form supportive peer groups, that is likely to reduce risks of negative self-esteem resulting

from HIV/AIDS denial and stigmatization (Chigubu, 1998), as well as developmental delays or psychological insults in these children (Apfel, & Telingator, 1995). Further, the orphans' kinship families' extension of positive interpersonal networks can strengthen the fabric of an orphan's life, consequently elevating an orphan's self-esteem (Chigubu, 1998).

THEORETICAL FRAMEWORK

As noted earlier on, this research comprises background and foreground approaches. In the background, lies the human ecological framework, (Figure 1.1), which is based on Bronfenbrenner's (1979) ecological perspective. In order to understand how we can explore the orphans' self-esteem as they interact with the kinship caregiver in the new environment, it is helpful to examine the structure of the human ecological eco-system perspective (Bubolz & Sontag, 1993; Bronfenbrenner, 1979) which views the developing person as the focal point of the environment.

Bronfenbrenner (1979, 1989) believes that the social context of individual interactions and experiences determines the degree to which individuals can develop their abilities and realize their potential. He states that ecology is the science of the interrelationships that exist between organisms and their environments.

Bronfenbrenner and Child-Rearing Practices

Bronfenbrenner (1985) indicates that members of various subcultures in the USA usually do not agree on which practices are abusive. He further states that the patterns of child-rearing that generate competence vary among cultures and historical periods. He concludes that, overall, because the social structure in which families are embedded has become increasingly unstable over the past forty years, it is believed that there has been a correspondingly increased need for structure, engagement, and discipline in the family context.

A critical feature about Bronfenbrenner's scheme is what he calls *ecological validity*, which means the extent to which the environment experienced by the subjects in a

scientific investigation has the properties it is supposed or assumed to have by the investigator (1979). It was important therefore that this research was done in Zimbabwe by someone from Zimbabwe. In order to better explore the orphans' self-esteem as they interacted with kinship caregivers in the new environments, it was helpful to examine the structure of the human ecological eco-system (Bronfenbrenner, 1979; Bubolz & Sontag, 1993). Bronfenbrenner's (1979) ecological perspective posits the developing person as the focal point of the environment. Bronfenbrenner highlights four crucial systems in the environment where the individual organism - the person- is seen as a psychological and biological human being. The environment is viewed as being composed of four interactive, interdependent, and dynamic systems, which are as follows:

1. *micro-system*: - situations and relationships of day-to-day life,
2. *meso-system*: - relationships between micro-systems,
3. *exo-system*: - systems in which the individual does not participate but which affect that individual, and
4. *macro-system*: - values and institutions guiding society.

Bronfenbrenner's (1979) Human Ecological Perspective in Relation to this Research

Bronfenbrenner believes that the ecology of human development comprises five levels of the environment; each embedded within the next, and can be conceptualized as a series of concentric circles. Bronfenbrenner's perspective is scientific, progressive and mutually accommodates events throughout the life course. It is applicable between the active, growing human being and changing properties of immediate settings in which a person lives.

Bronfenbrenner's perspective, therefore, forms the backbone framework of this study. The perspective addresses social, demographic, psychological, and cultural issues sensitive to ethnicity, and is adaptable to any neighborhood. It is a person, process, context, and chrono-system perspective. Developmental outcomes at any time are a joint function of person and environment, for example, orphan and caregiver (Habermas, 1987; & Kockelmans, 1979; & Bronfenbrenner, 1979) who in this study are both experiencing dynamic changes within their environments.

The Micro-systems

The *micro-system* is the immediate setting within which the child develops, or where the caregiver socializes the child in the realms of culture or society, and in so doing, the individuals' direct or indirect interactions create the day-to-day reality. The micro-system comprises activities, roles, and interpersonal relations of the developing individual and of those in the immediate face-to-face, physical, symbolic, and social setting. In this study, the home gives shelter to the caregiver, who then feeds the child.

The *micro-system* is molded by unique characteristics, beliefs, behaviors, and traits of each member of the micro-systems in relation to others (Bronfenbrenner, 1979). In this study, the extended family is an entity that could be termed a *micro-system* (Bubolz & Sontag, 1993). Although the developing person is most likely to assume different roles in different *micro-systems* (for instance at church, home, school), occurrences in one micro-system at a given time are likely to influence other micro-systems. Bronfenbrenner highlights that the relationship that exists between *micro-systems* is conceptualized as synergistic.

The child loses her/his parent(s) from a stigmatized ailment, and as an orphan, joins, uninvited, the extended family. According to Bronfenbrenner (1979), that orphan's behaviors in other *micro-systems* are affected. The impact on self-esteem for that orphan may also become conspicuous in daily activities, roles, and interpersonal relations within micro-systems of peers and adults who interact with that child. Further, the kinship caregiver's behaviors in other *micro-systems* are also affected, as she interacts with the orphan who unceremoniously joins her family with all the traumatic, emotional, and psychological baggage the orphan brings with her.

The Meso-system

The *meso-system* refers to interactions among settings and involves a person's relationship with the immediate settings, like the home, school, and neighborhood. The child's development is facilitated by and is interdependent in these settings.

The *meso-systems* of the developing individual encompass all *micro-systems* in which the developing person is active (Bronfenbrenner, 1979). A *meso-system* is the interactive combination of a group of the developing individual's *micro-systems* pursuant to a dynamic relationship, for example, a neighborhood. While kinship caregivers assume care-giving roles within the home or neighborhood, the school or health care environment for the developing person is closely associated with the home. There is a marked interruption of the kinship caregiver - child relationship at this layer of development because of other adult influences in the life of the child and the caregiver. For instance, kinship caregivers cited their concerns on negative interruptions from in-laws and the orphans' peers (Chigubu, 1998).

Exo-systems

The *exo-system* involves situations impacting the child's or caregiver's development but in which they do not play a direct role. Bronfenbrenner (1979) states that the term *exo-system* refers to one or more settings that do not involve the developing person as an active participant, but in which events occur that affect, or are affected by, what happens in the setting where the developing person is.

In this study, examples could be the dead parent's place of burial, the kinship caregiver's social support network, activities of the local school board (for instance the school board's decision to apply a school levy and school fees that the orphan might not be able to afford, thus prohibiting the orphan from going to school).

Exo-systems' Risk or Opportunity

The *exo-system* risk and opportunity come in two ways:

1. when parents or caregivers in the child's life are treated in a way that impoverishes (risk) or enhances (opportunity) their behavior in the *micro-systems* of home, church, extended family settings, and the impoverishing circumstances of the funeral; and
2. when decisions made in those settings affect the child or caregiver's day-to-day life.

Exo-system and the Neighborhood

The neighborhood has exo-systemic influences on both children and caregivers. Glod (1993) noted that the neighborhood in which adolescents and children reside does play an important role in molding the child's experiences and determining how well the child is able to adapt to many individuals and situations. Further, Glod indicated that a neighborhood also plays a big role in determining with whom a child comes in contact and how safe a child is within those contacts. The *exo-system* stands for a linkage of two or more *micro-systems*, one of which is outside the developing person's realm of direct experience, and where the developing person is not present (Bronfenbrenner, 1989). An influential *exo-system* of the orphan could be the caregiver and the kinship caregiver's social support networks.

Macro-system

The *macro-system* offers the blueprints for the ecological aspects of human development that reflect a people's shared assumptions about how things operate within a subculture or culture, and in institutions representing the societal regulations, values, ideology, laws, rules, beliefs, and customs relating to a particular culture. The *micro-*, *meso-*, and *exo-systems* are all embedded in the broad ideological and institutional patterns of culture or subculture. It is representative of *micro-*, *meso-* and *exo-systems* since these are characteristics that contribute to norms, rules, values, beliefs, attitudes, lifestyles, perceptions, stigma, denial, self-esteem, and guilt to which the developing person is exposed over time (Bronfenbrenner, 1979).

The *macro-system* involves inclusion of a broader cultural or societal setting that comprises patterns of belief systems, concepts, norms, values, rules, and knowledge systems which are present in a particular *exo-*, *meso-*, and *micro-systems* (Bubolz & Sontag, 1993). When a child loses his/her parent(s) to HIV/AIDS, and circumstances force him/her to migrate across country to unceremoniously join relatives in a society riddled with HIV/AIDS stigmatization, the *macro-systemic* input of experiences that mold the orphan's self-esteem will continue to be a filter for the orphan's present actions, personality attributes, and experiences.

In Bronfenbrenner's (1979) model, influence of persons and environments is transactional. They mutually influence each other. Over time, development is conceptualized as the *chrono*-system, which bears a measurable impact on persons, families, and relationships (Bronfenbrenner, 1979). For instance, an orphan who relocates to a new neighborhood due to the death of parents might dislike the neighborhood, and likewise, that environment might not provide play friends.

Conclusion

The *micro-*, *meso-*, *exo-*, and *macro-systems* represent an environmental network that comprises persons, objects, and symbols (Bronfenbrenner, 1979). Attributes of these systems are subsumed by Bubolz' and Sontag's (1993) concepts of:

1. the human-built environments, which are understood as interdependent with, emerging from, and existing within,
2. the natural physical, biological environment, and
3. the social, cultural environment.

Feedback loops systematically ensure that change in any single eco-systemic phase or level will in some way be felt, experienced, or realized at all system levels. Any insult, violation, or alteration in the flow of energy (as matter, information, experience, or resources) requires adaptive change throughout the various levels of human ecological *eco-systems* (Bubolz & Sontag, 1993).

Unplanned extended family kinship caregiving, impacts on the orphan's self-esteem, and the dynamics that support child-rearing practices, social support networks, and caregiver economic well-being are generated within *micro-systems*, and often are generated within the relatives' home setting. Extended families in which orphans whose parents died of the stigmatized HIV/AIDS are unceremoniously joined, may appear to be "normal" (Courtois, 1988) to the outside world.

Literature documents that such family systems tend to be enmeshed, disengaged, or chaotic (Courtois, 1988; & Chigubu, 1998). Enmeshed family systems reveal major boundary violations among family members, and mistrust toward outsiders. A good example is found in the research by Chigubu (1998) where a number of orphaned girls complained of sexual harassment by some adult relatives in the home setting to which the orphans joined (boundary violations); and where some kinship caregivers hid the HIV/AIDS status of orphans under their care in fear of being ostracized or stigmatized (mistrust toward outsiders).

Disengaged family systems lack meaningful, supportive, internal, and external connections. This is typical of the findings of the Chigubu (1998) research. The orphans joining in the relatives' homes come in with battered self-esteem, without any back-up resources, and carrying a stigma from their dead HIV/AIDS parents. Some relatives were

not happy to take care of these orphans, but just did it due to cultural obligations. In such a case, that extended family system became disengaged and insensitive to the needs of the orphans, hence depriving the orphans of building a positive self-esteem within that particular home setting.

On the other hand, we can have chaotic family systems. They tend to lack impulse control, and also seem to be disorganized. Adults from chaotic family systems fail to provide for basic survival needs of family members (Curtois, 1988). In this study, where adults from the extended family tend to be chaotic, we see the orphans joining in to live with relatives, but after a short while, we find these orphans running away from home to live on the streets and either beg, become drug addicts, or get exploited for sexual favors like money and food. Zimbabwe is facing a huge problem of children of this nature, who end up living in the streets, and are called "street kids."

Human ecological eco-systems approaches that form the backbone of this research develop from and connect the learned social and cultural dynamics. It is crucial to investigate the holistic links that exist between:

1. caregiver child rearing practices and orphan's self-esteem,
2. caregiver economic well-being and orphan's self-esteem, and
3. caregiver social support networks and orphan's self-esteem.

Overview

Knowledge gained through this study may help the present and future kinship caregivers of orphans whose parents died of HIV/AIDS to be sensitive to practices that may foster or undermine the orphans' self-esteem. This could be done by altering the

present social and cultural dynamics of *micro-systems*, and hence facilitate meaningful relationships and change. During the course of life, such changes are likely to alter the social and cultural dynamics of HIV/AIDS stigmatization and "blame-the-HIV/AIDS victim" victimization throughout human *eco-systems*.

Characteristics

Bronfenbrenner (1979) and Bubolz & Sontag (1993) state that the ecology of human *eco-systems* demonstrates the following:

1. Individuals (kinship caregivers, orphans, neighbors, extended family members) are shaped by intra-personal, interpersonal, environmental, and psychological factors.
2. Humans do not live in a vacuum, and cannot be considered apart from their environments.
3. Development is a joint venture and function of the individual person and environment over time.
4. All parts of the environment are interrelated and interdependent.
5. Changes occurring to one member, or part of a system, affect all other members and parts of the system.

Summary

Overall, destructive effects on the orphan's self-esteem are determined by multiple systemic factors like stability, support, and resources (Bronfenbrenner & Ceci, 1994) of the caregiver environment, and the presence or absence of an ongoing and reliable *meso-systemic* support system for the individual (Curtois, 1988; Kolk, 1987). Bronfenbrenner

(1989) mentions that resiliency of young children is mostly due to many factors, and that developmental dysfunction is visible at different phases, settings, and times, depending on the child's age and gender. However, this was not true to the research of Chigubu (1998).

This investigation was designed to collect relevant, critical, qualitative and in-depth data about each level of human *eco-systems*. The connection of researcher to the focus group members', and informants' *micro-*, *meso-*, *exo-*, and *macro-systems* within realms of critical scientific research, was the factor that facilitated access to an otherwise hard-to-locate sample, using a snowball-sampling frame for the study. The results of the research de-mystify, de-mythologize, unpack, re-define, and clarify ways in which systemic effects of grieving, bereavement, death, funerals, HIV/AIDS stigma, denial, self-esteem, support networks, economic well-being, child rearing practices, guilt disorder syndrome, courtesy stigma, trauma, forced migration, culture, traditions, beliefs, values, and many other aspects can be continuous throughout the lifespan.

Jurgen Habermas' (1971) Critical Social Theory in relation to this Research

Conducting research on a highly sensitive topic regarding families and children from a highly diverse target sample that is hard to locate, calls for a conceptualization of approaches and frameworks that bring about emancipatory aims and purposes characteristic of practical science. In carrying out sensitive research topics, there has been a concern about overemphasis on empirical/analytic science and technology which stems from a critique of its mode of cognition and possible limitations of its epistemological, political, and ethical bases (Habermas, 1971).

In the process of creating and recreating everyday life within extended families caring for orphans and society, families (including kinship caregivers, and orphans) encounter difficult questions about what to do and the kind of life to live (Plihal & Brown, 1969). Critical solutions of these value questions, individually or collectively, require reflective contemplation of judgment and action. Apparently, answers need to reflect practical reasoning, and critical understanding of the socio-cultural, historical, and personal context in which the problems are embedded.

Through critical inquiry, individuals, families, youths and children develop insight about personal blindness and unnecessary social constraints that limit their own and others' freedom to learn and grow (Plihal, 1987; Strom, 1980). This insight involves treating the current situation problematically and, nonetheless, probing beneath the surface realities for these situations can and should be short-changed and altered (Connelly, 1979).

The strength of the critical science perspective is that the educator acts as the facilitator of a free society where people reason, think, and talk together about more questions that affect society. Definitely, this school of thought fits in well with this

research where the Zimbabwean society is being challenged to open up dialogue and talk about the moral issues regarding the kinship care giving of orphans whose parents died of HIV/AIDS, the societal ingrained stigma attached to these HIV/AIDS dead, and the stigma which is subtly transferred to orphans of AIDS parents. Before we go any further, let us look at the history of critical inquiry.

As far back as the 1920s and 1930s, we see scholars of the Frankfurt Institute of Social Research getting strangely mystified as to why Karl Marx's theory had failed to evolve as predicted. They searched for answers and scientific reasons from economic as well as social theories, and these philosophers unfortunately could not get any immediate solutions to their questions. Finally, the philosophers turned to an examination of the dominant culture, including family life, to get answers to their current puzzle.

This is the very same frame of mind that this author adopted in doing her critical research in Zimbabwe. Here, we find that we have a beautiful country that is very rich in minerals and has very good soils for agriculture, an excellent infrastructure (one could actually argue that it is merely mischievous to label Zimbabwe as a Third World country, when we compare it with developing nations like Bangladesh, for instance), hard working, peace loving peasants and elites who shun away from carrying out a *coup d'etat*, and agriculturalists who are extremely committed to their endeavors to the extent that less than 15 to 20 years ago Zimbabwe used to be termed the *Bread Basket of the Region*, along with many other attributes.

This critical researcher also wondered, as did the Frankfurt Institute philosophers of the 1920s; and in 1998 she went to examine the dominant culture in question and the kinship caregiving of orphans whose parents died of HIV/AIDS. Zimbabwean families

were targeted in her search for answers. Habermas proposes that each major social theory has always received its prominence because it held a piece of truth. Habermas's work strives to achieve the following:

1. foster non-exploitative relations among people, and
2. discover the central place of morally inclined people in society, and engage them in development.

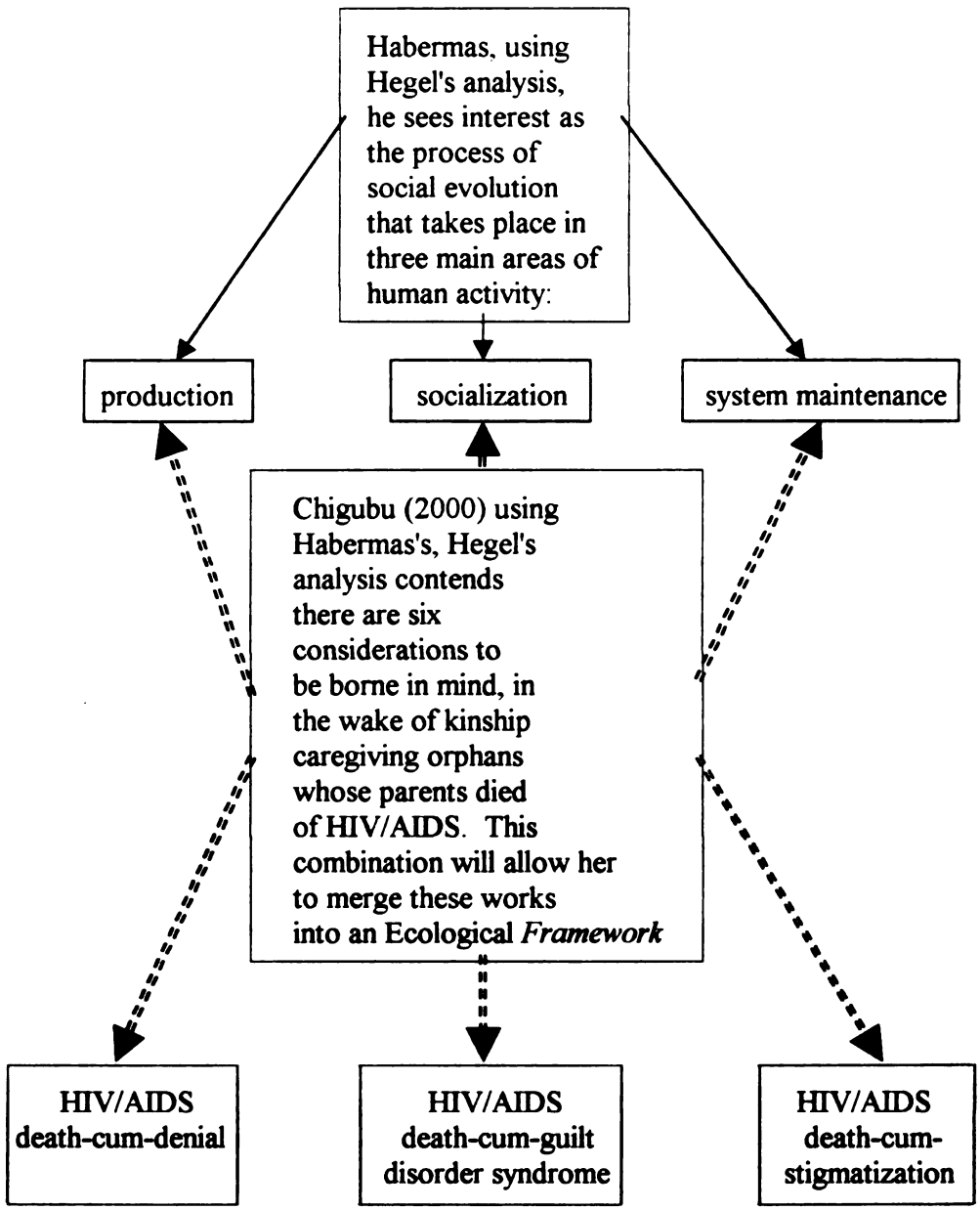
Habermas suggests that responsibility and autonomy are essential characteristics of a rational personality. He says that in a given society, the rational person can best foster development. In this study the assumption is that the extended family kinship caregiver is the rational person, and if "rationality" is found wanting, a toxic environment is bred for the survivor-guilt-disorder-syndrome orphan, whose low self-esteem could continue to be battered emotionally, physically, and psychologically. Habermas indicates that the knowledge that the individual gains through critique of social situations promotes self-reflection and hence sets people free to act in intellectually and morally responsible ways.

HIV/AIDS related deaths have left no option for the extended families but for them to self-reflect, and realize that there is nobody else coming to the rescue of these orphans. The extended families have acted intellectually, morally, and responsibly by accepting them in their homes. Habermas views self-formative processes as both theoretical and practical enterprises, contending that the kinship caregiver and the orphan have both gone through self-formative processes, hence indeed their interaction is both a theoretical and moral practice enterprise.

Human Interest

Habermas (1971) asserts that knowledge is married to human interest. This conception evolves from a rejection of Kant's transcendental consciousness, and his attraction to Hegel's work. At Michigan State University, Chigubu states in this research that, by using Hegel-Habermas's analysis, three aspects occur: AIDS death-cum-denial, AIDS death-cum-guilt disorder syndrome, and AIDS death-cum-stigmatization (Figure 2.1).

Figure 2.1 **Human Interest Analysis**



Legend

Chigubu's Human Interest Process

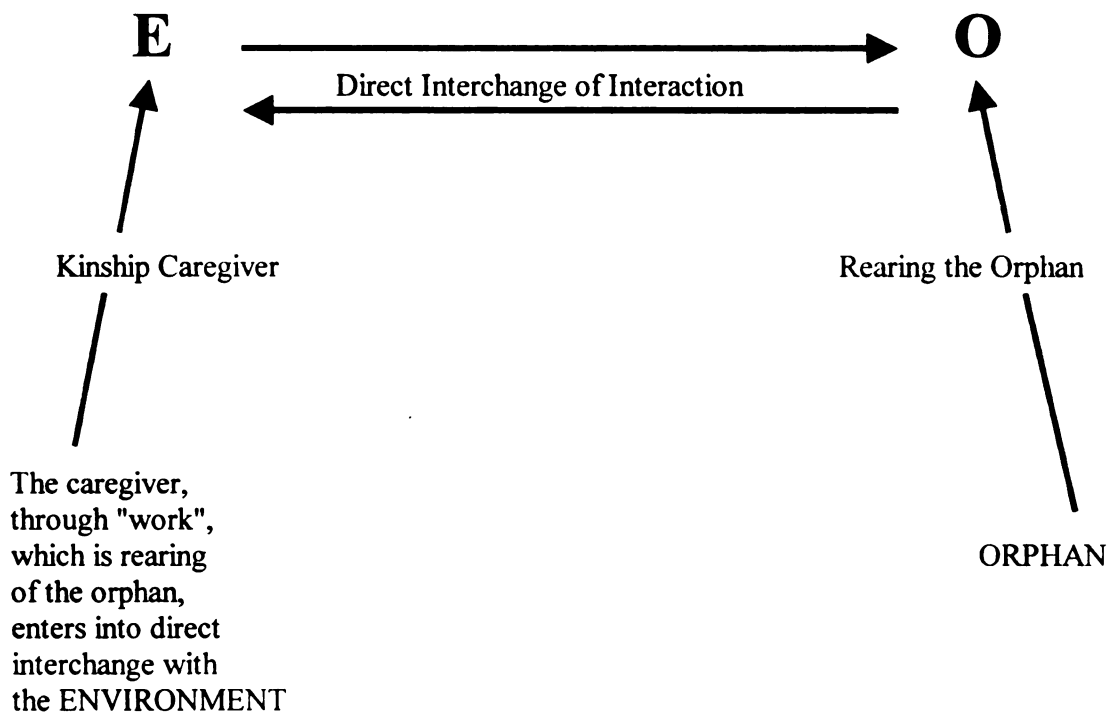
Hegel-Habermas' Human Interest Process

Designed by Mercy Chigubu, at Michigan State University, College of Human Ecology, (2000).

Explanation of the Habermas-Hegel-Chigubu Considerations

In production, nature is appropriated by society for the satisfaction of human needs, involved through work. "It is through work that man enters into direct interchange with his environment" (Kockelmans, 1979, p.4). This aspect of the theory relates with the research on kinship caregiving of orphans whose parents died of AIDS (Figure 2.2 below).

Figure 2.2 **Interchange with Environment**



...based on research of Chigubu (1998), in Zimbabwe.

Production

Coomer (1989) indicated that the production process takes place by means of purposive rational action, and is an instrumental action to meet people's needs and wants.

Socialization

Socialization is where we find humans interacting with society through communicative action. Language provides a medium through which man reflects about his world of objects. In this research, socialization had its share in the use of the socially acceptable term *"Svuura Matongo"* instead of HIV/ AIDS (Chigubu, 1998). At times, orphans were socialized in denial, and the result was that some of these orphans had no idea nor clue that their parent(s) had died of HIV/AIDS.

System Maintenance

The third dimension of critical theory includes changes in society's power, growth, and steering capacity to maintain itself in communicative interaction, which then struggles for recognition between and among contending human beings. For instance, many changes had taken place in Zimbabwe during this researcher's six years of absence. One glaring change that continues to be dynamic is the loss of economic power taking place in and among especially low-income families, when the rich continue to get richer, consequently hitting harder than ever the economic well being of kinship caregivers and orphans in Zimbabwe.

Central to critical inquiry is "rationality" which is:

> ...a specific set of assumptions and social practices that mediate how an individual or group relates to the wider society (McDonald, 1977, p.80).

It boils down to human interest being defined and qualified by how one looks at and interacts with the world. In this study, HIV/AIDS is a topic that negates human interest. The study findings reveal that one type of orphans in Zimbabwe blame witchcraft for the death of parent(s), and the other type of orphans blame themselves for allowing their parents to die of HIV/AIDS (survivor guilt disorder syndrome).

The relatives of the dead, for example will blame and ostracize the surviving wife for *alleged prostitution and supposedly infecting her late husband*, and vice versa for the late wife. The society will blame the government, which by any means is also facing severe economic hardships, for not providing state financial aid to help out with these numerous orphans who continue to join the extended families. Some folks in Africa blame the USA for developing the deadly AIDS virus, supposedly alleging that USA intended to wipe out the black race on the African continent, while some folks in the USA push the blame on Africa alleging that HIV/AIDS originated from Africa.

It is a vicious cycle, and meanwhile, orphans whose parents died of HIV/AIDS continue to experience the worst psychological, emotional, physical traumas and abuses the world has ever heard (discovered from interviews carried out in Zimbabwe's Harare ten peri-urban sites, (Chigubu, 1998).

Habermas (1971) in the critical theory states that in the process of acquiring knowledge, each area of human interest directly results in a different focus for rationality.

Habermas talks of *emancipatory interest*, and guesses that if all human beings are not able to denounce this HIV/AIDS stigma, for instance, emancipation will not prevail. He indicates that *emancipatory interest* is acquired by self-reflection, which is designed to enlighten and build communicative competence. What Habermas perceives is that when technical interests dominate human communicative interest, the result is degrading for human beings.

This is true from what was observed in Zimbabwe. Some orphaned children interviewed expressed sadness at how all their parent(s)' belongings had been disposed of during cultural rituals by their parent(s)' relatives after the funeral. One nine-year-old orphan sobbed as he narrated:

> "After my father was buried, my father's relatives divided among themselves all the good clothes that my father had, and I inherited a mere shirt. Right now, I do not have any clothes, and none of those relatives is helping me at all, none of them come to visit us now," said Tondi (pseudonym).

Further, most if not all the orphans interviewed stated that they never received any counseling following the death of their parent(s), which is a big issue that consistently bothers most of these orphans to this present date.

Habermas asserts that knowledge plays an important role in creating a balance between technical and communicative interest. He highlights that undistorted knowledge is the means people can use to free themselves from technical rationality that dominates our society (Habermas, 1971).

This is a challenge the research would unveil before the Zimbabwean society regarding "denial" which exists when it comes to issues relating to HIV/AIDS. Some of the orphans are being given "distorted knowledge", and Habermas says that for freedom to be abound in society, there must be "undistorted knowledge". This is a challenge for not only Zimbabweans today, but for Africa, which has to seek ways of utilizing Habermas's school of thinking. Scholars in the field of critical science contend:

> Truth is recognized in the deliberate rationality of formulating norms, roles, and knowledge about possible ways of life – ways undistorted by repressive forms of authority, privilege and vested interests of exploitation (van Manen, 1977, p.222).

What was upsetting during the 1998 research was that there would be an orphan, who would be totally ignorant of what illness his/her parent(s) died of; or in a worse scenario where the orphan thought the father visited some place else and would soon come back, yet the same environment enjoyed the full knowledge of the truth that it was HIV/AIDS that claimed the orphan's parent(s).

One could question: Is this not a way of life that lacks rationality - yet thriving with knowledge which is distorted by a somewhat repressive authority - repressing the truth to the child? A way of life that does not emancipate or free neither the kinship caregiver nor the orphan, hence spilling into society?

This author agrees with Habermas's school of thinking. Knowledge should be used to free individuals from oppressing forces so that the individuals can fully develop their potential. The author would argue that these orphans should know the truth now, not tomorrow. This quest for knowledge-cum-truth will suffice only in a situation that is ideal; that is, a distortion-free model of communication. For as long as the society

embraces "denial," the model will live to be a mirage for Zimbabwe, as long as AIDS is not curable.

The norms that are used to bind a society together can simultaneously (a) serve to sustain one part of the group within the society, and (b) keep the other in bondage. With the upgrading of belief systems, which can contain distorted meanings, distorted communication can be institutionalized. Just as racism can be institutionalized, the same applies to distorted communication. The author strongly advocates that if we distaste institutionalized racism the way we do, there is need to challenge the kinship child rearing practices that use "distorted communication" to the orphans. She would urge the Zimbabwean society to refrain from denial which forces the kinship caregivers to resort to distorted communication when dealing with orphans.

Deformed language in describing HIV/AIDS was also rampant throughout the research. Some of the orphans when asked what their parent(s) died of, gave answers like "...my father died because of *chikwambo* that his uncle be-witched him with". *Chikwambo* could be described as an alleged cursed spirit from witchcraft domains, a powerful devilish curse that is said to suck blood from the cursed victim, until they drop dead. What was amazing is the fact that the very same orphan who told of that "*chikwambo* episode" lived under the same roof with the kinship caregiver, who when interviewed separately from the orphan, revealed that the orphan's father died of HIV/AIDS. This is an example of deformed language episodes experienced, as both orphans and kinship caregivers responded to interview questions.

Habermas contends that "...deformed language can be used to deliberately mislead. Just because certain views of social reality exist, it does not validate them." The author's

main concern is what will happen on the day the truth will dawn on the orphans that their parent(s) died of HIV/AIDS. Are they going to receive any emotional or psychological therapy following the trauma? Will they receive counseling? Mischievous questions indeed, because all orphans interviewed stated that when their parent(s) died, they never received any counseling during or after the funeral. In the researcher's opinion, this type of rearing practice that is clouded by denial and stigmatization of HIV/AIDS, is analogous to a ticking time bomb.

In conclusion, there is need to highlight that the good aspect in critical inquiry is the assumption that people have the potential to alter the repressive forces that inhibit their power to develop emotionally, psychologically, physically, and intellectually.

Belsky's (1984a,b,c) Determinants of Parenting

In relation to this study, Belsky's (1984) work enmeshes well with Habermas's critical theory, and both were used in creating this study's theoretical framework foreground (Figure 1.1). This study utilized parts of Belsky's work because it presents discussion on the **economic well being** (work), **self-esteem** (child development), **social support network**, and **child-rearing practices** (parenting), variables utilized to design the operational framework for this research (Figure 1.2).

Belsky's (1984) Work and Relevance to This Project

The model indicates that parenting is directly influenced by forces arising from within the individual parent/kinship caregiver (personality), within the individual child/orphan (child characteristics of individuality), and from the broader social context embedding the parent/kinship caregiver relationship, specifically in marital relations, social networks, and occupational experiences of parents/kinship caregivers' economic well being.

The model presumes that parents'/kinship caregivers' developmental histories, marital relations, social networks, and jobs influence individual personality and general psychological well being of parents/kinship caregivers and consequently, parental/kinship caregiver functioning and in, turn, child development/orphans' self-esteem.

Two heuristic points regarding Belsky's (1984) work which makes it relevant to this project need to be noted.

1. Most of the Belsky's (1984) available research is based on non-experimental and correlational studies.

2. It does not document cause-and-effect relations.

According to Belsky (1984), regardless, the literature would in most cases be discussed in just such terms for heuristic purposes. Using the Determinants of Parenting Model (Belsky, 1984c) looks at parenting behavior in relation to child development, work, parent's personality, developmental history, marital relations, social support networks, and child characteristics. Belsky (1984c) explains the model of the "Determinants of Parenting" utilized in the Theoretical Framework, (Figure 1.1), as follows:

> The model presumes that parental/(kinship caregiver) functioning is multiply determined, that sources of contextual stress and support can directly affect parenting (kinship caregiving) or indirectly affect parenting ((kinship caregiving) by first influencing individual psychological well-being, that personality influences contextual support/stress, which feeds back to shape parenting (kinship caregiving), and that in order of importance, the personal psychological resources of the parent (kinship caregiver) are more effective in buffering the parent-child relation (kinship caregiver-child relation) from stress than are contextual sources of support, which are themselves more affective than characteristics of the child (orphan). (Jay Belsky, 1984c, (55), pp. 83-96).

Belsky's Evolutionary Perspective and Relevance to Study

During the Zimbabwe research, a few of the kinship caregivers interviewed had their own biological children attending school, while the orphans stayed home as child laborers selling vegetables door to door, or cleaning the house and many other household chores (Chigubu, 1998). The explanation given by the kinship caregivers who fell into this category was that they were economically challenged to be able to send the orphans to school, but rather engaged them in income generating ventures. In a few selected cases

the orphans were as young as 9 years old. From the point of view of the orphans under kinship caregivers in this category, the orphans' interpretation when interviewed was that this was child maltreatment. The orphans interviewed wanted to go to school, like the biological children of the kinship caregivers in question. The orphans saw it as discrimination, an act detrimental to the orphans' self-esteem.

What Belsky says Relating to Child Self-esteem

From the perspective of evolution enunciated by Belsky, Steinberg, and Draper (1991), child maltreatment damages self-esteem. Child maltreatment evolved through natural selection in order to promote reproductively strategic characteristics in individuals exposed to harsh and stressful ecological contexts. In Zimbabwe in 1998, the relatives taking in orphans, kinship caregivers, and orphans are all being exposed to harsh ecological contexts: the vestiges of the HIV/AIDS epidemic, stigma, and poverty. Some American scholars interested in AIDS state:

> Unfortunately, the extended kinship network that has historically functioned as a safety net for black families in the USA has been decimated disproportionately by HIV/AIDS (Chasnoff, *et al.* 1990, p.35).

Belsky, Steinberg & Draper (1991) and Belsky (1993)assert that, under certain conditions of limited resources, child abuse is as much a part of the natural condition in the animal (including human) world as is responsive, nurturing caregiving behavior. This writer agrees with Belsky based on the findings of earlier Zimbabwe research (Chigubu, 1998), where most of the kinship caregiving coping mechanisms leaned naturally toward

hiding the truths about HIV/AIDS from orphans, which could be detrimental to the orphan's emotional development, and which could be interpreted by some as child maltreatment.

Belsky, Steinberg, and Draper (1991) posit that females who grow up under stressful conditions develop insecure attachments, and adopt the "R" reproductive strategy of producing many children who are poorly cared for, rather than the "K" strategy of rearing a few offspring who are well cared for. This is a frightening phenomenon considering the high number of orphaned young girls that were interviewed by Chigubu (1998), and who indicated that they were living under stressful conditions and environments.

Belsky and others like Burgess and Conger (1978) argue that lack of parental/kinship caregiver resources decreases the probability of parental/kinship caregiver investment and bonding, thus increasing the risk of abuse. Further, the risk experienced could be likened to the status of being a stepchild, or an adopted child at the age of eight months or over, (damaged), or fragile that of a child in a large family. Belsky and colleagues's assumptions are relevant to the orphans' situation in this study. All orphans interviewed by Chigubu (1998), had joined the kinship families when they were far older and way past the bonding parameters. Belsky and others like Burgess and Conger (1978) say that when social and economic resources are scarce, parents/kinship caregivers will neglect or maltreat those of their children who are least likely to become productive successfully, or who are biologically unrelated to them, which harms the orphan's self-esteem.

Belsky as well as Patterson (1980) echo from their observations that children's problem behavior is often a cause, as well as a result, of parents'/kinship caregivers' feelings of depression and low esteem. A few of the kinship caregivers in Zimbabwe in 1998 complained about orphans' resentment and anger; while some orphans complained of child maltreatment.

Conclusion

What still needs to be determined is, however, whether the processes identified as exerting influence on negative self-esteem and, in extreme cases, child abuse, also function in the normal range of parental behavior. The critical question that causes us all to pause in viewing this research is whether a continuum of influence does exist.

Baumrind's Work in Relation to the Study

Prior to going to Zimbabwe to do research in 1998, this author read the following from the Zimbabwe Demographic and Health Surveys (ZDHS) in 1994:

> Given the evidence that the vast majority of HIV infections in Zimbabwe are contracted through heterosexual contact, information on sexual behavior is important in designing and monitoring intervention programs to control the spread of the disease (p. 159).

According to research findings made by ZDHS (1994):

> After hearing about HIV-AIDS, more than 80% of women had not changed in sexual behavior, and 40% of men had not changed in sexual behavior (p. 159).

Due to the fact that this research involved orphans from parental HIV/AIDS, there was urgent need to include questions on HIV/AIDS in this research. All four instruments had a few questions on HIV/AIDS (Appendices C, D, E, and F).

However, the researcher decided to target the kinship caregivers by probing questions that would provide some ideas on why, after all the comprehensive HIV/AIDS awareness campaigns made in Zimbabwe since the early 1980s, yet in 1994, ZDHS found disturbing results regarding change in sexual behavior? Hence the continual rise in the number of orphans from HIV/AIDS parental deaths.

The author used the Child-Rearing Practices instrument (Appendix E) based on Baumrind's work to obtain answers causing the supposed resistance to change in sexual behavior despite the rising HIV/AIDS-related deaths. Secondly, there was a need to examine if the kinship caregivers felt comfortable to disseminate educative information on HIV/AIDS to orphans joining their homes, so that the HIV/AIDS vicious cycle could

be reduced. This is where Baumrind's work comes into play in the study. One might ask: "Why an interest in Baumrind's work?" Baumrind (1995) asserts that:

> ...(N)ot all families exposed to high risk settings and environments lack child-rearing practices that nourish growth and development. Remarkably, the majority of families oppressed by similarly impoverished circumstances are not abusive or neglectful. Against great odds, many are able to provide their children with emotional and spiritual sustenance that enables them not only to survive, but to become healthy, productive members of society. Clearly, then, among those families who must cope with poverty there are parents/caregivers and child-personal attributes that distinguish maltreating from well-functioning members. All parents/caregivers, poor or non-poor, who abuse or neglect the children under their care must be held accountable for their acts of omission or commission (p. xviii).

This quotation is relevant to the study done in Zimbabwe. These were extremely low income extended family/kinship caregivers, who had varying child rearing practices and varying schools of thought on why there was no change in sexual behavior. Further, for those extended families that applied what might be termed as "harsh to extreme child rearing practices," this researcher often wondered during the research if she judged harshly those kinship caregivers who were deliberately hiding information from orphans regarding the dead parents(s)' HIV/AIDS status, at the expense of that child's emotional growth and development. Baumrind cautions:

> ...(T)o treat adults because they are impoverished as nothing but victims of their circumstances is a misperception that adds insult to injury (1995, p.xviii).

Baumrind also pays particular attention when carrying out a cross-cultural research utilizing instruments from a different culture. Baumrind (1995) states:

> Socialization practices that might appear authoritarian, punitive, or seductive by middle-class European American standards are used by many African-American parents to

> prepare their adolescents to cope with hazards of contemporary ghetto life, and are not indicative of mistreatment. Although an authoritarian approach promotes instrumental competence in children from middle class families (Baumrind, 1966, 1971a, 1978a, 1991a, 1991b), more restrictive practices are often necessary to protect children from dangerous and delinquent influences in the inner city (Baumrind, 1972). These parents' restrictive practices are not necessarily abusive; the conditions in which their children live are (p. 70).

Baumrind is sensitive to cross-cultural issues, and also cautions readers to be careful not to be judgmental. She cautions researchers to be sensitive when they transplant instruments from one culture to use on another, because what works for one culture, should not be judged against a different culture altogether (Baumrind, 1966, 1971, 1978, 1991a, 1991b). This is another point that caused this researcher to utilize Baumrind's school of thinking.

The findings from the caregivers on why there is no change in sexual behavior were astonishing, (Table 4.0). The kinship caregivers responded in depth to the open-ended questions on HIV/AIDS, and their answers are a crucial discovery that might provide alternative avenues for researchers, policy makers, humanitarian groups, donor agencies, and others, to address these four schools of thought that might be causing resistance to change in sexual behavior. This would cut down the escalating number of orphans from parental HIV/AIDS deaths.

Baumrind (1989) Child Rearing Dimensions Relevant Study

Baumrind, a US researcher, is particularly important to this study. Her compelling demonstration of a comprehensive, in-depth investigation, and critical evaluation of a vast amount of pertinent research, plus her theoretical works, played a

leading role in inspiring this author to go to Africa in 1998 and carry out an in-depth investigation on a highly sensitive social, problematic topic. Following Baumrind's pioneering studies, it is generally agreed upon that in normal families a meaningful balance of parental responsiveness (warmth, reciprocity, and attachment) and demandingness (firm control, monitoring, positive and negative reinforcement) is healthy for children, good for promoting their competence, child survival, welfare, emotional, and social adjustment.

Accordingly, to strike such a balance, which is characteristic of the "authoritative" pattern of child-rearing, caregivers should monitor and supervise their own behavior and their children's behavior carefully and continuously. In turn, this calls for a substantial investment of time, energy, and resources. On the other hand, favorable child-rearing practices are not ordinarily found in abusive homes, characterized by neglect and aversive treatment of children.

In her in-depth study, Baumrind (1989) looked at the life conditions and life quality of families most at-risk – families in poverty in the USA. She stated that "the environmental condition most strongly associated with child abuse and low esteem," encompasses such issues as single parents, foster and adoption care, marital discord and divorce, the presence of difficult children, social and economic pressures, hardships of the struggle for survival, and financial constraints.

Baumrind's in-depth study clearly distinguishes connections that exist between a family's social and economic situation and parental psychological characteristics – poor self-concepts, depressed moods, and emotional instability – which are translated and

reflected in aversive and often abusive interactions with the children, consequently maximizing the vulnerability of the children's welfare.

Baumrind (1989) highlights that there are some social context variables and interventions such as the presence of supportive family members or institutions, community or neighborhood cohesion, peer solidarity, and parent education that have frequently proven effective in buffering the effects of circumstances that often lead to child maltreatment and a child's low self-esteem. In responding to Baumrind's urgent call for researchers to make in-depth studies on at-risk families, this author went to Zimbabwe in 1998 to carry out research, utilizing Baumrind's thoughts as a yard stick when working with kinship caregivers who are unceremoniously joined by orphans whose parents died of AIDS in Zimbabwe.

Baumrind's work assisted this author in searching out classified information that could give both the Zimbabwe, sub-Saharan Africa, and international community some of the answers to the burning questions about why Africa continues to have a rise in numbers of orphans from HIV/AIDS, and not vice versa. Let us examine what Diana Baumrind states:

Baumrind (1995) says that data collected from normal families usually portray facets of responsiveness (attachment, warmth, reciprocity) and demandingness (firm control, monitoring, positive and negative reinforcement). She indicates that warmth refers to the parent's emotional expression of love that motivates high-investment parenting and brings about cohesive family relationships.

Baumrind indicates that affective warmth does not imply unconditional acceptance. She reminds us that a warm and loving parent may also be a firm

disciplinarian. Baumrind (1995) indicates that non-contingent aversive stimulation is likely to damage a child's self-esteem and sense of well-being more profoundly than its positive counterpart. Self-esteem in children is said to become shattered and battered with non-contingent reinforcement from abusive parents or caregivers who use physical abuse and harsh disapproval.

Baumrind cites that reciprocity and synchronicity in the parent-child relationship may coexist in an affective atmosphere of mild-mannered warmth or one of abrasive confrontation or both, but it is unlikely to coexist with abuse or neglect. Reciprocity is the extent to which caregivers take into account the wishes and feelings of the child (Maccoby & Martin, 1983). Maccoby & Martin observed that a child whose mother willingly complied with the child's wishes was likely to reciprocate with good-natured compliance to maternal demands.

An interesting phenomenon in Baumrind's work is the reminder she gives to parents or kinship caregivers who might be challenged by a child's persistent misbehavior. She states that persistent child misbehavior eliciting persistent parental disapproval is likely to reflect a past history of parental mismatch and lack of reciprocity (Baumrind, 1995). This is valuable information for the kinship caregivers especially, who might meet challenges of disciplining orphans in their household, and then persistently hold themselves accountable for the fact that there is disharmony between them. It is good for kinship caregivers in Zimbabwe to know that there is what is termed *parental mismatch* and *lack of parent-child reciprocity* or similarly the kinship caregiver mismatch and lack of kinship caregiver-orphan reciprocity in Zimbabwe.

Baumrind mentions that emic analyses are needed to establish the range of healthy adult-child bonding styles that human beings manifest in various cultures, which is one reason that Baumrind's work gains international credibility: Baumrind is sensitive to cross-cultural issues in research.

> An emic approach attempts to develop constructs, measures, and classifications of the phenomena under scrutiny from the perspective of the members of that culture, in contrast to an etic approach that imposes what is usually a European American perspective on other cultures in an attempt to formulate pan-cultural universals (Baumrind, 1995; pp.60-61).

Regarding parental force, she says that direct but rational confrontation enhances friendly give and take, and promotes the child's self-assertiveness and elevates the child's repertoire of communication skills, without overstimulating, angering, or undermining the child's self-esteem. Young children, especially middle-schoolers, are said to seek information to illustrate whether they are being *good* or *bad*. Baumrind stresses that when parents clearly articulate explicit norms, and further reinforce an act the child is already performing, it confirms the child's identity as being *good*.

Chapter 3

METHODOLOGY

This chapter discusses the methodology used in this research. The chapter further presents the research purpose, objectives, research questions, and description of the qualitative investigation, conceptual/operational definitions, subjects, design, instrumentation, sampling procedure, as well as data gathering, and approaches to data analyses. [*Following the Michigan State University Graduate School regulations (2000), some images in this dissertation are presented in color]*.

Research Purpose Statement

The general purpose of this study was to better understand the self-esteem of orphans whose parents died of HIV/AIDS, and to examine the economic well-being of these orphans as well as the extended family/kinship caregivers' economic well-being, social support networks, and child-rearing practices in Zimbabwe.

The Specific Objectives Are to:

1) explore the self-esteem that exists between non-orphans and orphans, whose parents died of HIV/AIDS in Zimbabwe,
2) describe the kinship caregivers' economic well-being,
3) investigate the kinship caregivers' available social support networks, and,
4) examine kinship caregiver child-rearing practices.

Research Questions

The research questions in this exploratory research were evolved from the research objectives stated above, and reflected upon the operational, and theoretical conceptual models described in Chapter 1 of this document. The instruments are found in Appendices C, D, E, and F. The general and specific research questions asked by this investigation were as follows:

General Research Question:

What are the self-esteem realities for Zimbabwean orphans whose parents died of HIV/AIDS and who migrate, and unceremoniously end up living with extended/kinship families, who in most cases are facing extreme economic hardships, and where HIV/AIDS is highly stigmatized?

Research Sub-questions:

1. What are the major sources of social support, the nature of social support networks, and resource allocations? Who provides social support?
2. How do the caregiver child rearing practices for orphans differ from non-orphan children?
3. What is the relationship like between the kinship caregiver and the orphans? Authoritarian? Permissive? Warm? Cold? Indifferent?
4. What is the socio-economic status of orphans and caregivers?

5. What are the caregiver/orphan's coping mechanisms that help to combat poverty?
6. Are the orphans in denial, or do they have knowledge of what their parent(s) died of?
7. What is the interaction between the orphans and the kinship caregivers? Are there any adjustment joys or stresses?
8. After the death of the parent(s), are there any physical and mental health problems that have impacted to the orphans?
9. Does the caregiver discuss HIV/AIDS with the orphans?
10. Did the orphans receive counseling after their parents died of HIV/AIDS?

Description of the Qualitative Investigation

This investigation was a phenomenological, (exploratory) and descriptive (case study) qualitative research. It was conducted in Zimbabwe's natural settings, and was based on three underpinnings of epistemology. The underpinnings are described below under three sub-headings (levels A, B, and C) as follows:

Underpinning of Epistemology: Level A

This is the disciplinary epistemological underpinning of Human Ecology and Family & Child Ecology (Appendix C), the building from current work in the philosophy of critical science (Habermas, 1971; Lakatos, 1976; Lakatos & Musgrave, 1970; Toulmin, 1972). The uniqueness of this inquiry is that critical science is not:

> ...just a science that is made up of a collection of laws, a catalogue of unrelated facts. It is a creation of the human mind, with its freely invented ideas and concepts (Einstein & Infeld, 1938, p. 294).

Further, the research allows the cataloguing of sense impressions, the experience of the phenomena, where meta-level considerations such as parsimony, explanatory power, and elegance geared towards misconception research and development of scientific ideas provide a fertile ground for educational and family scholars with insights into the nature of future learning, or future research.

Underpinning of Epistemology: Level B

Implications of this level include "the child as scientist" approach, resulting from such a reconceptualization that is highly endorsed by the community (Osborne & Freyberg, 1985). What needs to be investigated is "children's science" versus "adult science." The emphasis here emanates from the hypothesis that a child may not be "seeing" the same set of events as a teacher, kinship caregiver, researcher, consultant, or expert. It suggests that many times a child's response is labeled erroneous too quickly and that if one were to imagine how the child was making sense of a situation, then one would find the errors to be reasoned and supportable.

By exploring, the case study epistemological responses from both the kinship caregiver and the orphans baffled the researcher because in most situations, when asked the exact same question, the adult had totally different answers from the orphan or non-orphan, yet both shared the same environment. A good example was this question posed by this researcher: "Would you tell me any close relatives of yours that you know died of

HIV/AIDS?" The kinship caregiver would answer: "My sister and husband died of AIDS last year, leaving behind four orphans who now live here with us."

Upon asking the very same question to one of the orphaned children under care, here is an example of the popular responses: "I do not know any relative, but I know my friend's father died of HIV/AIDS two years ago." As a researcher, what would quickly come to mind is that the "child is giving a wrong answer." Indeed the answer is wrong, and facts are wrong if we are to confer with the schools of thought of Piaget and Inhelder (1975).

Further, this exploratory research (Chigubu, 1998) uncovered naivete that exists among some orphans. Asked to give a brief account of the orphaned parents' deaths, most orphans stated that their parent(s) had died of migraine, or fever. This naivete is hypothesized by DiSessa (1985) as the existence of phenomenological primitives, which compete in problematic situations and create significant fragmentation in what the young orphaned child knows.

Underpinning of Epistemology: Level C

The third level of the study is the epistemological basis for the conduct of the descriptive (phenomenology) conceptions and misconceptions. This is a project that involved multiple misconceptions, both locally and globally, for instance regarding the origin of HIV/AIDS, where we find some western and US literature blaming it on Africa, and some groups of people in Africa blaming it on the USA.

Researching on orphans whose parents died of HIV/AIDS is a study that is heavily value-laden, which carries stigma attached to both the dead parents from HIV/AIDS, the

living orphans who become victims by virtue of being born to parents who died of HIV/AIDS, and the extended families who finally take care of the orphans. When dealing with such a highly diverse topic, there is need for the researcher to become increasingly aware that multiple representations result in misconceptions, which might evolve from the narrowness of the means of representing phenomena. Another aspect of this category is the role of language in research. Instruments in this study were designed in English. However, during the fieldwork, the researcher utilized both English and vernacular languages that are spoken in Zimbabwe. Pines (1985) describes the importance of language in misconception research: "A word is like a conceptual handle, enabling one to hold on to the concept and manipulate it." This is self-explanatory in this study, where this researcher learned how trust could be severely damaged between the researcher and the participants if socially undesirable words like "HIV and AIDS" were to be utilized by the researcher instead of *"Svuura Matongo."* The formation of a focus group and the researcher's cultural immersion was crucial. This qualitative, critical science research challenges the Western tradition of assuming that cognition can be examined relatively independently of culture (Lave, 1977; Carraher, Carraher & Schliemann, 1985).

ANTECEDENTS AND INTERVENING CHARACTERISTICS

Antecedents

1. Did the caregiver's economic situation deteriorate due to the joining in of orphans?
2. Did the orphan lose one or both parents due to HIV/AIDS?
3. What was the economic situation of the orphans before joining in to live with extended relatives?
4. Did orphans know the HIV/AIDS status of their parents before they died? Did their parents hide or tell them?
5. Were the orphans invited or did they impose themselves?

Orphans' Intervening Characteristics

1. Age of orphans,
2. Length of time the child has been a one-parent orphan,
3. Length of time the child has lost both parents,
4. Gender of orphan girls preferred to boys or vice versa?
5. Were the orphans' economic situations viable before joining extended families?

Kinship Caregiver Characteristics

1. Economic well-being
2. Social support network
3. Child-rearing practices
4. Marital status
5. Knowledge, beliefs, myths, and facts on HIV/AIDS
6. Education
7. Work

CONCEPTUAL AND OPERATIONAL DEFINITIONS

Economic Well-being: Conceptual Definition

The economic well-being in relation to orphans' self esteem, relates to the financial status, which directly influences the type of environment, the type of housing, the pattern of life, living standards, type of food and many others. The economic status of the family frequently determines what the child's economic well-being would be. The parental or caregiver anxiety that is engendered by poverty, together with possible malnutrition and overcrowding will, in many cases, cause psychic wounds.

Economic Well-being: Operational Definition

In this study the economic well-being in relation to the orphans' self-esteem was assessed using two instruments: 1) the internationally standardized Zimbabwe demographic and health surveys and 2) a questionnaire. Families were surveyed on aspects pertaining to financial status, health facilities available to the families, types of housing, toilet facilities, demographics, caregiver social support, and many other aspects that are linked to the economic well-being of the child under care (Appendix J).

Social Support Networks: Conceptual Definition

In times of need, families, youths and children, tend to seek support from relatives (Taylor, 1997), and that support bears important implications for child development, the child's self-esteem, family functioning and development. Research indicates that there exists a positive association between kinship support, economic difficulties, adult

functioning, and child self-esteem (Dressler, 1985). Dressler reveals that kin social support is associated with lower depression. There is evidence that shows that for men, those with social support are less depressed by stressful life events than those lacking support. Meanwhile, Tietjen and Bradley (1985) found that mothers who had access to a stronger social support network during pregnancy report lower levels of stress, anxiety, and depression, and are more positive about their pregnancies. In similar studies, McLoyd *et al.* (1994b) found that among single, African-American mothers with adolescents, social support is negatively linked with maternal depression.

Simultaneously, Taylor and Roberts (1995) found a positive association between social support and maternal self-esteem. Regarding child rearing practices, social support has been closely associated with behaviors. Studies have indicated that assistance from relatives is linked with more positive maternal attitudes (Colletta, 1981; Colletta & Lee, 1983) and more adequate parenting behaviors (Wandersman & Unger, 1983). In a related research using both adolescents and parents as respondents, findings have shown that support from relatives is associated with parental attitudes and practices linked to adolescent adjustment.

Specifically, from a cross-section of studies (Taylor, 1994; Taylor *et al.*, 1993; Taylor & Roberts, 1995) are findings that reveal that in the context of kinship social support networks, African-American parents are more accepting, monitor adolescent behavior more firmly, and manage the home more effectively. Similarly, Taylor (1994) discovered that the more kinship support parents obtained, the more organized and structured is the home, and the more involved the parents are in partaking in the adolescents' schooling activities. Hence, in the context of social support networks,

parents are more than likely to structure the home environment around a clear, sound schedule (example: provide homework, regular meals, and bed times) and are very likely to be involved in their children's schooling functions.

On the other hand, Taylor *et al.* (1993) found that in single-parent households, kinship support social networks are positively linked with authoritative parenting, a parenting style that comprises a high degree of acceptance, firm control, close supervision, and encouraging of mature behavior. Further research has indicated that the lack of availability of social support networks is negatively associated with maternal punishment that includes yelling, shouting, and hitting (McLoyd *et al.*, 1994a), as well as with mothers' negative perceptions of the maternal role.

While working with younger children, Hashima and Amato (1994) found that, to the extent that low income parents and kinship caregivers perceive possible available social support networks, in most cases they are said to be less likely to exhibit punitive behaviors, such as spanking. Further, to the degree that kinship caregivers or parents have obtained assistance in the previous month, they are less likely to report unsupportive parental behavior that includes denying their children the praise they deserve, or not interested to hug or cuddle their children. Literature shows that for families that are void of social support networks, social isolation is positively associated with child abuse, neglect and low self-esteem (Corse, Schmid, & Trickett, 1990; Garbarino, 1976; Garbarino & Sherman, 1980). Garbarino and Sherman (1980) saw that among families that lived in areas at-risk for low child-esteem, families have little available social support networks, and consequently make limited use of the constrained social resources available. Findings on the effects of social support networks show that in times of need, individuals

receive assistance from social support networks, and that overall, social support networking is positively associated with individuals' mental health and also buffers them from the effects of stressful events. The absence of social support networks constitutes social isolation, and social isolation is associated with child abuse, which in turn impacts negatively on the child's self-esteem. On the other hand, the availability of social support networks is highly linked with more adequate parenting and developmentally appropriate child-rearing practices and positive self-esteem for both the child under care, and the parent/kinship caregiver.

Social Support Networks: Operational Definition

In this study the social support networks of the kinship caregivers in relation to the orphans' self-esteem were assessed using eco-maps (Appendix K) and open-ended questions. The kinship caregivers were surveyed on aspects pertaining to their social support networking including social welfare, work, health care, religion, extended family, recreation, school, friends and others.

Child-rearing Practices: Conceptual Definition

Child-rearing practices relate to families' facets of responsiveness (warmth, reciprocity, attachment) and demandingness (firm control, monitoring, positive and negative reinforcement). According to Baumrind (1995), these two orthogonal factors (responsiveness and demandingness) emerged from the early analyses of Schaefer (1959) and Becker (1964), and may still be seen as central dimensions of child rearing (Maccoby & Martin, 1983).

Child-rearing Practices: Operational Definition

In this study, the child-rearing practices of kinship caregivers in relation to orphans' self-esteem were measured using the instrument entitled: "Child-Rearing Practices" (Appendix L). The orphans' kinship caregivers were surveyed on aspects pertaining to measures taken by kinship caregivers when discipline, praise, HIV/AIDS stigmatization, rules, conflict resolution, in-laws, young children's' bed-wetting, play, noisy behavior, spouse assistance in care-giving if any, orphans' having boy friends or girl friends, and other aspects that are linked to the child-rearing practices, were applied to the children under care.

Orphans' Self-esteem: Conceptual Definition

Self-esteem is a positive or negative attitude toward a particular object, namely, self. However, **positive** self-esteem has two quite different connotations. Childhood is a critical age in the development of the child's emotions. If there are powerful forces for the good in the child's life, they must be good emotions, which, in this study, influence the orphan's self-esteem.

It is well known that a happy orphan is a healthy, emotionally stable child. It is increasingly, and belatedly, being recognized that parental deaths and preceding and subsequent caregiver mistreatment could affect the child's self-esteem, development and expression of feelings as well as a range of mental and cognitive faculties (O'Hagan, 1993). Orphaned children are often viewed and described negatively as "difficult" and "non-rewarding." Some even get labels like "orphans are containers of bad emotions" (O'Hagan, 1993). Environment and parenting styles and caregiver child-rearing practices have an impact on the emotional development of children. Stress can be overwhelming,

with overcrowding, bereavement, verbal abuse, stigmatization and chaotic transactions. The emotional status of children can be violated.

High self-esteem exists when the person thinks he/she is "very good," and a different connotation is that the person thinks he/she is "good enough." This is the person who considers that he/she is superior to most others but feels inadequate in terms of certain standards he/she has set for himself or herself. When we speak of high self-esteem, the person respects herself/himself, and he/she does not necessarily consider himself/herself better than others, but he/she definitely does not consider himself/herself worse. He/she does not feel he is the ultimate in perfection, on the contrary, recognizes his/her limitations and expects to grow and improve.

Negative self-esteem can be termed low self-esteem and implies self-rejection, self-dissatisfaction, and self-contempt. The person lacks respect for the self he/she observes. The self-image is conflicting and is disagreeable, resulting in the person wishing they were otherwise.

Self-esteem: Operational Definition

A self-esteem questionnaire reflecting conceptualization of esteem, faith in people, HIV/AIDS orphans, depressive affect, daydreaming, psychosomatic symptoms, interpersonal threats, and child interaction with the caregiver was used. Both non-orphans and orphans living in the same home were assessed using the self-esteem instrument (Appendix M).

RESEARCH DESIGN

Research Inquiry Methods

Qualitative, case study and descriptive, critical, in-depth, clinical and limited quantitative research methods were utilized on this diverse, hard-to-locate sample, in order to collect data. This was done by first of all, identifying indigenous focus groups in Zimbabwe. The researcher worked with the focus groups to necessitate the researcher's cultural immersion, and to learn the "socially desirable terminology" for use in this sensitive research. For instance, the researcher soon learned from the focus groups that the then socially acceptable term for HIV/AIDS was *"Svuura Matongo."* The focus groups were instrumental in pre-testing the questionnaires, checking for errors in measurement instruments, determining problems, and validating the tools that were prepared in the USA in 1997. The cultural immersion was crucial in that it would acquaint the researcher with the latest acceptable slang words, terminology, body language, communication styles, taboos, politics, norms, values, beliefs, traditions, myths, truths, facts, and tainted or untainted versions to be utilized in this highly sensitive topic which involved HIV/AIDS, stigmatization, scape-goating, denial, sorrow, loss, bereavement, mysteries, blaming, anger, many unresolved puzzles, and equations that failed to balance.

On the other hand, the researcher trained the focus group members in the appropriate ways to propagate snowball-sampling techniques, in order to identify the target sample families from the larger population without fear, or bias.

Using the qualitative participatory research methods, the researcher collected data using survey questionnaires written in English, and translated into the native language.

The outstanding feature of this critical, qualitative, clinical research model is that the data comes from the willing members within the culture of any particular organization or family institution because they initiate the process and have something to gain by revealing themselves to either the clinician, consultant or researcher. In this study, informants voluntarily initiated the process of participating by engaging in the snowball-sample technique.

Another advantage of the critical, qualitative, clinical research model when gathering data on highly sensitive issues such as HIV/AIDS and the related orphans, is that the inquiry process to some extent elevates the position of the consultant/clinician/researcher to become psychologically licensed by the clients to ask relevant questions that can lead directly into the cultural analysis of a given organization or family institution; thereby allowing the development of a research focus. The consultant/clinician /researcher is primarily there in the organization or family institution to help with some presented problem, but during the process of working on the problem, he/she uncovers culturally relevant information that helps the organization/ family institution to help itself (Schein, 1969, 1978, 1988).

This design allows the researcher/clinician/consultant and the client to become fully involved in the problem solving, and the search for relevant data is thereby a joint responsibility. During the process the clinician/researcher /consultant also has the opportunity to "hang around" and observe what is going on, allowing the researcher to combine some of the elements of the clinical and participant observer ethnographic models.

Research Subjects

The study utilized 50 women who were kinship caregivers of both orphans and non-orphans at the time of the study. These women were between the ages of 17 and 85 years old, and could either be married, separated, never married, divorced or widowed at the time of the field work. The study also included 50 middle childhood orphans and non-orphans between 6 and 12 years old. The orphans whose parents died of HIV/AIDS and the non-orphans who participated in the study had to be living in the same home environment, and both were under the care of the same kinship caregiver.

Instrumentation

The study investigated differences in care giving utilizing an adaptation of the caregiver's: (CRPQ) Child Rearing Practices Questionnaire (Barton, Dielman, & Cattell, 1974). This measure is a self-descriptive instrument, which is broken down into six dimensions. The CRPQ has been widely used to study relationships between rearing practices and early school achievement, behavior problems, family relationships, and early childhood personality (Appendix L). Information for scoring the inventories was obtained during a 45 to 90-minute home visit done during a time when the target child(ren) and the child's(ren's) primary caregiver were present. The procedure is a low-key, semi-structured observation and interview done so as to minimize obtrusiveness (*Pediatric Nursing*, 1988). The researcher added questions that would check if the kinship caregiver felt confident and comfortable to discuss openly and effectively any HIV/AIDS related topics with the children under care, especially the orphans.

A Self-Esteem (Appendix M) questionnaire reflecting the orphans' self-esteem, emotional status, feelings about self-worth, faith in people, societal HIV/AIDS stigmatization, depressive affect, daydreaming, psychosomatic symptoms, interpersonal threats, child-caregiver interactions, and relationships was used. Regarding the kinship caregiver economic well-being in relation to orphans' self-esteem, questions were adapted from the Zimbabwe's 1994 Demographic and Health Survey (ZDHS, 1994). The questions were adapted to obtain kinship caregivers' demographic, economic, and health factors that would impact children under care (Appendix B). Data on kinship caregiver's social support networks in relation to orphans' self-esteem was obtained by using questionnaires and eco-maps (Chigubu, 1998). The instruments included items on kinship caregiver's social support networks, marital status, AIDS stigma, education, and other items (Appendix K).

SAMPLING PROCEDURES

Snowball Sampling Technique

A snowball-sampling technique was utilized in this project. It was a very important approach in this study because HIV/AIDS is a health issue that is highly sensitive, value laden, socially stigmatized, and relies on the previously identified members to identify others.

> Often snowballing is used when a listing is unavailable and cannot be compiled by researchers. Sociological research on groups as diverse as illegal drug users, illegal aliens, and community 'power elites' use this method to build up sample sizes quickly, recruiting subjects who are hard to locate (Hammersley, Forsyth, & Lavelle, 1990).

This method was successfully used to study homosexuality among American priests (Cahill, 1983) and illegal drug users in Scotland (Hammersley, Forsyth, & Lavelle, 1990).

Justification for Using Snowball Sampling

Snowballing is a powerful, justifiable approach, inclusive of the indigenous people's perspective, cultural sensitivity of social stigma of HIV/AIDS deaths, and the predicament of orphans and their kinship caregivers, who by the nature of that culture, are not supposed to overtly complain of the stress of caring for orphans.

Henry (1990, p.21) states, "Often snowball sampling is used when a population listing is unavailable and cannot be compiled by researchers. Sociological research, on groups as diverse as illegal drug users, illegal aliens, and community 'power elites', uses this method of generating a sample of the population." This is typical of this project.

HIV/AIDS is a health issue that is highly sensitive, value laden, and has a social stigma. Snowball sampling relies on previously identified members to identify other members of the population. In Zimbabwe there is no listing for caregivers of orphans whose parents died of HIV/AIDS. The advantage of snowball sampling is that it can build up sample sizes quickly and/or it can recruit subjects who are otherwise hard to locate.

Previous References to Snowball Sampling

The snowball sampling method was utilized in the study of homosexuality among American priests in 1989 and in a study of illegal drug users in Scotland in 1990. In Zimbabwe, peasant resentment to change dates back to the 1800's during days of British rule through the use of a snowball technique. Similarly, it is important to indicate that snowball sampling works almost similarly to the conscientization approach that the President of Zimbabwe, Robert Mugabe adopted and used in the protracted, rural, guerilla war to attain independence in 1979.

The approach, developed in the 1940's, was a peasant political ideology, a program that was not captured or diverted by *petty-bourgeois* leadership during the period of open nationalism (Ranger, 1985). Snowballing won the favor and trust of the peasants who are not always very willing to divulge accurate information if they are suspicious, or do not trust an individual or individuals, or feel culturally threatened.

Snowball sampling, as applied to the Zimbabwean situation, took into cognizance the issue of *conscientization*, and networking, which is empowering especially to those eligible participants who might be very hard to identify without stirring up a feeling of

resentment to the demands of the research, which were somewhat culturally shocking to develop, adapt and implement effectively.

According to an article "Will China be democratic?" the Voices of Dissent: The Democratic Revolution in China (1992) utilized snowballing as a sampling procedure. In the USA, an empirical investigation on marriage research on under-represented populations of lesbians, the transgendered, and gays, used snowballing in 1995. Patrick (1993) used snowball sampling selection and evaluation methodology in his study of social networks. In the Journal of Marketing (1994), snowball sampling was adopted in order to study the evolving patterns of organizational beliefs in the formation of strategy. Further, in 1989 the University of California used snowballing in the network approach to outpatient service delivery systems, regarding the flow of resources flow and the influence of the system. In 1994 snowball sampling was used in a study to compare childhood backgrounds of teenage mothers and their non-mother's peers: new formulation (Journal of Families).

Finally, but not least, in 1996 the snowball sampling technique was used when studying hard-to-locate male adults who sexually molest young children (US interviews).

DATA COLLECTION

Information Gathering

When the researcher set out to go to Zimbabwe to gather data on the dissertation research, the project's future outcome was unpredictable. The project's approach was grounded on Bronfenbrenner's (1979) ecological perspective, which encompasses various paradigms, theories and models. The writer had been away from her home in Africa, for six years and since culture is dynamic, there are espoused values, rules, artifacts, behavioral norms, and tacit basic underlying assumptions that had definitely changed during her absence. Living in the USA for six years, made her become somewhat of an outsider upon arrival in Zimbabwe in 1998, an experience that would soon posit un-anticipated problems to the researcher when trying to identify the target sample at the early stages of the project. Regarding how informants would react to the topic, she was unaware of existing gray areas that, as it turned out, were somewhat explosive. Schein says: "When we do not understand something, we need to pursue vigorously why we do not. The best way to search is to use one's own ignorance and naiveté" (1992, p. 30).

The writer utilized her own ignorance as the basis for reaching out and building focus groups from which motivated informants who would work with her to initiate the snowball sampling of the appropriate sample would be identified.

As scholars on culture argue: "...unless one digs down to the level of basic assumptions, one cannot really decipher artifacts, values, and norms" (Schein, 1992, p. 52).

If one finds some of those basic assumptions and explores their interrelationship, one is getting the essence on it.

Self Administered Questionnaires:

Due to the sensitivity of this topic, questionnaires were delivered and administered at the homes of the respondents. The study was explained to informants and the researcher administered the survey questionnaires in person. It is well documented that the appearance of a research worker, whether in delivering the questionnaire, or picking it up, or both, seems to produce a higher completion rate than do straightforward mail surveys (Babbie, 1990). This activity is also cost efficient.

A thorough recording of methodological data always ensued using an invaluable tool: a completed survey rate graph. The day on which questionnaires were given out and completed, it would be tabulated and logged on the graph. The researcher would then compile two graphs for each question. One should show the total number completed each day, rising and dropping as the number of completed surveys fluctuated. The other graph should be used to report the cumulative number or percentage of completes. It became the guide on how data collection was systematically proceeding.

Further, it provided hints on when other questionnaires should be launched as dates of subsequent home deliveries were always noted on the graph. As completed questionnaires were entered, each would be assigned an identification number. The numbers would be assigned serially as questionnaires were completed.

Interview Surveys: Face-to-face interviews:

For both kinship caregivers and the children, the study comprised survey questionnaires administered by the face-to-face technique. The advantage is that it decreases the number of *don't knows* and *no answers*. However, the face-to-face interview technique requires the researcher to adopt a neutrality stance during the home visits.

Pencil and Paper method

This method was successfully utilized throughout the research. It is very efficient, very cost effective, and non-threatening, especially in in-depth studies where the researcher had to stay for as long as three to four hours a day in one home during observations. The researcher using pencil and paper, made anecdotal notes during and after the interviews, and carried out intensive home visit observations as part of data gathering.

Photographs

A few photographs related to the topic were taken. Some of the informants refused to have their pictures taken.

Researcher's Role in Data Gathering

In Zimbabwe, the researcher had the opportunity to "hang around," to gather demographic information, measure various aspects unobtrusively, and simultaneously engage the informants on their own terms, around their own identified problems.

Qualitative data gathering requires the researcher to engage in roles similar to those of clinician, theorist and ethnographer. An ethnographer's role is to study the symbols and values of a culture without passing judgment on those symbols and values (Marshall & Rossman, 1989). It was crucial that the researcher understand the data from the viewpoint of multiple informants, and work to maintain objectivity regarding spontaneous and emergent theoretical, and operational concepts.

The background knowledge, personal experience, perceptions, and cultural re-immersion of the researcher molded the outcome of the research to a significant degree. It was the tailored desire of the researcher to explore this topic that had never before been studied, and create a foundation for future research topics relating to children, families, and HIV/AIDS in Africa. The decision of the researcher to focus specifically on women as kinship caregivers of orphans whose parents die of HIV/AIDS does not reflect the notion that Zimbabwean men do not participate in kinship care giving. The choice of women was based on the researcher's desire to avoid complexities that the research would confront if all household members were involved. That would have called for longer time for study. Data were collected from completed administered self-report questionnaires, structured and open-ended interviews with the willing participants who signed a release of information and a consent form enabling such interviews and photographing to take place.

The researcher collected the data from participating kinship caregivers, orphans, and non-orphans with the assistance of Focus Group members from ten different research sites of peri-urban areas of Harare, the capital city of Zimbabwe, where the investigations took place. Potential informants from ten research sites in the targeted area were notified

of the opportunities to participate in the research by the research assistants from the Focus Group. The participants' preferences determined the place where interviews were held.

When a kinship caregiver and the orphans under care expressed desire and interest to participate, convenient time to the informants was scheduled for an interview. The orphans and non-orphans answered the Self-Esteem questionnaire, and the caregivers answered the three questionnaires on Social Support Networks, Economic Well-Being, and Child Rearing Practices. All the questionnaires were in English, and though English is the official language in Zimbabwe, the Focus Group, the informants, and the researcher agreed that the terminology in the questionnaires might mislead the informants if each informant self-administered their own questionnaires. In order to achieve continuity throughout the data collection process, the researcher translated and read the questionnaires to the informants in either English or vernacular language depending on the informant's language comfort zone.

The interview lasted two hours for each set of three administered caregiver questionnaires. However, the Self-Esteem questionnaire administered to the young children had two distinct differences in time lengths that emerged during the data collection process. The interview only lasted for 15 minutes when administered to non-orphans, but the same questionnaire, when administered to orphans, lasted 45 minutes to an hour. Orphans presented lengthy details, which described their plight and circumstances of orphanhood, while non-orphans were excessively brief without detail. The participants were debriefed concerning their responses to the questionnaire and the interview. The instruments utilized during the data collection process are in Appendices J, K, L, and M.

During the initial stages of the data collection process, the research assistant/focus group member identified the kinship caregivers through snowball sampling technique and scheduled an appointment for the researcher to meet the caregiver, the orphan, and the non-orphan. The following day, the researcher would drive, pick up the research assistant from her home, and then drive to the research site where the research assistant had identified the various willing participants. Upon arrival at the informants' house, the research assistant would introduce the researcher to all the members of the household, including the caregiver, her husband, if any, all her children, and all the orphans under care, depending on their availability. The researcher then briefed the whole household concerning who she was, and for whom she had visited the household. She explained why she would not interview every member of that household, and why she was only targeting the woman in that household and not the men, and why she needed to interview her informants separately and privately. The researcher and the kinship caregiver would get a private space to hold the interview on a one-on-one basis. When complete, the orphan and non-orphan would also be interviewed separately and in private.

Empathy is another important element in qualitative critical inquiry. Empathy is viewed as "social role taking" or the art of being able to put one's self in someone else's shoes. The qualitative critical process involves assisting all those involved to perceive other people as similar to themselves but also different in regard to their specific backgrounds, and consequently their feelings, thoughts, and ways of mirror-imaging of what is occurring in their world.

In relation to empathy, the researcher created conditions in which dialogue helped all those involved, to develop an increasingly more diversified and integrated social role-

taking perspective. Hence, information provided by participants, verbally or non-verbally, were treasured, and closely attended to by the researcher for de-coding. Qualitative critical science also notes that dialogue should be designed to assure everyone has equal opportunity to participate, and that all interests are served. In this project, the researcher held individual interviews with each individual research participant, an opportunity that gave both the women and children participating in the study, the chance to speak openly of interpersonal concerns that they might not have said in the presence of other participants.

Qualitative critical science acknowledges the notion that all knowledge is culture bound, and in a very logical sense, is inherently ideological. Consequently, the researcher was reflective on the informants' culture when summarizing comments utilized during the interviews to assist respondents to clarify the content of their responses so that the chances of misinterpretation would be minimized. According to Donna Leonhard Coomer (1989),

> ...the critique of existing social situations including ideologies, power, and oppression is possible in a critical conception since critique is grounded in reason that is open to examination and to inter-subjective agreement with those who are the social actors. The theory of communication is the means used to validate the criteria employed in critique" (p. 67).

Following Coomer's (1989) thinking, the researcher consciously used the native language that the informant felt comfortable to utilize during the interview. In terms of language and communication, most school-going orphans preferred to be interviewed in English instead of their native languages, unlike all kinship caregivers who chose a native language. On the other hand, the dyadic interviews revealed taken-for-granted levels of

consciousness and uncovered distortions. It equipped the researcher with new knowledge that had never been documented regarding kinship care of orphans whose parents died of HIV/AIDS.

Role of Informants versus Researcher in This Study

The informants' willingness to volunteer information about caregiving to orphans whose parents died of HIV/AIDS to the Focus Group members, dictated which ten research sites were utilized for interviews. Additional information was obtained from the Focus Group, media, and general populace.

In this critical science inquiry, in-depth, and qualitative research, the self of the researcher is viewed as intrinsic to the development of the research process (Daly, 1992). In this process, the researcher is seen as a primary component of the ecology of the research environment.

Throughout the research process, the researcher visited all ten research sites accompanied by a focus group member. As the interviewing progressed, the informants gained further trust in realizing that the researcher was very apolitical, but that she was a scholar interested in educating both the local and international community about the day-to-day hurdles faced by them regarding orphans and kinship care.

Procedures Adapted

1. Focus groups:
2. Critical inquiry, in-depth observations:

3. Content analysis of the stories narrated to me by the subjects; myths, rituals, symbols, traditions followed, and artifacts visible or unseen:
4. Questionnaires, ratings, scales:
5. Clinical, qualitative, participatory, action research.

Focus Groups

Even though a Zimbabwean citizen, this researcher, having lived outside the country for six years, was likely to be seen as an outsider in the circles of the research participants and informants. This could have been a limitation in terms of how the locals perceived her as a Zimbabwean "outsider" coming from the USA to do research on HIV/AIDS in Africa. The focus groups comprised informants who voluntarily showed interest in participating. In turn, the researcher used semi-structured interviews to obtain information from the focus group (Appendix O).

Why Focus Groups?

During the early days of the project, the researcher nearly abandoned the research due to unspoken and spoken resentment and animosity experienced when trying to establish the target sample. Formulating focus groups to identify the sample resulted in success. Of all the procedures utilized during this research, focus groups were the most critical. Without them, the findings would be diluted from reality and somewhat misleading. The rate of change in the economic, technological, political and socio-cultural environments had sky rocketed from the time the writer left Zimbabwe in 1992 to the year this project was carried out in 1998. This phenomenon depicts the fact that the very

strengths that used to be institutionalized within families before the advent of the HIV/AIDS epidemic could easily become liabilities in the era of HIV/AIDS. From these focus group members, the researcher learned new basic underlying assumptions embedded within the then culture.

The word "HIV/AIDS" was socially undesirable and the writer soon learned that she had to use the vernacular term, which was socially accepted which is *"Svuura Matongo,"* which literally implies "the tornado that devastates a ruin." This was the terminology utilized throughout the fieldwork. It was very surprising to see this paradigm shift. Further investigations identified why informants would get somewhat offended if a researcher doing participatory, in-depth interviews with them used the term "HIV/AIDS." One of the focus group members opened up and stated one of the reasons:

> Tell you what? You are coming here from USA, asking people all sorts of questions about HIV/AIDS, eh! and you think people will be happy with you? No ways! One thing for sure is that you are not going to be stoned or harmed as such if you decide to go about asking people using the term HIV/AIDS. However, people are going to look at you very suspiciously and indifferently like they would when dealing with a sell-out. To some extent, you might not get all the information that you require relating to HIV/AIDS, because the HIV/AIDS virus is said to have been deliberately manufactured in the US laboratories and shipped in contaminated blood as free AID to Central African hospitals from where it has spread like fire to all parts of Africa! And do you know the reason? To wipe out the black population. Now you come here from USA, to ask us about orphans who lost their parents from HIV/AIDS? And you expect people to be happy about that? Come on, give us a break! (Focus Group member in Zimbabwe, 1998).

Hearing this informant speak out was the biggest eye-opener for the researcher. The reason clearly dawned why there was this enraged bitterness to some folk at the mention of studying in the USA and the objective of coming to Africa to study the situation about

orphans whose parents died of HIV/AIDS. The researcher quickly learned never to mention "HIV/AIDS" to participants during the entire fieldwork. A tremendous paradigm shift in the way the researcher had to look at the whole study, especially the fact that while in the USA, she had read background information on HIV/AIDS, which included the origin of HIV/AIDS, the monkey theory, and the AIDS epidemic in Africa as a whole.

Data Gathering In Relation to Monkey Theory

Before leaving the USA for Zimbabwe to collect data in 1998, all the researcher was familiar with regarding HIV/AIDS was the "Monkey Theory" which she had heard and read about repeatedly in the USA. This unproven and alleged rumor, blamed that HIV/AIDS originated in Africa. Some of the monkey theorists have false notions that in Africa people eat monkeys, (an alarming rumor that has been dispelled by many Africans as untrue) which are believed to be the carriers of the HIV/AIDS virus (US CNN News, 1997).

Upon arrival in the Southern hemisphere in Africa, the speculations about the origin of HIV/AIDS were different. In this part of the world, the Africans with whom the researcher came in contact during research disputed the fact that HIV/AIDS originated in Africa. Worse still, in this part of Africa, nobody eats monkeys, so the "monkey theory" was taken as an insult. It was not a theory talked about the way it is in the USA. Instead, some of the people were very angry about the fact that the USA was said to have manufactured this deadly virus in order to wipe out the Africans.

In this qualitative critical inquiry research study, the researcher has become a life-long learner, from the exposure to both USA and Zimbabwe whose differences include the

way people speculate the origin of HIV/AIDS, blame each other, and the negative impact the whole scenario brings to orphans whose parents die of HIV/AIDS, and the kinship caregivers concerned. The researcher soon found that from the kinship caregivers interviewed, there emerged four schools of thought regarding HIV/AIDS issues (Table 4.1, page 187).

Origin of the Monkey Theory and HTLV-1

It is documented that areas commonly known as endemic for HTLV-1 include southeastern United States, Alaska, Papua New Guinea, Africa, southwestern Japan, and the Caribbean basin. Research on the simian T-lymphotropic virus (STLV) triggered further speculation about the origin of HTLV-1. Results revealed that STLV strains have been isolated from chimpanzees, African green monkeys, and baboons from Cameroon, Kenya, Gabon, Ethiopia, and Senegal (Ishikawa, Fukasawa, Tsujimoto, *et al.*, 1987). Sequence analysis indicated that simian viruses were closely related to, but distinct from, HTLV-1 prototypes from Japan and USA.

Formulation of the Monkey Theory

Conclusions drawn from these observations saw the birth of the "monkey theory" (Wanatabe, Seiki, Hirayami, & Yoshida, 1990). Summarizing these speculations, Ina and Gojobori (1990) and Gessian *et al.* (1990), stated that the HTLV family evolved independently of host-species divergence, and they indicated that inter-species transmission between humans and monkeys may have taken place.

Data Analysis after Collection of Data

The data analysis in this particular research called for immense background knowledge, past experiences, forethought, and previous preparations. The transcription process involved decoding of details from the informants' vocal responses, such as affective tone, volume, pitch and intensity of word production. In the transcriptions, pauses were noted with dotted dashes. Briefer pauses were shown by fewer dotted dashes. The uses of words like "aah," "heee," "iih," and "uh" and tangential use of the word "*nhingirikini*" (Shona language), or "*lokuza*" (Ndebele language), or "*futi*" (in Nyanja) synonymous to "like" in the American language were also transcribed. For words that informants emphasized, upper case letters were used.

When informants were emotionally upset and ended up sobbing bitterly, however, responding to the question at the same time, words and sounds were not clearly audible, a symbol was used to indicate the problem. Comprehensive, and accurate notation of communication content facilitates researcher objectivity (Marshall & Rossman, 1989).

Critical research is historically and qualitatively grounded. It helps participants identify contradictions between what they say they believe and value, and what they do in practice. The uniqueness of critical, qualitative research is to utilize the past, in order to understand the present, and help formulate what might be.

In this study, ongoing critical reflection about data provided during interviews, focus groups, and through responses to the research questions was supplemented by filed anecdotal notes, photographs, and theoretical memos. Careful attention was paid to incorporate all of these into the data analysis process (Miles & Huberman, 1994). The analysis process involved transcription of data from shorthand written field notes,

diagrams, and photographed data. Informants' statements and words were read and re-read to permit the essence of their accounts to condense in the researcher's mind (Miles & Huberman, 1994).

Critical qualitative research challenges the certainty, the meanings, the compartmentalization of knowledge and the place of researchers in the research act. Challenges in this process included the transcription of collected data. During and following transcription of photographs, and integration of the field notes, data were sorted by constant comparison (Glasser & Strauss, 1967). During fieldwork, evidences derived from the participants' use of common folk terms were noted. Analysis of critical qualitative data was confronted dialectically, and line by line.

The coding of data from participating orphans, non-orphans, and kinship caregivers was organized into groupings based on the research domains of (a) caregiver's economic well-being, (b) caregiver's social support networks, (c) caregiver's child-rearing practices, and (d) child's self-esteem. Categories and their properties were further integrated through pattern matching.

Critical reflection actually organizes thinking. Data were evaluated for accuracy of utility, centrality, information, reflection and credibility, (Marshall & Rossman, 1989). In this study, the framework was built as part of an on-going theme, and was put into action following the revelation of the interactional process, and was illustrated with data displays, and cases were compared to the literature. Themes that characterized the situation were recognized and evaluated for their role. Constructs were confirmed through triangulation of data from the informants, research instruments, and focus group members.

Mechanics Applied in the Analysis of Data

After collection of data in Zimbabwe in 1998, the researcher took a brief break "by letting the material sit for a short while, and then come back to it with a rested mind and refreshed ideas"(Bogdan, 1992). The next stage was the **sorting of data** sequentially, and in relation to the four variables utilized: (a) kinship economic well-being, (b) social support networks, (c) child-rearing practices, and (d) self-esteem.

Coding the data according to categories assisted the researcher to see clearly the patterns that stood out repeatedly in terms of language, phrases, attitudes, beliefs, behavior, informants' way of thinking, cultural norms, traditions, values, events, and others. Assembling a coding system in this research included (a) searching through the data for regularities, irregularities, patterns, and sub-topics the data covered; and (b) writing down diction to represent the identified sub-topics and headings.

Context and Setting Codes

The next stage was to place the whole study in a larger **context and setting** (Bodgan, 1992), including information on the setting. Information, which included general statements that the informants made about describing the setting, topic, or context, was coded here. For example a brief but highly loaded (Shona language) statement describing "family setting" was described in this way by a caregiver:

> "*Ende zvakaoma, sekupema mupostori*!" which in English can be translated as: "...(T)he family setting here is very stressful, tough, and hard." To describe it fully, is best done by the analogy of trying to relax or apply a perm to a very willing, highly assertive and persistent person, who has however, nothing but a bald head. (Zimbabwean kinship caregiver explaining her stressful experience during an interview with Chigubu, 1998).

Situation Codes

This phase in particular, included the defining of the **situation codes** (Bodgan, 1992). In this category, the researcher had interest in the informants' worldview, and how they perceived themselves in relation to the setting/ context of the topic in question. Included in this category were themes on what the informants wished to accomplish, how they defined themselves and what they did, what was important or stressful to them, and whether they had particular orientations which affected how they defined participation in their settings (religious, political, social, class, gender, race, and ethnicity). Following is an example of data that was coded under such a category. It is a statement that was made by an orphan, describing his worldview:

> The situation that my dead parents left me in is sorrowful, and spells nothing but poverty. However, if I could have a sponsor to educate me, I strongly feel that I am somebody that has a number of good qualities. I am good at Mathematics and Science. I definitely consider myself a future scientist! (Zimbabwean orphan interviewed by Chigubu, 1998).

Views and Perspectives Held by Informants Codes

The category that followed included **views and perspectives** (Bodgan, 1992) that were held by the participating informants. Coding in this category was oriented towards ways the informants thought or anticipated, including their blanket definition of the situation. The category included shared norms, rules, values, laws, as well as socially desirable or acceptable general points of view. It is important to assign a category that points to codes that get the informants' "understandings of each other, of outsiders, and of the objects that make up their world" (Bodgan, 1992, p. 168). To cater to this idea, a category was made, called the **informants' views about people and objects**. This stage

highlights definitions that informants had, for example, if the orphan viewed the caregiver as discriminatory, or if the caregiver defined the orphan as "un-thankful trouble-maker."

Following is an example of data that was coded under such a category. It is a statement made by an orphan, describing how he sees his own world as an orphan:

> Children whose parents died of HIV/AIDS tend to be ignored by most people. They say that their father enjoyed himself with prostitutes, now he is dead leaving his poor children behind. If he could not take care of himself, his children, and wife, why should we be obliged to take on his responsibilities? Let us leave those orphans to fend for themselves. *Pachavo*! (Shona meaning for "It's their own problem.") (Zimbabwean orphan interviewed by Chigubu, 1998).

Process Codes:

During the data collection, the researcher processed anecdotal notes relating to slang words used, or phrases that were popularly used to categorize sequences of events, dynamics of changing times, transitions, and downward or upward mobility from one status to one another. Process codes were utilized to code the collected slang words and phrases. Scholars in qualitative data analysis (Bodgan, 1992; Roth 1963) caution that in order to utilize a process code, the researcher should view a person, institution, group, activity, or organization over time and perceive change occurring in a sequence (transitions, benchmarks, turning points). This researcher, a Zimbabwean, had been away from the country for six years, and carrying out this research allowed her to identify transitions, benchmarks, and turning points that had occurred due to the HIV/AIDS catastrophe in Africa. The process coding was crucial in ordering the life histories and periods in life of the informants that signified separate important segments. A good

example of what the codes reflected in this category is (a) early life of informants, (b) death of a beloved relative, (c) grieving and funeral rites, (d) moving and joining the extended family or/getting joined by orphans; (e) adjusting to new life situations, (f) becoming a displaced orphan/a kinship caregiver, (g) current issues and beyond.

An example of a unit data coded under the process heading "stages in the transition from a child with two healthy parents, to a homeless, migratory orphan."

The following unit of data is an example used in this study:

> When both of my parents were alive, dad used to drive our family around during weekends. We would drive out to visit the zoo, safaris, and resort places where we would eat from luxurious hotels. Now ever since my parents died three years ago, I am so poor that I wear tattered clothes like you see me wearing right now, and I do not go to school (a Zimbabwean 12 year old orphan, interviewed by Chigubu, 1998).

Activity Codes

The complexity of this study also called for a category, which involved **activity codes**. According to Bodgan (1992), "Codes that are directed at regularly occurring kinds of behavior are what we are calling activity codes" (page 170). The examples of these behaviors included neighborhood HIV/AIDS stigmatization, basic food availability, and orphans' 'visits to the parents' graveyard, name-calling, radio and television awareness campaigns about HIV/AIDS, among many others. Following is one such unit reflecting information on "Zimbabwe's radio and television HIV/AIDS awareness campaigns" taken from a conversation held between the researcher and one of the participating kinship caregivers, who admitted that she did not have adequate knowledge and facts to effectively discuss HIV/AIDS with children and orphans under her care.

> I take care of orphans whose parents died of HIV/AIDS. I very strongly agree that I lack **real** facts on how HIV/AIDS spreads. What I hear from the radio and television are warnings that AIDS kills, and most of the time, the messages are not educative enough to make me have the full knowledge of how exactly HIV/AIDS is spread. Look, from time immemorial, we have had polygamous families, nobody died of HIV/AIDS. For a long time, we have had tattoos as part of our culture, and we have shared razor blades when tattooing, and nobody died of HIV/AIDS. From time immemorial, we have pierced our own ears for earrings, and we have shared the same needles for ear piercing, and nobody died of HIV/AIDS. Now what I hear these days is HIV/AIDS will kill you if you share needles and all the jazz that's said about HIV/AIDS. All I hear about AIDS does not add up to make any tangible meaning. That is why I say I do not know how HIV/AIDS is spread because something is fishy about HIV/AIDS!" After all, there is talk that it was shipped from overseas in the form of contaminated blood for donation in the hospitals that is the truth (Kinship caregiver interviewed by Chigubu, 1998).

Event Codes

The study also involved units of data that were related to particular events that occurred as part of the setting or lives of the participating informants. As part of data analysis, a process called event coding was applied. According to Bodgan (1992), "**Event codes** point to particular happenings that occur infrequently or only once" (page 170). Some of the examples for event coding in this study were: "counseling after a beloved relatives' funeral," "the will," "the orphans' loss of education," the caregiver "feminization of poverty" and others.

The following is an excerpt from this research that contains material coded under "counseling after a beloved relative's funeral":

> When my beloved mother died, nobody sat down with me to talk about death, or how I should face life as an orphan. When I think of her death, I get depressed, and do not

> know what to do (Zimbabwean orphan interviewed by Chigubu, 1998).

Relationship and Social Structure Codes

By using eco-maps, the data accumulated consequently formed regular patterns of behavior among the participants. These, among others, were units of data that formed patterned **relationships**, which, in turn, influenced the formation of cliques, for example, in-laws interfering in both the orphans' and kinship caregivers' lives, or formation of relationships in terms of enemies of the research itself, or mentors, coalitions, clusters, and others. Bodgan (1992) defines relations as social roles, role sets, and positions. He indicates that the total description of relations in a setting is called social structure. In this study, coding in the **relationship/social structure** domain included examples like orphan friendships, orphans' self-esteem enhancers, developmentally appropriate child-rearing practices, social support networks, and kinship caregivers' stressors, and others. The following unit data is an example of **relationship/social structure** domain denoting a code like "social support networks" in the study.

> Poverty hinders me from getting friends. Nobody likes to have a poor friend who is constantly asking for household items like candles, salt, sugar, soap and other items (Caregiver interviewed by Chigubu, 1998).

Strategy Codes

The study also involved the researcher becoming interested to better understand the orphans' and the kinship caregivers' coping mechanisms to their current harsh economic hardships, or grieving, among others. Coping mechanisms/**strategies** refers to the means, ways, tactics, ploys, and others. Bodgan (1992) calls them **strategy codes**.

An example of a **strategy code** utilized in this study includes the following citation coded under the strategy code "techniques to control HIV/AIDS stigma."

> When a loved family member dies of HIV/AIDS, most people avoid talking about it, and pretend it was not HIV/AIDS (Zimbabwean orphan fictitiously named Indate, during an interview with Chigubu, 1998).

Chapter 4

THE RESEARCH FINDINGS

Introduction

This chapter provides the research results.

Demographic data about kinship caregivers, orphans, and non-orphans are presented. A summary of results across cases is reported. Secondly, descriptive results on the kinship economic well-being, child-rearing practices, and social support networks are provided. Thirdly, the Chigubu (2000) "little theory" was formulated and based on the (1998) responses from kinship caregivers regarding HIV/AIDS and is presented in the text. Fourthly, results of orphans' and non-orphans' self-esteem are given. And fifthly, descriptive case reports of kinship caregivers and orphans are presented. Tables showing the results of the findings are found in Appendices F, G, I, L, and M. A summary concludes the chapter.

Demographic Data

The length of the orphans' stay in the kinship caregivers' homes varied from one year to five years, with a mean of 1.6 years. The orphans' ages ranged from six to fourteen years, comprising both girls and boys. In some cases, the orphans were separated from their siblings, and the siblings would be scattered in various homes of other extended families around the country, whereas in other cases, the orphans had all of their siblings

living together under the care of the same caregiver. The mean age of the kinship caregivers at the time of the interviews was 40 years of age. The kinship caregivers' actual ages ranged from 15 to 85 years. Their age distribution was 2% for those under 15 years, 12% for those between 15 and 24 years, 16% for those between 25 and 34 years, 42% for those between 35 and 44 years, 16% for those between 45 and 54 years, and 8% for those 65 years and over. From the sample interviewed, 36% of kinship caregivers were married, 52% were widowed, 10% were divorced, and 2% were never married. Of those who reported to be married, 34% reported that their husbands were living with them.

Kinship Caregivers' Education

Findings of those interviewed revealed that the kinship caregivers' education ranged from 0 years in school to 12 years in school. Of those interviewed, 8% never attended school, and 92% had attended school. Those who had attended Primary School/Middle School were 62% of the interviewed, while those who had attended High School made up 30% of the sample. None had gone further than High School. The report reveals that from the sample interviewed, 6% of kinship caregivers stopped attending school because they got pregnant, 2% stopped due to early marriage, 10% failed to pursue studies because their schools got burned down by soldiers during the war, 4% stopped because they had to take care of the younger siblings, 4% stopped in order to help on the farms, 56% stopped due to lack of fees, 16% stopped because of bad grades, and 2% stopped because they disliked school.

KINSHIP CAREGIVERS' ECONOMIC WELL-BEING:

Household Incomes

From the sample interviewed, the kinship caregiver household incomes ranged from Z$0 to Z$6000. One kinship caregiver reported her household monthly income to be Z$0, while two kinship caregivers reported their household income to be Z$6000 per month. The household income mean for all of the 50 kinship caregivers interviewed was within the range Z$400 - Z$600 monthly. Only 10% of the kinship caregivers had full-time paid jobs, while 6% worked part-time. Overall, 84% of the kinship caregivers did not hold meaningful paid jobs. The reported number of orphans under the care of each kinship caregiver varied from 1 to 10 orphans.

Basic Food Commodities

Regarding basic food commodities, 96% of the kinship caregivers reported that they have problems with lack of money to buy soap, salt, bread, meat, paraffin, candles, toothpaste, eggs, Vaseline, cooking oil, and milk. Only 4% of those interviewed stated that they did not have problems. When asked about jobs, 52% reported they had been looking for a job but had been unable to secure one, while 48% reported that they had not looked for a job.

Household Items

The findings reveal that from the sample interviewed, 6% had a modern oxcart, while 54% did not have such a vehicle, while 10% reported to have a bicycle, 90% did not own a bicycle. Only 2% of those interviewed had a motorcycle and 4% reported to have a

car. Of the kinship caregivers interviewed, 2% stated that they had a sewing machine in the household.

DATA ON KINSHIP CAREGIVERS' SOCIAL SUPPORT NETWORKS

Eco-map Open-ended and Structured Questions

By use of eco-mapping, and qualitative probing, kinship caregivers were asked where their social support networks came from in terms of school, friends, recreation, extended family, religion, social welfare, and others. Approaches in engaging in the in-depth intense conversations held between the researcher and each kinship caregiver varied from household to household depending on the nature of stigmatization experienced by that particular informant in that neighborhood. Informants also provided information on the sources of their stresses within the social networks.

Extended Family as Social Support Network

Of the kinship caregivers interviewed, 99% respondents cited in-laws as the source of stress to their kinship care-giving. Here is some of the supporting evidence:

> "My sisters-in-law say a lot of bad things about me, and they never come to visit the orphans. I do not receive any support from any of them," said one kinship caregiver.

Another case is an example of a kinship caregiver and a widower who was taking care of three orphans and three biological children. She had this to say:

> "The relatives that come to visit me are the ones from my side, but they do not bring any financial assistance nor food when they visit. If anything, I end up having to pump out money to feed them each time they visit. In fact, their visits are valued, but are a liability to my family. On the other hand, my late husband's relatives never visit, nor assist the

> orphans in any form. Apparently, when my husband died, the in-laws accused me of having killed my husband in order to inherit the house in town," said the kinship caregiver.

Some kinship caregivers had positive experiences and social support networks built around the extended family, and said:

> "My sisters, brothers, sisters-in-law, and brothers-in-law are very supportive. They actually take turns to visit the orphans, and each time they visit, we experience nothing but happiness here. They bring parcels of groceries and I am never broke, nor do I experience the hardships that most widowers caring for orphans do," said one kinship caregivers.

Friends as Social Support Networks

Most kinship caregivers complained that when orphans from parental HIV/AIDS deaths joined them, the social support networks from friends became restrained, and the circle of friends dwindled. When asked why, most kinship caregivers thought that in part, the kinship caregivers were partly to blame in the sense that they would try to be secretive about the status of the orphans' dead parents. When the word leaked to the friends that the truth was hidden from them, the friends then became alienated, arguing that if they were best friends, the kinship caregivers should have told the truth. However, those kinship caregivers who were secretive did it to protect the orphans from stigmatization from neighbors, which in turn cost the kinship caregivers' social support networks from friends.

On the other hand, some kinship caregivers stated that they dropped friends who, when they confided in them about the statuses of the orphans' AIDS dead parents, went about broadcasting to the whole neighborhood. If any friend did that to the kinship

caregivers, that friend would not be considered a source of social support network. In all, 90% of kinship caregivers reported that friends became fewer when orphans from HIV/AIDS parental deaths joined. Only 10% said friends were a source of their social support networks.

Neighbors as Social Support Networks

Due to the height of societal HIV/AIDS stigmatization going on in Zimbabwe right now, almost 99% kinship caregivers reported that neighbors constituted either subtle or open stigmatization to orphans whose parents died of HIV/AIDS, and one could see the difference in the way neighbors treat a family that is said to take care of orphans whose parents died of HIV/AIDS compared to a family that is considered "normal", or without orphans from parental HIV/AIDS deaths. One kinship caregiver commented:

> "Before the advent of HIV/AIDS, communities were cohesive, neighbors loved each other and stood up to be counted. Now with the coming of HIV/AIDS, neighbors no longer have that African spirit of long ago. There are no neighbors here any more!"

Recreation as a Source of Social Support Network

Of the kinship caregivers cited, 100% cited that money is their biggest hindrance to recreation. None of the kinship caregivers interviewed stated that they went to neither movies nor soccer tournaments. Most of them indicated that instead of worrying about recreation, they worry about what to feed the orphans. All kinship caregivers interviewed did not derive their social support networks from recreational facilities that are in their neighborhoods.

Church as a Source of Social Support Network

A third of the kinship caregivers interviewed did not attend church, and did not obtain any social support from church. They stated that before orphans joined them, they used to go, but what made them stop going to church was the fact that they could not afford to pay a church offering. They stated that each time the container for collecting money in church was handed to them, they felt out of place because they had nothing to offer. For those who attended churches that requested offerings to be brought up front and be dropped at the altar/pulpit/mercy seat by each individual church member, they reported that they had no money for offering, and they felt extremely miserable when it was time to give offerings. They could not join other members taking their offerings to the altar, which made them different.

Another third of the kinship caregivers stated that they went to church "once in a blue moon." When asked why, most of the kinship caregivers in this category stated that some of the pastors at their respective churches preached against prostitution, against adultery, which is good by any standards. However, those sermons would be qualified by statements like, "HIV/AIDS will catch up with you, if you choose to become a prostitute or commit adultery," said one kinship caregiver. She said that when the preacher says those words, she did not know what to do if orphans under her care start crying after hearing such words. This group of caregivers did not get social support from church.

The other third of kinship caregivers reported that the church was their biggest source of social support. They reported that they were very actively involved in church, and most of their friends were church members who offered each other tremendous social support in the form of visits, counseling, and spiritual as well as emotional refueling. This

group of kinship caregivers reported that they met other church members twice a week, Sundays and Thursdays for Bible study, feedback, consultations, and educational seminars, where HIV/AIDS issues were also discussed in a non-threatening atmosphere.

Social Welfare as a Source of Social Support

About 99% of kinship caregivers interviewed were very frustrated with the type of treatment they received from social welfare services when they tried to seek assistance from these organizations. One kinship caregiver who had nine orphans and hardly any food for that day stated:

> "I do not even bother to go and seek assistance from social welfare. I heard from many people that it is impossible to obtain help from social welfare."

One of the many kinship caregivers who complained about lack of sympathy or help from social welfare said:

> "See how old I am my child, I am 60 years old, and I do not like it when a young person, born yesterday, and happens to be employed by a social welfare agency thinks he / she is untouchable or superior than me. No! I will never set my foot ever again in those offices, no matter how poor I become. I keep eight orphans here, and like you see around this house, I do not have enough food to feed these orphans. I therefore decided to go and seek assistance from social welfare. Do you know what happened? I was treated like trash! The social welfare officer requested to visit my house in order to assess if I qualified for assistance. When the officer looked inside my bedroom and saw my beautiful imported bedspread that my grandchild sent me from Switzerland where she is studying, the social welfare officer told me point blank that I could not qualify for welfare, especially if I could afford such an expensive bedspread! That is how I got disqualified," said the kinship caregiver.

Overall, most kinship caregivers did not see the social welfare as a source of social support networks. Instead, the majority of participants were extremely frustrated by it.

School as Source of Social Support Networks

Of the kinship caregivers interviewed, almost 100% did not see the school as a source of social support networks. There was very little if any, interaction going on between teachers and kinship caregivers. A third of kinship caregivers expressed that the school system was not supportive of the efforts being made by kinship caregivers. Some of them cited that most orphans were being denied access to the school system due to lack of school levies that the kinship caregivers could not afford for each individual orphan. In some cases, orphans were sent away from school due to lack of school uniforms, and school fees.

Another third of kinship caregivers suggested that if school teachers spared some of their time to visit the homes of their pupils/students, that would help create the much needed social support networks, which was non-existent at the time of the interview. This group felt that most teachers did not have a clue that some of these children they sent away home for lack of levies were extremely poor orphans.

The other third of the kinship caregivers indicated that they only met the teachers at school when they were called by the school to say that their children or orphans under care had fainted during assembly, or in class. In most cases, these faintings would be due to hunger, but because of the seemingly social distance between this group of kinship care-givers and the teachers, the kinship care-givers would hide that the fainting was due to lack of food. Within these pockets of kinship caregivers, some of them stated that the

school provided social support by sharing the burden of educating HIV/AIDS to their children.

Assistance to Kinship Caregivers by Relatives

Of the kinship caregivers interviewed, 66% reported that nobody assisted them in caring for the orphans in their homes, 2% stated that they obtained assistance from social welfare, 6% reported that relatives assumed a fair part, and 24% indicated that relatives assisted very little.

DATA ON CHILD-REARING PRACTICES

Kinship Caregivers' Fear of HIV/AIDS and Child-rearing

On the question of HIV/AIDS, the results reveal that 82% of kinship caregivers interviewed feared HIV/AIDS, while 18% did not report a fear of HIV/AIDS. When asked whether as kinship caregivers they lacked knowledge about how HIV/AIDS is spread, 62% reported to lack such knowledge, while 36% said that they understood how HIV/AIDS is spread.

Stresses or Joys of Kinship Care giving

Reporting on stresses, 94% of the sample interviewed indicated they had trouble with in-laws or extended family members, while 6% did not. Further, 70% of the kinship caregivers reported that they did not have enough privacy to warrant a stress-free environment, while 30% reported to have adequate privacy.

Disciplining Children

Reporting on discipline, 84% of the kinship caregivers interviewed stated that when children made them angry, they applied physical punishment by spanking, while 16% did not apply any physical spanking.

Housekeeping Chores

Regarding housekeeping chores, 66% of kinship caregivers interviewed stated that all children under their care were involved in daily housekeeping chores, 12% indicated that every child is responsible to clean his/her own room, 6% stated that they cleaned the boys' rooms, 10% reported that only girls helped, 2% reported that all the work was done by the caregivers, while 4% said all boys helped.

Orphans that Keep Joining Relatives

Kinship caregivers interviewed had different reactions regarding orphans that keep joining them. Results showed that 50% of the interviewed kinship caregivers saw orphans joining them as a burden that was not easy to bear, 4% indicated that having orphans joining them was the most wonderful experience they ever had, 18% indicated that it would be easier if they had enough to eat. Of those interviewed, 14% stated that orphans are generally hard to please, and therefore they disliked caring for orphans whose parents died of HIV/AIDS. On a happier tone, 14% stated that no matter what, orphans were always welcomed in their homes.

Caring for Orphans

On the question of caring for orphans, 80% of the kinship caregivers interviewed stated that it was a great responsibility, a very heavy burden to bear, and wished they could get assistance, 12% stated that it was a great joy for them, "the more the merrier," while 8% indicated that if the culture provided a choice, they would never choose to take care of orphan kin whose parents died of HIV/AIDS.

HIV/AIDS

On the question of HIV/AIDS, 68% of the caregivers interviewed said that they did not feel comfortable to talk about HIV/AIDS, nor sex education for young children (including orphans), while 20% said they felt comfortable discussing this with children 11 years and over. Of those interviewed, 4% were comfortable with all ages of children, and 4% were comfortable with girls only.

Children and Play

The findings reveal that 26% of the kinship caregivers interviewed stated that in playing, if they heard that their children's friends had AIDS or were HIV positive, they would stop their own children from associating with those children, while 6% indicated that they would stop the HIV/AIDS children from playing with the kinship caregivers' children. On the other hand, 44% indicated that they would not comment at all, that HIV/AIDS does not harm play, and 12% stated that they would teach their children not to discriminate against friends who had HIV/AIDS. Of those interviewed, 12% reported that

they would ask the church minister to stop those children with HIV/AIDS from coming to play at the kinship caregivers' houses.

Children Fighting

Regarding children fighting, 88% of the kinship caregivers interviewed stated that if their own biological children fought with the orphans under care, they would definitely step in and settle the fight themselves, 6% reported they would physically punish both, 4% indicated that they would let them fight for a short while, and then perhaps intervene. Of those interviewed, 2% stated they would punish both orphan and non-orphan children by giving them extra work to do.

Orphans under Care Being Bullied

When asked how the kinship caregivers preferred the orphans to behave when being bullied, 62% of kinship caregivers interviewed stated that they expected the orphans to ask for the caregivers' help, and then the kinship caregiver would talk to the bully's parents. Of those interviewed, 4% of kinship caregivers stated they did not want to hear about the fighting because what happens out there should end there, while 6% of kinship caregivers said they would let the orphans settle it on their own, regardless. Of those interviewed, 20% of kinship caregivers reported that as long as the orphans were in no physical danger, let them settle it, while 2% of kinship caregivers said they would ask any of their children to fight the bully, and 6% kinship caregivers indicated that they expected the orphans should ask the kinship caregivers for help.

Orphans under Care Having Boyfriends or Girlfriends

Reporting on what the kinship caregivers would do if they found out that orphans aged 9, 10, or 11 years who were under their care had boyfriends or girlfriends, 58% kinship caregivers interviewed stated that they would be moderately strict and would warn the orphans of HIV/AIDS, 6% indicated that they would report the matter to their husbands to deal with it, 22% said that they would be fairly strict, and would scold the child to stop it, and 14% indicated that they would be very strict and would physically punish.

Kinship Caregivers' Reaction to Orphans' Bed-wetting

Reporting how the kinship caregivers would react if children between 6 and 12 years wet their bedding, 24% of the kinship caregivers interviewed stated that they would not give children any drinks after 6 pm, 38% said that they would wake them up twice every night, 12% felt sorry for the children who bed wet and told them it was normal to bed wet at that age, 6% stated that they would cure the bed wetting by asking the children to drink their urine, and 2% said that they would get a small branch of a tree, remove leaves, and thresh the child each time the child bed wet.

Time Spouse Spent Playing or Conversing with Children

When asked about the time the kinship caregivers' spouses spent playing or conversing with children each day on average, 10% of the kinship caregivers interviewed said about 2 hours a day, 10% stated 1 hour per day, 8% cited 30 minutes a day, and 12%

mentioned 10 to 15 minutes a day. The majority 60% indicated that very rarely if any, did their spouses play or converse with children per day.

DATA ON ORPHANS' AND NON-ORPHANS' SELF-ESTEEM

Children's Feelings of Self-worth and Equality

When asked whether the orphans felt they were persons of worth, and whether they felt equal to others, the findings reveal that 72% of the orphans and 4% of non-orphans interviewed did not think they were persons of worth, and only 18% of orphans versus 96% of non-orphans, agreed they were persons of worth. Asked if they felt that they were somebody that had a number of good qualities, 92% of orphans and 50% of non-orphans said, "Yes". Commenting on feelings of failure, 78% of orphans and 20% of non-orphans indicated that come to think of it, they tended to feel that they were a failure.

Children versus HIV/AIDS, Stigma, Denial, and Friends

The results reveal that 78% of orphans and 96% of non-orphans interviewed felt that too many of their friends hated to be around someone who had a relative that died of HIV/AIDS, while 80% of both orphans and non-orphans stated that no one cared much what happened to you. Regarding HIV/AIDS, 94% of orphans and 98% of non-orphans interviewed stated that when a family member died of HIV/AIDS most people deny and pretend it was not HIV/AIDS. The results revealed that 98% of both orphans and non-orphans interviewed felt that children whose parents died of HIV/AIDS tend to be ignored, and 4% of both orphans and non-orphans thought the opposite. On the question of stigma, 86% of orphans and 96% of non-orphans interviewed indicated that children

whose parents died of HIV/AIDS tend to be ignored and stigmatized by many people. 10% of orphans and 2% of non-orphans stated that few people ignore children whose parents die of HIV/AIDS, and 4% of orphans and 2% of non-orphans said nobody in their area ignored orphans from parental HIV/AIDS death. Regarding rejection, 94% of orphans and 20% of non-orphans interviewed felt stigmatized and dejected.

Children's Friends, People of Trust, in Wake of AIDS

The findings reveal that 92% of orphans and 96% of non-orphans interviewed stated that friends hated to play with orphans whose parents died of HIV/AIDS. Asked about people of trust, 70% of both orphans and non-orphans interviewed indicated that most people cannot be trusted. Regarding exploitation, 76% of orphans and 72% of non-orphans interviewed cited that if you do not watch your back, people take advantage of you.

Self-pride, Self-worth, Satisfaction, and Happiness

On the question of self-pride, 72% of orphans and 68% of non-orphans interviewed felt that they did not have much to be proud of. The report reveals that 60% of orphans and 2% of non-orphans interviewed did not feel happy when they saw themselves in the mirror. On the question of self-worth, 88% of orphans and 6% of non-orphans interviewed felt useless at times. Regarding life, 30% of orphans and 94% of non-orphans interviewed stated that they get a lot of fun out of life, while 70% of orphans and only 6% of non-orphans indicated that they did not get a lot of fun out of life. On the question of happiness, 56% of orphans and 6% of non-orphans interviewed indicated that

they were not happy with life or themselves, while 96% of both orphans and non-orphans wished they could feel happy about themselves.

Orphans' Reaction to Criticism, Scolding, and Sarcasm

The results show that 90% of orphans and 80% of non-orphans interviewed felt that criticism or scolding terribly hurt them. Regarding sarcasm, 72% of orphans and 20% of non-orphans interviewed stated that they felt disturbed if they were laughed at, while 18% of orphans and 60% of non-orphans said that they were fairly disturbed, and 10% of orphans and 20% of non-orphans would not be disturbed at all. Regarding criticism, 74% of orphans and 20% of non-orphans interviewed stated that they were very sensitive, 6% of orphans and 30% of non-orphans felt fairly sensitive, 20% of orphans and 30% of non-orphans were not.

Orphans' Self-opinion, Bereavement, and Daydreaming

When asked about fluctuating self-opinion, 86% of orphans and 20% of non-orphans interviewed stated that some days they had good self-opinion, other days they had very poor self-opinion. On the question of daydreaming, 86% of orphans and 6% of non-orphans interviewed stated that most of the time they would rather sit, daydream and worry. Further, 88% of orphans and 2% of non-orphans indicated that they daydreamed because when death(s) occurred in their families, they lost friends that they trusted.

Counseling Orphans and Non-orphans after a Funeral

The report shows that 96% of orphans and 100% of non-orphans interviewed stated that when their beloved relative(s) died, nobody sat down with them to talk about death, or how they should face life, when they thought about their relative(s)' death(s), they got depressed.

Human Nature and Cooperativeness

The report reveals that 38% of orphans and 40% of non-orphans interviewed felt that human nature is really cooperative, helpful, and kind.

Overall Satisfaction with Self

Regarding feelings of self-satisfaction, 42% of orphans and 100% of non-orphans interviewed stated that on the whole, they felt satisfied with self.

SUMMARY OF RESULTS

The research data from the study is summarized in the results as reported above, and is also presented in graphic presentation (Appendices L and M). The association that exists in kinship child-rearing practices, economic well-being, social support networks, and orphans' self-esteem is evident. Further, the predominant differences that exist in self-esteem between orphans and non-orphans that share the same environment, and live under the same care, are conspicuous and telling.

The next section discusses kinship caregiver case studies, and the interview comments obtained during interviews held between the kinship caregivers and the researcher during the field research in Zimbabwe, 1998.

CASE STUDIES

Organization of Case Records

Unique Encounters the Kinship Caregivers Had:

Caregiver No. 1

All three sisters are widowed and now live with their parents. The house has five rooms, and accommodates six orphans and ten other household members, which is a total of sixteen people, using one toilet and one communal tap. The caregivers of orphans lacked cornmeal for the staple diet, sugar, soap, cooking oil, and Vaseline for maintaining the oil in the skin. Orphans interviewed had one underwear each, and three blankets were being shared by four boys who slept together on the uncarpeted cement floor. For play, nobody wanted to play with them, and they rolled up plastic to form a ball, which they used for football.

Caregiver No. 2

She is of Malawi origin, and has never been in school. The household only has one room, in which five people sleep. The one room is divided by curtains on a string. The floor is made of earth and cow dung. Ants crawl in at will. Rent is Z$95 – for this one room. The caregiver only has two dresses. She has six biological children who are all in school. She takes care of one orphan who is not in school. The orphan is related to the caregiver. Her husband opposes the idea of taking care of the orphan, and therefore does not provide any money for school fees for the orphan nor buy clothes for the orphan. The eight-year-old orphan lacks food, clothes, and blankets. The caregiver is not allowed to

work by the jealous husband, who is said to assume that the wife might have boyfriends if she is allowed to go and work and earn money for herself.

Caregiver No. 3

The caregiver owns her own mini-project of a corner store. Her husband is terminally ill, and she takes care of him at home. They only had four children, until the husband's younger brother and wife died, leaving six orphans behind. These orphans, uninvited, just rode the bus and came to join these extended families. These orphans were never told that their parents died of HIV/AIDS, and when they join this family, the caregiver decides to keep the secret also. She tells them that their parents died of witchcraft *(chikwambo);* but unfortunately, she reveals it to her friends, who then tell their children not to play with these orphans, in case they catch AIDS from them. These orphans, aged 16, 14, 12, ten, eight, and six, are not in school. The caregiver is overwhelmed. Her husband is bed-ridden, and now she is the only breadwinner. She lacks money to sustain her mini-project, and lacks money to send these orphans to school or to buy them clothes. Nobody is helping her out. She tried social welfare, and her application was denied.

First Project Idea:

The corner store that carries groceries like sugar, cooking oil, bread, among others. She says:

> The clientele to buy groceries is there, but I lack money to buy groceries in bulk for sale.

2nd Project:

She extended her house to accommodate lodgers, to get extra cash for electricity, rent, water, food, and many others.

Caregiver No. 4

She has seven orphans. Her husband died of HIV/AIDS. She does not have a job. She lost all her friends when her husband died. She has a sixteen-year-old orphan who faints almost three times a week, and the caregiver is stressed out, she says. She lacks money to take the orphan to see a doctor. She lacks money for food, too. When her husband was alive, they had a health insurance, but it ceased when the husband died. She lost her house when her husband died, and now she has moved to a landlord who has let out two rooms to her. When the landlord heard through rumors that this caregiver's husband died of HIV/AIDS, and that she also is taking care of orphans whose parents died of HIV/AIDS, the landlord has given them notice to leave the premises in the coming three months.

Before her husband died, she owned a radio, but it was taken by her husband's younger brother after the funeral, when the husband's belongings had to be shared among close relatives. When her husband was alive, the caregiver's family used to own a car, and they used to visit various resort areas together with her husband. Unfortunately, she could not drive at the time of the husband's death. The car was taken by her husband's older brother.

Caregiver's project idea

She intends to run a preschool and generate income.

Caregiver No. 7

She had a suicide letter. I arrived at her house just in time to stop her from committing suicide. I actually asked her to give me the suicide letter. She takes care of orphans, and her in-laws are supposedly harassing her that she is not taking good care of the orphans from her husband's relatives. She claims that she does not get any financial support from relatives, but stress. She prefers to die than to live and keep on taking care of orphans whom nobody likes, and whom nobody assists financially.

She had four biological children and four orphans, and the husband is dead, as well as the husband's younger brother and wife who both left four orphans that she now has to take care of, through the instructions from her in-laws. On the question of fearing HIV/AIDS, she said yes; and she believes AIDS is a problem from the West. She says she is suspicious of western medicine too, and she would rather resort to traditional medicines from traditional healers, than to take western medicine when she believes HIV/AIDS was shipped from the West, and the USA in particular. Her father stopped her from schooling because he did not educate girls.

Caregiver's Project Idea

She stated that the only thing she wanted was to commit suicide; however, she promised she would quit the idea after convincing her not to get rid of her precious life.

Caregiver No. 8

She had six orphans and five biological children. Her complaint was about in-laws. She stated that on top of the stress she gets taking care of orphans, she gets stress from

interfering in-laws. By being a woman, she was stopped from going to school by her father when she was young.

Caregiver's Project Idea:

To sew children's school uniforms and sell them.

Caregiver No. 9

She had five orphans and three biological children. She complained that the orphans are older than her own children, and the orphans have literally taken over the place because they bully her own children, especially during her absence. Her husband's brother died of HIV/AIDS and left these five orphans behind. Two months later, the caregiver's husband, who originally came from Malawi, was run over by a car and died. She is now stuck with her own children partially orphaned, as well as the five orphans from the husband's brother. Her husband's relatives are in Malawi. Nobody assists.

None of the children are in school due to lack of fees. Her seven-year-old son is asthmatic, and each time the boy gets an attack, she carries him on her back to rush him to the clinic for the asthmatic pump. She cannot afford to buy the pump. When I got to this home, the water had been cut for the last four months due to bills. She has to pay monthly Z$170 for water. What she does is to go and beg for water, or to send the orphans and her own children to go beg for water from neighbors. This family lacks food, clothes, blankets, and money for rent.

In total, there are nine people in this household, who occupy two rooms and use the two rooms for cooking, sleeping, entertaining, and resting. She has trouble with the landlord and is constantly getting notices of eviction. She has unfriendly neighbors, she

says. This caregiver lacks knowledge about how AIDS is spread. Orphans under care never received counseling. The caregiver did not go further with school. Her father did not educate girls. She claims that poverty hinders her from having friends. She only had one friend who is also a widow. She has no TV, no radio, no car, no chairs, no table, no bicycle, no fridge, no electricity, no water, no sufficient basic food. In this two roomed "out house," the floor is made of mud. The height of poverty in this household is frightening.

Caregiver No. 10

The caregiver was widowed in 1991. She has six biological children and three orphans from her late sister and husband. She lost her house when her husband died. Now she lives as a tenant/lodger in an out house, where she occupies two rooms and pays Z$300 for rent. Her main problem is that Social Welfare told her that it would not sponsor her two children in advanced classes in high school (Forms 5 and 6). It was a luxury, they are said to have claimed. Now her brilliant two children are out of school due to lack of fees. She lacks basic food like corn meal, sugar, salt, and she consistently borrows from neighbors.

Caregiver's Project Idea

She does crocheting, burning the midnight candle making doilies, which she then takes to sell in South Africa. She said she does not make much, because she lacks money to buy the thread in bulk.

Second Project Idea: Free-lance HIV/AIDS Counselor:

This caregiver believes she is HIV-positive, and says her husband died of AIDS. She volunteers to counsel anybody that is HIV-positive or has AIDS.

Caregiver No. 11

This is an old caregiver, born in 1928. At the time of the interview, she had turned seventy years old. She works full time. She wakes up at 4 am, gets on a bus to go and order vegetables from another site, carries her load on the head, gets a return bus home, carries her load on the head, and walks a distance from the bus stop to her home carrying her produce. By 7:00 am she has set up her mini-vegetable market stall in front of her house, prepares breakfast for the two orphans she takes care of, and she spends the rest of the day selling the vegetables. She says that, on average, she makes Z$15 to Z$20 a day in profit.

She says she definitely fears HIV/AIDS. She says she is a caregiver who lacks knowledge, and her answer was "very strongly agree" that she lacks knowledge about how AIDS is spread. She said what we hear is the same rhetoric from people gossiping about someone they say is dying of HIV/AIDS, stressing that AIDS kills. However, she does lack full knowledge about how it is spread. She has no electricity, no radio, no television, no refrigerator, no car, no motorcycle, no bicycle, no chair, no table, no sofa, no bench, and no sewing machine. She uses candles, matches, and paraffin/kerosene. When I went into one of her two rooms, I was greeted by the strong lingering fumes of kerosene/paraffin from her room.

However, the good thing is that the two orphans she takes care of (eight years and ten years old) are attending school from the little she makes selling fruits and vegetables. They might not make it to high school, which is more expensive. She also gets Z$150 monthly from Social Welfare.

Caregiver's Project Idea

A tuck shop or corner shop with groceries.

Caregiver No. 12

She is 66 years old, and very frail looking and sick. She works full time as a housemaid, far away from her home. She has to ride two buses to the work site, and two buses back, which means waking up at 5:00 am and arriving back home around 7:00 pm.

She owns a large house with seven bedrooms. She is a retired schoolteacher, but because of the present economic situation, she now works as a housemaid. Her husband died of a stroke, and her three sons and their wives died of HIV/AIDS. As a result, she now takes care of eight orphans from three different families.

The oldest orphan is a fourteen year old girl who, when I interviewed her, sobbed bitterly that she hated the new school she now goes to after she relocated to join her grandmother. She told me that she was being constantly sexually harassed by her school teacher, who writes in her exercise book comments like, "See Me," and when the orphan goes to see the teacher in the presence of the whole class, he tells her to see him after school. When she goes to see him, he asks her to come into the storeroom, where he will grab her breasts, forces her to kiss him, and tells her that he "loves her." The orphan said she had not told her grandmother because she is too frail. The caregiver indicated that she

fears HIV/AIDS, and she started to cry when we were on the topic of HIV/AIDS. She said she lacked knowledge on how HIV/AIDS is spread, and she wailed bitterly:

> "Probably, I have AIDS right now. I hear you waste away if you have AIDS. See how thin I am; I never used to be like this; Ha! Ha! Ha!" she cried before me.

The family has a radio, television, electric stove, sofas, table, chairs, carpet, and a clean house indeed. However, she has stress from taking care of eight orphans.

Caregiver's Project Idea

Knitting machine, and sewing machine.

Caregiver No. 13

Her husband died. She now lives in a one-roomed shack. She has four orphans. She is self-employed. She sells vegetables and fruits for survival. She fears HIV/AIDS. However, she said she lacks knowledge on how AIDS is spread. Her answer was "very strongly agree." She has no radio, car, electricity, television, refrigerator, bicycle, sofas, table, and no chairs. She has one stool and a paraffin stove. The orphans are in school, but she lacks basic food and clothes for the orphans. This family eats one meal a day, or a meal in two days, and they drink water in between.

Caregiver's Project Idea

Corner shop for groceries and vegetables.

Caregiver No. 17

The caregiver of this household is a housemaid who had just stayed here for one month. The thirty-year old father, who used to be a prominent uniformed professional

man, with a nice car, big house with nine rooms, happy family comprised of a wife and three children aged six, eight, and ten years old, and a good paying job, died of HIV/AIDS. After he died, the wife inherited the insurance, and had a good financial back up to care for the children. Unfortunately, six months later, the 28-year old wife was down with TB. She kept on deteriorating fast within a short period, and she became mentally ill, beating up her children, destroying the household furniture, beating up the housemaids, and burning up all the blankets. Her parents came to take her to the rural areas to be treated by traditional healers, and they brought in this new "caregiver" I met with when I went to interview this family.

The state of the children is that of "emotional trauma." The three children are in school. The ten year old boy is reported to be acting out, playing truancy, bullying the younger siblings, and stealing from neighbors' houses, "a thing that never used to happen when the parents were alive," so I heard from one of the lodgers/tenants living at this house. The caregiver indicated she needed food, blankets, clothes and school fees for these orphans. She stated that nobody comes to visit the children at all. In-laws from the husband's side accuse the orphans' mother of spreading the HIV/AIDS virus to the husband, while the in-laws from the wife's side blame the dead husband for spreading the virus to their relative: the wife. So, nobody ends up visiting the orphans, and both sides are angry.

Caregiver's Project Idea

Caregiver suggested a knitting machine.

Caregiver No. 18

The caregiver has nine biological children and two orphans. She is self-employed. She knits doilies and sells them in South Africa. She also has a seven-roomed house, and she lets four rooms to four lodgers. Each tenant pays Z$250 per month. The orphans that she takes care of are not related to her. These children used to live next door with both parents. The wife died of AIDS. The husband then lost his job. He became poor and he could not feed his children aged six and eight years old. He started picking up food from the garbage bins in the neighborhood, and bringing it to feed his two children, who by then had stopped going to school.

In no time, these children joined their father in looking for food in the garbage bins, and it was not before long when the father became mentally ill, roamed in the streets, and never came back to his two children. These children became destitute, and this kind neighbor took them to her home and has informally adopted them. Nobody comes to visit them. This caregiver enrolled them in school, and she now has eleven children to take care of. The caregiver lacks sufficient food for eleven children, and struggles to raise school fees for the orphans because her husband has a job, but it does not pay well. The caregiver uses three rooms, and her six boys sleep on the bed in one room, and the four girls sleep in the dining room, on the cement uncarpeted cement floor.

Caregiver's Project Idea

Knitting machine, tuck shop, and doilies.

Caregiver No. 19

The caregiver was still mourning her husband who had just died two weeks prior to my visiting her. Upon my arrival, I saw her last born who was extremely sick, and I inquired why she had not taken her child to be checked by the medical doctor immediately. Her answer was that she "had no money, and when my husband died, he left us poor".

The caregiver says she is self-employed. She sells popcorn outside of her house. She also goes to Zambia to order plates for re-sale in Zimbabwe. The caregiver takes care of four orphans and three biological orphans. She lacks food, money for rent, and school fees for children.

Caregiver's Project Idea

Sewing and selling.

Caregiver No. 20

She has four orphans. She does not fear HIV/AIDS. AIDS gets a lot of publicity on TV, and she no longer fears AIDS. But she "very strongly agrees" that she lacks knowledge on how AIDS is spread. She lacks basic food, school fees, blankets, and children's clothes. She has two rooms, a bicycle, a modern oxcart, and a stool. Her orphans, unlike most orphans, received counseling after the death of their parents.

Caregiver No. 21

The caregiver is 26 years old, and her husband is a gardener in the nearby neighborhood. The caregiver has never been in school. She takes care of two orphans aged 10 and 11 years old. Both orphans are not in school, and are wearing tattered rags at

the time of the interview. The caregiver is self-employed. She cuts wild grass, cleans it, and sells it to farmers who thatch houses with cleaned grass. She has trouble with her landlord. The owner of this property is a small holding farmer, and every person who lives on this property has to work on the farmer's fields. This caregiver says the work is very hard:

> You work from 6:00 am to 6:00 pm, break for lunch for one hour (12:00 m to 1:00 pm) Monday to Friday; and get paid less than Z$200 per month. If you do not want to work in the fields, the farmer throws you out of the compound.

She does part-time cutting of the grass during weekends, and she says she earns more money from cutting grass and selling, than working like a slave for this farmer and getting less than Z$200 monthly.

The caregiver has one room, where she sleeps with the orphans and her husband. This room has no radio, chair, television, fridge, electricity, sofa, and no paraffin stove. This family owns one stool only, and all cooking is done outside, in an open fire. They have a problem of getting firewood, and it is costly to buy firewood on this compound. They pay Z$95 per month for this room. The floor is made of earth/dung. The household has a communal tap used by all who live on this compound. The water dries up from this pump every morning. At the time of the interview, there was no water. The caregiver fears AIDS. She agrees that she lacks knowledge on how HIV/AIDS is spread.

Caregiver's Project Idea

Cut grass and clean it, and sell.

Caregiver No. 22

The housing is the same as above. They are neighbors in the same squalid compound. She also works in the farmer's fields Monday through Friday, 6 am to 6pm. During weekends, she cuts and cleans wild grass, and she gets Z$100 per month from the grass. She fears HIV/AIDS. She fairly agrees that she lacks knowledge on how HIV/AIDS is spread.

The caregiver went to school, spent six years in school. She has one orphan and one biological child. The orphan is not in school, due to lack of fees. The biological child is still young, but this biological child is not from this husband. The first husband abandoned her and the child.

The caregiver stated that her husband, who works as a gardener nearby, is not supporting her financially because she is failing to conceive a child for him. The caregiver is only 20 years old. Her clothes were torn, as well as those of the children. They occupy one room, which has no electricity, no radio, no television, no refrigerator, no stool, no chair, and no table. The floor is of earth/dung.

Caregiver's Project Idea

Cutting grass and selling.

Caregiver No. 23

She has six children of her own, and four orphans. She is self-employed. She buys old clothes and re-sells them. She is a widow. When her husband died, she lost all but one friend. The husband owned a car and, after the funeral, her husband's brother took it, saying that the caregiver could not drive.

"But *baba mukuru* should have remembered that my first born would soon grow up into a man, and one day, he might have probably wanted to use that car!" wept the caregiver.

Besides taking the car, the husband's elder brother wanted to inherit the widow. When she refused, this brother decided to advertise and sell the widow's house without telling her of his intentions. She was shocked to see a stream of potential buyers coming to view the house, and she had to deplete all the finances her husband had left her, and she had to hire an attorney to stop the sale of the house.

Before her husband died, this family had two homes, one in town, and another home in the rural areas. Now when the caregiver was fighting in court to stop the sale of her house in town, her home in the rural areas was being inherited by the younger brother of her late husband. As soon as the caregiver's husband died, the younger brother got married and occupied the caregiver's rural home without her permission. This younger brother and wife inherited the caregiver's oxcart, bicycle, plough, plates, furniture, and all they had in the rural home. Due to expenses incurred hiring a law attorney, the caregiver does not have money to send both her own children and the orphans to school. She has two tenants/lodgers, and buys food from the rent the lodgers pay. At the time of the interview, the shared flush toilet was not working. She could not afford to pay for the plumber, and her two lodgers were threatening to leave, which left this caregiver stressed out.

Caregiver No. 24

The husband of this caregiver died of HIV/AIDS in February 1998 while the family used to live in the rural areas. So, at the time of the interview in August 1998, the

memories of her late husband were still very fresh. When the husband died, the in-laws from the husband's side accused the caregiver of having inflicted HIV/AIDS on the late husband. The in-laws then burned down this caregiver's storehouse that had all the grains she had collected or harvested that year. They also burned down her chicken run that had more than one hundred chickens. Realizing how angry her in-laws had become, she had no choice but to abruptly leave her rural home and come to town, and to an unknown destination.

The caregiver has four biological children who lost their father, and she also takes care of two orphans who lost both parents to HIV/AIDS. All the children are not in school, because she uprooted the children from their rural schools that were a lot cheaper and, when she arrived in town, she had no money to send these children to town schools that are more expensive than the rural.

Her eldest daughter, who is 16 years old, is now the breadwinner. She now plaits hair as a source of income and also works as a housemaid, a few houses away from where this family is lodging in one room, from a landlord who lets out rooms to many tenants. This orphan's father died in February, and in June she was sent away from her high school for lack of school levy Z$165. Social Welfare was willing to pay for school fees, but needs a letter from the Head of the School. In this case, the headmaster refused to give her the letter because she could not afford to pay Z$165 school levy, and that is how this orphan ended up not going to school, and applying to all orphans in this household.

At the time of the interview, the caregiver was very sick. She complained of weak, painful joints, constant headaches, dizziness, and chest pains. She did not have any money to go to the doctor. The caregiver's main problems include lack of money for rent, food,

and school fees for the children, and for her deteriorating poor health. She indicated that at times her family goes for two days without eating. As I interviewed the caregiver, her last child who was two and half years started singing this song:

Mvura naya naya
Tidye mupunga!

In English it would read:

Rains come on fall down
So that we can all eat rice!

I looked at the caregiver and asked her if her daughter liked rice very much, since she was singing about rains falling down, and eating rice. The caregiver said to me,

> Do not pay that much attention to her song; we never eat rice. We cannot afford rice since my husband died.

Caregiver's Project Idea

Hair plaiting, and hair perming.

What I saw about this family

This is a very frightening case. The degree of poverty is well beyond my limited vocabulary of giving the correct explanation that describes the poverty being experienced.

I asked to look inside the one room that this widow and six orphans use. It is what Zimbabweans term a "*Tangwena*," meaning a very poor makeshift shelter. The floor is made of earth that is well-carpeted with old tattered sackcloth. On one side of the wall, there is a mattress that is lying on the floor, and blankets that are "paper thin" are on the mattress, which has wire coils finding their way out to be seen at a distance. Opposite, there is a paraffin stove (one plate), whose strong hostile fumes are lingering in this

"match-box room," making the pungent smell become a permanent feature of this little room. An old string cuts across the rooftop that is not so high above. On that string hang a handful of torn old clothes for the family. There is no chair to sit on, and so the widow took her wrapping cloth from around her waist, spread it on the doorstep of the landlord's main house, and asked me to sit on it as I conducted my interview with her. I gave her Z$35 and she said she would buy food for that day!

The state of the six orphaned children

This family needs intervention right away! The children look hungry, pale and emotionally distraught. There is no food. I was told that the previous day they had only drank water for breakfast, drank water for lunch, and drank water for dinner. So the morning I arrived for the interview, they had only drunk water. Of all the interviews I had made, this was one of the most frightening cases of poverty.

Rent for this Make-Shift "Match-Box" or *Tangwena*

I was shocked to hear that they pay rent for this makeshift room. They pay Z$160 monthly, and family gets rent from the 16-year-old teen, a housemaid earning Z$150 monthly.

The state of the caregiver

A stressful life she is leading. Very poor environment. She feels hopeless, helpless, and dejected. She cannot work due to ill health. The school system has let her down because the headmaster will not give the orphans an official letter to take to Social Welfare so that the orphans' school fees could be paid. There is no back-up system. No friends, because she has just moved to this new area. All her property from her marriage, she lost after death of husband. She cannot walk to church, so nobody from church comes

to visit her. In-laws accuse her that she caused the husband to die of HIV/AIDS. A horror scenario indeed!

Caregiver In Terms of HIV/AIDS

She fears AIDS, but "fairly agrees" that she lacks knowledge about how AIDS is spread. Only her 16-year-old daughter knows that the father died of HIV/AIDS. The caregiver admitted that she is secretive to the younger children about what their father died of. All the other younger ones thought the father died of swelling feet and headache.

Caregiver No. 25

The caregiver's husband died in 1995. The caregiver takes care of two orphans, seventeen years old, and fourteen years old. Her biological children are six and nine years old. None of them are in school. The caregiver is self-employed: She makes doilies, and she makes clothes from tie and dye, and then sells them. She also sells bread that is ordered by her fifteen year old daughter who has to wake up at 4:00 am every day to walk and orders the rejects of bread from the bakeries in the industrial sites.

The caregiver used to rent two rooms. The boys would sleep in one room, and the girls would sleep with their mother in the other room. But now she only has one room. For the two rooms, the caregiver used to pay Z$900 per month. She failed to pay on time, and got constant threats of eviction. She had to surrender the other room. Now, they all use one room, (Z$450 monthly rent) which has no chair, no table, no sofas, but a bench and a paraffin stove. They cook and sleep in that one room.

She fears HIV/AIDS, but, "very strongly agrees" that she lacks knowledge on how AIDS is spread. When she hears about it from the radio, she fails to see any seriousness

of the message, she said. None of the orphans received counseling. The caregiver lacks basic food commodities like corn meal, sugar, salt, cooking oil, bread, milk and others. She also lacks clothing for the family.

Caregiver's Project Idea

Poultry keeping, tie and dye, knitting, and tuck shop to sell groceries including bread.

Caregiver No. 26

The caregiver's husband is dead. She is self-employed. She owns a tuck shop in the backyard, which she started after the death of her husband. She is 35 years old. She spent eight years in school. She takes care of six orphans. She earns about Z$3,300 per month, and pays about Z$1,500 monthly towards rent and water. She says her problem is from surrounding poor neighbors, who constantly come to beg for groceries, and basic food commodities like sugar and salt, and they never want to pay due to poverty. The caregiver has asthma, and constantly gets asthma attacks, but does not have a pump. The last-born aged three also has asthma.

The caregiver fears HIV/AIDS. She "fairly agrees" that she lacks knowledge about how HIV/AIDS is spread. The caregiver states that when her husband died, the husband's brothers would not sit down to discuss with her the future of her children; instead, they were arguing over the quality of her husband's casket, indicating it was ugly, and a better one and more expensive one should be bought instead. The employers of the caregiver's husband had donated a casket, which was said to be ugly by the husband's relatives.

The in-laws are said to have demanded from the caregiver her bank ATM (Automatic Teller Machine) pin and code number, and when she refused, the following day, her husband's father collapsed and died of a heart attack. Scapegoating began, and all the blame was placed on the caregiver. She was accused of causing her father-in-law to die because of her being adamant and refusing to let the relatives get her ATM pin to get the money to buy the casket. Out of guilt, the caregiver surrendered her ATM pin, and the in-laws went and took over Z$4,000 from her bank and paid towards buying a more expensive casket.

The caregiver was left without much money to support the six orphans. Since that funeral incident of 1996 to 1998 and the time I conducted the interview, nobody from her husband's side had ever visited that family. The caregiver's husband had a car, but the caregiver could not drive, so the car was permanently parked outside. I advised her to go for driving lessons, but she had no money for lessons.

Caregiver's Project Idea

1. The caregiver wants to teach others: What it means to lose a husband, especially from AIDS? What will happen to you? Ways and means to buffer stigmatization?
2. Counsel orphans.
3. Sew and sell clothes.

Caregiver No. 27

She works part-time. She has two orphaned boys aged eight and ten years. She is widowed. She earns Z$400 monthly, and pays Z$200 monthly for rent. As soon as the landlord knew that this tenant's husband died of HIV/AIDS, he gave her notice to vacate

this place. She has nowhere to go. She is heavily stigmatized, due to her husband's death, taking care of orphans, her poverty, and her wasting away. Neighbors gossip about her health, and make unfriendly remarks about HIV/AIDS in her presence. She occupies one room; she has a two plate electric stove, a radio, and a television from what they had when the husband was alive. They actually had a six-roomed house, but lost it when the husband died. Some of the furniture was shared among relatives.

My own interpretation

I saw this family as a crisis. The family has nowhere to stay, no decent clothes, no food, no corn meal for staple diet, no sugar, no matches, and no vegetables. They drank water for dinner the previous night, and on the morning I arrived, they had eaten nothing. The orphans are not in school due to lack of school levy (Z$60 each). An alarming setting.

Caregiver's Project Idea

Order and sell old clothes.

Caregiver No.28

The husband died in 1990. She is self-employed, orders and sells old clothes. She is 40 years old. Takes care of five orphans. Her income is approximately Z$600 monthly. She fears HIV/AIDS. She says she fairly agrees that she lacks knowledge about how AIDS is spread. She has no friends. She claims that because she is extremely poor, nobody likes to be around her. She constantly begs for food and money, and at first friends and neighbors used to help, but now nobody likes to assist. Her neighbors run a club comprising 11 people. They contribute Z$300 each. So they loan out for a month, e.g. Z$400 on November 25 must be paid back on December 25 with 20% interest =

Z$440. This caregiver would like to join this Chimbabdzwa Club, but cannot raise Z$300. She has no chairs, electricity, television, refrigerator, bicycle, car, table, and no radio (it was vandalized by one of the in-laws who borrowed it when the caregiver's husband died).

The caregiver has three rooms. The orphans are in school. They used to go to the neighbors' homes and watch TV, but the neighbors started chasing the orphans away. The orphans began to watch television by peeping through neighbors' windows, and the owners soon bought heavy duty curtaining material. When the caregiver buys meat in bulk, she puts lots of salt on the meat and dries it outside, and has to be there all the time to chase away flies. The family lacks school fees, clothes, blankets, and basic food. Though the orphans go to school, they do not eat anything for breakfast everyday, and when they come back from school, they only eat one meal a day, or nothing but to drink some water. The caregiver highlighted that cornmeal, for a staple diet, is expensive.

Caregiver's Project Idea

To manage a flea market. She says:

> You simply pay Z$20 a day for the table, and you can make a good profit from the sales, as well as make a sustainable living out of that. The problem is I lack starter funds.

Caregiver No. 29

The caregiver is married. She is 54 years old, and lives with her husband. She is a housewife, not holding any paid job. She and her husband are the owners of this house, and let out some of the rooms to lodgers. They occupy four rooms. They take care of one orphan. The caregiver fears HIV/AIDS, and she says she lacks knowledge about

AIDS. Regarding counseling the orphan, the caregiver only showed the girl where her mother's grave is, and said: "This is where your mum is".

Caregiver's Project Idea

To form a "Family Counseling Movement" that gives counseling to widows and orphans affected by AIDS.

Caregiver No. 30

She cares for one orphan, three children of her own, and is married. She was one of my focus group members and also my research assistant. I chose her because during the focus group sessions, she mentioned that HIV/AIDS was from overseas, especially USA. She was so confident about what she was talking about, and that confidence intrigued me, and I became curious to know why, how, and what made her think HIV/AIDS came from USA. She knew I was studying in U.A. She also said AIDS is spread by interstate truck drivers.

The caregiver fears HIV/AIDS. She "very strongly agreed" that she is a caregiver who lacks knowledge about how AIDS is spread. She had very little knowledge because she said that people simply said, "Ha! HIV or AIDS is now here in Zimbabwe, and AIDS kills. That is all you hear, and nothing more. It seems people lack in-depth knowledge." The caregiver is self-employed, owns a tuck shop in the backyard. Her husband has a car and a good paying job. One child is a student teacher in a middle school, one son is studying at a university, and the other child is still in middle school. The caregiver is influential in her community and is active in church. She spent only seven years in school, because her father stopped girls from getting educated. She has a refrigerator, has

electricity, a motorcycle, bicycle, six roomed house, sofas, electric stove, a car, six chairs, and table.

Caregiver's Project Idea

Tuck shop

Caregiver No. 31

She is twenty-eight years of age, and has completed her high school education but obtained bad grades to go on further with education. She is divorced, has one biological child, and she cares for three orphans from her late sister and husband. She is self-employed. She orders and sells old clothes at the Flea Market. Her income is Z$1000 monthly.

She fears HIV/AIDS, and she does NOT lack knowledge about how HIV/AIDS is spread. She knows how. Has three rooms with electricity, a radio, a television, a refrigerator, sofas, but does not have a bicycle, a car, a table, or chairs.

Caregiver's Project Idea

Ordering and selling old clothes.

Caregiver No. 32

The caregiver is sixty-five years old, and she takes care of five orphans. She is self-employed. She orders and sells vegetables and fruits. The caregiver commutes to buy from wholesale traders some vegetables and fruits, carries the load on her head to bring it to the bus stop, boards the bus, alights near her home, and then she carries the load on her head again to her vegetable stall in the backyard:

> "My neck is stiff and aching from carrying the heavy load of vegetables and fruits for sale on my head. This kind of life is too tough to bear, but I just have to work this hard in order to send these 5 orphans to school and feed them," she mourns.

She earns approximately Z$500 monthly. She spent four years in school, and she is divorced. She lives in the neighborhood that is termed "Sodom and Gomorra" due to high crime, and drug trafficking, and this caregiver complained that this neighborhood is infested with thieves, such that every other person you look at is a potential criminal! She hated to live here, and she stated that it is a bad environment, especially for her orphans who had just joined her coming from a decent neighborhood where the orphans' parents lived before they died.

She fears AIDS, and "strongly agrees" that she lacks knowledge on how HIV/AIDS is spread. I asked her why? She stated that she hears about HIV/AIDS consistently over the radio, but she just does not get what the message is about.

> "I just hear that it kills, and that we should not share needles and razor blades. I am 65 years old, and to tell me today that AIDS comes from needles and razor blades sharing? I do not buy it?" she said.

The household has one room. They have electricity, a radio, television, sofas, a chair, and a bamboo mat. The household does not have a refrigerator, a table, a car, a motorcycle, a bicycle, a modern oxcart, nor a sewing machine.

Caregiver's Project Idea

A tuck shop in the backyard to sell her produce from. She operates from an open space, on top of cardboard boxes.

Caregiver No. 33

She is unemployed, divorced, and 26 years old. She takes care of four orphans from her late sister and husband. She completed her high school education, but obtained bad grades. She fears AIDS, and she said she "fairly agrees" she lacks knowledge about how AIDS is spread. The household has three rooms, electricity, a television, paraffin stove, an electric stove, and sofas. However, the household does not have a table, a car, a motorcycle, a bicycle, a sewing machine, a radio, nor a refrigerator.

Caregiver's Project Idea

Tie and dyeing, sewing and selling: needs a sewing machine.

Caregiver No. 34

She works full-time on a farm, from 6:00 am to 6:00 pm. She is married, and she is 24 years old. The husband also works as a farm laborer. She takes care of three orphans. Both husband and wife make up to Z$870 monthly when the two wages are combined. The orphans get physically beaten up by both adults and children on this compound, when the caregiver and husband are at work. She fears HIV/AIDS, and "strongly agrees" she lacks knowledge about how AIDS is spread. She says she hears people talk about it, and it seems like a joke when she hears that AIDS is in Zimbabwe, and that it kills. Here is what she said about HIV/AIDS and death:

> If we die, let it be so. After all, death is as old as history itself. The next thing from life is death.

She only spent three years in school. Her school was burned down during the war, by soldiers who claimed that the terrorists were supposedly hiding in school buildings. The

household has a paraffin stove, a radio, and an open firewood stove. They do not have chairs, a table, a car, a bicycle, a refrigerator, television, or electricity.

This household has only one room. There are five people altogether: husband, wife, a thirteen-year old girl, an eight-year old girl, and a three-year old boy. The room is divided up into two by a sagging string that is holding some torn pieces of cloth, which is supposedly their room divider. They all sleep on the uncarpeted cement floor.

Caregiver No. 35

The caregiver is thirty-one years old, and never married. She is self-employed. She travels all around the country's rural areas to buy cowpeas, beans, groundnuts, and groundnuts for sale in town. She barter trades, exchanging bars of soap she brings from town to the rural people, who in turn give her grain in exchange. She seldom travels across Zimbabwe borders to South Africa to sell crocheted doilies. However, she had cut down on the trips to South Africa because the visa to South Africa had shot up from Z$150 to Z$3,000, which she found prohibitive and costly. She completed her high school education, but did not have enough money to proceed for professional training.

She fears AIDS that is why she has decided never to get married. She said she saw how wasted her sister and brother became when they died of AIDS,

> "...(M)oving skeletons, you would never look at them twice, they were finished," she remarked.

She said she is a caregiver who has knowledge on how AIDS is spread, from what she hears on the radio, and television. The caregiver makes about Z$500 per month. She takes care of four orphans who are all in school. At the time of the interview, the water was shut down because of non-payment of bills, and the caregiver said she did not have

any money to stop the water from being shut down. The caregiver lives in the house that her parents used to own when they were alive. She occupies four rooms, and the other three rooms are occupied by lodgers, who all pay rent very late. The household has electricity, and a radio. It does not have a refrigerator, a television, a bicycle, a car, sofas, a table, or chairs. This family lacks food, clothes, and blankets; in the morning the orphans just drink water, and sometimes skip lunch due to lack of cornmeal – the staple diet; dinner is skipped quite often due to lack of food.

The caregiver said she is constantly being called to come to meet with the orphans' teachers who then tell her:

> The orphans are not participating in school activities and are also constantly fainting in class, due to hunger.

Caregiver's Project Idea

Tuck shop and selling basic food commodities.

Caregiver No. 36

She is self-employed, sells old clothing, and earns about Z$500 monthly. She is widowed, and is aged thirty. She takes care of six orphans. She fears AIDS. She "fairly agrees" that she lacks knowledge about how AIDS is spread. The caregiver only did two years in high school. They were too many children in the family, and the father chose to provide for the boys' education, and not for the girls'. This family has one room only, which has electricity, a radio, and a television, but does not have a refrigerator, a bicycle, a car, a chair, a table, sofas, or a bench. The caregiver sleeps in that same room with the orphaned boys aged thirteen years and fifteen years. The caregiver lacks school fees for orphans, clothing, and food.

Caregiver's Project Idea

Sewing clothing and selling for profit.

Caregiver No. 37

She is an unpaid housekeeper, married, and is thirty-six years old. She takes care of five orphans and her four biological children. The husband is working a fairly decent job, but the family is overwhelmed by the number of young children it now has. Caregiver spent five years in school. She had to stop school because schools were burnt during the war, and she was what was termed as "*chimbwido*" during the war, which means "girls who cooked for guerrillas during the war." The household has three rooms, electricity, a radio, a television, and a refrigerator.

She is married, self-employed, and is 50 years old. She takes care of four orphans. One of the orphans completed his high school examinations, passing with flying colors, but could not find money to go further with career training. The orphan got extremely depressed, and became mentally deranged. At the time of the interview, he asked why President Bill Clinton cancelled his trip to Zimbabwe:

> "Go and tell him that his presence in this country could have helped the forgotten ones like us. If he had come, I was going to ask him to visit my home and see the poverty we have. Definitely he would have done something, because he is a good guy, and he would have helped us," said the mentally challenged, ill, and weary looking young boy.

For survival, the caregiver crochets and sells doilies. She also orders and sells paraffin. She fears AIDS, and "fairly agrees" that she lacks knowledge about AIDS. Her household has three rooms, but does not have electricity, radio, refrigerator, car, bicycle, sofas, chairs, or table.

Caregiver's Project Idea:

Tuck shop, and selling old clothes.

Caregiver No. 39

Caregiver is self-employed. For survival, she commutes and orders pigs' heads from the Cold Storage, which is a long distance from where she lives. She then chops the heads into small pieces, puts the meat in a big container, and goes door-to-door selling the meat. She also walks a long distance to order scraps of materials from the garment factory. She carries the packages on her head, and walks a long distance home, where she will sew up the pieces of material into boy's shorts and girl's skirts, and sells them. She said that with Z$50 she can order pieces of material, sew them up, sell, and get Z$150. She makes Z$500 monthly.

Her husband died in 1995. She does not get any support for the five orphans she keeps, nor for her own two children. She has one outside room. Fortunately, she does not pay rent because this is her mother's property. The father died, and the mother lives in the seven-roomed house. Her mother does not like the caregiver to live in the main house because her mother learned that her daughter's husband died of HIV/AIDS. The caregiver's mother, who works with a large organization in the city, openly despises her daughter (the caregiver) and, even at the time of the interview, made sarcastic remarks about HIV/AIDS and the caregiver's husband who died of HIV/AIDS. The caregiver's economic dependence on her mother made her mother disrespect her daughter.

The caregiver does not fear AIDS, because every single day her mother and neighbors are said constantly remind this caregiver that if her husband died of AIDS, she

also must have HIV/AIDS. So the caregiver said that she does not fear AIDS, she knows she has it, and is now immune to sarcasm and stigma she carries. She "fairly agrees" she lacks knowledge of how AIDS is spread. One of the orphans, who was twelve years at the time of the interview, had meningitis and pneumonia. The orphans are all in school. She has electricity, but not a radio, a television, a refrigerator, a bicycle, sofas, a table, or chairs.

The caregiver has no place to live. The one room she has, rains during the rainy season. She has to buy a plastic cover to spread over her roof to avoid leaking, and this is where she cooks, and sleeps with all the children. She lacks enough food for the family, clothes for the children, and school fees. There are days that the whole family sleeps without eating anything but drinking water, and they wake up the next day and drink water again for breakfast. She could not afford to buy a small packet of cornmeal for the staple diet, which cost Z$26 for 5Kg at the time of the interview. The caregiver only had $6, and had to buy a loaf of bread for Z$6, and have the family eat the bread accompanied with sugared water.

Caregiver's Project Idea

A cornmeal grinding machine, or a tuck shop.

Caregiver No. 40

The caregiver is twenty years old, and married. She is a full-time housewife. She spent nine years in school. She takes care of six orphans from her husband's relatives, and she has one biological child. Her husband used to work, but stopped due to ill health. He is a foreigner from Malawi, and hence has no rural home to go back to. He is asthmatic,

and when attacked by asthma, he has to walk a long distance to the clinic for the asthma pump, and this is a strain on the caregiver especially with six orphans to care for.

The family has three rooms, electricity, and a television. They do not have a bicycle. The family lacks blankets, clothing, food, and school fees for the orphans.

Caregiver No. 41

She works part-time, crocheting and going to South Africa to sell doilies in order to get money for rent, food, and school fees for children. She is widowed, and at time of interview, was 35 years old. She spent seven years in school:

> "My parents divorced, mother re-married, and step-father did not like me to go to school," she said.

She earns Z$1000 monthly, and she also takes care of two orphans, and has two biological children. She fears AIDS. She "fairly agrees" she lacks knowledge about how AIDS is spread. She has a six-roomed house that is cemented and carpeted. She has electricity, a bicycle, a radio, a television, sofas, chairs, and table; but does not have a car, motorcycle, or sewing machine. Overall, this is a caregiver who is widowed, and is still doing well for her family and orphans. The household is doing well, except that it is grieving the loss of the father of this house. When I interviewed one of the orphans in this household, and asked her what she would like in life to better herself, she did not say: *"I like to have basic food commodities,"* as was the norm with most orphans. She said:

> I like to have addresses of children my age from U.S.A. I like to communicate with them, so that I can learn the culture and other things from other parts of the world.

This caregiver's standard of life had a higher level of sophistication, compared to most of my informants that I had interviewed before. Lacy curtains, well-watered flower garden, very clean and well maintained house with a lot of rooms, dura-walled with fancy finish, and gated. I asked the caregiver out of curiosity, whether she maintained the family solely from her income from the trading of doilies she does between Zimbabwe and South Africa. She told me that her husband had a good job, and he left a good insurance, and he also had a will that stated that if he died, no in-law should touch or harass his family or take any possessions from his wife, children, and orphans.

This was a lesson I thought should be taught to most low income or even well-to-do families in Zimbabwe, where the tradition of leaving a will is practiced mostly by elite blacks and whites, but not by most layman; hence their wives lose their houses to in-laws if the husband dies first.

Caregiver No. 42

The caregiver is a full-time housewife, widowed, and she is twenty-five years old at the time of interview. She spent ten years in school and had to quit school because she fell pregnant. She has three orphans, and has two children of her own. She fears AIDS, and as a caregiver, she "fairly agrees" she lacks knowledge about how AIDS is spread. There are four rooms that this household occupies. They have electricity, a television, chairs, and a table. They do not have a radio, no refrigerator, no car, no bicycle, and no motorcycle.

Caregiver No. 43

She is self-employed. She orders and sells soft drinks from home. She is widowed. She is sixty-six years old. She only spent one year in school, because her father did not have school fees to send girls to school, but only for boys. She takes care of five orphans. From her home-operated business, she gets Z$1000 per month. She fears HIV/AIDS. She also is a caregiver who "disagrees" that she lacks knowledge of how AIDS is spread. She said she heard this information over and over again from the radio, and said:

> I pity the young people of today, I am old, my husband died of a car accident 20 years ago, and during our time, there was no AIDS. Today, *gukurahundi*, which means AIDS in Zimbabwe, is striking young people who are sexually active, married or not married, prostitute or not a prostitute.

The caregiver did counsel the orphans under her care.

She has four rooms, uses a communal tap, and a pit latrine. She has electricity, a television, and a refrigerator. Her home is cemented and well carpeted. She has chairs, sofas, an electric stove, a refrigerator, and a table but lacks a car, a bicycle, and a sewing machine.

Caregiver's Project Idea

Selling soft drinks from her home, targeting clientele that are old and cannot walk to the stores, and school-going children in the neighborhood.

Caregiver No. 44

The caregiver is self-employed. She is widowed, and is fifty-one years old. She spent five years in school. She takes care of six orphans. The caregiver makes Z$500 per

month from her self-help job. She commutes to sites where cow's heads are sold in bulk. When she gets off the bus, she carries her cow heads on top of her head, to her house, where she will chop the cow heads into pieces and then goes door to door selling the meat from the cow heads. She said if she orders a head for Z$40, she will chop it, re-sell, and get Z$80. She also is involved in the "Farirai Club," comprised of four people. Each week, every member contributes Z$100. Every Friday, one of the members takes home Z$400 from the contribution to use but come Monday, every member must contribute Z$100 again for the next "round" as termed.

She fears AIDS, and has knowledge about how AIDS is spread. They have a communal tap, a shared flush toilet, a paraffin stove, a bench, and have only two rooms. The household does not have a table, sofas, car, motorcycle, bicycle, chairs, radio, refrigerator, television, nor electricity. She lacks basic foods and even staple diet commodities.

Caregiver No. 45

She is self-employed. She owns a "*musika,*" a native name given to a vendor's stall. She sells vegetables and fruits. She is widowed, and she is forty years old at the time of the interview. She spent four years in school, and had to quit school due to lack of school fees when her father died. She takes care of five orphans. She makes Z$800 per month. She commutes to the big Open Market Stall, where all vendors from all over the country bring their produce into town. She orders her vegetables and fruits at a wholesale price, in bulk, carries the load on her head to the bus station, and rides home, where she will carry the load again to her house, for sale in her backyard "*musika*" vending stall.

The caregiver, at the time of the interview, was very depressed. Her house was in the process of being taken away from her. What happened is that when the husband died, he had not yet changed names on the Deed of Sale, with the previous owner of the house. So as soon as the previous owner learned that this man had died, he went to the lawyers and re-claimed his property showing the lawyers that the name on the title deed is his, and not the deceased. One of the caregiver's children had meningitis, and two of the orphans had asthma, but had no asthma inhalers in the house. Each time the girls had asthma attacks, the caregiver would walk them to the clinic which is a very long distance from her house. The caregiver fears AIDS, and "disagrees" that she lacks knowledge. She said there were a lot of AIDS awareness campaigns around the country, through newspapers, radio, and television.

The household has three rooms, electricity, a radio, a television, a refrigerator, chairs, a table, and sofas. The floors are cemented and carpeted. The household does not have a bicycle, a car, or a motorcycle. The caregiver is constantly having high blood pressure, headaches, and swollen feet. At the time of the interview, she had just been released from the hospital, where she had spent a month in the hospital. While she was in the hospital, her children and orphans ran out of food, and they ended up in the streets. This family has no place to live. Sooner or later, the house will be taken away. They lack basic food, blankets, and clothes.

Caregiver No. 46

She is a housewife. Her husband died in 1988. She is 42 years old at the time of the interview. She never went to school at all because she was an orphan, and the

relatives who took care of her never sent her to school. In fact, she said she grew up being treated like a slave. She takes care of two orphans, and her two biological children. The family has three rooms. At the time of interview, this household's electricity had been cut off, due to lack of money to pay off the outstanding bills. She fears HIV/AIDS. She "very strongly agrees" that she lacks knowledge about how AIDS is spread. She said she does not get the full meaning of what they are saying regarding the origin of AIDS and how it is spread. Her household does not have electricity, radio, television, car, refrigerator, chairs, table, or sewing machine, but has a bicycle, paraffin stove, and a bench.

Caregiver No. 47

The caregiver is 33 years old, and cares for two orphans: a 13-year-old girl, and an 11-year-old boy. The orphans are from her late sister and husband. The caregiver has her own three children: a set of twins that are 12 years old, and a nine-year old. She works part-time, selling "freezits." These were soft drinks packaged in small plastic bags, and frozen and sold as frozen coolers, called "freezits." She sells them near school grounds, and her clientele are school children during morning and afternoon breaks. From selling "freezits" she makes Z$30 a day in winter: May, June, July; and makes Z$70 a day in hot seasons. She fears AIDS, and "*strongly agrees*" that she lacks knowledge about how AIDS is spread. She owns a television, fridge, bicycle, a car, and has electricity.

Caregiver No. 48

The caregiver is an unpaid housekeeper. She is married. She is twenty years old. She spent nine years in school, and had to quit school because she fell pregnant. She takes care of one biological child and two orphans. Her husband has a job, and the family income is around Z$1000 monthly. She fears HIV/AIDS. She states:

> I take care of orphans from parental AIDS deaths. I very strongly agree to be lacking facts on how HIV/AIDS spreads.

I asked her to elaborate, especially since in Zimbabwe there are AIDS awareness campaigns over the radio and television.

> "What I hear from the radio are warnings that AIDS kills, and most of the time, the messages are not educative enough to make me have the full knowledge of how AIDS is spread," she said.

The household has a shared flush toilet, two rooms, a radio, and a bicycle. They do not have electricity, a television, a refrigerator, a car, or a motorcycle. The floors are cemented. The household lacks basic food commodities.

Caregiver No. 49

She is 38 years old. She is widowed, and is also a full time housewife. She has three orphans. She has a big house and in some of the rooms, she lets out to lodgers. She makes Z$1200 monthly. She spent three years in school, due to poverty. Parents were very poor. She fears AIDS. She "very strongly agrees" she lacks knowledge about how AIDS is spread. She elaborated her claims:

> We hear from that sharing needles and razor blades spread AIDS. To me that sounds ambiguous, and lacks clarity.

> We have always shared razor blades especially from time immemorial! We have always shared needles when we pierced our ears, or had tattoos from the time our ancestors began ear piercing up to now. Now what is the big deal about razor blades? I just do not get it. If they say AIDS is caused by sex, how can that be? Sex is something that has been there from day one in the history of life; now I am told sex can cause AIDS. I am totally lost when it comes to knowledge about how HIV/AIDS is spread. It is a disease that was shipped from overseas, that's it. To say razor blades, needles or sex is an excuse! Hiding the truth.

The household has one room, no electricity, no refrigerator, no car, no bicycle, no television, and no sofas. They have four chairs and a table, and a radio. She lacks food, clothing, and a place that is decent to stay.

Caregiver's Project Idea

To order old clothes and re-sell them.

My own opinion: The caregiver's husband died of HIV/AIDS. She is very angry about her loss. She is one of those who believes HIV/AIDS is a disease that was shipped from the U.S.A. to Africa. Her lack of full knowledge on the origin and how AIDS is spread equips her with that anger against the West, and finds U.S.A. as the scapegoat, which she believes has caused her to end up a widow. There is need definitely to educate that section of the population about how AIDS is spread, so that that anger is eradicated. Anger drains energy that would otherwise empower them to become innovative, assertive, and move on!

Caregiver No. 50

She is 19 years old, and she has never worked in her life. She is unemployed and widowed. She told me her husband died of HIV/AIDS. She completed her high school

education. She is an orphan, who takes care of one orphan, and her own biological infant, who was breast-feeding at the time of the interview. When her husband died, she was told to leave her husband's home and family because they accused her of causing the common law husband's death of HIV/AIDS. When she left her house, her in-laws told her to leave all behind:

> "After all, you accomplished your mission of spreading HIV/AIDS to our relative. He is dead, what do you still want here? To keep spreading AIDS here? Leave, and when you give birth to your child, do not even bother to come and tell us that you now have a baby! You were a prostitute before you married our relative!" said the in-laws.

She has Z$0 income. At the time of the interview, she had a baby, and had no penny in the one-room *"Tangwena"*: (a native name for a poor, make-shift, out house, usually used by squatters). She lived in at her brother's place, who owns a six-roomed main house. He is married, and has four young children. The caregiver gets food only from this extended family, not money.

At the time of the interview, she said that her worst nightmare is the mail deliverer. She constantly got bill collection notices from the hospital where she delivered her baby. She had nothing to pay off the bills with. The caregiver fears AIDS. The caregiver lacks knowledge about how AIDS is spread, and she "fairly agrees" she lacks knowledge. I asked her to elaborate, especially that she had told that she suspected she was HIV positive, because her husband had died of AIDS. Here is what she said:

> I lack knowledge of how AIDS is spread. Look at me now. My husband died of HIV/AIDS when I was pregnant. I now have this baby. I breast-feed. Each time I breast-feed this child, I am feeling guilty, confused, helpless, because I do not know if my milk is not poisonous to this baby. I might be giving her breast milk contaminated with HIV. Each time I think of it, I cry

> helplessly. My father is long dead of stroke, my mother is long dead from a bus accident, and my husband is dead from HIV/AIDS. Here I am breast-feeding when everyone tells me I have AIDS. I am not confident that I am not spreading AIDS to my infant or not.

This young woman used to live with her husband in the city, in an electrified house, with all modern electrical labor-saving devices. She lost everything after her husband died. When told to leave, she had to relocate to this poorer neighborhood in the township, where her brother took her in, and built her a makeshift out house "*Tangwena*," which had no electricity, no windows, no stove, no table, no sofas, no television, no radio, no plates, and no refrigerator.

The caregiver lacks food. She waits to be invited by her brother's wife, who she said was very nice. She lacks baby clothes, baby food, and has bills to pay for her maternity costs when she gave birth. She lacks money for just about everything.

In the following page, there are the researcher's findings that necessitated assembling the little-t theory (2000).

FINDINGS ON CHILD REARING PRACTICES THAT NECESSITATED THE CHIGUBU (2000) "LITTLE-t" THEORY BUILDING

This study was not about theory testing, but theory building. According to Graue and Walsh (1998), theory building is different from theory testing. Further, Graue and Walsh (1998) state that in theory building:

> ...(W)e find a distinction between upper-case-T (big-T) and lower-case-t (little-t) theory very useful. The Big-T theory (Theory) refers to theories that are, or have been, accepted in a field. Big-T theories are familiar. They have been accepted by a critical mass of scholars. They have recognizable names attached – some across disciplines, others within a discipline or a subdiscipline. Big-T theories are public; little-t theories are private. Little-t theories (theory) have not achieved acceptance within a field. A short list of big-T theories might include Marxist, Darwinian, Piagetian, grounded, relativity, probability, Vygotskian, social constructionist, Freudian, and so on (page 32).

The little-t theories are said to be encountered everyday, for instance from a colleague, a friend, a neighbor, a hairdresser, a taxi driver and so on. Further, it is understood that many of the little-t theories may or may never become accepted in the research community. However, it is cautioned that little-t theories should not always be dismissed as insignificant. After all, the big-T theories all began as little-t theories (Graue & Walsh, 1998).

Consequently, the Chigubu (2000) "little-t" theory was formulated (Table 4.1). It was based on the data collected from the kinship caregivers (1998), using structured questions from the child-rearing practices instrument (Appendix L) and open ended, unstructured, questions based on the Zimbabwe Demographic Health Survey: ZDHS

(Appendix B), whose results regarding HIV/AIDS were revealing, yet disturbing, and are sad news for Zimbabwe. A related discussion is given below.

Child rearing practices and HIV/AIDS

In exploring the orphans' self-esteem examined through kinship caregivers' child-rearing practices, the researcher was curious to better understand if kinship caregivers used child-rearing practices that were sensitive to HIV/AIDS. Kinship caregivers were asked in-depth, unstructured, probing questions relating to why; according to ZDHS (1994), there has been a resistance towards a marked change in sexual behavior in this era of HIV/AIDS that continues to kill people in huge numbers daily in Zimbabwe and the rest of Africa, leaving behind a trail of orphans. The clues and answers given by kinship caregivers regarding the ZDHS (1994) related questions were nonetheless shocking, and had never been documented before. The researcher thereafter, utilized the findings in question to assemble the clues and facts together in building a little-t theory (Table 4.1). Further, kinship caregivers were asked if they had heard about HIV/AIDS, whether they feared HIV/AIDS, and if they felt comfortable to discuss HIV/AIDS with orphans.

Kinship caregivers' coping with child-rearing

The four main coping mechanisms that appeared to dominate in this study in terms of child rearing practices are described below under sub-headings: Groups 1, 2, 3, and 4. The illustration of kinship coping mechanisms that the researcher then assembled into a little-t theory is given in (Table 4.1), and the explanation follows.

THE MERCY CHIGUBU (2000) "LITTLE-t" THEORY

Group 1 Kinship Caregivers' Perspective

The kinship caregivers in this category seemed to operate under the principles of the Group 1, (Type A): **"normalizing-as-much-as-can-be perspective"** (Chigubu, 1998). This group of kinship caregivers is highly convinced that HIV/AIDS emanated from a man-made virus. The group states that, in order to wipe out the black race from the face of the earth, the deadly HIV/AIDS virus was intentionally made in the USA laboratories, shipped as contaminated blood, and donated as free foreign AID to some targeted hospitals in sub-Saharan Africa, and that is how the HIV/AIDS problem struck Africa. Group 1 (Type A) will **normalize** (Table 4.1) by hiding from orphans under care, the information regarding the death(s) of the orphans' parent(s) due to HIV/AIDS.

Group 2 Kinship Caregivers' Perspective

Kinship caregivers in this category (Group 2, Type B) also operated under the Group 1, (Type A): **"normalize-as-much-as-can-be perspective."** They differed slightly from Group 1, (Type A); hence are called Group 2, Type B; (Chigubu, 1998). Group 2 (Type B) blames the HIV/AIDS catastrophe mostly on female prostitutes, and trusts both Western and traditional medicine. (Table 4.1). The group **normalizes** by utilizing the "open door policy" (Chigubu, 1998), of talking too openly and getting to extremes when discussing their own or their relatives' status about HIV/AIDS. The orphans under their care know that their parents died of HIV/AIDS, and the neighbors and kinship caregiver's friends are openly told that the orphans' parents died of HIV/AIDS.

Group 3 Kinship Caregivers' Perspective

The kinship caregivers in this category are seen as **restrictive** Group 3, (Type A) They strongly believe HIV/AIDS is a problem of female prostitution, and consequently, a punishment from God. Their thinking is based on the "you-reap-what-you-sow" mentality (Table 4.1). Group 3 (Type A) highly stigmatizes AIDS. Orphans are not told that their parents died of HIV/AIDS. The kinship caregivers in this group are strict on allowing their biological children and orphans under care to play with neighborhood orphans whose parents died of HIV/AIDS (Chigubu, 1998).

Group 4: Kinship Caregivers' Perspective

Kinship caregivers in the Group 1, (Type B) categories are **restrictive,** (Chigubu, 1998). They operate almost as Group 3, (Type A). The difference is that this group believes that irrespective of blaming the female prostitutes as culprits, HIV/AIDS is a curse from Satanic worshippers (Table 4.1). The group believes that witches and Satanic worshippers use (*chikwambo*): mobile evil spirits that are said to be invisible magic spells. Upon the witch/devil worshipper's commands, these evil spirits are believed to enter the targeted healthy person's body and follow the devil worshipper/witch's instructions. The instructions are said to include magic-remote-controlled entrance into the victim's body, staying in any part of that human's body or as commanded by the devil worshipper/witch, and thereafter, suck viciously the victim's blood night and day, until the victim becomes a wasted, moving skeleton, that would eventually drop dead. HIV/AIDS is stigmatized in this category. Orphans are not told that their parents died of HIV/AIDS (Chigubu, 1998).

DETAILS OF NORMALIZING AND RESTRICTIVE PERSPECTIVES

Normalizing: Type A & B, (Groups 1 & 2) Caregivers

There is a social stigma attached to HIV/AIDS, not only in Zimbabwe, nor sub-Saharan Africa only, but globally. Most families that were interviewed (Chigubu, 1998) attempted to achieve a balance between using "other afflicted kinship/extended families" taking care of orphans whose parents died of HIV/AIDS as a reference group, and maintaining themselves as part of the **normal** society.

The researcher observed that within those kinship/extended families, the orphans whose parents died of HIV/AIDS were treated as if their parents did not die of HIV/AIDS, but of a **normal**, socially acceptable disease; and with objective losses minimized (In-depth study in Zimbabwe's kinship families, seen by Chigubu, 1998).

The increased care-taking burden of orphans initially fell within the rubric of kinship caregiver's natural role as "mother" of the whole family. What was noticed was that the extended families and kinship caregivers that fell in this category attempted to retain "impressions of normality" within their immediate confines as much as possible, by being open about HIV/AIDS.

The researcher observed that these orphans have learned firsthand that the world is a mysterious venture, in which rare things are not so rare, that death is no longer a statistical oddity, though seemingly meaningless personal experience, and their fears of losses in life have come to be, and more so, that if anything traumatic, tragic and bad can happen, it will (in-depth observations: Chigubu, 1998).

Orphans' daily survival might be perceived by some as capricious, second-hand luck, rather than any form of mastery on their part, which is what is happening to these orphans: being kept in the dark, far from the truth that parents died of HIV/AIDS. Due to the vicious circle of confusing communicated information about orphans' parental HIV/AIDS death(s), these orphans are very likely to grow up with distorted concepts of illness, death, and the relationship of the two (Birenbaum, 1971; Fanos, 1996).

Orphans' Point of View

Some of the orphans interviewed, using both structured and open-ended questionnaires in Zimbabwe (1998), tended to have received mixed messages, and ideas from picking up clues here and there as they eavesdropped, or sneaked into a room where adults would be talking about the HIV/AIDS status of the orphans' dead parents. This act deliberately created "confusion" surrounding the orphans' dead HIV/AIDS parents, rendered the orphans powerless; a grave situation which can be equated to the perception of survival by concentration camp survivor victims (Benner, Roskies, & Lazarus, 1980).

Kinship Caregivers' Perspective

From among most kinship caregivers interviewed, there was that burning desire to spare the feelings of the surviving orphans in an effort to elevate the orphans' self-esteem, as well as **normalize** the experience within families. To some kinship caregivers, this normalizing perspective restricted them from divulging all necessary truths about orphans' parental HIV/AIDS stigmatized deaths. From observations done (Chigubu, 1998):

> ...(A)ll the secrecy about orphans' parental HIV/AIDS deaths was done in good faith, as a protecting shield against

> rough world, rough neighborhood, rough school mates, rough church mates, rough peers, who would stigmatize, and ostracize the orphans once they heard the orphans' parents died of HIV/AIDS (Kinship caregiver interviewed in Zimbabwe, 1998).

The questions the researcher would pose are:

> Is normalizing a plus or a negative on the part of the overall orphaned child's development, emotional growth, and ultimate self-esteem? And one day when the truth comes out, who is going to provide the emotional, and psychological counseling if any, bearing in mind that 99.99% of orphans interviewed said they never received any counseling before, during and after death of their parents? (Chigubu, 1998).

With these questions in mind, there is need to look at the other perspectives of the little-t theory that were found to be dominating among the kinship caregivers' child rearing practices offered to the orphans in this research.

Restrict Perspective Type A & Type B

Extended family/kinship caregivers' capacity to change the environment as orphans keep joining them is becoming more and more severely limited in Zimbabwe. Thus kinship caregivers are forced to rely on intra-psychic modes of coping that are essentially palliative in function.

As HIV/AIDS continues to devour the parent(s), an influx of orphans joining extended/kinship families is on the rise, while the HIV/AIDS social stigma is failing to die, but getting actively resuscitated as each and every victim continues to become a HIV/AIDS death row statistic. As kinship caregivers embrace orphans of the HIV/AIDS dead parents, some kinship caregivers adjust to the situation by using heavy defenses or armament, such as suppression of truths.

The entire extended family undergoes a change, adapting a denial wrap in the chronic web of silence described by Turk (1964). The unfortunate consequence is the shattering learning experience of denial and suppression of problems by extended families, caregivers and orphans, instead of facing up to the tragedy, dealing with the stressful events head on, mastering survival skills, adopting techniques, and moving on. Hiding HIV/AIDS information by most kinship caregivers as part of child rearing techniques was said to be an enormous burden of keeping secrets suppressed from orphans. What it means is, as noted by some psychoanalytic theorists:

> ...(T)he goals become keeping death at bay a little longer, increasing the value in living for the moment and re-channeling energies of child-rearing initiatives and achievements for survival for that day and situation (Futterman & Hoffman, 1973 in Fanos, 1996; p.4).

The researcher contends that this type of child rearing practice is perpetuated by denial, which corresponds to a gradual curtailment of hope, recovery, and sustainability.

Kinship Caregivers Phenomena

What Chigubu (1998) found among extended families and kinship caregivers in the restrict perspectives was that the future was rarely discussed in the family, and there was little being done to enhance orphans' self-esteem. There was minimal socialization with orphans that would give them clues that HIV/AIDS killed their parent(s), and for the kinship caregivers in the restrictive perspective, kinship parenting of orphans is viewed as problematic at best.

Parsons and Fox (1952) conceptualize that illness is both a deviant social role and a psychological disturbance. The deviant unit, set in the middle of an extended family

being joined by orphans whose parents died of HIV/AIDS; adopting a restrictive perspective as part of their kinship caregiving practice towards the orphan, might be expected to have widespread ramifications. The "deviant" child rearing practice is restrictive and, on the other hand, the "deviance" is usually controlled within the social structure by a complex system of mechanics, as Parsons (1951) states:

> Very broadly, these may be divided into three classes of a) those which tend to "nip in the bud" tendencies to development of compulsively deviant motivation before they reach the vicious circle stage, b) those which insulate the bearers of such motivation from influence on others, and c) the "secondary defenses" which are able, to varying degrees, to reverse the vicious circle processes (p. 321).

The kinship caregivers in this category were very strict about divulging the HIV/AIDS statuses of the orphan's late parents. In some cases friends had to be dropped if they failed to demonstrate a carefully "tailored insensitive inattention" to certain highly diverse, and sensitive facts about the extended/kinship family's orphans whose parents died of HIV/AIDS. For example, if a caregiver confided in a friend and told them that the orphan's parent(s) died of HIV/AIDS; and simultaneously, if that same kinship caregiver reaffirmed to the orphan that his/her parents died from consequences of witch craft; the kinship caregiver's friend was supposed to play to the tune of the kinship caregiver, by hiding the truth from the orphan(s). This is what is meant by a "carefully tailored inattention" to the truth.

However, if that friend insensitively violated the pact and went about sharing the kinship caregiver's confidential information in the neighborhood, which in turn had children who would end up telling the orphan about the status of her/his dead HIV/AIDS

parents, that alone would warrant dropping that particular "*gossiping*" kinship caregiver's friend (As witnessed personally by Chigubu, 1998).

Orphans in the Restrict Perspective Category

In the case of kinship caregiving of orphans whose parents died of HIV/AIDS, the orphans (a) are not responsible for the deviance; (b) are cared for primarily within the extended family unit itself, and (c) trigger the extended family to set a machinery of defenses in motion that serve psychological needs, not control of deviance. To the orphans, "illness" becomes mystic, let alone the death of beloved adults. Due to the fact that orphans' status will never change from being orphans to non-orphans, they are under no role obligation to "recover" from being called orphans from stigmatized HIV/AIDS dead qualifying for "contamination" elaborated by Parsons and Fox (1952).

Caregiver/Extended Family Adjusting to Orphans

In the restrictive category, the act of kinship/extended family caring for orphans from the stigmatized HIV/AIDS dead; sets the norm for what this author terms "deviance." Change may follow possibly when the orphans decide to leave this particular household to join another extended family. The situation tends to worsen when another set of orphans from parental HIV/AIDS deaths join the same extended family, forcing the kinship caregivers in this restrictive category to re-vitalize, strengthen, and re-cycle the restrictive formula on the orphans once more again.

The adults and especially kinship caregivers feel increasingly excluded from the normal community (Gordon & Kutner, 1965); friends drop in less and less (Turk, 1964);

fathers absent themselves from their families in order to hide their pain (Binger *et al.* 1969); communication between husband and wife (kinship caregiver) flounders as blame is shifted back and forth (Gordon & Kutner, 1965); and family integration is seriously endangered and frequently breaks down (Crain, Sussman, & Weil, 1966) directly or indirectly.

Summary

Researchers and scholars have shown keen interest to investigate the impact of different child-rearing practices regarding communication styles within families traumatized by various diseases including cancer (Spinetta & Maloney, 1978), Cystic Fibrosis (Fanos, 1987) and HIV/AIDS (Hardy, Armstrong, Routh, Albrecht, & Davis, 1994). In an open communication style that is characterized by parents being available for questions from inquisitive children or others, being honest with all family members and with children wishing to talk about the illness that has devastated the family's well-being, this style of communication has been found to enhance the coping strategies of both the sick in the family as well as the rest of the family or friends (Koocher & Malley, 1981).

Psychological adjustment, and positive, warm child rearing practices in the family have been related both to an open communication style and to emotional expression (Koch, 1985; Spinetta & Maloney, 1978). Providing information about a family member's illness like cancer or HIV/AIDS, treatment program, and death counseling to the other healthy family members has also been related to better coping with grieving and positive rearing of orphans (Kramer, 1984).

Disturbingly, in most US families with chronically or terminally ill, communication about the disease and its implications tends to be closed (Mellins & Ehrhardt, 1993). Similarly, in Zimbabwe, most extended families/kinship caregivers in the restrictive categories hold the same predicaments of hiding information as part of child-rearing strategies (Chigubu's own field work experience, 1998).

Although Kramer (1984) talks about openness with cancer issues, most kinship caregivers interviewed in Zimbabwe (1998); considered cancer as a death sentence, and as part of a group of HIV/AIDS viruses. Hiding of stigmatized information is an international problem. US scholars studying both Cystic Fibrosis (Fanos, 1987) and pediatric HIV/AIDS (Mellins & Erhardt, 1993) found that most parents do not talk about the child's illness. Hardy *et.al.* (1994) in a related US study found that only 20% of their sample of HIV-infected children had been informed of their diagnosis. This shows how global the restrictive perspective cuts across cultures in terms of child-rearing practices applied to stigma-topics, among highly diverse target samples who are battling to live with socially undesirable ailments, and terminology.

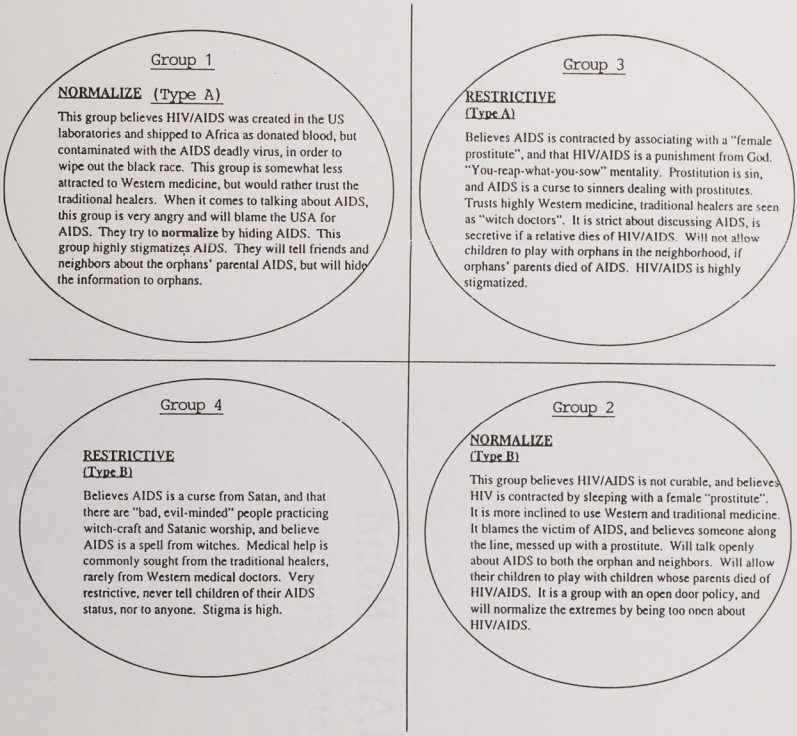
Conclusion

In exploring child-rearing practices of kinship caregivers and the impact on orphans' self-esteem, a holistic formula of concepts (Appendix C) was utilized in this study. Further, Table 4.1 displays the work, which illustrates the Chigubu (2000) "little-t" theory, which is based on the findings on the kinship caregivers' different child-rearing practices in relation to the advent of HIV/AIDS in Zimbabwe (Chigubu, 1998). The next

section that follows after Table 4.1 is on case studies and comments from orphans interviewed by Chigubu in Zimbabwe in 1998.

Table 4.1 THE MERCY CHIGUBU "LITTLE-t" THEORY (2000).

KINSHIP CARE GIVING PRACTICES ON ORPHANS WHOSE PARENTS DIED OF HIV/AIDS, and IMPACT ON SELF-ESTEEM: based on the Zimbabwe research (Chigubu, 1998).



CASE STUDIES

Organization of Case Records

Comments from the Orphans Interviewed

For confidentiality purposes, pseudo names were used in this project. These comments were made during the in-depth interviews between the principal investigator and orphan.

Orphan fictitiously named: Paul (lost both parents)

"I have very few friends. I am very unhappy because a few of my friends physically beat up my siblings. I am only 11 years old, but look at me! I'm fatherless, I am motherless, I do not have any schoolbooks, nor shoes! My friends whose parents are alive are better than me!" Paul said, tears rolling on both cheeks.

Orphan fictitiously named: Barbara (father died)

"I feel too many of my friends hate to be around someone who has a relative that died of HIV/AIDS. I strongly agree because most people I know think HIV/AIDS is contagious. I feel useless at times, especially at school because I do not have a pencil, ball point, school books, a school back pack nor even school lunch and I do not have a friend at school. Nobody likes to be around me!" sobbing. "Children whose parents or relatives died of AIDS tend to be ignored by some people: Many people do that!" remarked Barbara; "Many people do that. Tell you who the culprits are and what they do? The mothers are number one culprits. They stop their children from associating and even eating with such orphans! On the whole, I am not very happy because my late father's relatives are a sore in the neck. Most of the time I would rather sit, daydream, and worry because I really miss my dad, I lack that paternal love. After my dad died, the only relative from his side who would come to visit us was babamudiki: dad's younger brother, but he also died three months ago. Ever since, nobody from my father's side has ever come to visit us, except for babamukuru: dad's eldest brother who came once two and half months," she said.

Orphan fictitious name: Gamchirai (both parents died)

Gamchirai is in Form Three, which is third year in High School. Gamu strongly believes that when a loved family member dies of HIV/AIDS, most people avoid talking about it and pretend it was not HIV/AIDS.

> "Oh! Yes, nobody wants to be stigmatized by society. We all want to be accepted by the society we live in. I do not get a lot of fun out of life! How can I when I do not have school fees, adequate food, and clothes?" asked Gamchirai.

Orphan fictitiously named: Bandura (father died)

Bandura (15 years old) has his two siblings with him here. One is 13 years old, and the other is 5 years old. Bandura is not in school due to lack of school fees (Z$180), which is roughly (US$6). Bandura's father died in 1995.

> "I strongly disagree that I am a person of worth, nor do I feel I am equal to all others. Others get everything in life, look at me; I only have one pair of shoes, two shirts, one trousers, and one short! Come to think of it, I tend to feel that I am a failure. I spend all my time seated at home doing nothing, due to lack of funding to go to school nor to take driving lessons so that I can be employed as a bus or taxi driver. I certainly feel useless at times! You know I compare myself with those children who have their dads, and I see that I am an outcast. Nobody else is taking care of us ever since my dad died. My father's brothers do not care about us any more. When dad was alive, our life was very good. Dad had a company car, we ate good food and we went to school. Today, dad is gone, and my mother is poor, and now the family is experiencing economic hardships. I always feel downcast, unwanted, dejected, and stigmatized from my father's death. I actually see a dead end in my life. Nobody ever comes to visit us. Most of the time I would rather sit, daydream and worry about my life's future, how I can get food for the day, and how I can help out my be-widowed mother who wakes up everyday at 1 am or 4 am, walks a long distance to go and order bread that she re-sells in this neighborhood. What worries me is that she is going to be murdered, because the long winding dark alleys she walks through at that time of the morning are dangerous. Many victims have been murdered in those dark alleys. She comes back home at 12 noon from selling the bread, and she would be carrying the boxes of bread on her head as she goes from house to house selling the bread. As an

orphan, this eats my heart out, but I am powerless, I do not know what to do. If only I could have well-wishers to help me out of this plight. I would need clothes, shoes, school fees for taking driving lessons, food, a tennis racket. If I could get some funding, I would learn to become a driver, and I would start an income generating project of selling vegetables, and poultry keeping," mentioned Bandura.

Orphan's fictitious name is Boby: (father died in 1998)

Boby is a six-year-old boy, and he says:

> "I disagree that I am a person of worth, I feel I am not equal to all others because those children whose fathers are alive eat decent meals. Before they go to school, they eat breakfast that includes bacon and liver, while I go to school having a simple breakfast that comprises plain bread without any spread, and a cup of black tea without any milk. I feel that I am somebody that has a number of good qualities. I can write well in English, which is not my mother language, and I am good at Mathematics, and I draw very well. Come to think of it, I tend to feel strongly that I am a failure due to the fact that my father died this year. I have lost everything in life. I feel too many of my friends hate to be around someone who has a relative that died of HIV/AIDS. I strongly agree to the fact that the other children especially run away from such a person. The other children say they were forbidden by their mothers to play with someone whose relative died of HIV/AIDS. I strongly feel that I do not have much to be proud of. Look at me; look at the sweater I am wearing right now, all tattered. Further, I do not have a single toy to play with. When I look in the mirror, I do not feel happy about myself. The mirror's reflection of my old tattered clothes make me sad," said Boby.

Orphan fictitiously named Irina: (father died in 1995, and mother died 1996)

Irina a 15 year old girl is orphaned together with her other three siblings. They all live in this household, where the caregiver has her own five biological children, and one grandchild. The caregiver never revealed the truth to these orphans about the cause of their parental deaths. The caregiver in this case is Irina's mother's brother's wife. In this household, there are two adults: husband and wife; and a total of ten children altogether.

Irina innocently states:

> "My mum died of a swollen leg in 1996; and my dad died of asthma in 1995. I strongly disagree that I am a person of worth; I strongly feel that I am not equal to all others. Look at the clothes that I am wearing and you will see why? I strongly agree that many of my friends hate to be around someone who has a relative who died of HIV/AIDS. They think that if parents die of AIDS, there is a residue of HIV/AIDS found in all their children they leave behind. When I look in the mirror, I do not feel happy about myself, because my face resembles my mother very much such that I start to cry each time I look in the mirror. On the whole, I am not satisfied with myself. My life has no bright future when all my parents are dead. I certainly feel useless at times. If my mum and dad were alive, I would not be this poverty stricken the way I am now. Things would be a lot different. I disagree that human nature is really cooperative, helpful, and kind. For instance, if I request to have a new dress or new shoes from my relatives, I am simply told that there is no money. I only have two nice dresses, and only one pair that I use for school as well as for leisure. When a loved family member dies of HIV/AIDS, most people avoid talking about it and pretend it was not HIV/AIDS due to fear of the stigma. On the whole, I am very unhappy. The quality of life I have is way below the poverty datum. I have to struggle for basically everything. For instance, at school I never have lunch during lunch breaks because I only have Z$1 (US 3 cents) which cannot buy anything but a freeze-it. I am always extremely hungry during lunch breaks at school. I really miss my parents! I always feel downcast, unwanted, dejected, and stigmatized. The old torn clothes and old tight fitting shoes I wear, and the lack of school lunch money makes my age mates and school friends run away from me. Since my parents died, I have lost many of my friends that I used to trust. I am very lonely," sobbed Irina..

Orphan's fictitious name is Wendi: (mother died in 1996, and mother died 1997)

This is a 12 year old orphaned girl, who had to relocate from her previous home where she lived with mum, dad, and her other two older siblings. She used to live up north in the rural areas about 300 miles from where she now lives with her extended family. Her older siblings are not living here. At the time of the interview, she had only lived here for about eight months. When her mother died in 1996, she moved in to live with her stepmother (father's younger wife). Then misfortune struck again, and her father

died in 1997. Her stepmother was a younger woman who had only one child, became ill also and could not afford to keep the three stepchildren from her late husband. So what this young mother did was to get the three stepchildren on the bus, and take them to another distant district where these orphans' mother's brother had a chain of stores.

The uncle took the three orphans in, however, his wife did not approve of the idea. So the three orphans' presence in this home caused a great deal of friction. A month after the orphans had settled into this new home that was economically well off, another tragedy struck the family. The uncle was involved in a fatal car accident. After the uncle's funeral, the aunt gave some pocket money and bus fare to these orphans, and told them to go to the big city, Harare, in search of their late father's younger brother who had lived there for the rest of his life.

With the assistance of the police in the big city, they finally arrived at their uncle's home, an uncle they had never seen before. When these three orphans and the police arrived at this home, the excitement to see these children was somewhat lukewarm, according to Wendi's report. The uncle was very ill, and both the aunt and uncle suggested to the police that they could only accept Wendi in the home due to economic problems facing the uncle. They gave the police an address for this family's cousin who might take in the older siblings. So Wendi had to bid farewell to her 14 year old brother, and 16 year old sister.

Wendi is not in school. She now sells vegetable produce that the aunt orders for her to assist in selling. Apparently, the uncle is also extremely sick, and the caregiver (wife) revealed to me that the husband also had "*Mukondombera* meaning HIV/AIDS." The caregiver did not tell Wendi that her parents died of HIV/AIDS. Nobody told Wendi that her parents died of HIV/AIDS.

When I interviewed Wendi (orphan), she said:

> "My mum suffered from swelling feet, and she died in 1996. A year later, dad died of headache. Both of my parents were bewitched. A

curse was put on them, and the curse had power to suck all their blood during the night, so by the time my parents were very thin when they died. I do not feel I am a person of worth, nor do I feel equal to all others. Look at it, the children in this household go to school, but I do not. If I ask my uncle if I could go to school, he tells me he does not have any money. When my parents were alive, I used to go to school, and right now, I should be in 6th grade if my parents were alive. I feel that I am somebody that has a number of good qualities. When I used to go to school, I was very good at Math, and Content. I always was top of the class! Come to think of it, I strongly feel that I am a failure. The fact that I am no longer going to school, and that I am an orphan who is very poor, honestly, I wish my mum had not died. I do not feel I do not have much to be proud of. I have absolutely nothing of my own in life. Children of my age are going to school, they dress nicely, while I wear over-size torn clothes. I worry a lot that right now; the only close relative I have is my uncle who is extremely ill. What will happen to me when he dies? Ah! Only God knows. On the whole, I am not satisfied with myself. How can I be satisfied when all parents died, and now I am not in school? Don't you think my life is finished? No one cares much what happens to you, come to think of it. For instance, my uncle has children who are working in the city, and if they really cared, I would be in school now. When a loved family member dies of AIDS, most people avoid talking about it and pretend it was not HIV/AIDS. This is because AIDS is a stigmatized disease. If you tell people about a loved one dying of AIDS, they will ostracize you, and they will spread rumors that you also have AIDS. Children whose parents or relatives died of AIDS tend to be ignored by some people. For instance, if you say Good Morning, they keep quiet. Just like what is happening to me, since I moved to this area, all the other children run away from me. They run away saying that my parents died of HIV/AIDS. So far, I have had fistfights with one girl of my age. I only have one friend in this area. I just miss my mum and dad. On the whole, I am not very happy. The only friend that I have here is always in school, and I am always home, selling vegetables and fruits. Others put on nice clothes, and I do not. Others go to school, and I do not. Others have their own sisters and brothers around them, and I do not. Others have their parents with them, and I do not. I do not have anywhere to go and get help. Everyday, I think about my mum and dad. They loved me so much, they would send me to school," Wendi sobbing.

Immediately I finished my interview with Wendi, I asked the caregiver in privacy why she told Wendi that her parents had died from being be-witched: "*chikwambo*." The caregiver

told me that she had to hide the truth so that the other children from the same neighborhood would not stigmatize her, and shun playing or sharing food with her.

Orphan's fictitious is Watel: (father died in 1997)

This orphan is a young boy aged 14 years. His father divorced his mum, and remarried a younger wife. After a while, father became sick, and in 1997, he died. His new wife is now very sick too. Watel and his sister, aged 13 years, live with their biological mother who is their caregiver. They all know that their father died of HIV/AIDS, and they do not hide it. Watel is in his second year of High School. At the time of the interview, in 1998, he told me that he would not be able to sit for his October examinations because the school needed $85 (US $3.00) and his mum did not raise the amount needed on time. Watel told me that he would have to repeat this class next year, maybe by then his mother would have raised sufficient funds for him to be able to sit for the examinations.

> "I strongly disagree that I feel I am a person of worth, and I do not feel equal to all others. I have out grown my shirts, shorts and trousers. Talk of basic food! Ah! Today we can eat sadza/thick corn porridge, which is accompanied with vegetables and meat; and tomorrow mum can tell you that there is no corn meal, which means no dinner. We often drink water, and go to sleep. Just water, and nothing more," the boy said. "You then wake up in the morning, and go to school without any breakfast," he said. "Come to think of it, I tend to think I am a failure. The way I live makes me say that. They are four of us sleeping on the floor; and sharing three blankets. I feel too many of my friends hate to be around someone who has a relative that died of AIDS. I strongly agree with that statement because they think that if your father could die of HIV/AIDS, what could stop you from getting it and spreading it to them? So what happens is that all friends run away from you, and at school, if you sit down, everyone will not come to sit in that row of chairs or on the same bench you are sitting. So you end up sitting alone, ostracized most of the time," said Watel. "I am able to do things as well as most other children. I can play rugby. I play it very well at school," smiled Watel. "I feel I do not have much to be proud of. I always think in retrospect, and remember the good old days when dad was alive. Though he had divorced my mum, at least he supported us

with food and clothing. Besides, I had a dad, now I do not. Daddy used to buy me nice shorts and trousers, but now look at me, I now wear old torn clothes," sobbed Watel. "When I look in the mirror, I do not feel happy about myself. I just feel bored stiff with life," said Watel. "On the whole, I am not satisfied with myself. For instance, at school they might announce that our rugby school team is going to play against another school. When I come home and ask my mum for pocket money to use for the rugby trip, she tells me she does not have any money. At times I get it from grandfather who if he wins on horses (gambling) can afford to give me Z$2 (US 6 cents). What can you buy with Z$2 these days? Maybe Z$10 is better! I could buy pop-corn and a freeze-it at least," remarked Watel. "I wish I could feel happy about myself. Imagine I leave our house at 7 am everyday, and walk a mile to school. What makes me sad is that when I come back from school at 1 pm, my mother tells me that there is nothing to eat. So I just get myself a glass of water, and sleep outside under the cool shade of that peach tree. I will be very tired from walking back and forth from school, and also very hungry," narrated Watel. "I certainly feel useless at times. I am always very tired and very hungry that I feel useless to do anything at home but to sleep under this tree," said Watel. "No one cares much about what happens to you, come to think of it. For instance, if I ask for Z$2 to buy a book that costs Z$2.00 they tell me to look for the Z$2.00 on my own. Right now, what I do is to ask neighbors if they need to send me to the groceries or to do any odd job, in exchange for pocket money. When a loved family member dies of HIV/AIDS, most people avoid talking about it and pretend it was not HIV/AIDS. They do this so that it is kept as a secret, and that no one should know nor spread rumors to many people about it. Once people start talking about it openly, then everyone will ostracize you and will never want to come near you," said Watel. "Children whose parents died of HIV/AIDS are ignored by some people. Definitely many people do that. You will find that all along you have been in good talking terms, and once death from AIDS strikes your family, those "friends" all of a sudden cease talking to you. On the whole, I am fairly happy. I am sad from the way I do not have a dad, and the male figure I have at school is my teacher, however, this teacher is always picking on me, and he physically hits me, which makes me hate him, and hate school, which does not make me happy. Most of the time I would rather sit, daydream, and worry. I think about a lot of misfortunes that have befallen me and my family. I think about how poor we have become since my father died. We lack clothes, we have no basic food commodities like corn meal, bread, vegetables, and meat," said Watel.

Orphan's fictitious name will be Graum: (father died in 1994, and mother died in 1995)

This is a young boy, 11 years old, whose father died in Mozambique in 1994, and the mother died in Zimbabwe in 1995. Graum has now relocated to live with his mother's elder sister (aunt) and husband. They have six biological children, and the orphan is the seventh child in this family. He is not in school. This is a family that does not own this property on which they live. In fact, one of the well-to-do entrepreneurs in Harare owns this piece of land, which is about 50 acres in size. The entrepreneur is into small-holding farming, and has a compound where workers on this small-holding live, packed like sardines in the compound. So this family that looks after Graum live here temporarily for as long as they work for this entrepreneur. The living conditions at this compound are sub-human standard. The owner of the small-holding has a magnificent huge mansion located far away from this compound, and the compound has huts built of poles and mud, and thatched with decaying grass, and in some cases with old plastic. The compound huts are too close to each other and they spell out abject poverty, while the owner's mansion reveals a filthy rich outlook from a glance. Conditions in the compound are squalid and at their worst.

Graum knows his parents died of AIDS, and here are some of the highlights of our interview conversation:

> "I strongly disagree that I am a person of worth, and I do not feel equal to all others. I do not have my own biological mother like the rest of the children here, and besides, what I wear is far below standard compared to the other children," said Graum. "Come to think of it, I tend to feel I am a failure. I do not have my own mother, and I do not have nice clothes to wear," remarked eleven-year-old Graum. "I feel too many of my friends hate to be around someone who has a relative that died of AIDS. They think that you will spread the AIDS to them. Some of them will resort to gossip, some will tell you directly in your face! When I look in the mirror, I do not feel happy about myself. Once I look in the mirror, I see my mum's face. I looked just like her. So most of the times I hate to

look in the mirror," said Graum with tears rolling down his bony cheeks. "On the whole, I am very dissatisfied with myself. My mum is not around anymore. I loved her very much! When mum was alive, I used to go to school. Now she is gone, and my school days are gone too!" sobbed Graum. "I certainly feel useless at times. This is because I do not have my own mother any more. I do not have a dad too. Both of them died and left me behind to suffer the way I do now," mentioned Graum. "No one cares much what happens to you, come to think of it. I totally agree with this statement, that is what is happening to me because I do not have my mum," said Graum. "When a loved family member dies of HIV/AIDS, most people avoid talking about it and pretend it was not HIV/AIDS. Of course I do not blame them. It is happening to me. I told a few confidants that my parents died of AIDS, and what happened? They spread the word around, and I began to be stigmatized, ostracized, and ridiculed. Right now, most people treat me like a leper, and other children of my age run away from me. I do not have any friends," wept Graum. "On the whole, I am very unhappy because my mum died, and my dad died too." Ever since my beloved parents died, I have not gotten over it, and I am generally in very low spirits most of the time. This is because my mum died and my father died," cried Graum. "I always feel downcast, unwanted, dejected, and stigmatized because I wear tattered and torn clothes that most of the times, I am treated as a crazy or mentally ill person. I wear rags everyday, can't you see how I look?" questioned Graum with eyes glittering with endless tears. "Most of the time I would rather sit, daydream, and worry. This is what bothers me a lot. I tell myself that mum is dead, OK. Now I live with my mother's younger sister, and does she treat me like my mother used to? No, she shoes not! She gives me a lot of work to do, while the other children are at school. I am now the person who does all the chores like fetching water, sweeping the hut and collecting firewood, while all her children are going to school. I do not go to school, and I almost feel like I am now the slave of this household. Why did my mother die, to leave me suffering like this?" cried Graum.

When I came to the end of my interview questions, Graum was still weeping and sobbing, and I had to find questions that would sooth the crying I had started in this orphan. I went on to ask him what it is that he would need to better his life? Graum said:

"I need to go to school. I need basic food. I need shoes. I need clothes that are decent to wear. I only have two blankets, and I feel cold during the cold nights. I desperately need good accommodation. Right now, this hut that I live in leaks heavily in the rainy season.

> Imagine when it rains in the middle of the night, and you are sleeping. and you have to be woken up from rains leaking through the roof? We all get squashed up seeking shelter in the corner of that leaking hut. When it is not raining, we still have lots of ants creeping all around the hut. Some have gone into my ears during my sleep" sobbed Graum.

Orphan's fictious is Iraf: (father died in 1996)

In this household, there were five orphans aged 15, 13, 11, 10, and 9 years of age. The orphan that I interviewed was 11 years old and she was not in school, because when both her parents died, the orphans relocated, and during the transition period, Iraf's birth certificate got lost. So according to her words, she could not be in school because she did not have a birth certificate.

> "On the whole, I am not satisfied with myself because I am not in school. I would like to go back to school," sobbed Iraf.

Orphan's fictitious name will be Ntela: (father died in 1994, mother died 1995)

The orphan is 11 years old. He lives with his aunt and uncle who have six biological children. Ntela is in school, and admits openly that his parents died of HIV/AIDS.

> "When a loved family member dies of HIV/AIDS, most people avoid talking about it and pretend it was not HIV/AIDS. This is so because they will be judged by God, and burnt in Hell; I mean whoever talks about it" Ntela said bright-eyed.

I was amazed by the confidence he had about the outcomes that be-fall anyone who talked about HIV/AIDS. I therefore asked him where he had gotten that information?

> "From my teacher at school, replied Ntela, confidently. "On the whole, I am fairly happy because people and children his age who live next door laugh at him and make fun of his parental deaths due to HIV/AIDS. Some days they use vulgar words that I cannot even share with you, and most times they call me a mental case," said Ntela.

I asked Ntela if the caregiver knew about his predicament from neighbors. Ntela said he never shared that information with anyone, the caregiver did not know at all. I inquired why he would not tell the caregiver, and he told me that he feared to be reprimanded by the caregiver.

> "I always often feel downcast, unwanted, dejected, and stigmatized especially by a bully that is 14 years old and who goes to the same school as I do," remarked Ntela. "The bully is a boy, and he hits me most of the time on my way from school," said Ntela getting extremely upset.

I asked Ntela what he would like to have in life. He said:

> "Toys, books, writing pens, 2 writing note books, 1 back pack / school bag, shirts, shoes, and shorts. I only have one pair of shoes, and the pair is now too tight. I need food. Every morning I never have breakfast before I go to school. My school starts at 8:00 am, and ends at 1 pm. I walk to and from school, on an empty stomach. At school I beg for food from friends, and now everyone runs away from me except Brian who is a very good friend. Brian is lucky, all his parents are alive, and so he brings food and lunch money to school. He gives me a freeze-it everyday at school, but as you know, freeze-it it is only frozen colored water!' cautioned Ntela. After school, I walk home and when I get home I am very tired and hungry. I drink 1 cup of tea and 3 slices of plain bread that has no spread on it. The only decent meal I have is in the evening at around 7 pm, where I eat sadza (thickened corn porridge), nyama (meat) and muriwo (Green vegetables)" said Ntela.

I asked Ntela why he goes to school hungry, and whether he had discussed this with his caregiver. This is what Ntela said:

> "I have asked for breakfast before going to school, and my aunt says that if I choose to eat in the morning, then I should not come and eat again during lunch hour. That is why I go to school hungry," mentioned Ntela.

Fictitious name is Indate: (father died in 1989)

This is a young boy 16 years old, of Malawi origin, and whose father died in 1989 while the boy was only 7 years old. Indate is the first born in his family. Shortly after his

dad died, his mother remarried, and relocated to this small-holding that I shall give a pseudo name of Marasa Small-holding. This is the same place where the other orphan Graum lives. Indate relocated with his mother to join his stepfather who is a divorcee, and has his own two children that live with him.

Indate's mother had one child with the stepfather. In all, we have four children and two adults in this household. Indate is the only orphan in this home, and the stepfather does not want him here, but because Indate's father is from Malawi, all Indate's father's relatives are in Malawi, and therefore Indate has nowhere else to go. The stepfather hates Indate to the extent that he does not provide any school fees for Indate, and Indate is the only child in this household who is not in school.

His mother's health is deteriorating ever since Indate's father died, and has continued to deteriorate in this new marriage. Apparently, when Indate's father died, the mother knew it was HIV/AIDS, and Indate knew also. However, the stepfather did not know, until way into the marriage with this widow. When the stepfather learned about his new wife's AIDS status, it was after the new baby was born, and ever since he knew the health status of his new wife, he beats up Indate and scolds his late father, and he also beats up Indate's mother every now and again for not letting him know that her first husband died of HIV/AIDS. The situation in this household is extremely unsafe for all the household's members' psychological and emotional well-being. In this case, Indate's mother is the caregiver, and she admits openly that her first husband died of AIDS, and she did a big mistake of not telling her new husband.

> "I looked very healthy, and nobody told me I had it. My first husband is the one who looked really worn out, thin, and sick. I was never sick at all, and I was fat and bouncy, and I assumed I did not have it. Now the second husband beats me and threatens to kill me in front of my son, Indate (orphan), from the previous marriage," said the sickly caregiver as she introduced me to her son so that I could interview Indate.

Indate the orphan however, was wearing rags that almost revealed most of his body parts due to the holes in the clothes. His feet revealed to me that they had never worn shoes in the last four or five years. His rough, chipped, dark skin reflected extreme dryness and neglect. To sum Indate's physical appearance, I would say it was indescribable, and I had never seen anything like this in my entire life. The situation told nothing but horrendous poverty, to say the least! Indate had to say this:

> "I do not feel I am a person of worth, I do not feel equal to all others. Look what is going on here, I am the only one in this family who is not going to school. If I had my own biological father, I would be in school right now," said Indate. "Come to think of it, I tend to feel that I am a failure. If I were in school, I would be happy, and I would be channeling my energies to reading and writing and doing homework. Right now, I am wishing that if I could get money, I would like to go back to school. I used to go to a school where my (mother's father) grandfather lives, but I got sent away from the school because I did not have Z$250 (US $6.50) that was required per term. So that is why I had to come and join my mother thinking the stepfather might assist me," mentioned Indate. "I feel too many of my friends hate to be around someone who has a relative that died of AIDS. My dad died of AIDS, and I am hated for that reason. My stepfather hits me for that, my friends run away from me for that reason," said Indate solemnly. "I strongly feel that I do not have much to be proud of. I do not have clothes, I do not have any shoes, we do not have chairs to sit on, and no beds to sleep on. Overall, I am not satisfied with myself. When I look at myself, I see a very poor and powerless child. I do not have my own biological father, I do not go to school, I do not have friends who like to be seen with me, I spend the whole day here, doing nothing, I cannot even sit down to relax in our house because we do not have chairs, and no television to see the outside world. I am just as good as dead!" said Indate with eyes glittering with tears. "I certainly feel useless lots of times! No matter how I bath myself, I still feel useless, and feel that I am too black, blacker than anyone else, and hence very useless," reported Indate.

I could not understand why a 16-year-old young boy would hate to be black especially in Zimbabwe, a country where the majority of the population is black. I had to pursue this response and figure out what was going on in Indate's mind. So I asked him

why it bothered him to be very dark skinned, after all everyone around here is dark skinned. This is what Indate had to justify his thoughts:

> "Everyday, the other kids scold me that I am as black as the African black mamba snake, and they tease me with those words every time, and not only that, if I am walking towards them, they scream and run away yelling Blackie is coming, run away Blackie's dad died of AIDS," explained Indate as he stretched out his right hand to pick up a broken glass from the grass on the ground we were seated outside his hut, the broken glass that he ended up using to clean his nails. "I strongly agree that no one cares much what happens to you, come to think of it. For instance, in my case, all my step-siblings are well liked by their father's relatives, and friends, but not me," pointed Indate. "I totally disagree that human nature is really cooperative, helpful, and kind. I have never seen anyone who is like, especially after my dad died. Everyone I know is mean," he said. "When a loved family member dies of HIV/AIDS, most people avoid talking about it and pretend it was not HIV/AIDS. This is to protect yourself from being laughed at, stigmatized, and ostracized. Just see what is happening to me now. If only I had known better, I would never have told any of the people around this compound that my real dad died of HIV/AIDS', regrets Indate. "On the whole, I am fairly happy. This is because my life has no future, and it is not the same as the others I know," he said. "Most of the time I would rather sit, daydream, and worry. This is because my peers around here run back and forth enjoying life with their fathers. Whenever they want anything like pocket money or new clothes, they go to their dads to ask. That is not the case with me. For instance, I cannot even dream of asking him to buy me simple items like underwear, let alone school fees, because it is very hard for me to be open with him and tell him my basic needs. I always fear that he might turn around and ask me why I am a pain in the neck to him, while his own biological children never bother him the way I do. I just shut myself in, and die each day from within," Indate told me as tears rolled down from his left eye.

I did not want to end this interview with Indate's tears pouring out the way they were. So I ended up asking some open-ended questions that I had not intended to give. I asked him what he would like in life. Here is what he said:

> "I need to go to school. I just ended in Grade 7." (Zimbabwe's highest level in Middle School), he said. "I also need decent clothes, I only have four torn shirts that I have out grown. I need a pair of

shoes; I have never worn shoes in the last four years. I also need a decent house to live in. Right now, we only have one room in this compound, one room for six people: two adults, and four children. I am now 16 years old, and I should not be sleeping in the same room as my mother and stepfather. However, it helps in a way, because when stepfather decides to beat up my mother in the middle of the night, I am always helping my mother. At least he would not beat her much in my presence," remarked Indate. "But do you know what has happening in the last three weeks, my mother has negotiated with our neighbor who has extra room, and fewer children. So every evening, I go to sleep at our neighbor's place, and I hate it all. The children there make fun of me, however, I will not tell my mother about it. I wish I could have a room of my own, and where I could put my personal belongings. I hate to sleep in other people's places," he said. "Most of all, I wish I could have at least the basic food commodities. Most of the times, I go hungry. I do not even know when I last ate bread, or eat chicken rice!" said Indate.

Fictitious name is Nelle: (father died in 1991)

Nelle is a 13-year-old girl whose father died when she was six years old. She lives with her mother, and she attends school. Currently, she is in Form One, which is first year in High School, and she is very much aware that her father died of HIV/AIDS, because her mother is very open to her. This is what Nelle says about how being an orphan

"When a loved family member dies of AIDS, most people avoid talking about it and pretend it was not HIV/AIDS. This is because AIDS is a disease that society thinks it is caused by prostitution, but as far as I am concerned, I do not buy the idea, and I will never pretend like the rest of them," spoke Nelle confidently. "On the whole, I am not satisfied with myself because everything is not so equal. When dad was alive, I used to get a lot of nice food, a lot of nice clothes, but now things are different. For instance, at school, I feel unhappy at times especially when we have Parent-Teacher-Consultation Days. I do not have any parents to come for me. My mother is a self-employed trader. She goes to South Africa to sell her produce, and she can go for as long as two months, a thing that never happened when dad was alive," remarked Nelle. "However, I do not blame her, that is her only way of getting money now: I mean buying and selling. On the whole, I am fairly happy because I only have a mother, and I do not a dad. I miss the paternal love, maternal love void of paternal love is as good as losing both parents," she said. "Although my beloved parent died, I have got over it, and I am

> generally in good spirits. I think this is because, I know that at least I can go back to our home, where all members of my family live together except for dad who is gone," said Nelle.

From all orphans interviewed, Nelle's bravery and confidence was striking. She never cried throughout the interview, and she was not embarrassed to speak about her father's death from AIDS. She was in control of the situation.

Fictitious name is Ecnei: (Both parents died 1997)

Ecnei is 11 years old. She lives with her uncle and aunt. Ecnei knows that her parents died of HIV/AIDS. She is not in school due to lack of school fees. Originally, all her parents are from Malawi, so Ecnei has a very limited spectrum of extended family relatives.

> "I certainly feel useless at times. Actually I am very angry with my mother especially. How could she die and leave me alone suffering the way I do now. I no longer have socks to wear with my shoes any more. She used to buy me nice socks," said Ecnei. "No one cares much what happens to you, come to think of it. The people get irritated and angry with me for no good reason since my mother and father died. When a loved family member dies of HIV/AIDS, most people avoid talking about it and pretend it was not HIV/AIDS. This is what I sometimes tell some people, that they died of HIV/AIDS especially if I suspect that they are bad people who can turn around and laugh at me," Ecnei remarked. "Ever since my beloved parents died, I have not gotten over it, and I am in low spirits most of the time. The other children in this household yell at me, and they are always telling me to get out of their home. Even if I visit my friends at their homes, they chase me out like I am a leper. They think I have the disease that killed my parents," said Ecnei. "Most of the time I would rather sit, daydream, and worry. I miss my parents a lot. My father used to give me some pocket money to buy freeze-its, and ever since he died, I have never tasted a freeze-it," mentioned Ecnei.

Fictitious name is Wapita: (both parents died 1997)

This is a young boy who is 16 years old. He now lives with the cousin of his late father. The father's cousin is married, and has six children in this household. Wapita was the first orphan I interviewed, due to the fact that he lived with one of my research assistants. As he was my first encounter, there were flaws that I later on realized never to repeat with all the other orphans that I would interview in my study. The mistake I made was to interview Wapita in the presence of his caregiver/his aunt/and one of my research assistants. Wapita was very uncomfortable throughout the interview, and I could feel the tension building up. He had a lot to say, but he expressed fear and discomfort due to his aunt's presence. After this encounter, I decided that I would never interview either the caregiver or the orphan in the presence of the other.

> "I only wish my parents were alive," he kept on repeating those words, and he would not go further than that!

Fictitious name is Iazduk: (Mother died in 1997)

Iazduk is 13 years old, and she lives with her late mother's sister who is married, and has two children. During the time of the interview, Iazduk's mother had died the previous year. Before Iazduk's mother died, Iazduk's father had divorced her mother and left this family to start a new family with a new wife. Though Iazduk's father was alive, Iazduk felt she had no parents at all because her father had never come back since he abandoned them long before her mother died. Iazduk was extremely emotional about her plight, and from the time I introduced myself to her, to the time I ended my interview with her, she was crying non-stop, and it was like she is re-living her mother's funeral. This was one of the most traumatizing interviews I had with a young child, and it was emotionally draining that I did not know whether I should quit interviewing or press on. I decided to play the role of counselor and be brief in my talking, and did most of the listening. Here is what she had to say about her situation:

> "I am not a person of worth, I do not feel equal to all others. I wish I could feel happy about myself" she cried, "I am missing my mum, oh! Please help me to get my mum back! On the whole, I am fairly happy," she sobbed, "because of what I see myself to be! I am a loser in life! I lost my mum!" she cried, wailed, and sobbed frantically. "Most of the time I would rather sit, daydream, and worry. I am angry that my dad married another wife and abandoned us, and after he turned his back on us what did mum do? She turned her back on me!" sobbing faintly and tears rolling down her cheeks.

To speak the truth, this was one of the most traumatizing encounters I had, and I nearly quit continuing the research after this episode. I was dumbfounded, wanting, helpless, and lost!

Fictitious name is Erimda: (both parents died 1995)

Erimda lives with his grandmother who is now his caregiver. The grandmother is 70 years old, and from the looks of the environment of this household, the caregiver is extremely economically disadvantaged. However, despite being poor, Erimda goes to school. The grandmother orders some vegetables and fruits to sell to passersby. So from the little she makes, she sends her grandchild to school. Erimda had to relocate to this neighborhood when his parents died. Erimda admits that his parents died of HIV/AIDS. His caregiver did not hide it from him. Erimda had this to say:

> "When a loved family member dies of AIDS, most people avoid talking about it and pretend it was not HIV/AIDS. Most people feel that it must be a secret; or else you get stigmatized the way I do in this neighborhood. Probably grandmother made a big mistake in letting the secret out. Children whose parents or relatives died of AIDS tend to be ignored by some people. Actually many people do that. For instance, in my case I get ignored, and if they do not ignore me, people including my friends at school scold me. They say get away you mad person," said Erimda. "On the whole, I am very unhappy. At school I get physically abused by bullies who beat me up for no reason. At times, I get kicked at the bottom when I am walking down the corridor, and if I ask why they are kicking me, I am told 'AIDS puppies need a kick, and you are one of them'. I am

> lonely both at school and at home. Children of my age run away from me," said Erimda. "I do not get fun out of life. Friends in the neighborhood castigate and stigmatize me. They do not want to play with me. I always feel downcast, unwanted, dejected, and stigmatized. And when friends chase me away from them, I walk away and sit on those rocks nearby, and daydream. I end up missing my parents a lot," said Erimda with a stream of tears rolling down his cheeks. "I do not know what I should do, because when I tell my grandmother (caregiver) about the treatment I am getting in this neighborhood, she tells me to play alone, or with my six-year-old younger brother only. Both of us are extremely lonely," added Erimda crying.

When I completed working on all my survey questions, Erimda was still crying, and so I decided to add a few questions that might stop him from crying. I asked him what he needed to improve his life, and this is what he said:

> "I need clothes, shoes, shirts, blankets, toys and a ball to play with. Right now I only have 2 shirts, 3 shorts, 2 pairs shoes, 2 blankets that I share with my six-year old brother, and a home made plastic ball. I never have breakfast before I go to school because grandma cannot afford to buy bread every morning, and this makes me hate school sometimes because I am extremely hungry at school. Do you know what I end up doing? I always beg for food from school, and I have one friend called Blessing who always brings an extra piece to give me when I start begging, and other school children make fun of me," said Erimda.

Fictitious name will be Nostap: (Father 1996)

Nostap is nine years old. He lives with his mother who is the caregiver. Nostap knows his father died of HIV/AIDS. Here is what Nostap had for answers to some of the survey questions that I gave him:

> "Come to think of it, I tend to feel that I am a failure because my dad died and my mother has no money to even buy me school books nor a school bag to put books and pencils in. I do not have a backpack. I use plastic bags instead. I feel too many o f my friends hate to be around someone who has a relative that died of AIDS. Like in my case, they actually run away from me and say that they do not want to play with me because I might end up spreading the virus to them,"

sobbed Nostap. "When I look in the mirror, I do not feel happy about myself. I have seen dad's photographs, and I look like him. My nose especially is just like his. So the more I look into the mirror, the more I am reminded that I am an orphan that nobody likes to play with due to the death of my father. On the whole, I am very dissatisfied with myself. How can I be satisfied after all the horrible things that are done to me by the people in this neighborhood? The children around here do not want to play with me," sobbed Nostap. "I certainly feel useless most of the times. There are bullies in this neighborhood who physically beat me up for no reason. The worst of them is Tichaona, the boy who lives two blocks away from here. He is far older than me, and he just finds joy to beat me up whenever he wishes to," said Nostap. No one cares much what happens to you, come to think of it. On my way from school, the other children curse and yell at me if I try to join their company. Behind our house there is another boy who is a bully to me always. His name is Talent and if I just walk near him these are the words he uses against me: "Get lost you dog in a human body," mentioned Nostap. "At times he beats me up, and at times he scolds me with demeaning curse words," said Nostap. "When a loved family member dies of AIDS, most people avoid talking about it and pretend it was not HIV/AIDS. They fear that the word would spread like wild fire, and then people would start running away fearing to catch the virus," indicated Nostap. "On the whole, I am very unhappy. I just see that the quality of life has changed for the worse. Lots of people are dying from HIV/AIDS, and it just makes me sad. By losing my own father, I am always in very low spirits. I have no dad, I have no basic food commodities, I have no school books, I have no school lunch money, I do not have friends, I am poor and my mum is also poor," said Nostap with tears rolling down his cheeks. "Most of the time I would rather sit, daydream, and worry. I would be thinking about my dad. He used to give me money for school. He would buy me blankets and clothes, things that I lack now," said Nostap.

Nostap ended his conversation with me by giving me a list of some of the things he would need:

"I need clothes, blankets, back pack for school, and some pocket money like Z$2.00 at least. I would like to buy buns, and a drink at school. I have never had these things ever since dad died," remarked Nostap.

Orphan's fictitious name will be Liagiba: (Both Parents died 1996)

There were five orphans in this household. The eldest girl, who is 15 years old, is the caregiver of the younger siblings. I decided to interview her for her unique challenges of both being a child, a caregiver, and an orphan. Liagiba is not in school because she decided to take care of the younger four siblings in school. Their house is fairly big, so this family sublets two other rooms to lodgers. Here is what Liagiba had to say:

> "I strongly feel that I am not a person of worth, and I do not feel equal to all others. When others worry about which dress to wear with matching shoes, I am worrying about getting basic food commodities like salt, sugar, bread and cornmeal," mentioned Liagiba. "I feel that I am somebody that has a number of good qualities. I am good at buying and selling. I definitely consider myself a good self-trained sales-person. Come to think of it, I tend to feel that I am a failure. I have no shoulder to cry on when the going gets tough. I am the first born, I am only 15 years old, both mum and dad never left any money behind that we can fall back on, but thank God they had completed buying this house. That is the only source of income we have from the two rooms that we are subletting. I have problems with the lodgers who do not want to pay on time, and that was another reason I had to leave school, to be home looking after our property and chasing after these lodgers who seem to take advantage of my age," Liagiba indicated. "When I look in the mirror, I do not feel happy about myself due to the poor clothing I would be wearing. I certainly feel useless at times because when I am walking about the streets or going anyway, I look different from everyone. Some people say most people can be trusted. Others say 'Do not trust anybody except yourself'. As for me, I do not trust anybody. When a loved family member dies of AIDS, most people avoid talking about it and pretend it was not AIDS because they fear to be laughed at. On the whole, I am fairly happy. I miss both mum and dad a lot. My situation makes me feel fairly happy. I am an orphan, and I have a task of taking care of other orphans who are my siblings. At least, I still remember what mum taught me about household chores, and good civility. I will try to pass all our family values to my younger siblings," said Liagiba with confidence.

Fictitious name is Remo Yrt: (Father died 1990)

The mother is the caregiver in this household. Remo Yrt is in his second year of High School. He was well aware of the fact that his father died of HIV/AIDS. He said:

> "I feel I am not a person of worth, and I do not feel equal to all others. My friends whose fathers are alive get more clothes and more food than I do. For instance, I am in High School, but I do not take to school any money for school lunch," remarked Remo Yrt. "I strongly agree that I am somebody that has a number of good qualities, however, all my talents are being interfered with by the hunger I feel when I am at school. I would love to take at least Z$5.00 (US 30 cents) a day to school for lunch so that I can either buy pop corn, or buns, or freeze-its during lunch breaks, but I go to school without any food nor any money because my mum cannot afford," mentioned Remo Yrt. "Come to think of it, I tend to feel strongly that I am a failure. If only my father was alive, I would be getting enough to eat, and enough pocket money to take to school," he said crying. "I feel too many of my friends hate to be around someone who has a relative that died of AIDS. They will run away from that person saying that person would spread AIDS to them," indicated Remo Yrt. "I feel I have nothing to be proud of. I lack basic food commodities. I go to school on an empty stomach. Imagine, I start school at 7 am. I walk a long distance to go to school, without having eaten any food in the morning. If I am lucky, I might have a cup of black tea that does not have any bread. I come back from school at 12 noon, and will drink another cup of black tea with three or four slices this time. A fairly decent meal will be eaten once in the evening," said Remo Yrt. I certainly feel useless most of the times because the quality of life I am leading is very poor, and it was not like this when dad died," sobbed Remo Yrt. "On the whole, I am not satisfied with myself. Life is boring. Let us say I want to play with other youngsters of my age, they run away from me. They say that I do not bring any food to school," said Remo Yrt with tears rolling down his cheeks. "Since death occurred in our family, I notice that most days I have very poor opinion of myself," emotionally crying and weeping, he explained. "No one cares much what happens to you, come to think of it. I strongly agree because nobody looks at an orphan with pity, nor with love. Once you are an orphan whose parent died of AIDS, you start stinking to the rest of the world, and nobody cares," remarked Remo Yrt. "Human nature is not really cooperative, helpful nor kind. Once people hear that these are orphans that are suffering, and more so that the parents died of HIV/AIDS that is it! You just become condemned and stigmatized," said Remo Yrt. "I do not trust anybody," said Remo

Yrt with a laughter that revealed emotional pain. "Children whose parents or relatives died of HIV/AIDS tend to be ignored by many people. Like in this neighborhood, that is exactly what is happening on a daily basis. They ostracize me; nobody wants to associate with me. I only play with another orphan that lives two blocks from here. The father of that friend of mine also died of HIV/AIDS. When that friend is not around, I only play with my brother. We play football, actually we collect plastic balls and make them into balls, and use those for play," explained Remo Yrt. "On the whole, I am fairly happy that at least I have my mother who is alive. Though dad is gone, at least I still have a mum. However, what makes me sad is the fact that I am disliked by people just because my father died of HIV/AIDS," said Remo Yrt crying. Ever since my father died, I am always in low spirits. My friends ride their bikes and if I try to be among the bikers, they tell me to ask my mum to buy me a bike of my own first, and then I could be a member of the bicycle club. They do not seem to understand how poor my family is ever since dad died," he said.

Fictitious name is Nosiar: (Both Parents died 1997)

This is a very intelligent, 17 year-old, young man. He had just completed his High School final examinations with flying colors. His father had three wives and Nosiar's mother was the first and oldest wife. Beginning of 1997, Nosiar's mother died, and according to Nosiar, he believed that the second wife that was always quarreling with his mother before she died was the cause of his mother's death. Nosiar believed that his mother was given food poisoning by this second wife. However, by the end of the year 1997, Nosiar's father died. Soon, the third and youngest wife left to rejoin her birth family. Consequently, Nosiar was left to live with his late mother's former rival: his stepmother and caregiver. When I arrived at this home, Nosiar came to direct where to park my car, and he stretched out his hand to greet me. I asked to see any of the adults at home, and he told me it was his stepmother that was home. When I approached the stepmother, she was very reluctant that I interview Nosiar in privacy, and the reason she gave me was that Nosiar was mentally ill to some extent. I told her that as long as he does

not beat me up, I would not have any problems in hearing Nosiar's story. This is what Nosiar had to say during the interview:

> "I feel I do not have much to be proud of. All my clothes are in bad shape, and look at me, I do not have any pair of shoes," Nosiar pointed to the cracks on his feet that were actually turning into sores. "On the whole, I am very dissatisfied with myself. I am suffering from everything that you think abject poverty and loss of mum and dad can do to a young boy like me," said Nosiar, eyes glittering with tears. "I definitely feel very useless at times. I am sick; I have mental infection, which struck me after my High School results came out. I came out with highest grades on all the eight subjects that I sat the examination for. But now look at what has happened, I become mentally ill, how will I ever get a job? I need a job," emphasized Nosiar. "No one cares much about what happens to you, come to think of it ever since my mother died, nobody cares about me," he said. "I do not trust anybody, because human beings are bad! However, I want to go and see Bill Clinton and Tony Blair. These guys are good. But tell me, why did Bill Clinton not come to Zimbabwe when he was scheduled to come to visit us during his Africa tour?" he asked. "When a loved family member dies of AIDS, most people avoid talking about it and pretend it was not HIV/AIDS. People do not want to accept it. On the whole, I am not very happy. When my beloved relative died, nobody sat down with me to talk about death, or how I should face life. When I think about their death, I get depressed and I do not what to do, and this is very true," Nosiar stamped one of his feet to the ground to put emphasis to his statement. "I do not get fun out of life. How can I when I do not have clothes, no size-8 shoes, no tennis racket, no football sweater, no soccer shoes, no radio, no radio cassettes, no television, and no blankets. Do you know I only have one tattered blanket? I am suffering and I need help to have my health back. Other children make fun of me, I do not have any friends, they run away saying that my parents died of AIDS, that is why I am now mentally ill," said Nosiar with tears rolling down his cheeks.

Fictitious name is Halueb: (Father died in 1997)

Halueb is a 16-year-old girl, orphaned, and lives with her mother who is the caregiver. The mother openly discusses that her husband died of HIV/AIDS, and definitely she "would die of AIDS too," she would say in front of her children. I had a very traumatic experience with this family, especially the caregiver who constantly told me

that no matter what, she would die of AIDS, "Isn't true?" she would continually seek to hear from me, and I would find myself in the most awkward situations, because as soon as she posed that question to me, she would weep and cry in a way that left my whole body filled with chills and invisible goose pimples! This was one of the saddest interviews I had too. The orphan knew her father died of HIV/AIDS, and in my opinion, I would say there was a visible "role-exchange" going on in this household under prevailing circumstances. Halueb, though she was only 16 years old, was carrying on with life in a mature manner. One would think she was the mother of the house, and the mother had become fragile not physically, but emotionally and psychologically. The mother orders vegetables and fruits from the big city, and comes and sells in their own neighborhood of this small town. Halueb does most of the selling while the mother is resting or doing other household chores. Halueb had this to say about what I asked her regarding the survey questions:

> "On the whole, I am very dissatisfied with myself, because I miss my father," said Halueb. "I wish I could be happy about myself. I hate the way things are in our family right now. Most of the times I am very busy entrepreneur, selling vegetables and fruits. I have no time to study for my school work, and sometimes, I cannot even go to school selling at the market, and at times, even miss going to church. Other children of my age are playing, and here I am selling at the market all day long," explained Halueb. "When a loved family member dies of HIV/AIDS, most people avoid talking about it and pretend it was not HIV/AIDS. This is because people fear to be stigmatized and to be embarrassed. For instance, my mother is open about the fact that my father died of AIDS, and now look at what is happening to us, people talk about her, make fun of our family, and say very negative things about my father and my mother," said Halueb with tears in her eyes. "I do not get a lot of fun out of life. I am always too busy. I leave the market at 8 pm every day. I then have to carry all the market produce from the market to our house using a wheelbarrow and to finish taking all the produce from the market to our house I have to make four to five trips pushing and pulling the heavy wheelbarrow. When I get home, I then cook, because my mother sleeps for very long hours at times. By the time I have finished pushing and pulling the wheelbarrow, as well as cooking and eating, I am extremely tired that I have no time to study nor to do homework that I my teachers give me at school," said

Halueb. "I certainly feel useless most of the times. I am always being sent away from school due to lack of school fees. So far, I have been sent away up to ten times. My peers at school know that my father died of AIDS, and that is bad enough to make me feel useless. Now imagine how devastating it is to me when I have to be pulled out of class to be sent away home due to lack of fees all the time? I just feel useless always! Children whose parents or relatives died of AIDS tend to be ignored by many people. For instance, my peers ignore me and when I confront them for their cold behavior towards me they say, *Futseki*, shut up! No wonder you have a father who died of AIDS," exclaimed Halueb crying bitterly. "I feel hopeless and powerless about this situation. When I come to tell my mother about it, she just tells me to ignore them and pretend I never heard a word from them. How can I forget or ignore such cruel words? They keep ringing in my ears," she sobbed pitifully. I summed up by asking her what she would need in life to make her feel good. This is what Halueb said: "I need school uniforms, writing note books, school text books, food and clothing," said Halueb, calming down and investing her hope and dreams in me.

Fictitious name is Adnawat: (Father died in 1997)

This is a young boy who is eleven years old. His mother is the caregiver. He is aware that his father died of AIDS. When the father died, the wife lost the house because the husband had not yet finished buying it. This family had to move and they ended up renting a single room: the mother and her four children. Here is what he had to say during the interview I had with him:

"I do not feel I am a person of worth, I do not feel equal to all others. We do not have any one to look after us. Dad is gone!" explained Adnawat. "I feel that I am somebody that has a number of good qualities. I can play cricket very well," indicated Adnawat. "Come to think of it, I tend to feel that I am a failure. Our family no longer has enough to eat ever since dad died, and if we have anything to eat, or if we happen to have food on our plates, the food is no longer the quality we used to have. For instance, now we have a lot of chicken's feet, or pig's trotters yet when my father was alive we would have bacon or chicken, not the poor quality food we eat now!" exclaimed Adnawat. "When I look in the mirror, I do not feel happy about myself. I see a bony, thin person," said Adnawat. "Human nature is not really cooperative, helpful, nor kind. Our friends and relatives see us suffer the way we do, and they just look

on and at times laugh at us," explained Adnawat. "Children whose parents died of AIDS tend to be ignored by most people. They say that their father enjoyed himself with prostitutes, now he is dead, if he could not take care of himself, his children, why should we do that for him? Let us leave those children like that," said Adnawat. "On the whole, I am fairly happy because my siblings and I have our mother with us at least. She buys us clothes and cooks for us," said Adnawat. "I do not get a lot of fun out of life because my father died. I just feel empty," said Adnawat. "I just feel that nobody likes us any more, and my mother is not working which makes the situation worse because I need school fees, money for food at school, clothes and blankets," explained Adnawat.

Fictitious name is Aivilo: (Father died in 1997)

Aivilo is 16 years of age and she lives with her mother. She is had no idea that her father died of HIV/AIDS. Her mother told me that she is keeping it as a top secret, and does not want any of her children to know that their father died of AIDS. When I asked Aivilo what her father died of, she said that her father trusted a friend who later on poisoned him at work by giving him a piece of poisoned chicken drum stick. It was when the family consulted the traditional healer who gave them that version of the story. Here is what she had to say:

"Children whose parents or relatives died of HIV/AIDS tend to be ignored by many people. Most people tend to look at the material wealth. If the people around are poorer than the orphans, or if the relatives are far richer than the orphans, there gets to be serious problems for the orphans, either way. I do not get a lot out of life. I am always missing dad, since he died very recently," said Ailivo, ." And to make matters worse, all the relatives from my father's side do not visit us," mentioned Ailovo.

Fictitious name is Emash: (Both parents died in 1996)

In this household, there were five orphans, all boys. These children lived in the rural areas before their parents died, and when both parents died, they re-located to the city to live with their grandmother who had lived in the city most of her life. The

caregiver is their grandmother from the mother's side. At one time, the grandmother and grandfather used to have a glamorous business complex selling all sorts of household items. However, the grandfather died ten years ago, and the grandmother made huge losses from the business, and by the time these five orphans joined her, she had become literally poor, and dependant on selling scanty vegetables and fruits to passers-by. She still owned her big house, but economically, she was in a financial ruin, and the situation made worse with the coming of orphans. At the time of the interview, she had just turned eighty years. She confirmed that the parents of these orphans died of AIDS, and the orphans were also aware of the fact that their parents died of AIDS. For some unknown reason, Emash was very resentful of me at first, and he was extremely reluctant to open up. However, here is what Emash had to say:

> "I do not feel I am a person of worth at all, and I do not feel equal to all others. I compare myself with those children who have all their parents, and there is a big difference between us. They have good clothes to wear, and I wear horrible looking clothes, with holes at every other spot," he exclaimed. "I feel too many of my friends hate to be around someone who has a relative that died of AIDS. They always think that if your relative could die of AIDS, obviously you should have it too," said Emash. "When I look in the mirror, I feel happy about myself. The face I see is clever, and it looks just like my mum. So every single day, I look at myself in the mirror, and I just feel fulfilled, it is like I am seeing my own mother in that mirror," mentioned Emash with a smile on his face. "On the whole, I am satisfied with myself. I am happy that I live with my mother's mother, and that way, I do not think of myself as being an orphan too much," said Emash. "I do not trust anybody at all. For instance, at school if you leave your school bag lying around for a short while, by the time you return, the bag will be empty," Emash said. "When a loved family member dies of AIDS, most people avoid talking about it and pretend it was not AIDS. They fear being stigmatized, and being ostracized by others. On the whole, I am fairly happy. I have a hard time at school because my peers make fun of me saying that I live with a grandmother. Sometimes they call me "grandpa" and sometimes they call me "grandie," and if I keep asking why they call me all these horrible names, they will ask me of what killed my parents, as if they do not know," said Emash with tears glittering from his eyes. "Although my beloved parents or relatives died, I

have got over it, and I am generally in good spirits. I live with my grandma, at least I am far better off than other orphans I know that have ended up in the street," explained Emash.

Fictitious name is Retep: (Father died in 1997)

In this household there were two orphans, both boys aged 14 years and 7 years old. The mother was said to be extremely ill at the time of the interview, and she had gone to the rural areas 400 kilometers away, to be with her own biological family while she was ill. The housemaid was the caregiver. This is another case that was very emotionally touching. The family had just completed extending their house, bought in new expensive furniture, and the husband had just been promoted at work, and the first child had completed his middle school, while the younger child had completed his first grade, and daddy had just bought a brand new car for the family. It all ended when AIDS struck, and the father died. Within the next six months, the mother started losing her mind, and the situation deteriorated very fast and she soon started beating up the maid, and her children. The maid quit, and a new one came, and the same thing happened, and the maid quit, again. At the time of the interview, this newest maid had only been there for four weeks. For me as the interviewer, I could feel the chills when I looked at the wedding pictures on the wall, family photo on the other wall, classy leather sofas, expensive stereo on one end, and television, cell phone, computer, and these two beautiful boys who had lost everything too soon due to HIV/AIDS.

When I arrived, the 7-year-old boy had just arrived from school, and the housemaid prepared him food to eat. I was too emotionally drained to interview this 6 year old boy who in his light blue school uniform comprising a shirt and a pair of shorts, black laced up shoes, and very light sky blue pair of knee high socks, approached to greet me with a faint smile on his sorrow-laden face, that concealed the trauma and pain this young child was going through. He soon left the lounge to his bedroom to take off his school uniform, and I was relieved that he left before he could notice that my eyes were

full of tears I could not control from coming out. By the time the 14-year-older brother arrived from school, I had strengthened myself and gathered enough courage to handle the situation, and that is how I ended up interviewing Retep, who was in his first year of High School at the time. Both children knew that their father died of HIV/AIDS, and they told me that they suspected that their mother's illness was related to the same problem that had killed their father. Here are some of the highlights of Retep's responses:

> "Come to think of it, I tend to think that I am a failure. Right now I am now an orphan, even if my mother is still alive, but she is no longer the old mother I used to know. She is now acting crazy or should I say she is now a mental case who does not even remember her own children's school names, nor that we are in school. I have heard that AIDS can cause people to become mentally ill, and soon after that they will die. I feel lost!" said Retep crying. "I feel too many of my friends hate to be around someone who has a relative that died of AIDS. Like in my case, I used to have a bus-load of friends when my dad was alive, and especially when he would give me pocket money for school lunch, or when he would come and pick me up from school, and some of my peers would get a ride in my dad's new van. Now all those friends have deserted me. I only have two friends left. Most of my peers have run away from me, they think that they might catch AIDS from me since my father died of AIDS, and my mum is now very ill," said Retep. "I do not feel that I have much to be proud of. I do not have anyone to pay school fees for me anymore. I have no father that is alive, and though my mum is still alive, she is now just as good as dead because even if she is around this home, she beats us up and chases us away saying that she does not know who we are. We end up sleeping at neighbor's houses because she threatens to strangle the maid, my younger brother, and myself," explained Retep. "When I look in the mirror, I do not feel happy about myself. My face looks like my mum, and that makes me miss her the more, and that makes me miss dad, and that makes me miss the good old days when our family lived happily as one unit," Retep said crying. "On the whole, I am satisfied with myself only when I am at school. My teachers like me very much," said Retep with his face beaming with untold hope. "I certainly feel useless at times. I think about my future, and just the idea of living in this world without my father makes me have goose pimples. My dad used to play with us, now I am very lonely. My dad had brothers who are alive, but they never come to visit us anymore," mentioned Retep. "When a loved family member dies of AIDS, most people avoid talking about it and pretend it was not AIDS. They fear

getting laughed at, and they also fear gossip that might circulate resulting in stigmatization," said Retep. "On the whole, I am fairly happy. My father's relatives never come to visit us any more ever since daddy died. I know where they live, but I dare not visit them. They chase me away if I go visiting. They ask me what I have come for, and the worst treatment comes from my father's sisters who accuse my mother of having spread the virus to their brother (my father). So my brother and I just keep ourselves to ourselves," sobbed Retep. Finally, I asked Retep what he thought he would need to lighten his burden he had, and this is what he said: "I would need shirts, school fees, and school books. That's all!" explained Retep.

Fictitious name is Iaruat: (Father died in 1995)

This young boy is 13 years old, and he lives with his mother, the caregiver. Iaruat is well aware of the fact that his father died of HIV/AIDS. Here are some of the highlights of the interview:

"I feel that I am not a person of worth, I do not feel equal to others. For instance, the children of the government ministers in this country, they eat and get their bellies full to the brim. For some of us, it is different. Some days we go to sleep hungry and on empty stomachs. I can tell you the number of nights this month that I have gone to sleep having drunk a glass of water only. Just drink water and sleep?" he looked at me angrily. "Come to think of it, I tend to feel that I am a failure. Other children, or should I say other people go to sleep after they have had a plateful of food, yet some of us go to sleep without having eaten any single item of food except water," he said. "I feel too many of my friends hate to be around someone who has a relative that died of AIDS. Another boy I know whose father died of AIDS has a hard time getting friends because most of his friends tell him in his face that they do not want to play with him due to the fact that his father died of HIV/AIDS," he said. "I feel I do not have much to be proud of. I do not have enough clothes to go around with," exclaimed Iaruat. "On the whole, I am not satisfied with myself. Others are always better dressed than what some of us would be wearing. I certainly feel useless most of the times. I hate to sleep on an empty stomach most of the times. Human nature is really not cooperative, helpful, nor kind. Each time my family has nothing to eat; nobody helps us out with basic food items. At times I go to the tuck shop or food store to beg for sugar, and they never assist. Instead they chase me away and threaten to call the police if I do not leave their premises," exclaimed Iaruat. "When a loved family

> member dies of AIDS, most people avoid talking about it and pretend it was not AIDS. I do the same too. Most of the time, I say my dad died of a headache, however, it does not help because most of our neighbors know my dad died of AIDS, and they tell their children not to play with me," said Iaruat crying. "On the whole, I am not even fairly happy. At least my mother is alive. However, life is rough for us because other people especially children, laugh at me saying that no wonder my father died of AIDS, you are hopeless, and guess what? We are not going to play with someone whose father died of HIV/AIDS. "I do not get a lot of fun out of life. How can I when I lack clothes, basic food like corn meal, vegetables, meat, cooking oil, sugar, salt, Vaseline, shoes, and blankets?" asked Iaruat.

Fictitious name is Ehsanit: (Mother died in 1997)

In this household, there were two orphans; a five year-old boy and a girl aged two and half years old. These orphans were not blood relatives as such, but culturally, they would qualify to be called extended family. These orphans are children of a next-door neighbor who initially came from Mozambique, who became mentally ill after her husband died of HIV/AIDS. The mother of these two young orphans went to live on the streets, where she fell pregnant. After she had a baby, her mental illness deteriorated, and the baby died, and after the death of the baby, the mother also died leaving behind the two orphans in question. The woman next door took these two orphans in, and she assumed the role of caregiver. I decided to interview the five-year-old Mozambican girl, Ehsanit. Highlights of the interview are:

> "I do not feel I am a person of worth, nor do I feel equal to all others. Come to think of it, I tend to feel that I am a failure. My mother and father left us all by ourselves," she said biting her nails from her thumb. "I am able to do things as well as most others. I can play with my ball," pointing to a bundle of old plastic bound together with string. Criticism or scolding hurts me terribly," she said. "Children whose parents or relatives died of AIDS tend to be ignored by most people, she said.

Fictitious name is Aihtnyc: (Father died in 1997)

This orphan is a girl who is eight years old. Her mother is the caregiver. This is what Aihtnyc had to say:

> "Come to think of it, I tend to feel that I am a failure. For instance when the other girls beat me up on our way from school, and they start demeaning me by talking about AIDS that killed my father, I then feel useless, and I begin to miss my dad the more. When I look in the mirror, I feel happy about myself. I have beautiful hair that my mother is always braiding into fantastic styles," Aihtnyc smiled. On the whole, I am not satisfied with myself. My peers from school are too bossy, and they use curse words against me, especially attacking me by saying I lost my dad due to AIDS," mentioned Aihtnyc. "I feel too many of my friends hate to be around someone who has a relative that died of AIDS. Like in my case, they tell me that they do not want to play with me because I might have the virus and spread it to them," she stated. "I keep changing my mind about the way I feel about myself. I am happy at times, and most times I am sorrowful at the idea of my father's death. He used to buy me all the good things that I asked him to buy for me," she said with tears rolling down her cheeks. "No one cares much what happens to you, come to think of it. I have people who hit me at times, for nothing; and there are some who enjoy scolding and cursing me, consistently reminding me of how ugly I am. I know I am ugly, but I do not need to be cursed and ridiculed about my ugliness every so often," she remarked. "Although my beloved father died, I have got over it, and I am generally in good spirits. This is because I have my mum with me, and we have this big seven-roomed house that dad had finished buying for us. At least mum can let out some of the rooms to tenants, and that brings income to keep us going," she said. When I asked what she misses the most since dad died, and this is what she said: "I miss toys, Barbie dolls, ice cream and meat pies. Dad used to buy us pies and ice cream a lot," she said.

Fictitious name will be Somde: (Both parents died 1997)

Somde is nine years old. He lives with his late mother's sister and husband. Somde does not go to school due to lack of school fees. He is very much aware of the fact that his parents died of HIV/AIDS. Somde said:

"I do not feel I am a person of worth, nor do I feel equal to all others. I do not have a father, nor a mother, nor a brother, nor a sister. I am just nobody," he said shaking his hands to emphasize his predicament. "Come to think of it, I tend to feel that I am a failure. I failed to help my parents to overcome death, maybe I was not good enough of a child to them that they decided to leave me behind," sobbed Somde. "I feel I do not have much to be proud of. I do not have clothes to change, nor do I have any shoes at all. I do not go to school, yet all my age mates go to school," mentioned Somde. "When I look in the mirror, I do not feel happy about myself. I hate the image of a boy wearing tattered clothes that I see in the mirror," stated Somde. "I certainly feel useless most of the times. Just the idea of being an orphan is enough to make me become useless. I cannot go to school; I do not have enough to eat. For instance, when my parents were alive, I used to eat bread. Now I have not eaten bread in eight months, but I would love to! Human nature is not really cooperative, helpful, nor kind. For instance, most people hit me for no reason, call me with sarcasm and demean me in front of other children saying that my parents died of AIDS, and displaying very cruel behavior to me," he said.

Fictitious name is Iakipuhs: Father died in 1998)

In this household, there were six orphans aged 17, 15, 12, 6, 5, and 3 years old. They live with their mother, who is the caregiver. The mother told me in private that her husband died of AIDS, and when I asked her if her children knew, she told me that it was the 17 year old girl only that knew that dad died of AIDS. The rest had no clue, and actually the five year old and the three year old children thought that dad was coming back. I was interested in interviewing Yhtac the 12 year old, but then she had no clue of what her dad died of. When I asked her what her father had died of, she mentioned that her father had died of a severe headache. I ended up interviewing Iakupuhs, the 17 year old. She was not in school due to lack of school fees. She had been sent away from school, and now she was working at as a maid. I had to go with her to the house where she was working as a housemaid, and that is where I ended up conducting my interview. Here is what she said:

"I do not feel I am a person of worth, I do not feel equal to all others. My friends go to school, and because I am an orphan, I do not go to school," she said weeping. "At first when dad died, I was extremely disappointed and sorrowful, but then reality really hit me hard when I failed to go to school after his death," mourned Iakipuhs. "I feel that I am somebody that has a number of good qualities. I used to be very good at all subjects and for sure, if dad had not died, I was definitely going to make it in the final examinations," she mentioned.
"Come to think of it, I tend to feel that I am not a failure. I am hopeful that time is still there for me to recover from this tragic loss, and probably get into self-help projects like hair dressing which my mother does in her own back yard," she stated. "I do not feel I have much to be proud of. My family is very poor, we lack money, I lack school, and I do not have a good paying job. We are helplessly poor," indicated Iakipuhs.

"On the whole, I am not satisfied with myself. Life is very hard for me, my sister lives in the rural areas with a distant relative, and my brother who is six years old is out of school due to lack of school fees," she remarked. "I do not feel useless most times. At least I am able to be innovative. When I was sent away from attending school, I decided to get employed as a housemaid, but the pay is too little. Right now I am thinking of building up the capital I get from this job, and start hair dressing," explained Iakipuhs. "No one cares much what happens to you, come to think of it. The school chased me away because I had not paid Z$165 yet the school authorities knew that my father died and we are facing economic hardships. At the same time, my mother is very ill, however, grandmother works in the city but she also would not help me with the money needed by the school in order for me to go back to school," exclaimed Iakipuhs.

Fictitious name will be Yram: Father died in 1995)

There were two orphans in this household: a boy (16) and a girl (14) whose father died in 1995 and were currently living with their mother/caregiver. I decided to interview the girl: Yram, This young girl is no longer in school due to lack of school fees. She is aware her father died of HIV/AIDS, and her story is a very moving one. Her mother is ill, and she has now assumed the role of an adult or of a parent so to speak. The family is extremely economically disadvantaged. Yram wakes up at 4 am every day and walks for an hour to a location where she orders bread for re-sale. She is one of eight people who will pull the hired persons-pull-cart that carries numerous dozens of bread. These are reject loaves of bread that they order from the bakery at reduced prices. One dozen of

reject loaves of bread is ordered for Z$38; which is re-sold by these self-made traders for Z$54 a dozen. On this particular day that I interviewed Yram had only ordered two dozen due to lack of funds to buy more. She told me that for each dozen she makes a profit of Z$16 and that is what her family of three would survive on for that particular day. With that amount, the family could buy vegetables and a few items for the day. I asked her whether there would be a lot of people who wake up that early to go and order reject loaves of bread, and according to her words; "*Jahwi chairo rinenge ririko*" which means "a great number of people," but mostly adults she added. She told me that each person pays $4 for the cart. These are the highlights of the interview:

> "I do not feel that I am a person of worth, nor do I feel equal to others. I do not have a father, and I do not have money to eat decently, and I do not go to school. Come to think of it, I tend to feel that I am a failure. I do not have sufficient sleep every day of my life because I have to wake up at 4 am every day to walk very long distances to order bread. It is a dangerous life style," she remarked. "I feel too many of my friends hate to be around someone who has a relative that died of AIDS. I have lost all my childhood friends, and they gossip behind my back or even in my presence about the death of my father and his AIDS status. Some of them run away from me saying that I might spread the virus to them," she explained with tears rolling down her cheeks. "I feel I do not have much to be proud of. People laugh at me that I do not go to school, but I am always an early bird to order reject loaves of bread for sale," Yram said crying. "On the whole, I am not satisfied with myself. I would like other people to like me, especially my peers, but they do not like me due to the AIDS stigma I carry from my father's death," she exclaimed. "I certainly feel useless most of the times. Here I am, 14 years old, and I am out of school not because I hate school, but due to circumstances beyond my control. Everyday, my heart bleeds when I see my friends wearing school uniforms and I am knocking door to door selling reject loaves of bread," sobbed Yram. "Human nature is not really cooperative, helpful, nor kind. For instance, if my family has no corn meal, sugar or maybe salt, we go and ask from neighbors, and they are all say that they do not have anything to spare. That is why I have to sell reject loaves of bread everyday so that we do not bother our neighbors who would not help anyway. On the whole, I am fairly happy. Though I am not in school, at least I have a home, and I have my mother and brother. However, I am always tired from ferried loaves of bread from long distances.

I always feel sleepy because during daytime, I am selling bread, and I have little time to rest since I wake up at 4 am every single day of the week. I cannot even go to church, all because I am trying to make our family eat and survive," Yram said with eyes glittering with pools of tears. "When my beloved father died, nobody sat down with me to talk about death, or how I should face life. When I think about his death, I get depressed and I do not know what to do. Ever since my beloved father died, I have not got over it, and I am generally in low spirits most of the time," she remarked. "I am the second born, 14 years old, and I am now the breadwinner of the family. I wish my father had not died," she sobbed. "I do not get a lot of fun out of life. Where to sleep for me is a problem. We have only one room. My mother and I sleep in the one room, while my brother has to sleep with friends in the neighborhood. I sleep on the floor, while my mother sleep on the single bed. I wish I had my own bedroom. When dad was alive, we had a six roomed house, and as soon as he died, we lost the house and the car and we had to relocate to this area where we now lodge in this one room," she mentioned weeping. "I always feel downcast, unwanted, dejected, and stigmatized. I just see myself as a low class person," she explained. "Some of the adults that I order bread with laugh at me and ask what I am working for at such a tender age that should be in school. I tell them that I am working so that my family can be able to eat just the basic food items, and for survival. At least if I can buy food items for the day, I feel thrilled to have accomplished a goal for the day. I will sure say to myself: 'Ah! Thank God, today I am going to eat, today I am not going to have an empty stomach, Oh! What a relief', she said. "Most of the time I would rather sit, daydream, and worry. I would be saying to myself that I wish I could get a better paying job that would allow me to have food as well as go to school," she said. "I guess I day dream because since we had death in our family, I lost many of my friends that I used to trust. A very tragic thing happened to me this year. I lost my best friend. She died and when she died I lost everything. All children of my age group stigmatize me from my father's death, and that only friend who liked me, died" she sobbed.

Fictitious name is Iabmiv: Father died in 1993)

There were four orphans in this household. They all live with their mother. I interviewed one of the orphans, a 12-year-old girl. She is in school. All of them live in one room where they are living as tenants. Here are some of the highlights of the interview I had with Iabmiv:

"I do not feel I am a person of worth, nor do I feel equal to all others. All my friends laugh at me because I wear an old school uniform that has a tattered collar. I certainly feel useless most of the times. I miss my father all the time. No one cares much what happens to you, come to think of it. People use curse words at me at times, referring to my father's AIDS death, and how I might spread the virus to them. On the whole, I am fairly happy. I am not extremely happy because my peers and people I consider to be my friends curse me with words like: dog, human feces, shut up your father died of AIDS, get away from us your mother is a prostitute that is why your father died of AIDS, we do not care a bit even if she hears that we are calling her a prostitute, the bottom line is you do not have a dad and we have our dads," she explained with tears rolling down her cheeks. "When my beloved father died, nobody sat down with me to talk about death, or how I should face life. When I think about his death, I get depressed and do not know what to do. For instance, if my friends demean me because of my father's AIDS death, I try to tell my mother so that she can intervene, but my mother brushes it aside and tells me that she does not listen to gossip from outside of her home. It seems my mother is in denial, and I just do not know what to do," exclaimed Iabmiv. "I do not get any fun out of life. The loss of my father eats my soul every day. By being an orphan, I can see how hard life is. I do not have nice clothes. I only have one skirt that is tattered, three blouses, and one pair of tight fitting shoes. When dad died we lost everything including our big house, and we had to relocate. This time we are lodgers, and I share the same bedroom with my mother," she said with eyes full of tears.

Fictitious name is Rehtse: Father died in 1990

Rehtse is a young girl 13 years old. Her mother re-married, and the step-father did not want this orphan to join his new family and therefore Rehtse ended up relocating to live with her (aunt) father's sister and husband, who also had their own five children living with them. Her aunt sometimes travels to England and Germany where her other sisters are. When the aunt is gone abroad, Rehtse assumes the role of caregiver: cooking, cleaning, and all household chores. All her aunt's five children are boys who do not assist in household chores at all. Rehtse's main complaint was that she felt strongly that her uncle, (father's sister's husband) did not like her at all. She said that at times, he can spend the whole day ignoring her and sending hate cues through non-verbal communication. She

did not know where to go because she stated that her new step father hated her even more. Rehtse is in school. She is in Form One/First class in high school. She said:

> "I do not feel I am a person of worth, I do not feel equal to all others. I do not have my father any more, and I have lost my mother to a stepfather who does not want me to live with my mother. The house that once belonged to us is no longer ours since dad died. I am a poor orphan without anything now," she started crying. "I feel that I am somebody that has a number of good qualities. I can clean the house, you can see how spotlessly clean this house is! I am also good at athletics at school," she said. "Come to think of it, I tend to feel that I am a failure. I wear clothes that are too torn, and school fees are always a problem ever since my father died. Most of the time, I am sent away from school due to lack of fees which is Z$165 per term," she stated. "I feel too many of my friends hate to be around someone who has a relative that died of AIDS. Once they know about it, they will ostracize you and their argument is that if your father dies of HIV/AIDS, that means your mother has HIV/AIDS, and therefore when your mother bore you, she also spread the virus to you," mentioned the 13-year-old orphan, crying. "When I look in the mirror, I do not feel happy about myself. I will start asking myself why my father had to die and live me suffering the way I do," indicated Rehtse. "On the whole, I am not satisfied with myself. The quality of life and survival means I have, are hard to describe. Lack of decent clothing, lack of shoes, lack of pocket money to buy school lunches and lack of school fees are just a few of the many problems troubling me as an orphan," she stated weeping. "I certainly feel useless most of the times. I am poor, I am an orphan, and I do not have a stable home that I call my own. At this new school that I have relocated to, I do not have a lot of friends, and to make matters worse, I do not bring any food to eat during school lunch breaks. So most of my peers avoid hanging around me because I have nothing to offer them. When others are eating, I just sit under a tree all by myself, and thinking about my poverty," she remarked. "No one cares much what happens to you, come to think of it. Like in my case, my mother seems to have forgotten all about me, and I do not really like to live here with my aunt. Most of the times when I come back from school hungry, I am told that there is nothing that I could eat until dinner time," she added. "I do not get a lot of fun out of life. Ever since my father died, I have no joy in me, and my life is very rocky, and a very heavy burden to carry," she said crying. "I always feel downcast, unwanted, dejected, and stigmatized. At school all my peers run away from me, and here at home my aunt's husband shows nothing but hatred towards me," she ended.

Fictitious name is Tsenre: Father died in 1989)

In this home there are four orphans, three boys and one girl, ages: 10, 12, 14, and 16. They all live with their mother who is the caregiver. I decided to interview one of the boys, who is 12 years old, and in the sixth grade at school. This is what Tsenre said:

> "I do not feel that I am a person of worth, I do not feel equal to all others because I have no father, yet others have. Look at those children whose fathers are alive, they have money, we do not have, they eat plenty of food, and we do not," said Tsenre. "I certainly feel useless most of the times. I do not have any books for school, and I have no text books to read for my home work," he remarked. "I always feel downcast, unwanted, dejected, and stigmatized. Our family had to relocate when my father died because we were chased away by our relatives where we used to live, they blamed my mother for spreading the virus to my father," he said with eyes glittering with tears.

Fictitious name is Aihpos: Father died in 1995)

Originally, this family came from Malawi. There are five orphans in this home who all live with their mother/ caregiver. All six sleep in one room that the grand mother (caregiver's mother) is renting out to this family. They cook using paraffin/kerosene; and the smell of it is hits your nose first as soon as you set your foot into this small room. Before their father died, they used to live in Banket, a much smaller town that is about one hundred kilometers away from this new location.

They had to relocate because the neighbors in Banket were stigmatizing and ostracizing them due to the AIDS status of the father. When he died, the friction became worse, and the situation forced them to relocate to a new place where they would hide their past history of a father who had died of HIV/AIDS. The ages of the orphans are 15, 12, 7, 5, and 2 years old. There is a glaring tension between the grandmother/landlord of the main house, and this family that lives in the little annex that is outside the main house.

Apparently, when the grandmother realized that I was not going to interview her (the landlord), but her daughter (lodger/tenant) and one of the orphans, she was very

upset and she openly said words of sarcasm and mentioned she did not understand why I would be interested in interviewing someone who symbolized prostitution by having a husband who died of HIV/AIDS. The caregiver, orphan, and I had to leave the main house, and seek a more secluded spot where we would not continue to be bombarded with the AIDS-related sarcasm from this grand mother. There were strong power conflictual issues going on between these two families. I interviewed Aihpos, the eldest 15 year old girl who is in High School and here is what she had to say:

> "I do not feel I am a person of worth, and I do not feel equal to all others who have enough to eat, when some of us always sleep on empty stomachs," she started crying. "When I look in the mirror, I do not feel happy about myself at all. As soon as I look in the mirror, many thoughts come to my mind. I look like my father, and so I see AIDS, I see death, I see my father smiling, I see my father in the coffin, I see my father talking to me, I see my father leaving me behind to suffer in this cruel world where nobody including my own grandmother hates us for being born to a father who dies of AIDS," she sobbed. "When a loved family member dies of AIDS, most people avoid talking about it and pretend it was not HIV/AIDS. Ever since we relocated from Banket, we never tell anyone that our father died of HIV/AIDS. The only person who tells people in order to hurt our feelings is my grand mother," remarked Aihpos. "As soon as people know that a family member died of HIV/AIDs, they make jokes out of your plight, they laugh at you, they become sarcastic, and very mean. If you try to join their conversation, they start making unpleasant non-verbal cues," she said. "On the whole, I am very unhappy. Most of the times at school, my peers tend to look down upon me, especially those who come from well to do families, and have their own fathers who are alive. At my school, people have cliques, and it is the orphan who is poor that is left out and marginalized. I am extremely poor, and you can imagine what goes on at school, and when I come home, I have a sarcastic grand mother, and if I need to sleep, I sleep on the floor of a tiny room that is just as good as a match box. I cannot study at home; the only place to study is school. I miss my father!" crying really loud.

After she had calmed down, I asked her what she thought she needed in life to better her state of life. She said:

"I need school fees, Z$174 per term. I need basic food, there are times I go to sleep without having eaten anything except a cup of water. I need money for lunch at school, and I need some clothes. All my clothes are either tight fitting because I have out-grown them, or there are torn and tattered," she stated.

Orphan's fictitious name is Ienit: Father died in 1997)

Ienit is a boy, 13 years of age. He knows his father died of HIV/AIDS. He also has two younger brothers. His mother is the caregiver. Here is what he highlighted:

"I do not feel I am a person of worth, I do not feel equal to all others. All my peers avoid playing with me both at school and at home. I end up playing with my younger brothers only. My peers run away from me saying that I might be carrying the deadly virus," Ienit began to cry. "Come to think of it, I tend to feel that I am a failure. I feel powerless, and there is nothing to do to improve the situation. I am always going to school without any breakfast at all, because my mother is all of a sudden very poor following dad's death. When I come back from school, I am hungry, and come supper time, the food I get is way too little to satisfy my hunger," he said. "I feel too many of my friends hate to be around someone who has a relative that died of HIV/AIDS. They claim that I might spread the virus to them; and they say these things straight in my face," he said with tears rolling down his cheeks. "I feel I do not have much to be proud of. I do not have a school uniform at all. Everyone in my class has school uniform except my brother and I. If dad did not die, we would be having school uniforms," wept Ienit. "On the whole I am satisfied with myself. At least I have my mother with me, and she is my greatest source of security," he said with a smile on his sad face. "I certainly feel useless most of the times. Lack of food is a major source of my problem, especially at school; I never have any school lunch nor snacks. When my peers sit in groups to eat, I just go to the nearest tap to drink water," he said. "No one cares much what happens to you, come to think of it. People never care about orphans," he remarked. "When a loved family member dies of AIDS, most people avoid talking about it and pretend it was not HIV/AIDS. If I tell, many will hate me, so to those who do not know anything, I will keep the secret that dad died of AIDS," he said. "Children whose parents or relatives died of AIDS tend to be ignored by many people. That is what people in this area do to me most of the time," he mentioned. "On the whole, I am very unhappy because what adults and youngsters do to me in this neighborhood is bad. For instance, they scold me and say 'Hey, your father died of HIV/AIDS, we do not want to play with you', and this happens to me a lot of

> times both at school and around this area," he sobbed, crying. "Sometimes, I get a lot of fun out of life. For example, my brothers and I go out and play football using a home made ball that I make using old plastic which I collect from garbage bins," said Ienit with eyes glittering with tears.

To sum up, I asked him what he needed in life, and he said:

> "I would like a new soccer ball, a bicycle, school uniforms, track suits, socks, and shoes. I also would like to have some fulfilling food, and to be happy at school, and at home. I would like to have more friends that would like to play with me, right now I only have four people that talk to me at school," stated Ienit.

Fictitious name is Awzdafat: (Both parents died 1993)

This was one of the most traumatic experiences I had when I introduced myself to the caregiver. As soon as she learned what my mission to her house was; she started crying before I could even sit down to ask for permission to interview any of the five orphans that were under her care. This is an old lady who is sixty six years old, and taking care of five orphans ages 11, 12, 9, 7, and 5 years old. As soon as I told her I had visited her home in relation to her care giving of orphans whose parents died of HIV/AIDS, she re-lived the funerals of her son and daughter-in-law, and the crying was nerve chilling. She told me her husband died in a car accident twenty years ago, and she was responsible for the upbringing of her children, and now two of them died of HIV/AIDS, and she is starting all over again to take care of young ones left behind by her sons. She told me the burden of caregiving that she is carrying is enormous, and frustrating. After some deliberations, I then had the chance to interview one of the five orphans; 11 years old Awzdafat, and here are some of the interview highlights:

> "I am not a person of worth, I do not feel equal to others who have their parents. The person who cares for me is grandmother. I have some things to be proud of. For instance, school. I am very good both in class, and out-of-class school activities. When I look in the mirror, I feel happy about myself. I am pretty. I certainly feel useless at times. Some of my peers use curse words at me at times,

and use sarcasm like: 'No wonder your dad died of HIV/AIDS'. That really hurts my feelings because I loved my dad dearly, however, I become powerless when such things are said about him because that is the truth. He died of AIDS," Awzdafat said. "When a loved family member dies of AIDS, most people avoid talking about it and pretend it was not HIV/AIDS. They do not want people to know the truth, and be ostracized," she stated.

Fictitious name is Adnelra: (Father died in 1997)

This orphan is 7 years old, and she lives with her mother. She is in the second grade at school. Here are some of the interview highlights:

"I do not feel I am a person of worth, I do not feel equal to all others. My friends whose fathers are alive have a lot of toys to play with. I do not have a single toy, nor do I have a school bag for my books. I use old plastic bags to carry books," she said. "Come to think of it, I tend to think I am a failure. Life for me is just too hard to bear," Adnelra stated. "I feel too many of my friends hate to be around someone who has a relative that died of HIV/AIDS. They say that if my father died of HIV/AIDS, I should be carrying the virus, which I might spread to them. I heard this from my friends that I sometimes play with," she remarked. "I feel I do not have much to be proud of. I have nothing," Adnelra indicated. "When I look in the mirror, I do not feel happy about myself. I hate the rugged, tight fitting clothes that I see in the mirror, and I also hate that person wearing them," said Adnelra. "On the whole, I am satisfied with myself. I enjoy school," remarked Adnelra. "No one cares much what happens to you, come to think of it. Most of my friends are mean to me," stated Adnelra. "Human nature is not really cooperative, helpful, and kind. Many people that I know are mean, cruel, and stigmatize orphans whose parents died of HIV/AIDS. For instance, I get pushed around and at times get beaten up if I try to argue that it is none of their business that my father died of HIV/AIDS," she said. "When a loved family member dies of HIV/AIDS, most people avoid talking about it and pretend it was not HIV/AIDS. They will go about spreading rumors in the whole neighborhood, and consequently no one will want to play with you," she indicated. "Most of the time I would rather sit, daydream, and worry. I would be missing my father. He loved me very much, and he would buy me anything that I requested. If he were alive today, I would be having my own toys and a school bag," she said.

Fictitious name: Edialeda: (Father died in 1997)

There are five orphans in this household. I chose to interview the 5-year-old girl. The mother is the caregiver. Here are some of the interview highlights:

> "I do not feel I am a person of worth, I do not feel equal to all others. Those children whose fathers are alive dress well, I do not," she stated. "I feel I do not have much to be proud of. I need pretty lacy dresses, jeans, and a cap to go with the jeans. I wish my dad were alive; he would buy me those clothes! I always feel downcast, unwanted, dejected, and stigmatized. The other children are mean at me at times. They say: 'Get lost, you are too dark skinned and besides, your dad died of HIV/AIDS'. When they say this to me, I start to cry, and go home to tell my mother," Edialeda pointed out.

Fictitious name is Rettam On: (Mother died 1998)

In this household, there were four orphans aged 11, 13, 15, and 18 years old. At the time of the interview, these orphans had just lost their mother to AIDS. Apparently, all these children had never seen their father, and so when their mother died, they relocated from the rural areas they used to live with their mother, to come and join their mother's brother who had his own three young children and a wife to support. All these children were not in school, and the 18 year old was not present; in search of a job in the bigger Harare Metropolitan city. Before their mother died, the children were in school due to lack of school fees. I decided to interview 13 year old, Rettam On. She said:

> "Come to think of it, I tend to feel that I am a failure. I do not have parents, my mum never told me where or who my dad is before she died," she said tearfully. "When I look in the mirror, I ask myself if I am a person or an animal. I just see myself as an animal. On the whole, I am not satisfied with myself. Life is very hard for me, I have no place to sleep, I do not have enough to eat, and I end up begging for food from neighbors, who end up looking down upon me. Begging is something I hate to do, it makes me lose my dignity," she said crying. "I certainly feel useless most of the times. Life is a struggle for me through and through, when mum was ill it was hard, and now after she is dead, life is like living hell for me. I wish I could feel happy about myself. I am no longer going to school, I do not have decent dresses to wear, I always never have enough to

eat, and where I sleep is like a dog sleeping area. When I complain about the condition to my aunt and uncle, I am told to pack and go some place else, yet I do not have any other relative I know in this area, nor do I have any money to ride a bus and go back to rural areas where my other distant relatives are. Since death occurred in our family, I have noticed that my ideas about myself seem to change very quickly. At least when mum was alive we could eat. Now it is hard even to get enough to eat. Some days I have a very good opinion of myself; other days I have a very poor opinion of myself. I ask God why He allowed that I should lose my mother, why me? No one cares much what happens to you, come to think of it. For instance my uncle works in the public bar to wash dishes, he owns this house, however, he never helps us out with money for school fees. He does not care about us a bit," she exclaimed. "Human nature is not really cooperative, helpful, nor kind. I am not experiencing anything positive from humans, and I just see everybody as unkind and never helpful. When a loved family member dies of AIDS, most people avoid talking about it, and pretend it was not HIV/AIDS. This is because people will laugh at you, or they will go about spreading the word around, and you end up getting stigmatized. Most people say any person who dies of HIV/AIDS is a dead prostitute," she remarked. "On the whole, I am very unhappy. Other children especially big boys, physically abuse me by hitting or kicking me, telling me that I am a daughter of a dead prostitute I should not walk near them or play with them," she said weeping. "I am extremely sensitive to criticism. Most of the time, I am treated like I am a dog, or a worthless creature that is sub-human. When my beloved mother died, nobody sat down with me to talk about death, or how I should face life. When I think about their death, I get depressed, and do not know what to do. Actually, I get mad at my dead mother at times, why did she never want to tell us who our dad is, nor his name? Probably right now we would be with him. I hate to live here where nobody likes us including uncle and aunt. I do not get a lot of fun out of life. How can I, when my peers tell me that they do not want to play with someone whose mother died of HIV/AIDS?" she wept.

Fictitious name is Eiggam: (Both parents died 1997)

There were four orphans in this household who were aged 8, 9, 10, and 11 years old. The 8 year old had her own father who died in 1996 when the mother died. The other three children had the same mother with Eiggam, but with a different father who died 1991. The four orphans had to relocate to come and live with their elder mother's

sister, who is single, never been married, and had no children of her own. They all lived in a one room, and they used outdoor cooking most of the times. The landlord had a large house that he let out to families. This was a very unique situation, in the sense that it involved one woman and two successive husbands dying, and leaving behind two sets of orphans from the same mother but different fathers, all dying of the same cause. Sooner or later, I learned that these four orphans had cliques within their group. Those three siblings from the same father teamed against the 8 year old Eiggam, who ended up getting ostracized form within her immediate family, and from without. I decided to interview Eiggam, and here is what she had to say:

> "I do not feel I am a person of worth, I do not feel equal to all others. I do not have enough food to eat, and I do not have school fees," she stated. "Come to think of it, I tend to feel that I am a failure. My half sisters and brother are always chasing me away from them and they tell me that it is my dad's HIV/AIDS that killed our mother. If I decide to play on my own, they come to snatch from me the ball or any item I am playing with," she added. "I feel too many of my friends hate to be around someone who has a relative that died of AIDS. Like in this neighborhood, my peers team up against me, and at times they beat me up, telling me to get away from them," she remarked. "I feel I do not have much to be proud of. I do not have nice clothes, nor do I have a school bag," she said. "When I look in the mirror, I do not feel happy about myself. I feel very sad because I start missing my mum. I see the face of my mother when I look in the mirror because my face looks like hers. Usually I avoid looking in the mirror," she said sadly. "On the whole, I am not satisfied with myself. I am always without friends because they run away from me or if I try to join them, they chase me away from them. My own half siblings are the worst. They resent me and are always cursing me and accusing my dead father of having spread HIV/AIDS to my mother. Who knows, maybe it is their father who spread it first to my mother before he died, and maybe when mum got remarried to my father, she had already acquired the deadly virus from her previous marriage, and who knows? Maybe she is the one who could have spread it to my own father. However, I dare not say it to my half siblings! They would skin me alive!" she remarked.
> "I certainly feel useless most of the times. I am always lacking enough food to eat, and I lack friends, I do not have school fees, nor do I have a school bag, and I miss my mother and my father," she said emotionally. "No one cares much what happens to you, come to

> think of it. Nobody likes me, and my siblings are always beating me up if I get near them. They are all very cruel to me', she said. "My care-giver/ aunt who is supposed to protect me I assume, beats me up at times with a branch from that tree right there," she exclaimed.

SUMMARY

Understanding the orphans' feelings and concerns provides a basis for creating effective home-neighborhood-school-community relationships. Positive self-esteem in orphans should be enhanced through sustained counseling, a non-threatening school environment, safe and secure neighborhoods, and a re-assuring family atmosphere, all void of HIV/AIDS stigmatization. The chapter that follows is a discussion pertaining to the research results.

Chapter 5

DISCUSSION OF FINDINGS

This chapter is a discussion of the research results, and it is divided into sections and sub-sections. The first section is a discussion relating to the kinship caregivers' economic status, social support networks, and child-rearing practices. The second section contains a discussion relating to the orphans' and the non-orphans' self-esteem. The response to each research question is divided into three areas of evidence: (a) the description of results, (b) the illustrations of possible answers from the data, and (c) the supporting literature. The last section is the conclusion.

Sub-question on Kinship Caregivers' Economic Status

What is the kinship caregiver's economic status?

Both orphans and kinship caregivers interviewed were from a very low economic status (Appendix J). Of the kinship caregivers interviewed, 100% were not attending school, and two thirds of the kinship caregivers were single parents (Appendix G), and of the orphans interviewed, 60% were not in school. Asked whether the household had electricity, radio, television, or refrigerator, 56% of orphans and caregivers said yes, and 44% said no. Regarding radios in the home, 50% did not have them. For television sets, 44% had televisions, and 56% did not. Finally, 22% had refrigerators, while 78% did not.

On the question of rooms used by household, of the orphans and caregivers interviewed, 13 households used one room, ten households used two rooms, 15

households used three rooms, seven households used four, six households used two, and only one household had seven rooms. The same findings revealed that from the sample of kinship caregivers interviewed, 26% of orphans and kinship caregivers used one room as the kitchen, dining room, bedroom, and lounge, while 20% had only two rooms, and 30% had three rooms. Only 2% had seven rooms. If one has to compare the standard of living between the "haves" and "have-nots" in Zimbabwe, this group of the population shows extreme poverty. Definitely both local and international interventions are critical.

Poverty (Macro-systems Influences)

According to Duncan (1984), poverty refers to a condition in which income of an individual or family falls short of the amount needed for food, shelter, and other necessities, as estimated by the U.S. government. The U. S. government defines a person as living in poverty if his or her cash income from all sources is less than three times the cost of an adequate diet.

Poverty is an endearing predicament for many of the children that are affected by parental deaths due to HIV/AIDS. Where poverty exists, so too does the likelihood that these families are or become single-parent families with the mother being typically the primary caregiver of these children before her death. In Zimbabwe, the target sample interviewed stated that poverty, single-parenthood, and kinship care-giving of orphans was a burden, and had a negative impact on self-esteem (Chigubu, 1998).

Other research has focused on the effects of families' economic prospects on parents' or caregivers' child rearing practices. According to Conger *et al.* (1984), the lack

of economic resources has an adverse effect on parents' or caregivers' relations with their children, and has been linked to diminished emotional support and harsh parenting. Finally, research clearly shows that poor children are more likely to drop out of school than their more advantaged peers. Studies have consistently revealed the relationship between the number of poor students in a district and the number of school dropouts (Coles, 1971).

Research Sub-question Relating to Economic Status

What are caregivers' coping mechanisms to combat poverty?

The study reveals that caregivers had income generating projects. However, it was unfortunate to find that some orphans were not going to school in order to work and bring in income for survival. (Chapter 4, Kinship Caregiver No. 24). It was encouraging to see that even if kinship caregivers were very poor, they still managed to be innovative and generate some income generating projects for survival.

What was discouraging was that some orphans had dropped out of school, in order to participate in income generating projects for survival. The poverty on the sample of orphans whose parents died of HIV/AIDS, and kinship caregivers interviewed in Zimbabwe 1998, is pervasive and endemic.

Sub-question on Caregivers' Social Support Networks

What are the major sources of social support networks, and resource allocations?

Findings reveal that instead of obtaining social support, 99% of kinship caregivers interviewed cited in-laws as a source of stress, while 1% stated in-laws were a source of

social support. On the question of friends, about 90% of kinship caregivers interviewed reported that friends became fewer when orphans from parents who died of AIDS joined them, and 10% cited friends as a source of social support. Regarding neighbors, 99% caregivers stated that neighbors constituted either subtle or open stigmatization to orphans whose parents died of AIDS, and hence, neighbors did not provide social support. When asked about social support that could be associated with recreation, 100% cited that money was their number one problem; therefore they never had recreation or social support networks associated with recreation.

Both orphans and kinship caregivers indicated that there was nobody that provided social support besides family members. When asked about availability of social support, 80% of orphans interviewed stated that no one cares much what happens to you, come to think of it, and 96% of non-orphans agreed to that statement, which clearly indicates that no one provides substantial social support networks. When asked if the kinship caregivers ever had the problem of lacking food to cook for their children, family, and especially orphans joining in uninvited, 96% of the kinship caregivers interviewed, said "Yes, they had huge problems."

Regarding church, one third of those interviewed cited the church as a source of social support, and the other two thirds said that by orphans joining them, attendance or strong participation in church dropped due to poverty, lack of church offerings, and peer stigmatization of HIV/AIDS.

Commenting on social welfare agencies, about 99% of kinship caregivers interviewed stated that they did not get social support from social welfare agencies.

Regarding schools, 100% of the caregivers interviewed said they did not get substantial social support from these institutions.

Based on the results provided, the situation about social support networks seems bleak for kinship caregivers taking care of both orphans and non-orphans. HIV/AIDS stigmatization and denial does seem to contribute to the problem. There is a strong body of evidence that suggests that economic hardship has a negative influence on individuals' psychological functioning and on the quality of family relationships (Conger *et al.*, 1994; Conger *et al.*, 1992; Lempers, Clark-Lempers, & Simons, 1989).

As noted in (Chapter 4), the data collected from the kinship caregivers strongly support that when orphans whose parents died of HIV/AIDS join the extended families, social support networks decrease dramatically, and stigmatization worsens the situation in many cases. Further, the study results show that there are differences in social support networks available to non-orphans and orphans of parental HIV/AIDS. Data showed that the mutual dependency of kinship caregivers' and orphans' parental HIV/AIDS stigma was a key dynamic in the absence or shrinking numbers of social support networks available to the extended families that were joined by orphans. The report shows support networks existed before orphans joined. Social support networks that caregivers/parents find supportive may provide a protective buffer for vulnerable children and families (Baumrind, 1995). Further, well-organized neighborhoods with caring neighbors who show respect for each other appear to buffer the effects of poverty (Garbarino & Sherman, 1980). Clear differences exist in kinship care-giving resource allocations for non-orphans and orphans. The report in Chapter 4 indicates that 60% of orphans interviewed indicated they were not in school, and 100% of non-orphans interviewed were in school.

When their parents die, the migration that the orphans undertake in search of extended family members, places them in a very vulnerable position that leads some of them to lose their schooling. Those orphans who often relocate are likely to lose birth certificates, and without birth certificates, most heads of schools will not give that child a place for schooling. All orphans interviewed indicated that they did not inherit any wealth from their dead parent(s), and when they joined the extended families, they were poverty stricken. In most cases, these orphans ended up not going to school. Lack of school among orphans is a demeaning social indicator of poverty, a phenomenon that has long-term disastrous impact on these children's development.

In addition to this, lack of schooling symbolizes economic hardship and poverty. This may adversely affect children's self-esteem as well as their socio-emotional functioning abilities by increasing their exposure to demeaning, humiliating, and otherwise negative treatment precipitated by the stigmas of this economic hardship. Economically impoverished people contend with stigmatizing living conditions and circumstances that mark or symbolize their membership in the category of the poor (Taylor, 1997).

Sub-question on Caregivers' Social Support Networks in Relation to Orphans and HIV/AIDS Stigmatization:

Is there stigmatization of HIV/AIDS orphans from friends, neighbors, school, and the community? Did orphans lose friends when parents died of HIV/AIDS?

When asked by Chigubu (1998) if friends hated playing with orphans whose parents died of HIV/AIDS, 92% of orphans and 96% non-orphans interviewed strongly agreed that friends hated to play with orphans whose parents died of HIV/AIDS; which

clearly indicates that stigmatization by friends of orphans whose parents died of HIV/AIDS is rampant. Further, these findings clearly show that orphans lose friends when parents died of HIV/AIDS. When asked what happened when a family member died of HIV/AIDS in their neighborhood, 94% of orphans and 98% non-orphans interviewed stated that most people deny and pretend it was not HIV/AIDS. This clearly indicates that there is neighborhood stigmatization of orphans whose parents died of HIV/AIDS (Chigubu, 1998)

Concerning the school and community, the researcher asked questions regarding stigmatization of HIV/AIDS. Of the orphans interviewed, 86% stated that they often felt downcast, unwanted, stigmatized, dejected, and ostracized. When the same question was given to non-orphans, nobody stated that they ever felt downcast, unwanted, stigmatized, dejected, and ostracized; which clearly indicates that both school and the community stigmatizes an orphan whose parents died of HIV/AIDS.

Working from a developmental model, Bronfenbrenner (1979); Gruendel and Anderson (1995); and Chigubu (2000) discuss the importance of friends, neighbors, school, and the community in helping orphaned children recover the loss of their parent(s) from HIV/AIDS. They explored the existing research, which indicates that there are three main factors contributing to children's capability to achieve social, cognitive competence, and school success after a parent(s)' death. These are: a) the manner in which the orphan approaches the challenges, b) the nature of the child's experience within the extended family, and c) the external supports which exist for the child.

Peers (Micro-systems Level)

Indeed poverty has been linked with problems in peer relations (Langner *et al.*, 1992), depression (Gibbs, 1986), somatic symptoms (McLoyd, 1990), and conduct disorders as well as social maladaptation and psychological disorders (Kellam, Ensminger, & Turner, 1977; Myers & King, 1983).

Apfel and Telingator (1995) suggest that a connection with peers who have undergone similar experiences may help in overcoming the developmental delays which may result from the traumas of losing parent(s) to HIV/AIDS. Hudis (USA, 1995) and Chigubu (Africa, 1998) studies discovered that the loss of a parent to HIV/AIDS resulted in isolation from friends and delinquent behavior. Evidently, such children require support not only on a micro level, but also from outside resources, including relationships that are linked to the school and community systems, in order to buffer some of the potential negative outcomes of this experience.

School (Meso-systems Level)

In terms of linking the child with the school system, the stigma of HIV/AIDS warrants a cautionary approach in suggesting what person within the school system should know about the cause of the child's parents' death. However, due to the intensity of HIV/AIDS stigma, it would be important for someone at the school to be aware of the child's situation in order to provide an important supportive link with the changing situation going on within the extended family.

Neighborhood (Exo-systems Influences)

According to Garbarino, Galambos, Plantz, and Kostelny (1992), the neighborhood plays a very important part in determining the safety of the developing child. It is true that children who continue to live in the same neighborhood after the death of their parents would have a sense of familiarity with their surroundings and the ability to have access to persons who provided them support before and during their parents' illnesses. Unfortunately, the opposite is taking place in Zimbabwe. Orphans have become persistent migratory victims of the HIV/AIDS epidemic.

Sub-question on Caregivers' Social Support Networks in Relation to Orphans' Mental/physical Health:

After the death of the parent(s), are there any physical and mental health problems that have occurred to the orphans and been left unattended due to diminished social support networks?

The study report indicates some orphans had acquired mental health problems after their parent(s) died, and experienced a lack of social support networks to provide solace and counseling (Chapter 4). During the interviews, here is what one of the mentally challenged orphans had to say when asked if he trusted anybody:

> I do not trust anybody, because human beings are bad, except Bill Clinton. I want to go and see Bill Clinton and Tony Blair. These guys are good. But, tell me, why did Bill Clinton avoid coming to Zimbabwe when he was scheduled to come visit us during his 1998 Africa tour? (Orphaned 14-year old boy in Zimbabwe, interviewed by Chigubu (1998).

Upon asking the kinship caregiver how long ago the mental illness had occurred, she stated that it had been going on for the last two months. However, the young boy had not been taken to the hospital at the time of the interview. Asked why the kinship caregiver had not taken any steps to have the young orphan receive medical treatment for his challenged mental health, here is what she had to say:

> "The young boy's parent(s) died of HIV/AIDS, and towards their last days, both of them became mentally ill. That is exactly what is happening to this boy. I am sure that is HIV/AIDS. After all, there is no cure for HIV/AIDS, so why waste time taking him to the hospital when it is obvious that his mental illness resembles what killed his parents who died of HIV/AIDS," she said.

Adversity that is chronic, rather than discrete, may also exact a toll on children's mental health (Taylor, 1997). McLoyd (1990) has argued that among some of the factors responsible for the elevated mental health problems in the poor are the large number of frustrating, unremitting succession negative life events like illness, death, forced child migration, and poverty-stricken conditions that are beyond one's control.

As long as denial to openly discuss HIV/AIDS with orphans, lack of counseling of the bereaved, and societal stigmatization of HIV/AIDS exists, social support networks for orphans that promote child survival in Zimbabwe will continue to be stifled. Failure to deal with stigma and denial ultimately weakens neighborhood and family cohesion.

Research Sub-question on Child Rearing Practices:

How does the caregiver child rearing practices for orphans differ from non-orphan children?

Differences in Child Rearing Practices

As noted Chapter 4, the data strongly suggest that the child rearing practices results of kinship caregivers towards the orphans were different from those towards non-orphans. When it came to revealing the status of the orphans' parents, some caregivers resorted to hiding truths about orphans' parental AIDS from orphans and not to non-orphans, mostly due to the impact of the stigma attached to AIDS (Chigubu's 1998 findings: Table 4.1).

Of the kinship caregivers interviewed, 80% indicated that caring for orphans is a great responsibility, and eight% stated that if the culture provided a choice, the kinship caregivers would never choose to take care of orphans whose parents died of HIV/AIDS. Only 12% stated that caring for orphans is a great joy, compared to 100% of kinship caregivers, who stated that it was a great joy for them to take care of non-orphans or their own children.

The report findings reveal that 60% of orphans interviewed were not in school, compared to 100% interviewed non-orphans who were in school. This phenomenon was related to the caregivers' child rearing practices. In most cases, the caregivers did not have school fees for the orphans. This meant that while non-orphans were being treated as young children who had to wear a clean school uniform, carry a packed lunch for school, do homework, and all that is appropriate for growing school children, the orphans received different treatment. They did not have resources to go to school, nor to buy

school uniforms. Rather, in a desperate way to combat poverty, these orphans ended up selling vegetables and fruits under the guidance of those kinship caregivers who could not afford to get school fees and the school levies to send the orphans to school.

It is important to note that poverty is a major determining factor for most of what is happening currently in Zimbabwe as regards child rearing practices. When orphans continue to join their relatives, who face severe economic hardships even without them, there are bound to be discrepancies in the child rearing practices applied to these unwanted children. Further, the HIV/AIDS stigma has ripped apart family institutions, and this has had a very negative impact on the child rearing practices applied to orphans versus non-orphans. The reality of orphans assuming adult roles of selling vegetables and fruits, at the expense of schooling, is cause for concern.

Documented evidence indicates that in many cases the lives of young, poor children separated from their parents by death, may be conditioned by either a lack of educational resources, or by the excessive burden of responsibilities that a kinship caregiver or guardian may impose on the child. This is said to negatively impact and lead the orphan to become what is known as the "parental child" (Winn, 1984, p. 146). A number of psychotherapists have pointed out that this dysfunction involves a premature assumption of responsibilities, which, paradoxically, may lead to problems in fulfilling, or even in undertaking, the parenting role when these orphans become themselves adults, due to what is termed saturation effect (Dreman, 1997).

Similarities in Child Rearing Practices

Similarities in kinship caregivers' child rearing practices given to both orphans and non-orphans also existed in several areas. For instance, when the kinship caregivers were asked at what age they felt comfortable to discuss HIV/AIDS with the children under their care, 68% stated that they were not comfortable in discussing sex education with either their orphan or non-orphan children.

When asked if they gave any counseling to bereaved young children, 100% of the kinship caregivers interviewed stated that they never provided psychological nor emotional counseling to their non-orphan, or orphan children. Further, when the same question was asked of the non-orphan or orphan children, 96% of orphans and 100% of non-orphans interviewed stated that when their beloved relative(s) died, no one talked to them about death, or how they should face life following their loss. When they thought about their relative(s)' deaths, they said they got depressed and they did not know what to do about these feelings.

The kinship caregivers taking care of orphans whose parents died of HIV/AIDS are going through a difficult change in the ways they take care of children. These are women who grew up without facing any epidemic of HIV/AIDS; they never experienced such great numbers of funerals in their lives until the advent of HIV/AIDS; and they never received any training on counseling the bereaved or the emotionally traumatized. Most of these young orphans are experiencing what we term Post Traumatic Stress Disorder, survivor guilt disorder syndrome, grief, anger and many others that are shown in Appendix E. Zimbabwe and all sub-Saharan Africa shares this problem, hence there is a need to train the kinship caregivers.

According to Berns (1993), counseling services help in emotional maladjustment problems such as lack of communication between parents and teenagers. Similarly, this researcher contends that the same principles apply to Zimbabwe's kinship caregivers and orphans, or parents and biological children when a beloved relative dies, and adults ignore sitting down to counsel the growing children. The purpose of counseling bereaved young children should be to preserve a healthy family life, that in turn aids family members to achieve harmonious relationships. Lack of counseling bereaved children when a beloved relative dies in a family is likely to trigger problems that threaten the stability of family life, children's emotional and psychological growth, and community interaction. Community interaction in the era of HIV/AIDS is also an important factor in development, as the developmental potential of a setting, in this case the community, is enhanced as a function of the number of its supportive links with other settings the child might be in, such as the neighborhood, school, or extended family (Bronfenbrenner, 1979).

Research Sub-question on Child Rearing Practices

What are the kinship caregivers' child rearing practices in relation to orphans? Authoritarian? Permissive? Warm? Cold? Indifferent?

The study shows four different categories that were unique to kinship caregivers of orphans whose parents died of HIV/AIDS (Chigubu's 1998 Findings, Table 4.1). Due to the elements of HIV/AIDS stigmatization, denial, and poverty, it was hard to classify the kinship caregivers' child rearing practices as authoritarian, permissive, controlling, warm, cold, or indifferent. The fact that these kinship caregivers did not grow up during the era of HIV/AIDS and were not trained to deal with such a catastrophe, it became evident

during research that to obtain a true picture regarding the above question was somewhat problematic and misleading.

Research Sub-question on Child-rearing Practices

Are the orphans in denial, or do they have the knowledge of what their parent(s) died of?

Based on the research findings in Chapter 4, several of the orphans under the care of some kinship caregivers did not genuinely know that their parents died of HIV/AIDS. One orphan who had never been told that her mother and father died of HIV/AIDS stated:

> Mum died of swelling feet in 1996. In 1997, dad died of headache (Orphan in Zimbabwe, 1998).

In a nation that has been devastated by HIV/AIDS denial and stigmatization, most orphans will not have anyone to tell them openly that their parents died of HIV/AIDS. However, through gossip and eavesdropping, some of the orphans will soon know, and in that case, it is hard to tell if a child is in denial, or is totally ignorant. The stigma attached to HIV/AIDS is said to have a developmental impact on children (Nagler, Adnopoz, and Forsyth (1995) and Chigubu (1998) because it is typically associated with prostitution, homosexuality, intravenous drug use, and behaviors that are marginalized as well as rejected by both the local and global community.

Research Sub-question on Child-rearing Practices

What is the interaction between the orphans and the kinship caregivers?

Are there any adjustment joys or stresses?

The interaction between orphans and the kinship caregivers is affected by multifaceted problems and joys. Most caregivers' interaction with the orphans seemed to be very genuine and challenging. Of caregivers interviewed, 80% stated that caring for orphans is a heavy burden to bear, and only 12% stated that it was a great joy, while eight% said that if they could make a choice, they would never choose to take care of orphans whose parents died of HIV/AIDS. Of the orphans interviewed, 96% stated that children whose parents died of HIV/AIDS tend to be ignored. These two findings reveal the level of joy and stress existing between orphans and caregivers.

Research (Solomon & Marx, 1995; Chigubu, 1998); indicates that as the kinship caregivers adjust to the new situation, they are faced with anger, ambivalence towards the children's parents, and sometimes towards the children themselves. Consequently, some kinship caregivers will experience stress, heightened illness, depression, alcohol use, and a decline in or lack of both instrumental and emotional support.

Research Sub-question on Child-rearing Practices

Does the kinship caregiver discuss HIV/AIDS with orphans?

Did the orphans receive counseling after their parents died of HIV/AIDS?

As these were kinship caregivers of orphans whose parents died of HIV/AIDS, it was very important to ask questions regarding HIV/AIDS. Chigubu (1998) asked: "Are you a kinship caregiver who has fears of how HIV/AIDS disease was spread to the orphan(s)' parents?" Of the kinship caregivers interviewed, 82% said, "Yes" (Appendix

H). Further, the kinship caregivers were asked this question: "Are you a caregiver who lacks knowledge about how HIV/AIDS is spread?" (Chigubu, 1998). Of the kinship caregivers interviewed, 60% said they lacked knowledge about how HIV/AIDS is spread. When asked this question: "... do you feel comfortable to talk about sex education, HIV/AIDS, or death as a result of HIV/AIDS?", of the kinship caregivers interviewed, 68% stated that they were never comfortable with sex education, HIV/AIDS, nor death as a result of HIV/AIDS. On the question of counseling, 94% of kinship caregivers interviewed stated that when the orphan(s)' parent(s) died of HIV/AIDS, the children did not receive any counseling regarding their parent(s)' death. Emotional strain is basically felt to be one of the most prevalent and difficult aspects of kinship care-giving to deal with (Cantor, 1983; Horowitz, 1985). Literature suggests that kinship caregivers of elderly, orphans, or sick children experience considerable psychiatric morbidity, such as depression, demoralization, anger, and anxiety (Baillie *et al.*, 1988; Barusch, 1988; Fengler & Goodrich, 1979; Gallagher *et al*, 1989; Haley *et al.*, 1987; Jones & Vetter, 1984).

One study (Erkberg, 1986) has found that care-giving spouses manifest symptoms of burnout in its first two stages (emotional and physical exhaustion; resentment, negativism, and cynicism). In the Zimbabwe study, (Chigubu, 1998) kinship caregivers categorically made it clear that the predominant culture and traditions hindered them from discussing sex education and HIV/AIDS with the young children under their care. Further, most kinship caregivers did not have the counseling skills to impart information to orphans whose parents died of HIV/AIDS, and felt helpless in discussing HIV/AIDS with

the orphans, which in turn was a negative that obviously elevated kinship caregiver stress. psychiatric depressive disorders, demoralization, and a "wearing out" over time.

Results of Self-Esteem of Orphans and Non-Orphans

The self-esteem results (Appendix I) reveal that the self-esteem of the orphans was conspicuously low (Chigubu, 1998). When this researcher asked if they had positive feelings of self-worth and equality, of the 50 orphans interviewed only 18% had positive feelings about themselves. On the other hand, 96% of 50 non-orphans interviewed had positive feelings about themselves. Of the orphans interviewed, 78% stated that they had a tendency to feel that they are a failure, while 20% of non-orphans indicated that they had a tendency to feel that they are a failure. Regarding feelings of not having much to be proud of, 72% of orphans and 68% of non-orphans reported they did not have much to be proud of.

This researcher asked the children being interviewed to look in the mirror and comment on how they felt about the person they saw in the mirror. Of the orphans interviewed, 60% stated that they did not feel happy about themselves. One orphan stated: "I feel like a dog." On the other hand, 98% of the non-orphans interviewed stated that they felt happy about themselves when they looked in the mirror. Regarding feeling satisfied with self, 42% of orphans and 100% of non-orphans felt satisfied with themselves. Further, of the orphans interviewed, 88% stated that they certainly felt useless at times, while 6% of the non-orphans interviewed indicated that they also certainly felt useless at times. As regards fluctuating feelings of good and poor self-opinion, 86% of the orphans interviewed stated that some days they have a good self-

opinion, but other days they have a very poor self-opinion. On the same item, 20% of non-orphans agreed with that statement.

Of the orphans interviewed, 30% stated that they got a lot of fun out of life. On the other hand, 94% of non-orphans agreed that they got a lot of fun out of life. When further asked about worrying, 86% of orphans and only 6% of non-orphans interviewed stated that most of the time they would rather daydream, sit, and worry. Regarding feelings of having lost trustworthy friends since death occurred in the family, 88% of orphans and 2% of non-orphans interviewed stated that they daydream because ever since death occurred in the family, they lost friends they trusted. This researcher is of the opinion that when parents die of HIV/AIDS in Africa, the orphans relocate in search of willing relatives, and by so doing, these young children lose their friends. If they do not relocate, still they lose peers due to parental HIV/AIDS stigmatization.

This researcher went on further to ask: "On the whole, are you happy?" Of the orphans interviewed, 44% of orphans stated that they were happy; while 96% of non-orphans indicated that they were happy. From this finding, this researcher is of the opinion that to become an orphan from parental HIV/AIDS is synonymous to being sorrowful and unhappy.

When asked about feelings of having good qualities, 79% of orphans and 100% of non-orphans interviewed stated that they have feelings of having good qualities. Upon analyzing this item, this researcher is of the opinion that orphans, irrespective of the low self-esteem, do value the good qualities that they have.

However, when asked about stigmatization, 86% of the orphans and 0% of non-orphans interviewed stated that they often felt downcast, unwanted, stigmatized, dejected,

and ostracized. This finding clearly indicates that the orphans whose parents die of HIV/AIDS are experiencing serious problems regarding stigmatization from parental HIV/AIDS.

Of the orphans interviewed, 98% of orphans stated that children whose parents die of HIV/AIDS tend to be ignored. When asked the same question, 86% of non-orphans interviewed agreed with the orphans. This finding reveals that young children in Zimbabwe, irrespective of being orphaned or not, feel HIV/AIDS has a stigma attached to it, and that orphans whose parents die of HIV/AIDS are ignored by society.

When asked about happiness, 96% of orphans and 96% of non-orphans interviewed stated that they wished that they could feel happy about themselves. This finding reveals that although the orphans have a low self-esteem, they wish for happiness like all the other children around them. Overall, these research findings reveal the prevalence of negative low esteem among orphans from parental HIV/AIDS. In Zimbabwe and the rest of Africa, self-esteem is an area that has not received a great deal of attention in the informal, non-formal, and formal educational settings. Further, there is a critical shortage of skilled personnel qualified to respond to problems regarding low self-esteem experienced by orphans whose parents died of HIV/AIDS. This is a challenge that Africa will have to face now and in many years to come for as long as there is no cure for HIV/AIDS.

Friends in Recovery (1989) state that during childhood, if parent(s) die, the anger of losing parent(s) in children becomes a major source of problems, many of which are toxic to self-esteem. Most orphans are said to feel repressed, and for those who end up in chaotic homes, they feel denied of their anger, and to be safe, they push away their

feelings. Denying anger or repressing it can result in resentment, self-pity, stress/pressure, anxiety, depression, acting out, rebellion, withdrawal, and sadness.

It is documented that orphans will have a fear of abandonment from the existing parent(s) or caregiver(s) (Friends in Recovery, 1987). Fear of abandonment may result in orphans feeling insecure, becoming people-pleasers (which can lead to sexual exploitation), becoming co-dependent, worrying excessively, feeling guilty when standing up for themselves, suffering from survivor guilt disorder syndrome, and many others illustrated in Appendix E.

In terms of self-esteem, this researcher's earlier work indicates that childhood low self-esteem can cause family problems (Chigubu, 1998). When orphans hold themselves in low esteem, it affects their abilities to set and achieve goals. They become fearful of making mistakes, strive to become perfect, become non-assertive, fear failure, appear incompetent, fear rejection, isolate from others, and have a negative self-image. As one of the orphans in Zimbabwe stated: "When I look at myself in the mirror, I think of an ugly bulldog, that no child nor adult wants to be around."

Similarities between orphans and non-orphans were revealed on the following two items: (a) "feelings of being able to do most things like others", where 98% of orphans and 98% of non-orphans interviewed believed that they were able to do most things like others, and; (b) "wishing to feel happy about self" where 96% of non-orphans and 96% of orphans interviewed wished to feel happy about themselves.

Despite HIV/AIDS' horrendous impact on the orphans, this writer observed "hope" in some of the ways that they perceived life. Further, though the findings on self-esteem are low, the orphans believe that if they could have the resources that all other

children have access to, they would be able to do most things like others. It is interesting to note that young children share the same feelings relating to opportunity: that is, the opportunity to do things that most people do, if they had the resources. The same applies to feelings of wishing to be happy: all children, regardless of socio-economic status, wish to be happy.

Conclusion

Self-esteem for the orphans in Zimbabwe is cause for concern, based on the results of this research study. What it implies is that these orphans, besides being tormented by the survivor guilt disorder syndrome following the death(s) of their parent(s), the orphans are also experiencing the "agony of internalized shame" (Bradshaw, 1988). Internalized shame attacks the orphans' self-esteem, and the attack comes in layers. According to Bradshaw (1988), these layers include: "abandonment trauma, displacement, delusion, denial, dissociation, primary ego defenses, idealization, fantasy bond, scape-goating, rage, envy, criticism, blame, borderline personality, paranoid and narcissistic disorders, eating disorders, offender/victim bonding, sexual abuse, syndromes of shame, ingestive addictions, activity addictions, behavioral cover-ups, interpersonal transfer of shame by acting shameless, being judgmental, perfectionism, patronizing, people-pleasing, and false self" (page 72).

The Zimbabwean and international community should help these orphans re-gain their lost childhood, which is being lost in grieving. The orphans' childhood abandonment trauma must be validated as real, or else it fails to become resolved. How can orphans' frozen grief be resolved in a society that has become paralyzed with stigmatization and

denial of HIV/AIDS? The study results reveal a lack of social support networks for orphans and their kinship caregivers. The tragedy of the lack of social support networks is that the orphans would go into delayed grief, because there is nobody there to validate or support them. Delayed grief is the core of post-traumatic stress syndrome, which includes symptoms of unreality, for instance, panic, nightmares, getting easily startled, thinking negatively about self, and sleeping disorders. Most orphans interviewed had these symptoms.

The next chapter discusses the summary, conclusions, limitations and strengths of study, theory construction, and implications for public policy and research.

Chapter 6

SUMMARY, IMPLICATIONS, AND RECOMMENDATIONS

This chapter summarizes the research connections to the conceptual mapping and literature pursuant to conclusions drawn within the proposed models. This section also discusses the limitations, delimitations, and strengths of the research study. Following that section is a discussion on implications for theory construction, global and public policy, future research, and implementation of intervention programs. A concluding statement is provided.

Connections to the Conceptual Models and Literature

The participant kinship caregivers' economic well being, social support networks, and child-rearing practices consequently affect the children's self-esteem (Chigubu, 1998). The results of the investigation of orphans' self-esteem in this study demonstrated characteristics related to the human ecological ecosystems approach. These dynamics are illustrated in Appendix C. A review of Bronfenbrenner (1979) explains that the orphans' self-esteem and kinship caregivers' situations is critical. As seen in the context of the ecology of human development:

> The scientific study of the progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between those settings, and by the larger contexts in which the settings are embedded (Bronfenbrenner, 1979, p.21).

In this study, the research informants voluntarily participated in the research through the snowball sampling technique, which is a critical approach to educational research, and is grounded in the critical social theory (Frankfurt Institute of Social Research, 1920). The informants had knowledge about what was taking place in their homes, especially as the kinship caregivers provided care for orphans whose parents died of HIV/AIDS. The researcher had no knowledge of what was going on. However, she had human interest, whereas, the kinship caregivers had both knowledge and human interest. The voluntary participation of kinship caregivers and their snowballing to assist others to participate in this study demonstrated characteristics advocated by Habermas's (1971) critical social theory as shown in Figure 2.1 and Figure 2.2 of this research by Chigubu. According to Habermas (1971), knowledge and the pursuit of knowledge are guided by the technical, emancipatory, and communication interests of people. In this study, we see these particular women in Zimbabwe coming out of their hiding places or closets, shunning away denial, and opening up to the researcher, and discussing a "taboo" topic of HIV/AIDS – thus emancipating themselves from the shackles of oppressive stigmatization that has been deliberately woven into the social fabric of society. Certainly, this was not easy for them to do. "Interest," in general, is the pleasure we connect with the idea of the existence of an object or action (Coomer, 1986). Habermas argues that human interest cannot be divorced from knowledge and vice versa.

Further, critical theory cites human activity as involved in this dimension of life in the form of work. Kinship caregivers are engaging in this tremendous human activity of caring for orphans whose parents died of AIDS. Unfortunately, this is unpaid work. Nonetheless, "...it is through work that a person enters into direct interchange with his/her

environment" (Kockelmans, 1979, p. 4). In this study, orphans migrate across the country in search of kinship families that might take them in. Habermas's critical theory defines this migration as socialization, where human beings themselves interact with society through communicative action. The active ingredient that is allowing smooth passage of orphans to these extended families is language, which is not seen as a barrier to stop them from joining their relatives unceremoniously. Habermas's critical theory indicates that language provides a medium through which a person reflects about his/her objects.

The other crucial dimension wherein participants in this study demonstrated the characteristics predicted by the literature on critical social theory was in society's power to be able to maintain itself. In this case, orphans, and kinship caregivers stated that they do not receive any form of assistance from any organizations, and yet in their own humble way, they maintain the communicative interactions, which focus on the struggles for recognition among contending human beings.

Further, each area of work, language or power yields a distinct system of principles underlying development that determines what is defined as progress in each area (American Home Economics Association, 1989). Three related areas of interest here are technical, communicative, and emancipatory interests (Habermas, 1971). Amidst varying contributions of the effects of stigmatization and denial of HIV/AIDS, rationality tones down the anxieties of kinship caregivers and orphans. In critical theory:

> Rationality is a specific set of assumptions and social practices that mediate how an individual or group relates to the wider society (MacDonald, 1977, p.80).

Some kinship caregivers in the name of rationality, decide to "normalize" (Chigubu, 1998) by pretending that AIDS does not affect their "normal" family, and will

keep it a secret that the orphans' parents died of HIV/AIDS. By pretending that everything is normal, this group of kinship caregivers would feel comfortable to interact with the rest of society that stigmatizes HIV/AIDS. In this study, each area of human interest that participated, directed its efforts to acquire knowledge. According to Habermas (1971), "each area of human interest results in a different focus for rationality." What Habermas's critical theory manifests is that improvement in technical rationality implies acquiring better means to accomplish particular ends.

Secondly, by improvement in communication, rationality is evaluated by whether the actions of a subject actually express his/her intentions and meanings, because both are identified to determine the degree of distortion in the socialization process. However, what is disturbing in this study is that the future of orphans is rarely discussed in both the orphans' biological families (before the HIV/AIDS parents die) and the extended families joined by orphans.

The socialization process for orphans in this study typifies growing up as inextricably associated with dying. Consequently, the kinship care-giving of orphans that follows, is seen as problematic at best; one of the main reasons being the burden of unfolding the HIV/AIDS status of orphans' parents to the orphans under kinship care.

When young orphans are being denied of truths about their parental HIV/AIDS status, or when a spouse holds back information and fails to disclose his/her HIV/AIDS status to the other partner, when society is in denial of HIV/AIDS due to stigmatization, when society adopts the "blame-the-victim" attitude, and when the global community is in denial of HIV/AIDS, definitely that whole ecosystem does harm to "rationality". According to Giroux (1980), rationality accesses the "removal of distortion in

communication." The outcry in this study, based on the results, is that Zimbabwe and the rest of sub-Saharan Africa should strive to embrace the critical social theory's "rationality," which advocates the removal of distortion in communication.

What is needed is the "emancipatory interest" which is acquired by self-reflection, which in turn enlightens and builds communicative competence, which in turn assists in freedom from technical control. Critical reflection on technical control is the central task of the Habermas's critical perspective. He perceives that if technical interests dominate human communicative interest, the result is degrading for human beings. In this study, stigma of HIV/AIDS is degrading to human beings.

Habermas's viewpoint is that undistorted knowledge is the means people can use to free themselves from technical rationality that dominates our society (Habermas, 1971). In this study, orphans of HIV/AIDS parents, HIV/AIDS parents, kinship caregivers, peers, social welfare, schools, health settings, society, and the international community ought to have knowledge of what is truly happening in the homes that are taking care of orphans whose parents died of HIV/AIDS.

The critical form of knowledge, which is an emancipatory concept of truth, is what is crucial.

> Truth is recognized in the deliberative rationality of formulating norms, roles, and knowledge about possible ways of life – ways undistorted by repressive forms of authority, privilege, and vested interests of exploitation (van Manen, 1977, p. 222).

Critical knowledge is paramount, because it is used to free individuals from oppressing forces so that the individuals can fully develop their potential. The element of this study that appeals to Zimbabwe and the rest of Africa, as well as the global

community is that critical truth can come about only in an ideal situation, that is, a distortion-free model of a communication which Habermas (1984) describes as the "Universal Pragmatic Aspects" of language. Habermas states:

> The three general pragmatic functions – with the help of a sentence, to represent something in the world, to express the speaker's intentions and to establish legitimate interpersonal relations – are the basis of all the particular functions that an utterance can assume in specific contexts. The fulfillment of those general functions is measured against the validity conditions for truth, truthfulness, and rightness. Thus every speech act can be considered from the corresponding analytic viewpoints (p. 5).

Critical theory proposes society as a human construction that can be altered through human understanding of the taken-for-granted structures that form the social fiber of human life. From the research findings it is revealed that what is happening currently in Zimbabwe is that HIV/AIDS knowledge is being taken for granted, which is dangerous. When asked if the kinship caregivers had heard about HIV/AIDS, 100% said, "Yes." However, when further asked if they were kinship caregivers who feared HIV/AIDS, 82% of those interviewed said, "Yes," while 18% said "No."

Regarding the question of kinship caregivers lacking or not the knowledge about how AIDS is spread, 62% of those interviewed said they lacked the knowledge, while 38% said that they did not lack knowledge. After all the HIV/AIDS awareness campaigns that have been championed in Zimbabwe from time immemorial, one would assume that 100% would have said "No." The problem here is what Habermas terms: "taken-for-granted" realities. From a critical theory viewpoint, society is historically grounded with values elevating human freedom against structural constraints that perpetuate or serve as a medium of oppression:

> The comparative absence in interpretative theory of political categories such as ideology, power, struggle, and oppression is a symptom of these deficiencies in its social epistemology (Connelly, 1979, p. 408).

Applications of the Habermas critical social theory in this study have unidirectional influences on the Belsky (1984c) parenting model (Figure 1.1) which presumes that parenting/care-giving is directly influenced by forces emanating from within the individual parent/caregiver (personality), within the individual child (child characteristics of individuality), and from the broader social context in which the parent-child or kinship caregiver-orphan relationship is embedded.

The model assumes that parents' or kinship caregivers' developmental histories, social networks, marital relations, and jobs influence individual personality and psychological well-being of parents/kinship caregivers, and thereby, parental/kinship caregiver functioning, in turn child development and ultimately self-esteem. In this study, 8% of kinship caregivers interviewed were unemployed, 4% retired, 28% full-time housewives in unpaid house-keeping work at home, 44% were self-employed, 6% were working part-time, and 10% were working full-time paid jobs.

As children grow older, parental/kinship caregiver use of induction or reasoning, consistent discipline, and expression of warmth are said to relate to positive self-esteem, internalized controls, pro-social orientation, and intellectual achievement during school years (Hagarty, 1973; Coopersmith, 1967; Hoffman, 1970; McCall & Applebaum, 1973). In this study, when kinship caregivers were asked: "What do you do if the child/orphan interrupts you and demands attention while you are busy talking to other adults?" Of all the adults interviewed, 20% always respond to the child's demands, 34% give a look that tells them to disappear, and 46% said they never respond, but reprimand after visitors go

away (Chigubu, 1998). The participants' responses to the above item mark two dimensions: either the kinship caregivers are positively affectionate, accepting, stimulating, helpful, approving, and sensitive to promoting the child/orphan's self-esteem, or cold, unresponsive, rejecting, disapproving, and unstimulating.

The study's findings indicate that 80% of kinship caregivers interviewed gave responses that, according to Baumrind's scholarly writings and interpretation, point to the cold and unresponsive category, while only 20% gave warm, positive responses. Bearing in mind that the data analyzed from the self-esteem instrument shows that orphans displayed dangerously low self-esteem in Zimbabwe; the above interpretation of Baumrind's work should be cause for concern regarding the Zimbabwean case. However, Baumrind cautions us of cross-cultural differences to be taken into account when utilizing her scale, which is based on research done on middle class, European-American families in the USA.

Consideration of these 1998 findings of Chigubu and others suggest that, across childhood and orphanhood, parenting and kinship care-giving that is sensitively attuned to the children/orphans' capabilities and to the developmental tasks they face promotes a variety of highly valued developmental outcomes, including emotional security, behavioral independence, social competence, dependability, and intellectual achievement (Belsky, Lerner, & Spanier, 1984). The question to pause following this study is: "What kind of a person should be able to give such developmentally flexible, growth-promoting, and self-esteem enhancing care? The knowledgeable and sensitive kinship caregiver, one might argue, able to de-center, decompress, and to appraise accurately the perspective of others

who are grieving, should be able to empathize with them, and more so, be able to adopt a nurturant orientation.

Going back to Habermas's cautioning remarks on taking things for granted, it is reasonably easy to speculate that those most able to provide developmentally appropriate child rearing practices would be mature, psychologically healthy adults. Unfortunately, literature linking personality and parenting/kinship caregiving is not nearly as rich nor as extensive as expected. The available limited data can be marshaled to provide support for the notion that personal maturity, psychological well-being, and growth-facilitating parenting/kinship care-giving are paramount.

Based on the findings (Chigubu, 1998) from the kinship caregivers' responses, Zimbabwe and the rest of Africa need to introduce emergency developmentally appropriate parenting and parent education kits that would help promote the self-esteem of orphans which is dangerously low, bearing in mind that these kinship caregivers are not trained nor equipped with the "critical knowledge" on parenting orphans whose parents died of HIV/AIDS utilizing de-stigmatization strategies (Appendix F). These are kinship caregivers who grew up in an era that was void of HIV/AIDS.

Child characteristics that have received the most attention in terms of influencing parental functioning are those pertaining to temperament; especially those behavioral styles that make parenting/kinship care-giving more or less difficult. Campbell (1979) says that select evidence does not exist in support of the notion that difficult temperament can undermine parental/kinship care-giving functioning.

Belsky (1984a, 1984b) states that, nevertheless, the limited evidence just reviewed does illustrate the now well-accepted point that, even in non-abusive samples,

characteristics of children hypothesized to make them more or less difficult to care for, do indeed seem to shape the quantity and quality of parental/kinship caregiver care they receive. When kinship caregivers were asked: "How do you react when orphans keep joining your family?" of all kinship caregivers interviewed, 50% said that it is a burden not easy to solve, 14% said that orphans are generally hard to please and they hated the idea, 18% said that it is hard, and only 18% said that they loved to have orphans keep joining them. For future research, it would be very interesting to investigate why kinship caregivers resent orphans who unceremoniously joined them.

What Belsky cautions us is that what does exist may be marshaled to support the conclusion that neither temperament nor other child characteristics per se, shape kinship care-giving/parenting, but rather the "goodness-of-fit" between parent/kinship caregiver and child/orphan determines the development of parent-child or kinship-caregiver and orphan relations (Lerner & Lerner, 1983). Belsky also cites that parenting/kinship care giving appears to be positively associated with social support, and well-being and social support have been repeatedly linked.

The Chigubu (1998) findings of the Zimbabwe study are alarming. When kinship caregivers were asked about social support, 66% of those interviewed said nobody assisted them with social support, 2% said social welfare gave them social support, 24% said relatives helped in a very little way, and 6% said relatives assume a fair part. Based on these results, Zimbabwe definitely needs to revamp its standpoint on social support networks available to kinship caregivers.

To qualify this statement, of the orphans interviewed and asked open-ended questions on HIV/AIDS, 96% stated that "children whose parents died of HIV/AIDS tend

to be ignored" and only 4% did not agree. These results are telling that there is definitely a problem in Zimbabwe, and most probably the rest of the sub-Saharan Africa, regarding kinship caregivers of orphans, and the orphans whose parents die of HIV/AIDS.

Belsky advocates that, in line with documented extensive literature on social support, three general ways of giving support when parenting/kinship caregiving are:

1. by providing instrumental assistance,
2. by providing emotional support, and
3. by providing social expectations

Instrumental assistance can take a variety of dimensions, including the provision of information, guidelines and advice, and help with routine tasks, including childcare. Social expectations can be defined as guidelines, or guides about what is and is not appropriate behavior. Finally, emotional support can be described as interpersonal acceptance and love an individual receives from others, either through explicit statements to the effect or as a result of caring and considerate actions.

In terms of support, orphans and kinship caregivers had questions that were directly or indirectly meant to provide answers regarding support. In this study, 86% of orphans interviewed stated: "I feel stigmatized, and dejected," which is a social indicator that orphans whose parents die of HIV/AIDS in Zimbabwe lack emotional, social, and instrumental support. On the question of deficient emotional support, only 36% of kinship caregivers interviewed were married. The other 52% were widowed, 10% were divorced, and 2% were never married. Regarding marital emotional support, 64% caregivers interviewed lacked it.

In-depth conversations in this research also revealed that 94% of kinship caregivers had trouble and stress from in-laws, which is an indicator that kinship caregivers of orphans in Zimbabwe lack instrumental, social, and emotional support.

In this project, Belsky's model cuts across the contribution made to this research by Baumrind.

Baumrind (1978a, 1989) looks at patterns of child rearing in a continuum. According to Baumrind, parents/ caregivers who are responsive and demanding (the engaged pattern and the authoritative prototype) were most likely to produce children who were socially responsible and argentic. On the other hand, parents/kinship caregivers who were highly responsive, and not demanding (the lenient pattern and the permissive prototype) were likely to have daughters who were not socially assertive but moderately socially responsible and sons similar to sons from authoritarian families, but did not differ significantly from other boys.

Similarly, parents/kinship caregivers who were low on both demanding and responsive dimensions (the unengaged pattern and the rejecting-neglecting prototype) were likely to have children who were (a) low on social assertiveness and responsibility, or (b) low on non-gender-normed competencies (that is, social responsibility for boys and social assertiveness for girls). Parents/kinship caregivers who were highly demanding but not responsive (the restrictive pattern and the authoritarian prototype) were said to be likely to have sons who did not differ from other boys, but daughters who were socially assertive and not highly socially responsible. Baumrind cautions that these results might not be compatible with other cultures:

> Socialization practices that appear authoritarian, punitive, or seductive by middle-class European American standards are used by many African American parents to prepare their adolescents to cope with hazards of contemporary ghetto life, and are not indicative of mistreatment (Baumrind, 1995, p.70).

With this notion in mind, this researcher utilized Baumrind's school of thought when carrying out research on child rearing practices of low-income families in Zimbabwe. However, the several pieces of research Baumrind carried out in the USA were not on families that had orphans whose parents died of AIDS.

It must be noted that Baumrind's approaches served as a yardstick in the study done in Zimbabwe in 1998 which reveals that a good percentage of kinship caregivers showed warmth in terms of praising their children and orphans. When asked the question: "If children in your care do what they are told to do, what do you do?" Of all the kinship caregivers interviewed, 48% said they occasionally praised the children, 8% said they sometimes praised, 24% said they always praised, 16% said they reserved their comments because it was not necessary to speak it, and 4% said they never praised at all.

Baumrind states that responsive warmth refers to parents/kinship caregivers' emotional expression of love that motivates high-investment parenting/kinship care giving and brings about cohesive family relationships.

On the other hand, demandingness includes firm discipline and monitoring of children's behavior. According to Baumrind, demandingness as well as responsiveness is a manifestation of a high parental/kinship caregiver investment. Demanding parents/kinship caregivers directly confront rather than attempt to subtly manipulate their child(ren)/orphan(s) and this may invite open conflict with their child(ren)/orphan(s) at the

points of disagreement. Demanding parents/kinship caregivers supervise and monitor children's activities and have high aspirations for them.

In this study, the kinship caregivers displayed traits or patterns of demandingness. When asked what they would do if their child(ren) and orphan(s) under care, aged 9, 10, 11, or 12 years old had boyfriend(s) or girlfriend(s), 14% of the kinship caregivers interviewed said they would physically punish, 22% said they would scold in order to stop the child(ren)/orphan(s), 58% said they would warn the child(ren)/orphan(s) about HIV/AIDS, and 6% said they would report the matter to their husbands.

Baumrind further states that although an authoritative more than an authoritarian approach promotes instrumental competence in children from middle-class families (Baumrind 1966, 1971a, 1991a, 1991b), more restrictive practices are often necessary to protect children from dangerous and delinquent influences in the inner city (Baumrind, 1972). She cautions that these parents/kinship caregivers' restrictive practices are not necessarily abusive, but the conditions in which their children live are.

Bearing in mind that Baumrind cautions the practice of transplanting instruments from the west and using them on other cultures, this researcher's instrument adapted Baumrind's approaches to design an instrument on child rearing practices that would suit the nature of the Zimbabwe study, targeted towards low income families taking care of orphans whose parents died of HIV/AIDS.

Earlier on, this researcher had read an article from ZDHS: Zimbabwe Demographic Health Surveys (1994) which revealed that after all the HIV/AIDS awareness campaigns done in Zimbabwe, by 1994, more than 80% of women and more than 40% of men interviewed had not changed in behavior after hearing about HIV/AIDS

that had been contracted by engaging in sexual activity (Appendix B). The instrument that this researcher prepared for the 1998 Zimbabwe research included work by Baumrind and also included questions that would investigate why their was resistance to a change in behavior after hearing about HIV/AIDS. These were kinship caregivers who were taking care of orphans whose parents died of HIV/AIDS, and this researcher felt that these women could become instrumental in the orphans' future lives in terms of HIV/AIDS knowledge. On the question of counseling, the study findings reveal that 100% of non orphans and 96% of orphans stated that when a beloved parent or relative died in the family, no one sat down with these young children to talk about death. Upon asking the kinship caregivers the related question: "When the child(ren)/orphan(s)' parents died of HIV/AIDS, did the child(ren)/orphan(s) receive counseling of their relatives/parent(s)' death?", of all the kinship caregivers interviewed, 6% said "Yes" and 94% said "No."

Further, on the question of HIV/AIDS, although 100% of kinship caregivers said they had heard about HIV/AIDS, 62% said that they lacked adequate, informative, and substantial knowledge on how exactly HIV/AIDS is spread. They reported that they heard "wishy-washy stories" about how AIDS is spread, but they lacked enough knowledge to empower them as kinship caregivers of orphans, to be able to sit down and educate children and orphans under their care on how HIV/AIDS is spread.

From the in-depth conversations held between this researcher and the kinship caregivers, it was reported that HIV/AIDS was mysterious to kinship caregivers because polygamy (which involves multiple sex partners on the part of men) has been in Africa from the days of ancient "Abraham in the Bible." and HIV/AIDS never was heard of. It was also echoed by the informants that from time immemorial, African traditions and

cultures involved tattooing of the bodies, which included sharing razor blades, and HIV/AIDS never was heard of and nobody died of HIV/AIDS.

The kinship caregivers concluded that that is why they said they lacked knowledge on how HIV/AIDS was spread, and some of them expressed their suspicions that HIV/AIDS was a virus cooked in American laboratories in order to wipe out the black race on the African continent (Chigubu's Findings, Table 4.1).

When kinship caregivers were asked what they thought was the reason why according to ZDHS (1994), there was no change in behavior after hearing about HIV/AIDS, by sex, the informants stated that the messages that they heard regarding HIV/AIDS were: "*Mukondombera/Svuuramatongo yakauya muZimbabwe*" which when literally translated to English, may read: " HIV/AIDS is in full force and is here in Zimbabwe." They said such statements lacked substance.

Other kinship caregivers said that they consistently heard statements like: "*Svuuramatongo/Mukondombera inouraya, E! hii*!" which, when translated to English may read: "HIV/AIDS kills, watch out!" (Chigubu, 1998). The kinship caregivers complained that this kind of rhetoric had become nothing but an ineffective cliché that lacked punch and meaning, and according to them, that might be one of the reasons that is contributing to the resistance to change.

Meanwhile, these kinship caregivers stated that what they wanted to hear regarding HIV/AIDS was informative and educative approaches to HIV/AIDS, which could include simple, down-to-earth epidemiology of HIV/AIDS, that equips them with knowledge and skills, in a way that the kinship caregivers would then be able to sit down with their children/orphans and teach them about how HIV/AIDS spreads.

During the in-depth conversations carried out with the kinship caregivers, this researcher discovered four schools of thought and groups regarding HIV/AIDS and these are:

1. kinship caregivers who said HIV/AIDS was shipped from the USA. to Africa deliberately to wipe out the black race,
2. kinship caregivers who believed Zimbabwe had witches capable of cursing with HIV/AIDS symptoms and signs,
3. those who believed HIV/AIDS was from Satan, and,
4. the group that said HIV/AIDS was from prostitutes, and also a punishment from God (Table 4.1).

Limitations of the Study

One of the major methodological concerns throughout the course of this research was the potential validity problem of retrospective interpretations by women and children in the interviews. Retrospective interpretation refers to the fact that a person's views and interpretations change over time; past behavior is reinterpreted in light of new information and experiences. For instance, social stigmatization might not be prevalent at the time of interviews, but might occur later, forcing the respondent to treat the orphan with a different outlook than at the onset of the interview. Or if a rise in the cost of bread, sugar, corn meal or meat occurs after the interview, the kinship caregiver's reaction to the care-giving roles can be negatively impacted, and the accounts people formulate about care-giving roles to orphans are likely to be shaped by the structural and institutional context in which there are embedded.

Secondly, whenever people are asked about events in their lives, that bring memories of death, HIV/AIDS, social stigma, their responses are always retrospect (Wilson, 1987). The question then becomes one of degree - how can effect be reduced? Thirdly, the variables cannot be manipulated as in laboratory experiments. Due to the sensitivity of HIV/AIDS, the study lacks random sampling, and instead uses snowball sampling which, however, is popular for highly sensitive, hard to reach groups. Cross-sectional survey data is not used since deceased parents are not sampled, thus confounding "survival bias."

Further, methodological concern arises due to potential validity problems of retrospective interpretations by subjects. Generalizability of the research findings was limited by the size and homogeneity of the sample intended for study. Cross socio-economic status studies of kinship care-giving roles of women to displaced children who lost their parents have shown that orphans from all socio-economic levels display similar emotional and behavioral symptoms as a result of parental deaths (Wilson, 1997; Solomon & Marx, 1995; Siegel & Freund, 1994). Last but not least, in this highly diverse qualitative study, the findings could be subject to other interpretations (Kunes, 1991, pp. 21-22; Chigubu, 1998).

A Delimitation of the Study

Initially, this research study confined itself to interviewing and observing the kinship caregivers within the Mashonaland Central province, one of ten provinces of Zimbabwe, and within only ten of the numerous surrounding peri-urban areas of Harare, the capital city of Zimbabwe.

Strengths of the Study

This is a study that involves a taboo topic of HIV/AIDS, which is highly stigmatized, and diverse. It involves human lives, anguish, gender, race, class, denial, and stigmatization and child survival. It involves a sample that is very hard to locate or identify. The study calls for specialized snowball sampling techniques that need special training and skills that include trust building among highly vulnerable, but voiceless groups that can easily go unnoticed due to their invisibility.

The good thing is that with proper training on utilizing the snowball sampling techniques, the study can be replicated in other parts of Zimbabwe and the sub-Saharan Africa, where the family institutions continue to crumble down due to the HIV/AIDS stigmatization and denial. The purposive snowball sampling procedure used in the study enhances the generalizability of the findings.

Further, the validity of the plight and responses provided by the orphans in this study is strengthened by the fact that the researcher did not only limit her interviews and observations of the orphans whose parents died of HIV/AIDS, but also included the same number of non-orphans who were living in the same environment, and were under the same caregivers as the orphans. The researcher did this triangulation in the classic sense of seeking convergence and validation of results from both orphans and non-orphans, which is strength to this study.

On the question of reliability, statements about the researcher's position, central assumptions, the selection of informants, the biases and values of the researcher, enhance the study's chances of being replicated in another setting. In this study, the investigator

explored multi-site cases, and the same patterns and thematic constructs were replicated in different settings.

Implications for Research

Issues regarding HIV/AIDS, children, families, and women in Africa include persistent and pervasive poverty, problems of economic development, health care, environmental quality, and issues of stigmatization, denial, forced migration, homelessness, school drop-out and failure, crime, family and community lack of cohesion, unsafe sex, developmentally inappropriate child rearing practices, battered self-esteem and many other issues that are confronting Zimbabwe's, as well as the sub-Saharan Africa's children and families. This study provides useful frame-works for future researchers interested in children, families, HIV/AIDS and many other life issues, in not only Zimbabwe but also the whole of Africa.

The difficulty that involved finding participants for this research project indicates that research regarding taboo topics that embed stigma is extremely challenging, but nonetheless, possible. Identifying the root causes of stigmatization and social practices that perpetuate denial might provide an alternative research avenue for family scholars, sociologists, psychologists, and anthropologists.

Battered self-esteem should not be allowed to foster, especially in children as well as the kinship caregivers. The research findings imply that there is work waiting to be done by future researchers. As social scientists, we cannot afford to stand by and look on, ignoring the phenomena revealed in this study. This research project suggested a myriad

of implications for cross-cultural research on children, youth, and families. For the future, investigation of the following is needed:

1. Why there is resistance to change in behavior after hearing about HIV/AIDS contracted through sexual activity.
2. Why a good percentage of kinship caregivers resent the idea of taking care of orphans whose parents died of HIV/AIDS.
3. The importance of counseling the grieving and bereaved.
4. The intra- and interpersonal dynamics that exist between kinship caregivers and in-law.
5. The role of superstition, witchcraft, and traditional healing in the wake of HIV/AIDS.
6. The role of Christian religion, satanic worship, and ancient traditional religion in the era of HIV/AIDS.
7. The transition between the time a child loses a parent to HIV/AIDS, and the time the child joins relatives.
8. The relationships that exist between school and home, of children orphaned by HIV/AIDS.
9. Social support networking in the era of HIV/AIDS.
10. Post Traumatic Stress Disorder syndrome in children who lose their parents to HIV/AIDS.
11. The impact of survivor guilt disorder on orphans from parental HIV/AIDS, and effects on adult relationships.

Implications for Policy

The publication of this research should be utilized as a reason and a basis for pursuing broader discussions of policy issues pertinent to Zimbabwe's children, youths, families, and women, especially kinship caregivers of orphans whose parents die of HIV/AIDS. This discussion is timely and appropriate because today in Zimbabwe and the rest of Africa, there exists no national youth policy and also no policy on food security that act as buffer zones for "at-risk families and children " that go without basic food. There is need to address the problem of hunger among families. During the interviews, a good number of orphans and kinship caregivers stated:

> I had my last meal two days ago, last night I only drank a cup of water before retiring to sleep, and this morning, for breakfast, I drank two cups of water. Our family does not have anything to eat. I am very hungry right now as I speak with you (Said some of the interviewed research participants in Zimbabwe, 1998).

1. Policies should guide Zimbabwean standards of conduct for individuals, organizations, and institutions.
2. Policies we formulate and follow should structure our actions and enunciate to others how they may expect us to function in regard to the substantive issues to which our policies pertain.
3. Policies should reflect what we value, what we believe, and what we think is in our best interests.
4. Policies should indicate the things in which we are invested, and about which we care.

5. Policies should aim to close the existing gap between the rich and poor, based on race, class, and gender.

This study reveals that the probability that a Zimbabwean child or adolescent will be poor – and thus experience the several "rotten outcomes" (Schorr, 1988; Chigubu, 1998) of poverty are so glaring and alarming. This points to an emergent need for a comprehensive and integrated national policy pertinent to all of the Zimbabwe nation's children.

Further, just as we may be concerned with developing better policies for sustaining and/or enhancing Zimbabwe's agricultural, industrial, manufacturing, and business interests, there is need to sustain communities - and the people - involved in the production, distribution, and consumption of the products of our economy. We must remind ourselves that orphans and their respective kinship caregivers in the era of HIV/AIDS have become a vulnerable group that needs to be sustained.

Implications for Theory Construction

What the study reveals is that as social scientists and researchers of highly diverse and taboo topics, there is need to become sensitive to issues surrounding the informants with whom the researcher would be working, when constructing a theory during and after the onset of the qualitative study. In this study, the author's "little-t" theory (Table 4.1) reflects the issues surrounding the informants.

Concluding Statement

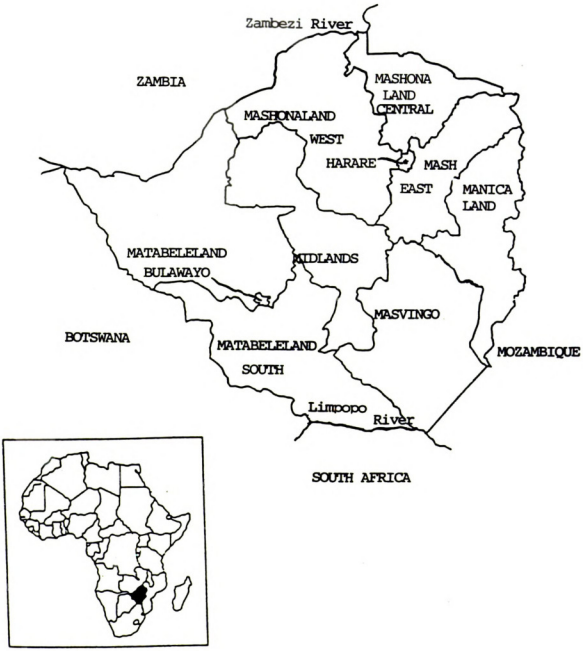
This is a study that has formed a foundation for future quantitative researchers, theorists, policy makers, activists, and humanitarian advocates. It provides a baseline to formulate quantitative theories to utilize when carrying out research or intervention projects on families, children, women, and taboo topics like HIV/AIDS in Africa.

The dissertation committee and all professors mentioned in this document who have contributed to the success of this research are openly invited to become collaborative partners for the projects in Zimbabwe, and the rest of the sub-Saharan Africa, where immediate intervention is needed to alleviate the agony being experienced by most low income families taking care of orphans whose parents died of HIV/AIDS.

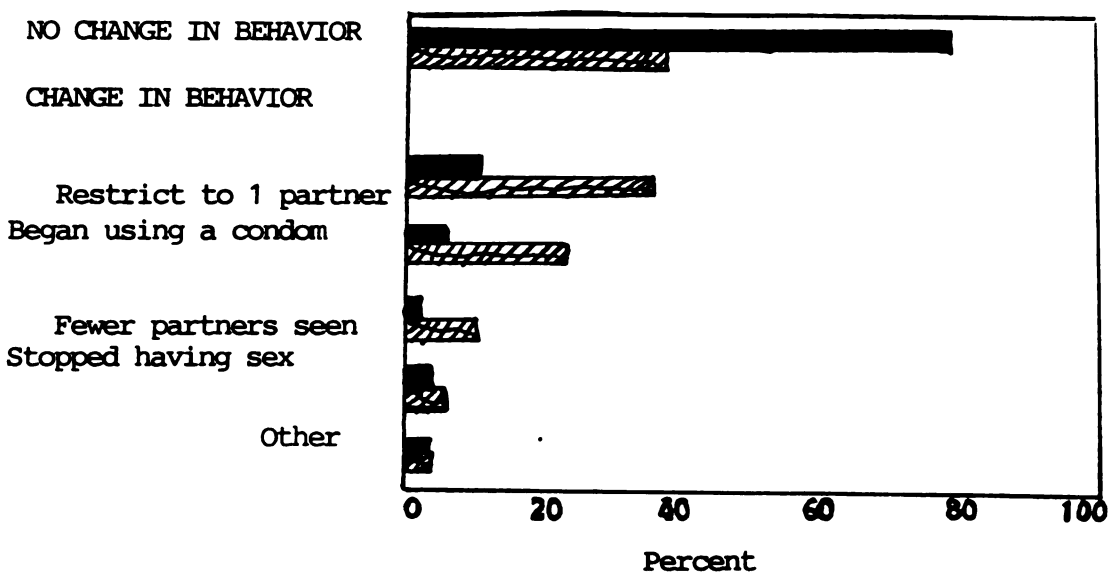
APPENDICES

Appendix A

ZIMBABWE



CHANGE IN BEHAVIOR AFTER HEARING ABOUT HIV/AIDS, BY SEX.



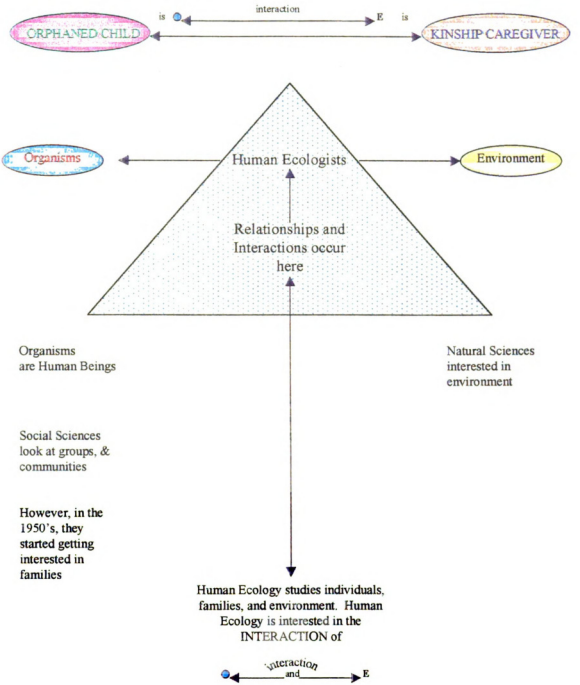
Legend

Women

Men

Adapted from ZDHS. With permission granted by George Bicego, Ph.D (15 September, 1997); Demographic Expert: Macro International, Calverton: MD. USA.

Formula of Concepts Utilized in the Project: *(Holistic Approach).*



Designed by Chigubu M, (2000) Michigan State University, College of Human Ecology, Dept. of Family & Child Ecology.

Appendix D

Categories of Research on Organizations & Institutions
(Source: Edgar H. Schein, 1997)

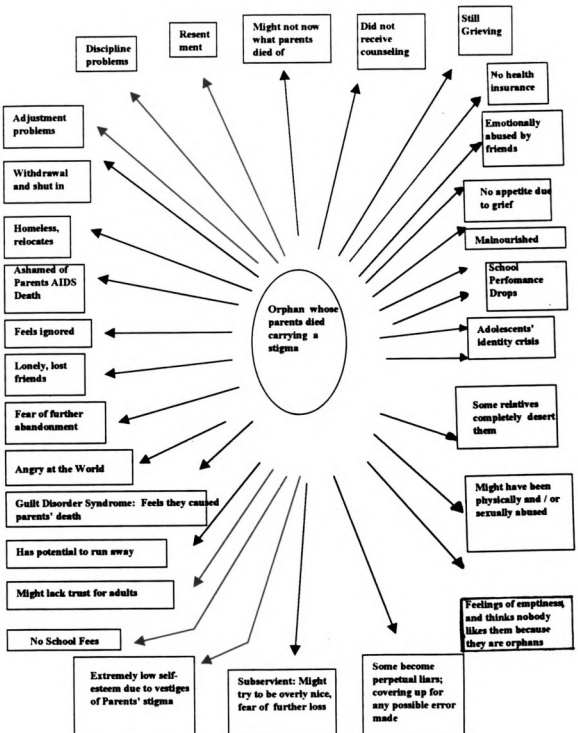
Level of Researcher Involvement ↓

Level of Subject	Quantitative (Low to medium)	Qualitative (High)
Minimal	Demographics; measurement of "distal" variables	Ethnography, observations, content analysis of told stories myths, rituals, symbols, artifacts
Partial	Experimentation, Questionnaires ratings, scales	Questionnaires interviews, ratings, scales
Maximal	Total quality tools such as statistical quality control, action research	Clinical research, in-depth study, action/participatory research, critical science research.

Appendix E

CONCEPTUAL MAP:

ANALYZING THE ORPHANS' BAGGAGE



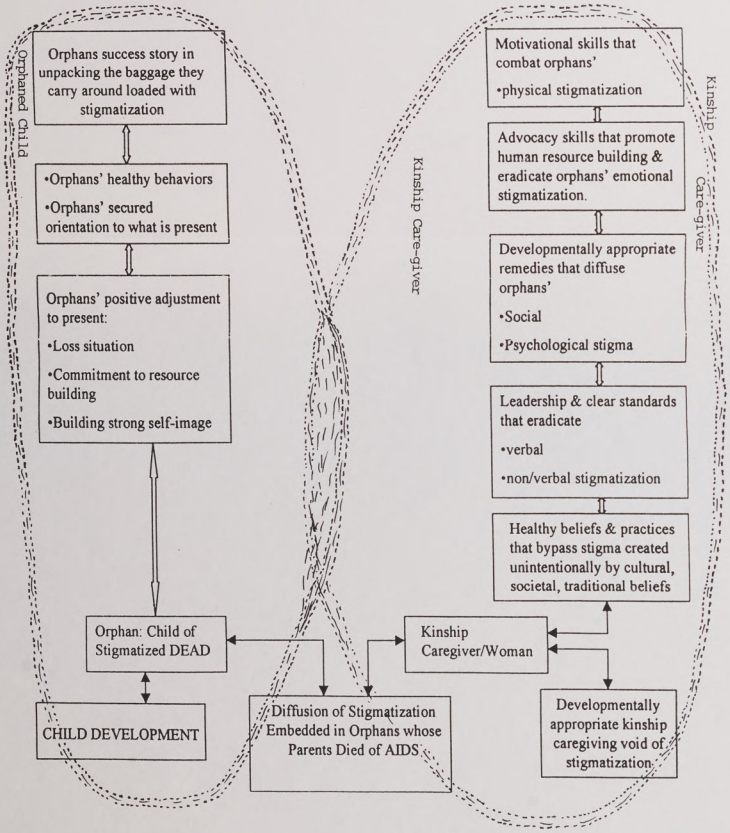
....based on research of Mercy Chigubu (1998), Zimbabwe.

Appendix F DE-STIGMATIZATION STRATEGIES

THE COLLECTIVE CONCEPTUAL MAP

KINSHIP CAREGIVING ORPHANS: STIGMATIZATION

....based on the research of Mercy Chigubu (1998), in Zimbabwe.

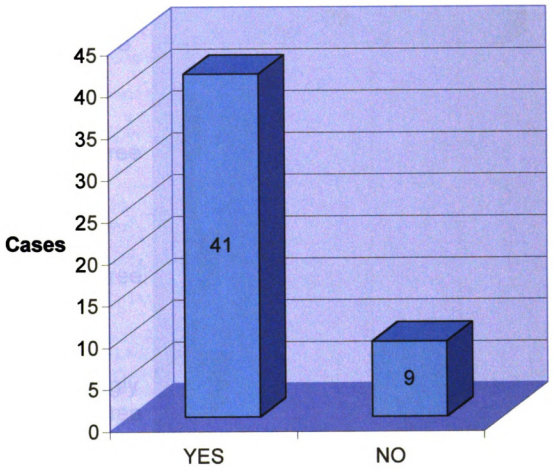


Appendix G

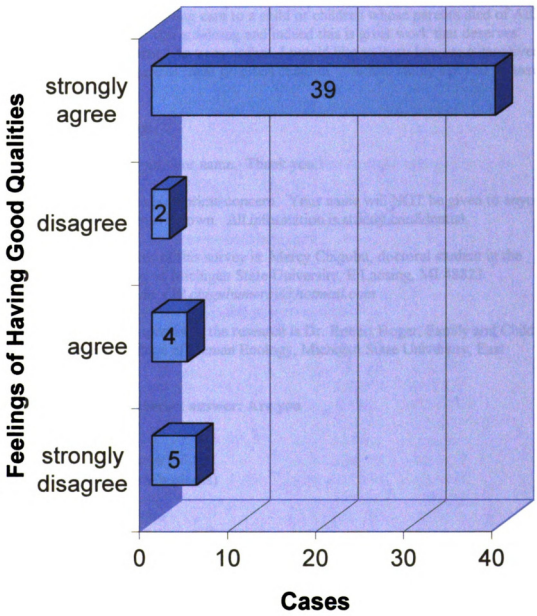
KINSHIP CARE-GIVERS' MARITAL STATUS

...based on research of Mercy Chigubu (1998) in Zimbabwe.

APPENDIX H
Are You a Care-Giver Who Fears HIV/AIDS?



APPENDIX I
Orphans' Self-Esteem Graph



Appendix J

Questionnaire designed by Mercy Chigubu (1997) at Michigan State University, College of Human Ecology, Department of Family and Child Ecology:

Questionnaire on the Economic Well Being of the Care Givers Taking Care of Orphans Whose Parents Died of HIV/AIDS in Zimbabwe.

INSTRUCTIONS

We understand that you are giving care to a child or children whose parents died of AIDS. We are very proud of what you are doing and indeed this is great work that deserves praise and acknowledgement. As a researcher, I would like to learn how, as a caregiver, you are coping in taking care of these precious children. I would kindly ask you to answer the following questions.

Please note the following:

1. You DO NOT have to put your name. Thank you.

2. Confidentiality of names is of prime concern. Your name will NOT be given to anyone, and you do not have to write it down. All information is strictly confidential.

3. The principal investigator of this survey is: Mercy Chigubu, doctoral student in the College of Human Ecology at Michigan State University, E.Lansing, MI 48823
e-mail: *chigubum@msu.edu OR chigubumercy@hotmail.com*

4. The professor who is supervising the research is Dr. Robert Boger, Family and Child Ecology Department, College of Human Ecology, Michigan State University, East Lansing, MI 48823, USA

1. **Circle ONLY ONE correct answer: Are you**
   a. Working full-time
   b. Working part time
   c. With job (not at work)
   d. Self-employed (own business)
   e. Unemployed
   f. Retired
   g. In school
   h. House-keeping
   i. Other

2. **Circle <u>ONLY ONE</u> correct answer: Are you**
   a. Married
   b. Widowed
   c. Divorced
   d. Separated
   e. Never married
   f. Other

3. **AGE: Circle the age category that you fall into:**
   a. Under 15 years
   b. 15 to 24 years
   c. 25 to 34 years
   d. 35 to 44 years
   e. 45 to 54 years
   f. 55 to 64 years
   g. 65 and over

4. **EDUCATION: Circle the years you spent in school/college/ university as a student?**
   0 1 2 3 4 5 6 7 8 9 10 11 12 years

5. **Circle the number of orphans under your care.**
   10 9 8 7 6 5 4 3 2 1

6. **INCOME:**
   Circle total family income at the end of each month

a.	Z$0		l	Z$3100	-Z$3299
b.	Z$100	-Z$299	m.	Z$3300	-Z$3499
c.	Z$300	-Z$499	n.	Z$3500	-Z$3699
d.	Z$500	-Z$699	o.	Z$3700	-Z$3899
e.	Z$700	-Z$899	p.	Z$3900	-Z$4099
f.	Z$900	-Z$1099	q.	Z$4100	-Z$4299
g.	Z$1100	-Z$1299	r.	Z$4300	-Z$4499
h.	Z$1300	-Z$1499	s.	Z$4500	-Z$4699
i.	Z$1500	-Z$1699	t.	Z$4700	-Z$4899
j.	Z$1700	-Z$1899	u.	Z$4900	-Z$5099
k.	Z$1900	-Z$2099	v.	Z$5100	-Z$6000

7. **Place an [X] next to the correct answer**
   a. Is your husband living with you? **Yes ___ No___**
   c. Is your husband away from home more than half because of a job or other reason? **Yes ___ No___**
   d. Do you have ever have problems of lacking food to cook for the children and the family? **Yes ___ No___**
   e. Do you have problems with lack of money to buy soap, salt, bread, meat, paraffin, candles? **Yes ___ No___**

f. Do you get hassled by people you owe money? **Yes ___ No___**
g. Have you been looking for a job? **Yes ___ No___**
h. Does your work interfere with your family life? (No if not working) **Yes ___ No___**
i. Does your husband's work interfere with your family life? (No, if not working). **Yes ___ No___**
j. Do you have trouble with your in-laws? **Yes ___ No___**
k. Do you feel that you do not have enough privacy? **Yes ___ No___**
l. Do you have people living with you----relatives or friends that you wish weren't there? **Yes ___ No___**
m. Do you have neighbors who are unfriendly or are giving you problems? **Yes ___ No___**
n. Do you or someone in your household have a long-term illness? **Yes ___ No___**

8. **Do you have fears of how AIDS disease was spread to the child(ren)'s parents?**
Yes or No

9. **Are you a caregiver who lacks knowledge about how HIV/AIDS is spread?**
Circle any of these: [1, 2, 3, 4, 5]

disagree	agree	fairly agree	strongly agree	v.strongly agree
1	2	3	4	5

10. **When the child(ren)'s parents died of HIV/AIDS, did the children receive counseling?** Yes or No

11. **Up until you were 12 years old, did you live in a**
township, farming community, peri-urban, or rural area?

12. **What is your age on this day (May - August 1998) of the interview?**

13. **Have you ever attended school?** Yes No

14. **What is the highest level of school you attended?**
no school, primary, secondary, or higher?

15. **Are you currently attending school?** Yes No

16. **What was the main reason you stopped attending school?**
Got pregnant
Got married
War, schools were burned down
Had to take care for the younger children
Family needed help on the farm
Could not pay school fees

Bad grades
Disliked school

17. What is source of drinking water for members of the household?
Piped water into own residence/yard
Communal Tap
No water in last 1-5 months, tap disconnected due to non-paid bills

18. What kind of toilet facility does your household have?
Own flush toilet
Shared flush toilet
Own pit toilet/latrine
Shared pit toilet/latrine
Blair toilet

19. Does your household have:

electricity?	= Yes	No
a radio?	= Yes	No
T.V.?	= Yes	No
Refrigerator?	= Yes	No

20. Circle the number of rooms used by household:
7 6 5 4 3 2 1

21. Circle the number of sleeping rooms used by household
5 4 3 2 1

22. What is the main material of the floor?
Natural floor: Earth/Dung
Finished floor: Vinyl
Cement
Carpet

23. Does any member of your household own:

	YES	**NO**		**YES**	**NO**
A modern oxcart?	**YES**	**NO**	A paraffin/kerosene stove	**YES**	**NO**
A bicycle?	**YES**	**NO**	An electric stove	**YES**	**NO**
A motorcycle	**YES**	**NO**	A bench to sit on	**YES**	**NO**
A car	**YES**	**NO**	A stool to sit on	**YES**	**NO**
A sewing machine	**YES**	**NO**			
Between 1-6 chairs	**YES**	**NO**			
A table	**YES**	**NO**			
Sofas	**YES**	**NO**			
Between 1-6 stools	**YES**	**NO**			

Appendix K

ECOMAP: For Social Support Networks

Instructions for and a simulation of an ecomap (adapted from Hartman 1979) are on the next page.

A note to the respondent
We understand you have connections between your environment and yourself. In this ecomap, we would kindly ask to know who those connections are.

PLEASE NOTE THE FOLLOWING:

1. You DO NOT have to put your name. Thank you.

2. Confidentiality of your names is of prime concern. Your name will NOT be given to anyone, and you do not have to put it on this ecomap. All information is strictly confidential.

3. The principal investigator of this survey is: Mercy Susan Chigubu, a doctoral student in the College of Human Ecology, at Michigan State University, East Lansing, MI 48823, USA: e-mail: chigubum@msu.edu OR chigubumercy@hotmail.com

Ecomap Instructions

The purpose of the ecomap is to show the connections between you and different sections of your immediate environment. In this study, we are especially interested in the connections that you have in the community.

1. On a separate sheet of paper, list the people, organizations, and institutions with which you come in contact. Examples may include school, neighbors, recreation, stores, markets, extended family, friends, and others.

2. Determine a color, size, and shape to represent each group of people, organization or institution. Select the color and size to represent strength or importance of the connection. Use different symbols in addition to the ones supplied.

3. Draw the connections between you and the components in your environment. The following symbols will help you illustrate the connections.

i). Use a solid line to indicate current connections.

ii). Use a double solid line to indicate particularly strong connections.

iii). Use dotted lines to show past connections that currently do not exist, but may become active again, e.g. with school, church.

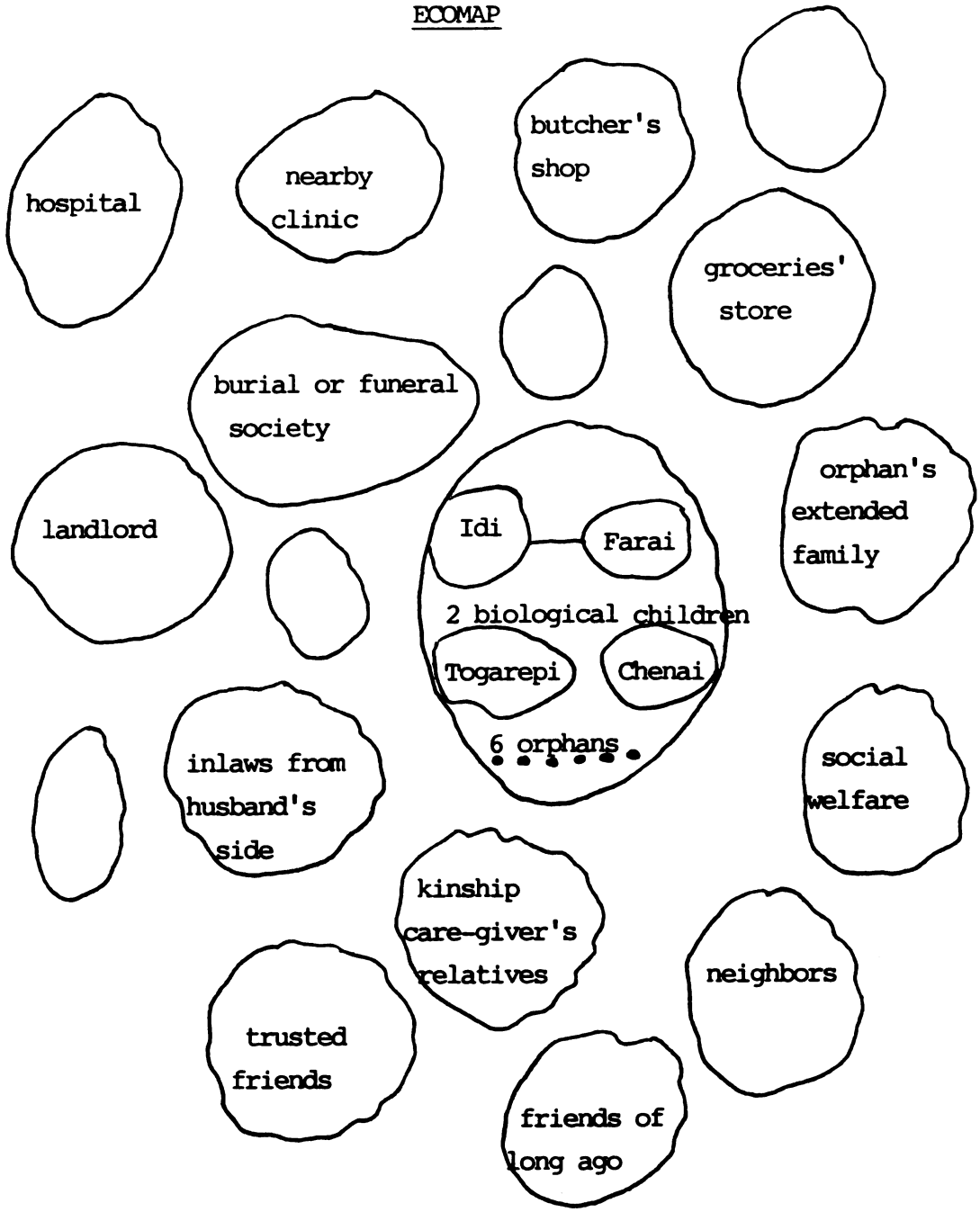
iv). On each dotted line, label the resources (i.e., food, clothing, gifts, cash, information, services, love/affection) that flow within the connections.

v). Use arrows to show direction in which the resources flow.

4. Refer to the illustration of a sample ecomap on the next page.

Instrument for social support networks using open-ended questions

ECOMAP



Legend

Fill in connections where they exist.

Indicate nature of connections with a descriptive word or drawing of lines:

Example: _____for strong .....for tenuous.

Appendix L

Kinship Care-Giver Child Rearing Practices Survey Instrument

Questionnaire designed by Mercy Chigubu (1997) at Michigan State University, College of Human Ecology, Department of Family and Child Ecology, East Lansing, MI 48823, USA. E-mail: chigubum@msu.edu OR chigubumercy@hotmail.com

Instructions

Inside this booklet, there are some questions that guide us to see how you feel about certain situations and problems involved in raising children. There is no "right" or "wrong" answer because it is true that every person has his or her own views about the way children should be raised. All you have to do is answer what is true for you. First of all, read the example below and decide which answer best describes your opinion or experience.

EXAMPLE: Children must participate in group activities such as boys scouts, girl guides, athletics, sports. If you "strongly agree" with the statement in this example, you would circle the "A".

A) strongly agree B) agree C) disagree
D) strongly disagree E) none of the above

1. **When the children under your care do what they are not supposed to do, and make you angry, you would apply**
   a) physical punishment by spanking b) no physical punishment

2. **How would you react to a child under your care who makes faces at you or frown at you when you are talking to them?**
   a) do as much as possible to ignore it
   b) all to happen only seldom
   c) stop it from happening ever again
   d) allow it: feel it is normal for children to do that
   e) permit it, but try to keep it from becoming a habit

3. **Do all the children under your care have house keeping chores?**
   a) yes, daily housekeeping duties
   b) yes, every child is responsible for keeping his/her room neat and tidy
   c) I help by cleaning the boys' rooms only
   d) only girls, not boys help with the house keeping chores

4. **In disciplining children, who should punish them?**
   a) men in the home
   b) women in the home
   c) men mostly, women sometimes
   d) women mostly, men sometimes
   e) 50% men, 50% women in that household

5. **How do you react when orphans whose parents died of HIV/AIDS continue to come and join your family?**
   a) it is a burden that is not easy to solve
   b) it is the most wonderful experience, the more the merrier
   c) would be easier if we had enough to eat, now it is hard
   d) orphans are hard to please, so I dislike the idea
   e) no matter what, I love children, orphans are very welcome

6. **What do you do if children under your care do well in school?**
   a) do not say anything: after all children need to do well
   b) once in a while; occasionally
   c) often will praise the child and maybe give a reward
   d) always give praise and reward
   e) always praise, but do not give reward

7. **With a middle childhood child, how much affectionate attention should adult caregivers give?**
   a) as much as possible
   b) enough to keep the child happy
   c) just some, but not too much to spoil the child
   d) little time; they need to start behaving like adults
   e) no time at all; they must set example for younger ones

8. **If the child became angry and struck you, would you**
   a) get a whip, belt or little branch to thresh the child
   b) talk to child to find out the reason
   c) wait until your husband comes and deals with the child
   d) probably would reason with the child
   e) never sit down and reason with the child

9. **What do you do if the child interrupts you and demands attention while you are busy talking to other adults?**
   a) always respond to the child's demands
   b) sometimes give attention, but not always
   c) respond very little to this behavior
   d) will give the child a look that tell them to disappear
   e) will not respond, but reprimand after visitors are gone

10. **At what age do you feel comfortable to talk about sex education, HIV/AIDS, and death as a result of AIDS?**
    a) 11 years and over
    b) 9 to 10 years
    c) 7 to 8 years
    d) 5 to 6 years
    e) never, I am not comfortable with sex education.

11. Taking care of your children as well as orphans can be a real challenge. How much of a burden is it to you?

a) a heavy burden to bear, I wish I could get assistance
b) a great joy for me indeed, the more we are the merrier
c) take a fair amount of pleasure in caring for orphans, there is no choice, so I just have to do it
d) if culture provided a choice, I would never choose to take care of orphans whose parents died of HIV/AIDS
e) caring for orphans is never a burden for me at all

12. Who decides rules concerning children under your care?

a) I do, always
b) I do mostly, my husband sometimes
c) I do mostly, other adults in the home sometimes
d) My husband mostly, I never do it
e) Other adults in the home mostly, I never do it

13. What do you do when children do what they are told?

a) reserve comments; it is not necessary to speak about it
b) occasionally praise the children
c) sometimes praise the children and maybe give rewards
d) always give praise
e) never praise nor give rewards; or they get spoiled

14. What do you do if the children shouted at you in anger?

a) strong physical punishment: slap, or leather belt
b) medium physical punishment: pinch, thresh with a small branch
c) mild physical punishment: spanking, pushing
d) punish by not giving them anything to eat for dinner
e) no physical punishment, no blocking of food to eat

15. What do you do if any child in your care asks you to do something that you think could be done by him/herself?

a) always insist that the child do it on their own
b) have the child to do it as often as possible
c) occasionally do it, but try to get child to do it
d) do it most of the time
e) will never do it, they need to learn to be responsible

16. Which of the children assist in doing household chores?

a) All housework is done by girls, even if boys are present
b) Sometimes boys do housework, but mostly it is the girls
c) Very rarely do boys do housework, only in emergencies
d) Boys never do house chores, except if girls are absent
e) None of the children assist me in doing household chores

17. How well does your spouse handle discipline problems?

a) extremely, children fear getting disciplined by him
b) very well, he is a strong force to reckon with
c) permissive, he only wants to appease the children
d) poorly, he will always say "next time do not do it"
e) never opens his mouth, I always end up disciplining

18. What age group do you enjoy to take care of?

a) 13-18 years
b) 6-12 years
c) 1-5 years
d) under 1 year old
e) none of the above

19. In playing, if you heard that your children's friends have AIDS or are HIV positive, how would you react?

a) stop my children from playing with those children
b) stop the orphans from playing with my children
c) will not comment at all, HIV/AIDS does not harm play
d) will teach my children not to discriminate orphans
e) ask church minister stop orphans coming to my house

20. What do you do if your child hits orphan in your care?

a) let them fight until the weaker one surrenders
b) let them fight for a while, and later on intervene
c) definitely step in and settle the fight myself
d) physically punish both of them
e) will punish both, by giving them extra work to do

21. What kind of rules do you have for engaging in school truancy, lying, not obeying school rules, and stealing?

a) no rules, the teachers should do the job
b) a few rules, most rules should be given by teachers
c) many, these days teachers never give strict rules
d) rules that just about cover everything
e) give rules only after a problem arises

22. To what extent does the extended relatives assist you in caring for the orphans in your home?

a) takes a very large part
b) assumes a fair part
c) takes a little part
d) before orphans joined us it was high, now it is low
e) nobody assists at all

23. How do you prefer orphan(s) in your care to react if bullied by child(ren) who knows of orphan's HIV/AIDS parents

a) ask your child to assist the orphan to fight the bully
b) ask me for help
c) ask for my help, then I ask bully's parents to settle it
d) if orphan is in no physical danger, let them settle it
e) definitely let orphan settle it on their own, regardless

24. How strict are you about the children's bedtime?

a) no set time, child goes to bed when ready to fall asleep
b) child has a bedtime set and is expected to stick to it
c) child has a bedtime but often goes much later
d) child must be quiet and fall asleep when bedtime comes
e) child must finish housework first before going to sleep

25. How much time does your spouse spend playing or conversing with the children each day on average?

a) about 2 hours a day
b) about 1 hour a day
c) about 30 minutes a day
d) about 10-15 minutes a day
e) very rarely if any, per day

26. Children are often noisy and may like to shout or play the radio loud. What are your rules about noise?

a) children should not be allowed to make noise
b) children must be quiet enough not to disturb others
c) it is OK to be noisy at certain times and places
d) children can be noisy almost anytime
e) if everyone else is noisy, they might as well be noisy

27. Some people get intimidated taking care of children ages 6 to 12. Is it because at this stage children:

a) are too independent
b) talk back and like to disobey
c) become rough, too active, and like to use slang words
d) are too much trouble to take care of
e) get outside influence from friends and in-laws

28. Does your spouse get angry with the children so often?

a) yes very often
b) quite often
c) sometimes
d) very rarely
e) no, hardly ever

29. If the child in your home has boyfriend or girlfriend at the age of 9, 10 or 11 years, what would you do?

a) very strict. Child is physically punished
b) fairly strict. Child is scolded and told to stop it
c) moderately strict. Child is warned of HIV/AIDS
d) I report the matter to my husband to deal with it
e) Ignore, after all that is part of growing up

30. Most adults cannot understand why middle childhood children wet their bedding. How do you react if children between 6 and 12 years wet their bedding?

a) do not give the children anything to drink after 6 pm
b) wake them up twice every night
c) feel sorry for them and tell them it is a normal thing
d) embarrass them and that way they can stop
e) make them drink their urine, it cures the bed wetting.

Appendix M

Self-Esteem Questionnaire

Questionnaire designed by Mercy Chigubu (1997) at Michigan State University, College of Human Ecology, Department of Family and Child Ecology, for young children, including orphans under home-based family care in Zimbabwe.

INSTRUCTIONS

Please give answers to the questions that you are given in this questionnaire.

1. **I feel I am a person of worth, I feel equal to all others**
   1----------Strongly agree
   2----------Agree
   3----------Disagree
   4----------Strongly disagree
2. **I feel that I am somebody that has a number of good qualities**
   1----------Strongly agree
   2----------Agree
   3----------Disagree
   4----------Strongly disagree
3. **Come to think of it, I tend to feel that I am a failure**
   1----------Strongly agree
   2----------Agree
   3----------Disagree
   4----------Strongly agree
4. **I feel too many of my friends hate to be around someone who has a relative that died of HIV/AIDS**
   1---------Strongly agree
   2---------Agree
   3---------Disagree
   4---------Strongly disagree
5. **I am able to do things as well as most other**
   1---------Strongly agree
   2---------Agree
   3---------Disagree
   4---------Strongly disagree
6. **I feel I do not have much to be proud of**
   1---------Strongly agree
   2---------Agree
   3---------Disagree
   4---------Strongly disagree
7. **When I look in the mirror, I feel happy about myself.**
   1---------Strongly agree
   2---------Agree
   3---------Disagree
   4---------Strongly disagree

8. On the whole, I am satisfied with myself

1---------Strongly agree
2---------Agree
3---------Disagree
4---------Strongly disagree

9. I wish I could feel happy about myself

1----------Strongly agree
2----------Agree
3----------Disagree
4----------Strongly disagree

10. I certainly feel useless at times

1---------Strongly agree
2---------Agree
3---------Disagree
4---------Strongly disagree

11. Do you keep changing your mind about the way you feel about your self?

1------Yes, this happens often
2------Yes, this happens sometimes
3------Yes, this rarely happens
4------ No, this never happens

12. Since death occurred in our family, I have noticed that my ideas about myself seem to change very quickly

1----- Agree
2----- Disagree

13. Some days I have a very good opinion of myself; other days I have very poor opinion of myself.

1----- Agree
2----- Disagree

14. I feel that nothing, or almost nothing, can change my mind in the way I feel about myself

1------Agree
2------Disagree

15. No one cares what happens to you, come to think of it.

1--------Agree
2--------Disagree

16. Human nature is really cooperative, helpful and kind.

1--------Agree
2--------Disagree

17. Some people say most people can be trusted. Others say, "Don't trust anybody except yourself." What do you say?

1---------Most people can be trusted
2---------Don't trust anybody!

18. If you do not watch your back you can be taken advantage

1--------Agree 2---------Disagree

19. When a loved family member dies of AIDS, most people avoid talking about it and pretend it was not HIV/AIDS 1. Yes 2. No

20. How sensitive are you to criticism?

1---------Extremely sensitive
2---------Quite sensitive
3---------Somewhat sensitive
4---------Not sensitive

21. Criticism or scolding hurts me terribly

1--------Agree 2--------Disagree

22. How disturbed do you feel when anyone laughs at you or blames you for something you have done wrong?

1--------Deeply disturbed
2--------Fairly disturbed
3--------Not disturbed

23. Children whose parents or relatives died of AIDS tend to be ignored by some people.

1--------Many people do that
2--------Very few people do that
3-------- Nobody in my area does that

24. On the whole, how happy would you say you are?

1------Very happy
2------Fairly happy
3------Not very happy
4------Very unhappy

25. When my beloved relative died, nobody sat down with me to talk about death, or how I should face life. When I think about their death, I get depressed and do not know what to do.

1--------This is very true. It happened to me
2--------This is not true. It never happened to me

26. Although my beloved parents or relatives died, I have got over it, and I am generally in good spirits.

1--------Yes, I am generally in good spirits
2--------No, I am in low spirits most of the time

27. I get a lot of fun out of life.

1---------Agree
2---------Disagree

28. How often do you feel downcast, unwanted, dejected, and stigmatized?

1---------Always
2---------Fairly often
3---------Rarely
4---------Never

29. Most of the time I would rather sit, daydream, and worry

1---------Agree
2---------Disagree

30. I guess I daydream because since we had death in our family, I lost many of my friends that I used to trust.

1---------Agree 2---------Disagree

Appendix N

Informed Consents

Informed Consent for Participants

* This project will explore self-esteem of orphans whose parents died of HIV/AIDS; determined by the extended family /kinship caregivers' economic well-being, social support networks, and child rearing practices in Zimbabwe.

* Research participants include a kinship care-giver (woman), an orphan under care, and a non-orphan under care.

* The focus group member will accompany the researcher, but will not be included in the interview, and each research participant will be interviewed separately, and privately.

* The orphan should have been in the home-based care of the kinship caregiver for at least 12 months long.

* Information shared by research participating members will be utilized for research purposes only.

* Please note: You DO NOT have to put your name on this questionnaire. Thank you. Confidentiality of names is of prime concern. Your name will not be given to anyone. All information is strictly confidential.

* Mercy Susan Chigubu, a doctoral student in the College of Human Ecology, Department of Family & Child Ecology, at Michigan State University, East Lansing, MI 48823, USA, e-mail: chigubum@msu.edu is responsible for this project.

* A summary of what is learned from the project, and copies of any published reports about the project, will be provided to participants who request reports.

* Information will be collected through interview and questionnaire; therefore you will notice that the researcher will engage in a lot of writing during the interview. This process should not at all intimidate you, because it is just the nature of the research process, that I should record as you respond to the questions.

* The interview with the kinship caregiver will last two hours, and for the children, the interview shall last between 15 minutes and 1 hour. At the end of the interview, each participant will receive a Z$50.00 fee.

* For those participants who do not feel comfortable to answer the questions in either English or Shona (researcher's vernacular language), but might feel comfortable to use either Ndebele or Nyanja, then the researcher will audiotape the interviews. Only the researcher will have access to the audiotapes. The audiotapes will be used for this research project only, and will be kept in a locked file in the researcher's office. The tapes will be transcribed and erased within 30 days of the time the interviews take place.

Participation in this project is a choice. You have all the right to drop out of the project interview process at any time, or refuse to answer any question at any time. Your agreement to participate may be withdrawn at any time. Withdrawal from the project is without penalty, as it will have no adverse effects on your continuing relationship with the focus group member who made us know each other.

As a participant in this research project, I agree to the terms as stated.

Signature of kinship care-giver _____Date:

Signature of orphan under care _____Date:

Signature: non-orphan under care _____Date:

Witness _____Date:

I/We received a ZS50.00 fee for participation in this research project.

Signature of kinship care-giver _____Date:

Signature of orphan under care _____Date:

Signature: non-orphan under care _____Date:

Witness _____Date:

Informed Consent for Focus Group Member/Participant

* You have been asked to participate in focus group meetings because the target sample to participate in this research is not listed in any telephone directory, and the sample is very hard for the researcher to locate without your assistance. The target sample is highly diverse, dealing with a very delicate but explosive topic, that is, HIV/AIDS or *Svuuramatongo* or *Mukondombera*.

* Mercy Susan Chigubu, (telephone number) is responsible for this project, where, as the researcher, she is exploring the self-esteem of orphans whose parents died of HIV/AIDS; examined through the extended family/kinship caregivers' economic well-being, social support networks, and child-rearing practices in Zimbabwe.

* Information you share will be utilized for research purposes only, and will be confidential. Neither your name, nor the participants that you identify for target sample, will appear on interview materials. Easily recognized unique attributes of all research participants will be disguised in any publications of the research.

* Your data is requested because, as community activists, and participants of this focus group, you may have experience and have insights into the dynamics of the target sample.

* Your information may be included in two ways in the report of the project:
(1) Information specific to the target sample members will be included with the analysis of data specific to the target sample member(s)' case as provided by each sample member.
(2) Your information will be reported in a separate section in which perceptions of all participants will be reported and analyzed in a confidential way. In this phase, efforts will be made to successfully mold the link between the focus group members' remarks and the particular research participants.

* A summary of what is learned from the study, and copies of any published reports about the project, will be made available upon request to participating focus group members.

* If your interview will be audiotaped, only the researcher will have access to the audiotape. The audiotape will be used for this research project only, and will be securely

kept in a locked safe in the researcher's office. The tapes will be transcribed and erased within 30 days of the time the interviews are conducted.

Participation in this research study is an informed choice. You have all the right to drop out of the project interview process at any time, or refuse to answer any question at any time. Your agreement to participate may be withdrawn at any time. Withdrawal from the project is without penalty, as it will have no adverse effects on your continuing relationship with the focus group member who made us know each other.

As a participant in this research project, I agree to the terms as stated.

Signature of focus group member

Date:

Appendix Q

Dissertation Title

Exploring Self-Esteem of Orphans Whose Parents Died of HIV/AIDS; Examined Through Extended Family/Kinship Care-Givers' Economic Well-Being, Social Support Networks, and Child-Rearing Practices in Zimbabwe.

Instrument/Guides for Semi-Structured Interviews for the Focus Group Participants

Instrument designed by Mercy Chigubu (1997) at Michigan State University, College of Human Ecology, Department of Family and Child Ecology, East Lansing, MI 48823, USA.

E-mail: chigubum@msu.edu OR chigubumercy@hotmail.com

Instructions

Inside this booklet, there are some questions, which guide us to see how you feel about certain situations and problems relating to the advent of HIV/AIDS in your communities. There is no "right" or "wrong" answer. All you have to do is answer what is true for you. All you have to do is to decide on which answer to provide, that best describes your opinion or experience.

Guides for Semi-Structured Interviews for Focus Group

1. Since the advent of HIV/AIDS, do you and your families ever talk openly about the problems that orphans whose parents die of HIV/AIDS are likely to face? Is there anything that you consider a taboo to talk about? Is there anything bound by culture, traditions, and norms?

2. Is there anything you have noticed about yourself, your family, relatives, neighbors, community, or society, regarding HIV/AIDS, orphans, or kinship care giving?

3. How does taking care of a child whose parents died of HIV/AIDS differ from taking care of a non-orphan?

4. For those extended families that have been unceremoniously joined by orphans whose parents died of HIV/AIDS, do you think that the orphans have made the lives of these relatives: a) unbearable?

b) joyful?

c) impoverished?

d) stigmatized?

e) comfortable?

Explain in detail, the choice of your answer(s).

5. Imagine you were an orphan whose parents died of HIV/AIDS. What are the problems that you were likely to face:

a) before death of your parent(s)?

b) at the funeral of your parent(s)?

c) after the burial rituals of your parent(s)?

d) when migrating across the country searching for relatives that you can unceremoniously join?

e) adjusting to live with the extended family?

f) regarding school, fees, levy, new friends?

g) regarding friendships, stigma, trust and denial?

6. How would you solve any conflicting problems arising as a kinship caregiver, an orphan, a friend to an orphan, or a friend to the kinship caregiver?

7. Does culture in any way affect the way kinship caregivers react to taking care of orphans?

8. Is there any terminology that is considered "socially undesirable" that as a researcher, I should be aware of when conducting this study? If yes, elaborate please.

9. What do you think about what society regards as taboos, or socially acceptable or socially undesirable terms?

10. Are there any organizations in your community that assist in any form orphans whose parents die of AIDS?

11. We understand "denial" does exist when people have to discuss HIV/AIDS. Do you know why? Explain fully.

12. Have there been any times when something has happened

to you or your families that reminds you of the words:

a) *Self-esteem?*

b) Social support networks?

c) Economic well-being?

d) Child rearing practices?

13. Describe briefly what each of these four mean to you.

Guide for Semi-Structured Interview about Instruments

14. Having gone through the Child Rearing Practices, Economic Well-Being, Self-Esteem, and Social Support Networks instruments:

a) Are there any ambiguous questions in these instruments?

b) Are there questions you would consider "not sensitive to culture?"

c) Are there taboo questions that you would not feel comfortable to answer?

d) Are there questions that you would re-word?

15. How would you like the study to be different?

16. What ideas, techniques, or approaches would you change if you were to direct this study in later years?

17. Rate the things that you think can bring stress to kinship caregivers of orphans, orphans, and non-orphans under care. From the list below, choose only 5 top items that

are stressful to orphans, and make a separate list of stressors for kinship caregivers. Rate like this: highest stressor =1st

Example: Orphan: (highest) could be poverty: recorded as: (1st) Follow: lack of counseling:(2nd) and so on up to 10. When complete, make a list for kinship caregivers.

List to choose from: Feel free to add new items:

in-laws, school, poverty, lack of counseling, church, social support networks, lots of money, HIV/AIDS stigma, neighbors, child rearing practices, loss of peers, guilt disorder syndrome, culture, societal pressure, and relatives.

BIBLIOGRAPHY

BIBLIOGRAPHY

Aber, J. L., & Cicchetti, D. (1984). The socio-emotional development of maltreated children. An empirical and theoretical analysis. In H. Fitzgerald, B. Lester (Eds.), *Child abuse and neglect*, New York: Cambridge University Press.

Adamchak, Donald, *et al.* (1990). Male knowledge of and attitudes and practices towards AIDS in Zimbabwe. *AIDS*, 4, 245-250.

Agar, M. H. (c.1980). *The professional stranger: An informal introduction to ethnography*. New York: Academic Press.

Albrecht, K. M., & Plantz, M. C. (1991). *Developmentally appropriate practice in school-age child care programs*. Alexandria, VA: Project Home Safe, American Home Economics Association.

Alonzo, A. A., & Reynolds, N. R. (1995). Stigma, HIV and AIDS: An exploration and elaboration of a stigma trajectory. *Social Science and Medicine*, 41(3), 303-315.

American Home Economics Association (1989). Alternative modes of inquiry in home economics research. *Home Economics Teacher Education*. Peoria, IL: Glencoe Publishing Co.

Apfel, R. J., & Telingator, C. J. (1995). What can we learn from children in war? In S. Geballe, J. Gruendel, & W. Andiman (Eds.), Forgotten *children of the AIDS epidemic*. New Haven, CT: Yale University Press, 19-31.

Aschennbrener, J. (1973). Extended families among Black Americans. *Journal of Comparative Family Studies*, 4, 257-268.

Babbie, E. (1990). *Survey research methods*. Belmont, CA: Wadsworth.

Bacon, F. (1620). Aphorism XIX: Novum Organum. In D. Reynolds (1971), *A primer in theory construction.* New York: MacMillan Publishing Co.

Barrera, M. Jr., Chassin, L., & Li, S.A. (1993). Ethnic group differences in vulnerability to parental alcoholism and life stress: A study of Hispanic and non-Hispanic Caucasian adolescents. *American Journal of Community Psychology*, (21), 15-35.

Barrera, M., Jr. (1986). Distinctions of social support concepts, measures, and models. *American Journal of Community Psychology*, (14), 413-445.

Barrera, M., Jr. (1988). Models of social support and life stress: Beyond the buffering hypothesis. In L. H. Cohen (Ed.), *Life events and psychological functioning: Theoretical and methodological issues*. Newbury Park, CA: Sage Publications, 211-236.

Barton, K., Dielman, T. E., & Cattell, R. B. (1974). Child rearing practices and achievement in school. *The Journal of Genetic Psychology,* 124, 155-165.

Barusch, A. S. (1988). *Caregiver support project: Final report.* Salt Lake City, UT: Social Research Institute.

Batezat, E., & Mwalo, M. (1989). *Women in Zimbabwe*. Harare: Southern Africa Political Economy Series Trust.

Baumrind, D. (1966). Effects of authoritative parental control on child behavior. *Child Development*, 3(4), 887-907.

Baumrind, D. (1971). Current patterns of parental authority. *Developmental Psychology Monographs*, Part 2, 4(1), 1-103.

Baumrind, D. (1972). An exploratory study of socialization effects on black children: Some black-white comparisons. *Child Development,* 43(1), 261-267.

Baumrind, D. (1978). Parental disciplinary patterns and social competence in children. *Youth and Society*, 9(3), 239-276.

Baumrind, D. (1989). Rearing competent children. In W. Dammon (Ed.), *Child development today and tomorrow*. San Francisco: Jossey-Bass, 349-378.

Baumrind, D. (1991a). Parenting styles and adolescent development. In R. Lerner, A. C. Peterson, & J.Brooks-Gunn (Eds.), *The Encyclopedia on Adolescence*. New York: Garland, 758-772.

Baumrind, D. (1991b). The influence of parenting styles on adolescent competence and substance abuse. *Journal of Early Adolescence*, 11(1), 56-94.

Baumrind, D. (1995). *Child maltreatment and optimal care giving in social contexts*. New York: Garland.

Becker, W. C. (1964). Consequences of different kinds of parental discipline. In M. L. Hoffman & L. W. Hoffman (Eds.), *Review of child development research*, Vol. 1. Chicago: University of Chicago Press, 169-208.

Belsky, J. (1984a). Child maltreatment: A developmental-ecological analysis. *Development and Psychopathology*. 3(1), and 31-36.

Belsky, J. (1984b). Child maltreatment: An ecological integration. *American Psychologist*, (35), 320-335.

Belsky, J. (1984c). The determinants of parenting: A process model. *Child Development*, 55, 83-96.

Belsky, J. (1993). Etiology of child maltreatment: A developmental-ecological analysis. *Psychological Bulletin*, 114(3), 413-434.

Belsky, J., Lerner, R. M., & Spanier, G. B. (1984). *The child in the family*. Reading, MA: Addison-Wesley.

Belsky, J., Steinberg, L., & Draper, P. (1991). Childhood experience, interpersonal development, and reproductive strategy: An evolutionary theory of socialization. *Child Development*, (62), 647-670.

Benner, P., Roskies, E., & Lazarus, R. (1980). Stress and coping under extreme conditions. In J. E. Dimsdale (Ed.), Survivors, victims, and perpetrators. *Essays on the Nazi holocaust*. Washington, DC: Hemisphere, 219-258.

Benson, P. (1997). *All kids are our kids*. San Francisco: Jossey-Bass.

Berkeley, S., *et al.* (1990). AIDS and HIV infection in Uganda: Are women more infected than men? *AIDS*, 4:1237-1242.

Berman, L. E. (1978). Sibling loss as an organizer of unconscious guilt: A case study. *Psychoanalytic Quarterly*, 47(4), 568-587.

Bernstein, H. (1983). *Death is part of the process*. London: Sinclair Browne.

Bertalanffy, L. A. (1968). *General systems theory: Foundation, developments, applications*. New York: Braziller.

Billingsley, A. (1968). *Black families in white America*. Englewood Cliffs, NJ: Prentice-Hall.

Binger, C. M., Ablin, A. A. R., Feuerstein, R. C., Kushner, J. H., Zoger, S., & Mikkelsen, C. (1969). Childhood leukemia. Emotional impact on patient and family. *New England Journal of Medicine*, (280), 414-418.

Birenbaum, A. (1970). The mentally retarded child in the home and family cycle. *Journal of Health and Social Behavior*, (12), 55-65.

Black, D., & Urbannowicz, M. A. (1987). Family intervention with bereaved children. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 28, 467-476.

Bledsoe, C. H. (Ed.) (1993). *Social dynamics of adolescent fertility in Sub-Saharan Africa*. Washington, DC: National Academy Press.

Bloom, B. (1964). *Stability and change in human characteristics*. New York: Wiley.

Bobbitt, N. (1999). (Professor who taught me Theory Construction Graduate Course. offered in the Department of Family and Child Ecology, College of Human Ecology, Michigan State University, East Lansing, MI).

Bodgan, R., & Biklen, S. (1992). *Qualitative research for education: An introduction to theory and methods*. Neadham Heights, MA: Simon & Schuster, Inc.

Boland, M. G., Tasker, M., Evans, *et al.*, 1987. Helping Children with AIDS: The role of the child welfare worker. *Public Welfare*, 26.

Bonis, J., Verdier M., & Denis, F. (1993). Low HTLV-II seroprevalence in Africa. *Journal of Nature*. (Submitted for publication)

Bowbly, J. (1961b). Processes of mourning. *International Journal of Psychoanalysis*, 42, 317-340.

Bowlby, J. (1961a). Childhood mourning and its implications for psychiatry. *American Journal of Psychiatry*, 118, 481-498.

Bowlby, J. (1969). Attachment. *Attachment and loss*, Vol. 1. New York: Basic Books.

Bowlby, J. (1980). Loss: Sadness and depression. *Attachment and loss*. (Vol. 3). New York: Basic Books.

Bowman, P., & Howard, C. (1985). Race-related socialization, motivation, and academic achievement: A study of black youth in three-generation families. *Journal of the American Academy of Child Psychiatry*, 24, 134-141.

Boyce, W. T., & Jemerin, J. M. (1990). Psychobiological differences in childhood stress response: Patterns of illness and susceptibility. *Developmental and Behavioral Pediatrics, II*, 86-93.

Bradley, R. H. (1993). Children's home environments, health, behavior, and intervention efforts: A review using the HOME Inventory as a marker measure. *Genetic, Social, and General Psychology Monographs*, 119, 439-490.

Bradley, R. H., Caldwell, B. M., & Rock, S. L. (1990). Home Environment classification system: A model for assessing the home environments of the developing child *Early Education and Development*, I, 238-265.

Bradley, R. H., Rock, S. L., & Whiteside, L. (April, 1990). *Home environment and intellectual development in the first 3 years: A structural analysis*. Paper presented at the 7th International Conference on Infancy Studies, Montreal and Quebec, Canada.

Bradley, R., & Caldwell, B. M. (1979). Home environment and locus of control. *Journal of Clinical Child Psychology*, 8,107-110.

Bredo, E., & Feinberg (Eds.). (1982). *Knowledge and values in social and educational research.* Philadelphia: Temple University Press.

Brinich, P. M. (1989). Love and anger in relatives who "adopt" orphaned children: Parents by default. *Bereavement Care*, 8(2), 14-16.

Brody, G. H., Stoneman, Z., Flor, D., McCrary, C., Hastings, L., & Conyer, O. (1994). Financial resources, parent psychological functioning, parent co-care-giving, and early adolescent competence in rural two-parent African-American families. *Child Development*, 65(2), 590-605.

Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.

Bronfenbrenner, U. (1985). Freedom and discipline across the decades. In G. Becker, H. Becker, & L. Huber (Eds.), *Ordnung and Unordnung [Order and Disorder].* Weinheim, Germany: Beltz Verlag.

Bronfenbrenner, U. (1989). Ecological systems theory. *Annals of Child Development:* (6), 187-249.

Bronfenbrenner, U., & Ceci, S. (1994). Nature-nurture reconceptualized in developmental perspective: A bio-ecological model. *Psychological Review*, 101 (4), 568-588.

Brooks-Gunn, J., Duncan, G. J., Klebanov, P. K., & Sealand, N. (1993). Do neighborhoods influence child and adolescent development? *American Journal of Sociology*, 99, 355–395.

Brown, M. (1985). *Philosophical studies in Home Economics in the United States: Our practical-intellectual heritage, (two volumes).* East Lansing, MI: Michigan State University, College of Human Ecology.

Brown, M., & Paolucci, B. (1979). *Home Economics: A Definition.* Washington D.C.: American Home Economics Association.

Bubolz, M. M., & Sontag, M. S. (1993). Human ecology theory. In P. G. Boss, W. A. Doherty, R. LaRossa, W. R. Schumm, & S. K. Steinmetz (Eds.), *Sourcebook of Family Theories and methods: A contextual approach.* New York: Plenum, 419-448.

Burgess, R. L., & Conger (1978). Family interaction in abusive, neglectful, and normal families. *Child Development,* (49), 1163-1173.

Burke, P. (1995). In E. Reid (Ed.). *HIV & AIDS: the global inter-connection.* West Hartford, CT: Kumarian Press.

Burton, R. V., & Whiting, J. W. M. (1960). The absent father and cross-sex identity. *Merrill-Palmer Quarterly of Behavior and Development*, 7, 85-95.

Cahill, K. M. (Ed.) (1983). *The AIDS Epidemic.* New York: St. Martin's Press.

Cain, A. C., Fast, I., & Erickson, M. E. (1964). Children's disturbed reactions to the death of a sibling. *American Journal of Orthopsychiatry*, (34), 741-752.

Caldwell, B., & Bradley, R. (1984). *Home observation for measurement of the environment*. Little Rock, AR: University of Arkansas at Little Rock.

Campbell, A. (1979). *Listen to the children*. London: Grosvenor Books.

Cantor, D. W., & Drake, E. A. (1983). *Divorced parents and their children: A guide for mental health professionals*. New York: Springer.

Carovano, K. (1991). More than Mothers and Whores: Redefining the AIDS Prevention Needs of Women. *International Journal of Health Services*, 21 (1): 131-142.

Carr, Wilfred, & Kemmis, S. (1986). *Becoming critical: Education, knowledge, and action research*. London; Philadelphia: The Falmer Press.

Carraher, T., Carraher, D., & Schliemann, A. (1985). Mathematics in the streets and schools. *British Journal of Developmental Psychology*, (3), 21-29.

Chase, H., & Martin, H. (1970). Undernutrition and child development. *New England Journal of Medicine*, 282, 933-939.

Chasnoff, I., Landress, H., & Barrett, M. (1990). The prevalence of illicit drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. *New England Journal of Medicine*, 322, 1202-1206.

Chigubu, M. (1997). *Who will take care of my children? Orphans of after HIV/AIDS on the eve of 2000 AD*. Paper presented for a Research Grant Proposal: presented at the Rockefeller African Development Dissertation Workshop at the University of Illinois at Urbana-Champaign: May 11-14, 1997. Michigan State University, East Lansing, MI.

Chigubu, M. (1998). *Orphans and kinship care-giving*. Unpublished Research for Dissertation. Michigan State University, East Lansing, MI.

Chin, J. (1990). Current and future dimensions of HIV/AIDS pandemic in women and children. *Lancet*, 336, 221-224.

Chipika, J., & Getecha, C. (1995). *Zimbabwe women's voices.* ZWRCN Zimbabwe Women's Resource Centre and Network: Harare, Zimbabwe.

Chisvo, M., & Jayne, T. S. (1991). *Is grain availability an important determinant of variation of nutritional status among children? Preliminary evidence and policy implications from Zimbabwe's communal areas.* Paper presented at the Seventh Annual Conference on Food Security in Southern Africa, October 1988, Victoria Falls.

Christ, C. (1987). Toward a paradigm shift in the academy and in religious studies. In C. Farnham (Ed.), *The impact of feminist research in the academy.* Bloomington, IN: Indiana University Press.

Clark, R. (1983). *Family life and school achievement: Why poor black children succeed or fail.* Chicago: University of Wisconsin Press.

Clayton, L. T. (Ed.) (1985). *Tabers Cyclopedic Medical Dictionary,* 15th ed. Philadelphia: F. A. Davis.

Cobb, S. (1976). Social support as a moderator of life stress. *Psychosomatic Medicine,* (38), 300-314.

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin,* (98), 310-357.

Coles, R. (1971a). Migrants, sharecroppers, mountaineers. *Children of crisis, Vol. 2.* Boston: Little, Brown and Co.

Coles, R. (1971b). The South goes North. *Children of crisis, Vol. 3.* Boston: Little, Brown and Co.

Colletta, N. (1981). Social support and the risk of maternal rejection by adolescent mothers. *Journal of Family Issues,* 4, 127-143.

Colletta, N., & Lee, D. (1983). Impact of support for black adolescent mothers. *Journal of Family Issues*, (4) 127.

Colletta, S. P., Clement, & Edwards, H. P. (1983). *Community and parental influence: Effects on student motivation and French second language proficiency*. Quebec: International Center for Research on Bilingualism

Columbia University, Bureau of Applied Social Research. (1981). *The snowball technique as a device for studying foreign broadcast listeners*. Microfiche. New York: Clearwater Publishing Co.

Comstock, D. (1982). A method for critical research. In E. Bredo and W. Feinberg (Eds.), *Knowledge and values in Social and Educational research.* Philadelphia: Temple University Press.

Conger, R. D., Conger, K. J., Elder, G. H., Lorenz, F. O., Simons, R. L. & Whitbeck, L. B., (1992). A family process model of economic hardship and adjustment of early adolescent boys. *Child Development*, 63(3), 526-541.

Conger, R. D., Elder, G. H., Lorenz, F. O., Simons, R. L., & Whitbeck, L. B. (1994). *Families in troubled times: Adapting to change in rural America*. New York: A. de Gruyter.

Conger, R. D., McCarty, J., Yang, R., Lahey, B., & Kropp, J. (1984). Perception of child, child-rearing values, and emotional distress as mediating links between environmental stressors and observed maternal behavior. *Child Development*, 55(6), 2234-2247.

Connelly, E. (1979). Review essays: History and Theory. *Journal of Teacher Education* 56(9), 13-19.

Conrad, P. (1990). Qualitative research on chronic illness: A commentary on method and conceptual development. *Social Science and Medicine*, 30, 1257-1263.

Coomer, D. L. (1986). Reformulating the evaluation process. In K. Sirotnik and J. Oakes (Eds.), *Critical perspectives on the organization and improvement of schooling*. Boston: Kluwer Nijhoff Publishing.

Coomer, D. L. (1989). Introduction to critical inquiry. *Journal of the American Home Economics Association*. Peoria, IL: Glencoe Publishers.

Coopersmith, S. (1967). *The antecedents of self-esteem*. San Francisco: W. M. Freeman.

Corse, S. J., Schmid, K., & Trickett, P. K. (1990). Social network characteristics of mothers in abusing and nonabusing families and their relationships to parenting beliefs. *Journal of Community Psychology*, (18), 44-59.

Courtois, C. A. (1988). *Healing the incest wound: Adult survivors in therapy*. New York: Norton.

Courtois, C. A. (1995). Assessment and diagnosis. In C.Classen & I.D.Yalom (Eds.), *Treating women molested in childhood*. San Francisco, CA: Jossey Boss, 1-34.

Crain, A. J., Sussman, M. B., & Weil, W. B. (1966). Effects of a diabetic child on marital integration and related measures of family functioning. *Journal of Health and Human Behavior*, (7), 122 - 127.

Cravioto, J., & Delicardie, R. (1972). Environmental correlates of severe clinical malnutrition and language development in survivors of Kwashiorkor or Marasmus. In *Nutrition: The nervous system and behavior*. Scientific Publication No. 251. Washington DC: Pan-American Health Organization, 73-94.

Cuff, M. (1994). *Infections Frequently Associated with AIDS*. New York: Gay Men's Health Crisis.

Dadds, M. (1987). Families and the origins of child behavior problems. *Family Process*, 26 (3).

Daly, K. (1992). The fit between qualitative research and the characteristics of families. In J. F. Gigun, K. Daly, & G. Handel (Eds.), *Qualitative Methods in Family Research*. Newbury Park, CA: Sage.

Dane, B. O. (1994). Death and bereavement. In B. O. Dane & C. Levine, (Eds.) *AIDS and the new orphans: Coping with death*. Westport, CT: Auburn House, 13-32.

Dane, B. O., & Miller, S. O. (1992). *AIDS: Intervening with hidden grievers*. Westport, CT: Auburn House.

Davies, R., & Sanders, D. (1987). Adjustment policies and the welfare of children: Zimbabwe 1980-85. In A. Cornia *et al.* (Eds.), *Adjustment with a human face: Country case studies. Vol.2*. Oxford: Clarendon Press.

Delaporte, E., Dupont, A., Peeters, M., *et al.* (1988). Epidemiology of HTLV-1 in Gabon (Western Equatorial Africa). *International Journal of Cancer*, (42), 687-689.

Denhe, K., Dhlakama, D., Richter, C., Mawadza, M., McClean, D., Huss, R. (1992). In M. Essex, S. Mboup, P. J. Kanki, & M. R. Kalengayi (Eds.) (1995), *AIDS in Africa*. New York: Raven Press. 38: 139-143.

Denis, F., Bonis, J., Verdier, M. (1992). The Prevalence and Incidence of HTLVs in Africa. In *Epidemiologie mondiale des virus HTLV-1 et II.* Symp HTLV, Lemoges, France: Montpellier, 114-118.

Department of Health and Human Services (1988). Secretary's Work Group on Paediatric HIV Infection and Disease. Washington, DC: Superintendent of Documents, U.S. Government Printing Office, 13.

DiSessa, A. (1985). Phenomenology and the evolution of intuition. In D. Gentner & A. L. Stevens (Eds.), *Mental models*. Mahwah, NJ: Lawrence Erlbaum Associates.

Dodge, K. A., Pettit, G. S., & Bates, J. E. (1994). Socialization mediators of the relation between socioeconomic status and child conduct problems. *Child Development.* 65(2), 649-665.

Dornbusch, S., Ritter, P., Leiderman, P., Roberts, D., & Fraleigh, M. (1987). The relation of parenting style to adolescent school performance. *Child Development,* (58), 1244-1257.

Dreman, S. (1997). *The family on the threshold of the 21st Century: Trends and implications.* Mahwah, NJ: Lawrence Erlbaum Associates.

Dressler, W. (1985). Extended family relationships, social support, and mental health in a southern black community. *Journal of Health and Social Behavior*, 26(1), 39-48.

Duncan, G. J., & Coe, R. D. (1984). *Years of poverty, years of plenty: The changing economic fortunes of American workers and families.* Ann Arbor, MI: Survey Research Center, Institute for Social Research, The University of Michigan.

Duncan, G., & Rogers, W. (1992). Single parent families: Are their economic problems transitory or persistent? *Family Planning Perspectives, (19)*, 171-178.

Egeland, B., & Sroufe, A. (1981). Developmental sequelae of maltreatment in infancy. In R. Rizley & D. Cicchetti (Eds.), *New directions for child development: Vol. II. Developmental perspectives on child maltreatment.* San Francisco: Jossey-Bass, 77-92.

Einstein, A., & Infield, L. (1938). *The evolution of physics.* Cambridge, MA: Cambridge University Press.

Elardo, R., & Bradley, R. (1981). The Home Observation for Measurement of the Environment: A review of research. *Developmental Review,* 1, 113-145.

Elder, G. H., Jr. (1974). *Children of the Great Depression.* Chicago: University of Chicago Press.

Elder, G. H., Jr., Van Nguyen, T., & Caspi, A. (1985). Linking family hardship to children's lives. *Child Development*, 56(2), 361-375.

Engel, G. (1961). Is grief a disease? A challenge for medical research. *Psychosomatic Medicine*, 23, 18-22.

Erickson, J. (1986). Non-formal education in organizations for American youth. *Children Today*, 15(17), 9.

Escalona, S. K. (1982). Babies at double hazard: Early development of infants at biologic and social risk. *Pediatrics*, 70, 670-676.

Fanos, J. H. (1987). Developmental consequences for adulthood of early sibling loss. *Dissertations Abstracts International*, 48-8B, # 8723871.

Fanos, J. H., & Weiner, L. (1994). Tomorrow's survivors: Siblings of human immunodeficiency virus-infected children. *Developmental and Behavioral Pediatrics*, 15(Suppl. 3), S43-S48.

Fanos, J.H. (1996). *Sibling loss.* Mahwah, NJ: Lawrence Erlbaum Associates.

Fay, B. (1975). *Social theory and political practice*. Boston: George Allen & Unwin.

Fischbein, E. (1975). *The intuitive sources of probabilistic thinking*. Dordrecht, Holland; Boston, MA: D. Reidel Publishing Co.

Flanagan, C.A., & Eccles, J.S. (1993). Changes in parents' work status and adolescent adjustment in school. *Child Development*, 56(2), 361-375.

Fletcher, A. C. (1994). *Parental and peer influence on the academic achievement of African-American adolescents*. Unpublished doctoral dissertation, Temple University.

Frankfurt Institute for Social Research (Institut für Sozialforschung, Frankfurt am Main, Germany). (1973). Translated by J. Viertel from *Soziologische Exkurse. Aspects of sociology*. London: Heinemann Educational.

Freire, P. (1972). *Pedagogy of the oppressed.* New York: Herder and Herder.

Freund, B., & Siegel, K. (1994). Early cognitive and environmental correlates of language development at four. *International Journal of Behavioral Development*, 5, 433. Amsterdam, The Netherlands: North- Holland.

Friends in Recovery (1987, 1989). *The twelve steps for adult children from addictive and other dysfunctional families.* San Diego, CA: Recovery Publications.

Friends in Recovery (1988). *The twelve steps for Christians from addictive and other dysfunctional families.* San Diego, CA: Recovery Publications.

Furstenberg, F. F. (1993). How families manage risk and opportunity in dangerous neighborhoods. In W. J. Wilson (Ed.). *Sociology and the public agenda.* Newbury Park, CA: Sage, 46-52.

Furstenberg, F. F., & Crawford, D. B. (1978). Family support: Helping teenagers to cope. *Family Planning Perspectives*, 11, 322-333.

Gadamer, H. (1975). *Truth and method.* Translated by J. C. B. Mohr. New York: The Seabury Press.

Gallagher-Alfred, C. R. (1989). *Nutritional care of the terminally ill.* Rockville, MD: Aspen Publishers.

Gallo, R. C. (1986). The first human retrovirus. *Scientific American*, 255, 88-98.

Garbarino, J. (1976). A preliminary study of some ecological correlates of child abuse: The impact of socioeconomic stress on mothers. *Child Development*, 47(1), 178-185.

Garbarino, J., & Sherman, D. (1980). High-risk neighborhoods and high-risk families. The human ecology of child maltreatment. *Child Development*, 51(1) 188-198.

Garbarino, J., Kostelny, KI., & Dubrow, N. (1998). *No place to be a child: Growing up in a war zone.* San Francisco, CA: Jossey-Bass.

Ge, X., Conger, R. D., Lorenz, F., & Simons, R. D. (1994). Parents' stress and adolescent depressive symptoms: Mediating processes. *Journal of Health and Social Behavior*, 35, 28-44.

Geballe, S., Gruendel, J., & Andiman, W. (1995). *Forgotten children of the AIDS epidemic*. New Haven, CT: Yale University Press.

Gersten, J., Langner, T., Eisenberg, J., & Ozerk, L. (1974). Child behavior and life events: Undesirable change or change per se? In B. S. Dohrenwend & B. P. Dohrenwend (Eds.), *Stressful life events: Their nature and effects*. New York: Wiley, 159-170.

Gessian, A., Gallo, R. C., & Frachini, G. (1992). Low degree of human T-cell leukemia/lymphoma virus type 1 genetic drift vivo as a means of monitoring viral transmission and movement of ancient human populations. *Journal of Virology* (66): 2288-2295.

Gibbs, J. (1986). Assessment of depression in urban adolescent females: Implications for early intervention strategies. *American Journal of Social Psychiatry*, 6(1), 50-56.

Giroux, H. (1980). Critical theory and rationality in citizenship education. *Curriculum Inquiry* 10(4).

Glod, C. (1993). Long-term consequences of childhood physical and sexual abuse. *Archives of Psychiatric Nursing*, 7(3), 163-173.

Goduka, Ivy (1987). *Behavioral development of Black South African children: An ecological approach*. A Doctoral Dissertation, Michigan State University.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice-Hall.

Goldberg, G. S., & Kremen, E. (Eds.) (1990). *The feminization of poverty: Only in America?* New York: Greenwood Press.

Gordon, N., & Kutner, B. (1965). Long term and fatal illness in the family. *Journal of Youth and Adolescence*, (16), 511-525.

Gore, S. (1973). *The influence of social support and related variables in ameliorating the consequences of job loss.* Doctoral Dissertation, University of Pennsylvania.

Gore, S. (1978). The effect of social support in moderating the health consequences of unemployment. *Journal of Health and Social Behavior*, 19, 157-165.

Gottfried, A. W., & Gottfried, A. E. (1984). Home Environment and cognitive development in young children of middle socio economic status families. In A. Gottfried (Ed.), *Home environment and early cognitive development*, 57-115.

Graue, E. M., & Walsh, D. J. (1998). *Studying children in context: Theories, methods, and ethics.* Thousand Oaks; London; New Delhi: Sage Publications: International Educational and Professional Publisher.

Greaves M. F., & Miller G. J. (1987). Are haematophagous insects vectors for HTLV-1? *Hamatol Bluttrasf*, (31), 382-386.

Greenberg, J. S., Boyd, M. D., & Hale, J. F. (1992). *The caregiver's guide: For caregivers and the elderly.* Chicago: Nelson-Hall.

Gurney, R. M. (1981). Leaving school, facing unemployment, and making attributions about the causes of unemployment. *Journal of Vocational Behavior*, (18), 79-91.

Haan, H. C. (1982). *The structure of manufacturing industry in Zambia and its implications for the develoment of the informal sector.* Lusaka, Zambia: International Labour Organisation.

Habermas, J. (1970). *Toward a rational society.* Translated by Jeremy Shapiro. Boston: Beacon Press.

Habermas, J. (1971). *Knowledge and human interests.* Translated by Jeremy Shapiro. Boston: Beacon Press.

Habermas, J. (1979, 1980). *Communication and the evolution of society*. Translated by Thomas McCarthy. Boston: Beacon Press.

Habermas, J. (1984). *The theory of communicative action, Vol. I: Reason and the rationalization of society.* Translated by Thomas McCarthy. Boston: Beacon Press.

Habermas, J. (1987). *The theory of communicative action, Vol. II: Life world and System*. Translated by Thomas McCarthy. Boston: Beacon Press.

Hahn, B. H., Shaw, G. M., Popovic, M., Lo Monico, Gallo, R. C., & Wong-Staal, E. (1984). Molecular cloning and analysis of a new variant of human T-cell leukemia virus (HTLV-1b) from African patient with adult T-cell leukemia-lymphoma. *International Journal of Cancer*, (34), 613-618.

Haley, J. (1987). *Problem-solving therapy*. San Francisco, CA: Jersey-Bass.

Hamill, P. V. V., Drizd, T. A., Johnson, C. L., Reed, R. B., Roche, A. F., & Moore, W. M. (1979). Physical growth: National Center for Health Statistics percentiles. *American Journal of Clinical Nutrition*, 32, 607-629.

Hamilton, M. L. (1972). Evaluation of a parent and child center program. *Child Welfare*, 51, 248-258.

Hammersley, R., Forsyth, A., & Lavelle, T. (1990). The criminality of new drug users in Glasgow. *British Journal of Addiction*, 85, 1583-1594.

Harding, S. (1991). *Whose science, whose knowledge?: Thinking from women's lives.* Ithaca, NY: Cornell University Press.

Hardy, M. S., Armstong, F. D., Routh, D. K., Albrecht, J., & Davis, J. (1994). Coping and communication among parents and children with human immunodeficiency virus and cancer. *Developmental and Behavioral Pediatrics*, (15) (Suppl.3), S49-S53.

Harter, S. (1982). The perceived competence scale for children. *Child Development*. (53), 87-97.

Hashima, P., & Amato, P. R. (1994). Poverty, social support, and parental behavior. *Child Development*, (65), 394-403.

Haworth, J. (1991). *Rock of refuge*. Wheaton, IL: Crossway Books.

Henry G. T. (1990). Practical sampling: Applied Social Research Methods. Vol. 21. Newbury Park, CA: Sage Publications.Hill, R. (1958). Generic features of families under stress. *Social Casework*, 49, 139-150.

Hill, R. (1978). *The strengths of black families*. New York: Emerson-Hall.

Hinde, R. A. (1974). *Biological bases of social behavior*. New York: McGraw-Hill.

Hoerder, D., & Nagler, J. (1995). *People in transit: German migrations in comparative perspective*. Washington, DC: German Historical Institute.

Hoffman, M. A., Ushpiz, V., & Levy-Schiff, R. (1988). Social support and self-esteem in adolescence. *Journal of Youth and Adolescence*, (17), 307 -316.

Hoffman, M. L., Rosen, S., & Lippitt, R. (1960). Parental coerciveness, child autonomy, and child's role at school. *Sociometry*, 23, 15-22.

Hoffman, R. (1970). *Language, minds, and knowledge*. New York: Humanities Press.

Hogan, D. P., & Kitagwa, E. M. (1985). The impact of social status, family structure, and neighborhood on the fertility of black adolescents. *American Journal of Sociology*, 90(4), 825-855.

Horowitz, D. L. (1985). *Ethnic groups in conflict*. Berkeley, CA: University of California Press.

Hudis, J. (1995). Adolescents living in families with AIDS. In S. Geballe, J. Gruendel, & W. Andiman (Eds.), *Forgotten children of the AIDS epidemic*. New Haven, CT: Yale University Press, 19-31.

Hunt, J. M. (1961). *Intelligence and experience.* New York: Ronald.

Hunter, A. (1990). *Policies and procedures for long term care dietetic services.* Rockville, MD: Aspen Publishers.

Ina, Y., & Gojobori, T. (1990). Molecular evolution of human T-cell leukemia virus. *Journal of Molecular Evolution,* (31), 493-499.

Ishikawa, K., Fukasawa, M., Tsujimoto, H., *et al.* (1987). Serological survey and virus isolation of simian T-cell leukemia/T-lymphotropic virus type 1 (STLV-1) in non-human primates in their native countries. *International Journal on Cancer,* (40), 233-239.

Jacob, T. (Ed.) (c.1987). *Family interaction and psychopathology: Theories, methods, and findings.* New York: Plenum.

Jay, M. (1973). *The dialectical imagination.* Boston: Little, Brown and Co.

Johnson, E. C. K. (1985). *The feminization of poverty in the third world.* Champaign, IL: Office of Women in International Development, University of Illinois at Urbana-Champaign.

Johnson, K. (1988). Women and the rural energy economy of Zimbabwe: Research findings and policy issues. In Beijer Institute and Scandinavian Institute of African Studies, *Energy for rural development in Zimbabwe.* Energy and environment and development in Africa series, 11.

Kagan, J. (1984). *The nature of the child.* New York: Basic Books.

Kagan, J., & Moss, H. A. (1962). *Birth to maturity: A study in psychological development.* New York: John Wiley & Sons.

Kellam, S. G., Adams, R. G., & Brown, C. H. (1977). Family structure and mental health of children. *Archives of General Psychiatry*, 34(9), 1012-1022.

Kellam, S. G., Adams, R. G., Brown, C. H., & Ensminger, M.A. 1982). The long-term evolution of the family structure of teenage and older mothers. *Journal of Marriage and the Family*, 44 (3), 539-554.

Kinsey, B. (1986). *The socioeconomics of nutrition under stressful conditions. A study of resettlement and drought in Zimbabwe*. Occasional Paper Series. Center for Applied Social Sciences, University of Zimbabwe, Harare.

Kliman, G. (1973). Facilitation of mourning during childhood. In I. Gerber, A. Weiner, & A. H. Kuttscher (Eds.), *Perspectives of bereavement*. New York: Amo Press, 76 -100.

Kockelmans, J. (1979). Why interdisciplinarity? In Joseph Kockelmans (Ed.), *Interdisciplinarity and Higher Education*. University Park, PA: Pennsylvania State University Press.

Kockelmans, J. (1986). *Some philosophical reflections on position paper, Home Economics: A definition*. Paper presented at American Home Economics Association Regional Meeting in Indianapolis & Washington, D.C.: American Home Economics Association.

Koocher, R. F. (1981). *The Damocles syndrome: Psychosocial consequences of surviving childhood cancer*. New York: McGraw Hill.

Kopp, C. B., & Krakow, J. B. (Eds.) (1982). *The child: Development in a social context*. Reading, MA: Addison-Wesley.

Korbin, J. E. (1992). The impact of poverty on children. *American Behavioral Scientist*, 35, 13-39.

Kramer, R. F. (1984). Living with childhood cancer: *Comprehensive Psychiatry*, (20), 560-568.

Kronenberger, W. G., & Thompson, R. J., Jr. (1992). Psychological adaptation of mothers of children with spina bifida: Association with dimensions of social relationships. *Journal of Pediatric Psychology*, 17(1), 1-14.

Lakatos, I. (1976). *Proof and refutations: The logic of mathematical discovery*. Cambridge, England: Cambridge University Press.

Lakatos, I., & Musgrave, A. (1970). *Criticism and the growth of knowledge*. Cambridge, England: Cambridge University Press.

Langner, T., Herson, J., Greene, E.,. Jameson, J., & Goff, J. (1970). Children of the city: Affluence, poverty, and mental health. In V. Allen (Ed.), *Psychological factors in poverty*. Chicago: Markham, 185-209.

Lave, J. (1977). Tailor-made experiments and evaluating the intellectual consequences of apprenticeship training. *Quarterly Newsletter of the Institute for Comparative Human Development*, 1(2), 1-3

Lavee, Y., McCubbin, H. I., & Patterson, J. M. (1985). The double ABCX Model for family stress and adaptation: An empirical test by analysis of structural equations with latent variables. *Journal of Marriage and the Family*, 47(4), 811-826.

Lee, R. D., & Nieman, D. C. (1993). *Nutritional Assessment*. Mt. Pleasant, MI: Wm. C. Brown Publishers.

Lempers, J., Clark-Lempers, D., & Simons, R. (1989). Economic hardship, parenting, and distress in adolescence. *Child Development*, 60 (1), 25-49.

Lerner, R. M. (1986). *On the nature of human plasticity*. New York: Cambridge University Press.

Lerner, R. M. (1991). Changing organism-context relations as the basis of development. A developmental contextual perspective. *Developmental Psychology*, (27), 27-32.

Lerner, R. M. (Ed.) (1983). *Developmental psychology: Historical and philosophical perspectives*. Hillsdale, NJ: L. Erlbaum Associates.

Maccoby, E. E., & Martin, J. A. (1983). Socialization in the context of the family: Parent-child interaction. In E. M. Hetherington (Ed.), P. H. Mussen (Series Ed.), *Handbook of child psychology: Vol. 4, Socialization, personality, and social development*. New York: John Wiley & Sons, 1-101.

MacDonald, K. (1992). Warmth as a developmental construct: An evolutionary analysis. *Child Development*, 63 (4), 753-773.

MacDonald, M. (1977). The curriculum and cultural reproduction. Milton Keynes, U.K.: Open University Press.

Mahommed, K., Houston, S., Neill, P., Ray, C., & Marowa, E. (1991). In M. Essex, M. Souleymane, P. J. Kanki, & M. Kalengayi (Eds.) (1995). *AIDS in Africa*. New York: Raven Press, 37, 322-325.

Mandelbaum, D. G. (1976). Social uses of funeral rites. In R. L. Fulton (Ed.), *Death and identity*. Bowie: Charles Press Publishers, 343-363.

Mann, J. (1991). Global AIDS: Critical issues for prevention in the 1990s. *International Journal of Health Services*, 21(3), 553-559.

Marans, S., & Adnopoz, J. (1995). *The police-mental health partnership: a community-based response to urban violence*. New Haven, CT: Yale University Press.

Margolis, P. A., Greenberg, R. A., & Keyes, L. L. (1992). Lower respiratory illness in infants and low socioeconomic status. *American Journal of Public Health*, 82, 1119-1126.

Marshall, C., & Rossman, G. B. (1989). *Designing qualitative research*. Newbury Park, CA: Sage Publications.

Mason, E. (1990). *The nutrition situation and current strategies and plan: Consequences of malnutrition in Integrating food, nutrition and agricultural policy in Zimbabwe in UZ MSU Food Security Project (1990).* Proceedings of the First National Consultative Workshop on Integrating Food, Nutrition and Agricultural Policy. Montclair Hotel, Juliasdale Zimbabwe (July 15-18). Sebri Printers, Borrowdale, Zimbabwe.

Masten, A. (1994). In M. C. Wang & E. W. Gordon (Eds.), *Educational resilience in inner city America: Challenges and prospects*. Mahwah, NJ: Lawrence Erlbaum Associates, 3-26.

May, W., & Zimpher, N. (1986). An examination of three theoretical perspectives on supervision: Perceptions of pre-service field supervision. *Journal of Curriculum and Supervision*, 1(2), 83-89.

Mazur, R. E., & Sanders, D. (1988). *Socioeconomic factors associated with child health and nutrition in peri-urban Zimbabwe.* Proceedings of Third Africa Food and Nutrition Security. University of Zimbabwe/Michigan State University Food Security Research in Southern Africa Project. Department of Agricultural Economics and Extension, University of Zimbabwe, Harare, 1012-1041.

McAdoo, H. P. (1982). Stress-absorbing systems in black families. *Family Relations*, 31(4), 479-488.

McAdoo, J. L. (1988). Changing perspectives on the role of the black father. In P. Broeinstein & C. P. Cowan (Eds.), *Fatherhood today: Men's changing role in the family*. New York: John Wiley and Sons.

McCall, R. B., Applebaum, M. I., & Hogarty, P. S. (1973). *Developmental changes in mental performance*. Chicago: University of Chicago Press for the Society for Research in Child Development.

McConachie, H. (1994). Implications of a model stress and coping for services to families of young disabled children. *Child: Care, Health, and Development*, 20, 37-46.

McCubbin, H. I. (1995). Resiliency in African-American families: Military families in foreign environments. In H. I. McCubbin, E. A. Thompson, A. I. Thompson, & J. A. Futrell (Eds.), *Resiliency in Ethnic Minority Families: African American families* (Vol.2). Madison, WI: University of Wisconsin, 67-98.

McCubbin, M. (1989). Family stress and family strengths: A comparison of single- and two-parent families with handicapped children. *Research in Nursing and Health*, 12(2), 101-110.

McCubbin, M. A. (1994). Ethnicity, schema, and coherence: Appraisal processes for families in crisis. In H. I. McCubbin, E. A. Thompson, A. I. Thompson, & J. E. Fromer (Eds.), *Sense of coherence and resiliency: Stress, coping and health*. Madison, WI: University of Wisconsin, 41-67.

McCubbin, M. A., & McCubbin, H. I. (1993). Family coping with health crises: The resiliency model of family stress, adjustment, and adaptation. In C. Danielson, B. Hamel-Bissell, & P. Winstead-Fry (Eds.), *Families, health, and illness*. New York: Mosby, 21-64.

McLoyd, V. (1990a). A hypothetical model of how poverty and low SES influence socio-economic functioning in African American adolescents. Mahwah, NJ: Erlbaum Associates.

McLoyd, V. (1990b). The impact of economic hardship on Black families and children: Psychological distress, parenting, and socio-emotional development. *Child Development*, 61, 311-346.

McLoyd, V. C., Jayaratne, T. E., Ceballo, R., & Borquez, J. (1994). Unemployment and work interruption among African American single mothers: Effects on parenting and adolescent socio-emotional functioning. *Child Development*, 65, 562-589.

Medalie, J. H., & Goldbourt, V. (1976). Angina pectoris among 10,000 men: Psychosocial and other risk factors as evidenced by a multivariate analysis of a five-year incidence study. *American Journal of Medicine*, 60, 910.

Mehretu, A., & Mutambirwa, C. (1990). *Gender differences in time and energy cost of distance for regular domestic chores in rural Zimbabwe*: Case study in the Chiduku Communal Land. Department of Geography, Geography, University of Zimbabwe, Harare.

Mellins, C., & Erhardt, A. (1993). *Families affected by pediatric AIDS: Sources of stress and coping*. International Conference of AIDS, (9), 120.

Merriam, S. B. (1988). *Case study research in education: A qualitative approach*. San Francisco: Jossey-Bass.

Mertens, T., Tondorf, G., Siebolds, M., *et al.* (1992). In M. Essex,. S. Mboup, P. J. Kanki, & M. Kalengayi (Eds.) (1995). *AIDS in Africa*. New York: Raven Press.

Merton, R. K., Fiske, M., & Kendall, P. (1956). *The focused interview: A manual of problems and procedures.* Glencoe, IL: Free Press.

Metzl, M. N. (1980). Teaching parents a strategy for enhancing infant development. *Child Development*, 51, 583-586.

Mhloyi, M. (1995). Racing against time: In *HIV & AIDS: The global inter-connections.* United Nations Development Programme. Kumarian Press: West Hartford, CT.

Miles, D. (1990). *Minority Families: African American families* (Vol.2). Madison, WI: University of Wisconsin.

Miles, M. B., & Huberman, M. A. (1994). *Qualitative data analysis.* Thousand Oaks, CA: Sage Publications.

Miller, J. B. (1971). Children's reactions to death of a parent: A review of psychoanalytic literature. *Journal of American Psychoanalytic Association*, 19, 697-719.

Morgan, D. (1988). Focus groups as Qualitative Research. Beverly Hills: Sage Publications.

Muirragui, E. I., & Anderson, E. S. (1995). *Gender and socio-economic considerations in environmental programs and projects: Lessons learned in the Brazilian Amazon*. Washington, DC: United States Agency for International Development, Office of Women in Development.

Mulenga, L. C. (1993). *Orphans, widows, and widowers in Zambia: A situation analysis and options for HIV AIDS survival assistance*. Lusaka, Zambia: Institute for African Studies.

Mwale, G., & Burnard, P. (1992). *Women and AIDS in rural Africa*: Rural womens' *views of AIDS in Zambia.* Aldershot, Brookfield, USA: Avebury

Myers, H. F., & King, L. (1983). Mental health issues in the development of the Black American child. In G. Powell, J. Yamamoto, A. Romero, & A. Morales (Eds.), *The psychosocial development of minority children*. New York: Bruner/Mazzel, 275-306.

Nagy, S., & Ungerer, J. A. (1990). The adaptation of mothers and fathers of children with cystic fibrosis: A comparison. *Children's Health Care*, 19(3), 147-153.

Neighbors, B., Forehand, R., & McVicard (1993). Resilient adolescents and inter-parental conflict. *American Journal of Orthopsychiatry*, 63, 462-471.

Nelson, K., & Gruendel, J. (1986). *Event knowledge: Structure and function in development*. Hillsdale, NJ: Erlbaum.

New York Academy of Medicine (1992). *American Journal of Public Health*, 76, 499-501.

Nieswiadomy, R. M. (1998). *Foundations of nursing research*. Stamford, CT: Appleton & Lange.

Nordquist, J. (1987). *The feminization of poverty*. Santa Cruz, CA: Reference and Research Services.

O'Hagan, K. (1993). *Emotional and psychological abuse of children.* Toronto; Buffalo: University of Toronto Press.

Osborne, R., & Freyberg, P. (1985). *Learning in science. The implications of children's science.* Portsmouth, NH: Heinemann.

Parke, R., & Collmer, C. (1975). Child abuse: An interdisciplinary review. In E. M. Hetherington (Ed.), *Review of child development research* (Vol. 5). Chicago: University of Chicago Press.

Parker, D. (1981). The relationship between demographic variables and NART perfomance in normal subjects. *Personality and Social Psychology Bulletin,* 7(2), 302-308.

Parker, S., Greer, S., & Zuckerman, B. (1988). Double jeopardy: The impact of poverty of early child development. *Pediatric Clinics of North America,* 35, 1127-1241.

Parsons, T. (1951). *The social system.* Glencoe, IL: The Free Press.

Parsons, T., & Fox, T. (1952). Illness, therapy, and the modern urban American family. *Journal of Social Issues,* (8), 31-44.

Patrick, D. L., (1993). *Health status and health policy: Quality of life in health care evaluation and resource allocation.* New York: Oxford University Press.

Patterson, G. (1980). Mothers: The unacknowledged victims. *Monograph of Society for Research in Child Development,* Serial No. 186.

Patterson, G. R., Reid, J. G., & Dishion, T.J., (1992). *Antisocial boys.* Eugene, OR: Castalia.

Patterson, G., & Stouthamer-Loeber, M. (1984). The correlation of family management practices and delinquency. *Child Development,* 55(4), 1299-1307.

Peters, M. E. (1985). Racial socialization of young black children. In H. McAdoo & J. McAdoo (Eds.), *Black children: Social, educational, and parental environments*. Newbury Park, CA: Sage Publications.

Piaget, J., & Inhelder, B. (1975). *The origin of the idea of chance in children.* London: Rouledge and Kegan Paul.

Pines, A. L. (1985). Towards a taxonomy of conceptual relations. In L. West & A. L. Pines (Eds.), *Cognitive structure and conceptual change*. New York: Academic Press, 101-116.

Plihal, J., & Brown, M. M. (1969). Evaluation materials: Physical and home environment and psychological and social factors. Minneapolis: Burgess.

Plihal, J. (1987). *Critical inquiry perspective: Studying critical thinking in home economics.* Paper presented at the annual meeting of the American Educational Research Association, Washington D.C.

Pollock, G. H. (1961). Mourning and adaptation. *International Journal of Psycho-Analysis*, (42) 341-361

Popkewitz, T. (1984). *Paradigm and ideology in educational research: The social functions of the intellectual.* London: The Falmer Press.

Price, H. P. (1985). A model for explaining adolescent stress. *Health Education,* 16(3), 36-40.

Ranger, T. O. (1985). *The invention of tribalism in Zimbabwe*. Gweru, Zimbabwe: Mambo Press.

Raynice, E. J., Lawhon, T., & Lawhon, D. (1995). Stress in families with chronically ill children. *Journal of Family and Consumer Sciences*. American Association of Family and Consumer Sciences. (Spring, 1995, 87).

Reynolds, D. (1971). *A primer in theory construction.* NY: MacMillan Publishing Co.

Roberts, D., & Taylor, R. D. (1994a). *Association of family stress, parenting and psychological adjustment among African-American adolescents and mothers.* Unpublished raw data. In Taylor, R. D. (1997), *Social & emotional adjustment family relations in ethnic families.* Mahwah, Lawrence Erlbaum.

Roberts, D., & Taylor, R. D. (1994b). Neighborhood characteristics, parenting, psychological well being and adolescent adjustment among African-American families. Unpublished raw data. In Taylor, R. D. (1997), *Social & emotional adjustment family relations in ethnic families.* Mahwah, Lawrence Erlbaum.

Rosen, B. C., & Thomas, D. L. (1975). A theory of parental power and child compliance. In R. E. Cromwell & D. H. Oldson (Eds.), *Power in families.* Beverly Hills, CA: Sage Publications, 38-60.

Rosenblatt, P. C., Walsh, R. P., & Jackson, D. A. (1976). *Grief and mourning in cross-cultural perspective.* New Haven, CT: Human Relations Areas Files Press.

Rubin, A. M., & West, R. S. (Eds.). *1982 Professional guide to diseases.* Springhouse, PA: Interned Communications.

Russell, M., Carr-Hill, R., & Illsley, R. (1984). The sociological study: Differences related to childhood environment. In R. Illsley & R. G. Mitchell (Eds.), *Low birthweight – a medical, psychological, and social study.* New York: Wiley, 51-90.

Sameroff, A. M. (1983). Developmental systems: Contexts and evolution. In W. Kessen (Ed.), *History, theories and methods.* Vol.1 of P. H. Mussen (Ed.), *Handbook of child psychology.* New York: Wiley, 237-294.

Samuelson, J. J., Foltz, J., & Foxall, M. J. (1992). Stress and coping in families of children with myelomenoingocele. *Archives of Psychiatric Nursing,* 6(5), 287-295

Sandler, I. N., Miller, P., Short, J., & Wolchik, S. (1989). Social support as a protective factor for children in stress. In D. Belle (Ed.), *Children's social networks and social supports*. New York: Wiley, 277-307.

Schaefer, E. S. (1959). A circumplex model for maternal behavior. *Journal of Abnormal and Social Psychology*, 59, 226-235.

Schatzman, L., & Strauss, A. L. (1973). *Field research: Strategies for a natural sociology*. Englewood Cliffs, NJ: Prentice-Hall.

Schein, E. H. (1969). *Process consultation: Its role in organization development.* Reading, MA: Addison-Wesley.

Schein, E. H. (1978). *Process consultation. Vol.2: Lessons for managers and consultants*. Reading, MA: Addison-Wesley.

Schein, E. H. (1988). *Process consultation: Its role in organization development.* (2nd ed.) Reading, MA: Addison-Wesley.

Schein, E. H. (1992). *Organizational culture and leadership.* San Francisco, California: Jossey-Bass.

Schorr, L. B.. (1988). Breaking the cycle of disadvantage [sound recording]. Racine, WI: The Johnson Foundation.

Schrijvers, D., Delaporte, E., Peeters, M., Dupont, A., & Meheus, A. (1991). Seroprevalence of retroviral infection in women with different fertility statuses in Gabon, western equatorial Africa. *Journal of AIDS*, (4), 468-470.

Schroyer, I. (1973). *The critique of domination: The origins and development of critical theory.* Boston: Beacon Press.

Schutzman, D., Frankenfield-Chernicoff, M., Clatterbaugh, H., & Singer, J. (1991). Incidence of intrauterine cocaine exposure in a suburban setting. *Pediatrics*, (88), 825-827.

Shor, I. (1987). *Critical teaching and everyday life.* Chicago: The University of Chicago Press.

Siegel, K., & Freund, B. (1994). Parental loss and latency age children. In B. O. Dane & C. Levine (Eds.), *AIDS and the new orphans: Coping with death.* Westport, CT: Auburn House, 43-58.

Siegel, L. (1984). Home environment influences on cognitive development in pre-term and full-term children during the first 5 years. In A. Gottfried & A. Gottfried (Eds.), *Home environment and early cognitive development.* New York: Academic Press, 197-234).

Simmons, R., Rosenberg, F., & Rosenberg, M. (1973). Disturbance in the self-image at adolescence. *American Sociological Review,* (38), 553-568.

Slaughter, D. (1977). Relation of early parent-teacher socialization influences to achievement orientation and self-esteem in middle childhood among low income black children. In J. Glidewell (Ed.), *The social context of learning and development.* New York: Gardner Press, 101-131.

Smyth, J. (1986). Toward a collaborative reflective and critical mode of clinical supervision. In John Smyth (Ed.), *Learning about teaching through critical supervision.* London: Croom Helm.

Solomon, J. C., & Marx, J. (1995). "To grandmother's house we go": Health and school adjustment of children solely raised by grandparents. *The Gerontologist,* 35 (3), 386-394.

Speechley, K. N., & Noh, S. (1992). Surviving childhood cancer, social support, and parents' psychological adjustment. *Journal of Pediatric Psychology,* 17(1), 15-31.

Speth, J.G., (1995). *HIV & AIDS: The global interconnection.* United Nations Development Programme.

Spinetta, J. J., & Maloney, L. J. (1978). The child with cancer: Patterns of communication and denial. *Journal of Consulting Clinical Psychology*, (46), 1540-1541.

Starfield, B. (1988). *Social factors: Poverty, class, race.* Unpublished dissertation manuscript. University of Minnesota

Starr, R. (1982). A research based approach to the prediction of child abuse. In R. Starr (Ed.), *Child abuse prediction: Policy implications.* Cambridge, MA: Ballinger, 105-134.

Steinberg, L., Mounts, N., Lamborn, S. D., & Dornbusch, S. M. (1991). Authoritative parenting, and adolescent adjustment across varied ecological niches. *Journal of Research on Adolescence,* 1, 19-36.

Stevens, M. S. (1994). Parents coping with infants requiring home cardio respiratory monitoring. *Journal of Pediatric Nursing,* 9(1), 2-12.

Stewart, D. (1990). *Focus groups: Theory and practice.* Newbury Park: Sage Publications.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: Sage Publications.

Strom, S. (1980). *Potential contribution of alternative modes of inquiry to the improvement of knowledge and values guiding professional training.* Minneapolis: College of Education, University of Minnesota.

Swezey, T. A. (1993). *Women AIDS in Africa: Unequal experiences, unequal representations.* A Master's thesis: Anthropology department: Michigan State University Press.

Tasker, M. (1992). *How can I tell you?* Bethesda, MD: Association for Care of Children's Health.

Taylor, R. D. (1994). Kinship support, family management, and adolescent adjustment and competence in African-American families. In Taylor R. W. (1997), *Social and emotional adjustment family relations in ethnic families.* Mahwah, NJ: Lawrence Erlbaum.

Taylor, R. D. (1997). *Social and emotional adjustment family relations in ethnic minority families.* Mahwah, NJ: Lawrence Erlbaum.

Taylor, R. D., & Roberts, D. (1995). *Stressful life events, parenting, and adolescent well being in economically disadvantaged African-American families.* Manuscript submitted for publication.

Taylor, R. D., Casten, R., & Flickinger, S. (1993). The influence of kinship social support on the parenting experiences and psychosocial adjustment of African-American adolescents. *Developmental Psychology,* 29(2), 382-388.

Thoits, P. A. (1986). Social support as coping assistance. *Journal of Consulting and Clinical Psychology,* (54), 416-423.

Thomas, M. (1992). *Comparing theories of child development.* Belmont, CA: Wadsworth.

Tietjen, A. M., & Bradley, C. F. (1985). Social support and maternal psychosocial adjustment during the transition to parenthood. *Canadian Journal of Behavioral Science,* 17(2), 109-121.

Toulmin, S. (1972). *Human understanding.* Princeton, NJ: Princeton University Press.

Treviño, F. M., *et al.* (1988). *The feminization of poverty among Hispanic households.* San Antonio, TX: Tomás Rivera Center.

Trommsdorff, G. (1995). General model of the influences of cultural environments on prosocial ac[1]tions. University of Konstanz, Germany. *European Journal of Social Psychology,* 22, 41-45

Tswana, S., & Laher, S. (1989). Abstract 096 in HIV and AIDS in Southern Africa and the Islands: Edited by Essex, M., Mboup, S., Kanki, P.J., & Kalengayi, M.R. In *AIDS in Africa*. New York: Raven Press, (1195).

Turk, J. (1964). Impact of cystic fibrosis on family functioning. *Pediatrics*, (34), 64-71.

U. S. Department of Health and Human Services (1991a). *Healthy people 2000.* Washington, DC: Government Printing Office, DHHS Pub. No. PHS 91-50212.

U. S. Department of Health and Human Services (1991b). *Promoting health preventing disease: Objectives for the nation,* 1990. Washington, DC: Government Printing Office.

UNICEF, Pediatric AIDS (1990). Children and AIDS: an impending calamity. *The growing impact of HIV infection on women, children and family life in the developing world.* New York: UNICEF, 1990.

United Nations Development Population, (UNDP) Annual Report: *Community-based AIDS interventions in Africa* (1992).

Vadasy, P. F. (1987). Children's health care: Brief report. Grandparents of children with special needs: Supports especially for grandparents. *Children's Health Care,* 16(1), 21-23.

Van der Kolk, B. A. (1987). Psychological Trauma. Washington, DC: American Psychiatric Press.

Van Manen, M. (1977). "Linking ways of knowing with ways of being practical". *Curriculum Inquiry (6),* 105-128.

Vaux, A. (1988). *Social support: theory, research, and intervention.* New York: Praeger Publishers.

Verdier, M., Denis, F., Sangare, A., *et al.* (1989). Prevalence of antibody to human T cell leukemia virus type 1 (HTLV-1) in populations of Ivory Coast, West Africa. *Journal of Infectious Diseases, (160)* 363 - 370.

Wallace, F. C. (1966). *Religion: An anthropological view*. New York: Random House.

Wallinga, C., & Reed, M. (1990). The elementary school counselor's role with siblings of ill children. *Elementary School Guidance and Counseling, 25*(2), 91-97.

Wallinga, C., Paguio, L., & Skeen, P. (1987). When a brother or sister is ill. *Psychology Today*, 21(8), 42-43.

Wandersman, L. P., & Unger, D. G. (April, 1983). *Interaction of infant difficulty and social support in adolescent mothers*. Paper presented at the biennial meeting of the Society for Research in Child Development, Detroit, MI.

Warner, K. E. (1989). Smoking and health: 25-year perspective. *American Journal of Public Health, 79*, 141-143.

Watanabe, T., Seiki, M., Hirayami, Y., & Yoshida, M. (1986). Human T-cell leukemia virus type 1 is a member of the African subtype of simian viruses (STLV). *Virology (148),* 385-388.

Werner, E. (1989). High-risk children in young adulthood: A longitudinal study from birth to 32 years. *American Journal of Orthopsychiatry, 59*, 72-81.

WHO Global Programme on AIDS (1990). *Progress report*. Geneva, Switzerland: World Health Organization.

WHO Global Programme on AIDS (1991). *The HIV/AIDS Pandemic: Overview*. Geneva, Switzerland: World Health Organization.

WHO Global Programme on AIDS (1993). *The HIV/AIDS Pandemic: Overview*. Geneva, Switzerland: World Health Organization.

WHO Global Programme on AIDS (1995). *The HIV AIDS Pandemic: Overview*. Geneva, Switzerland: World Health Organization.

Williams, E. (1995). Clients and Commercial Sex Work in HIV & AIDS. *The global inter-connection*. Connecticut, USA: Kumarian Press,93.

Williams, G. (1986). Meaningful human actions concerning clothing: Methodology for an alternative perspective. *ACPTC Proceedings*. Monument, CO: Association of College Professors.

Wilsman, M. (1986). *Modes of rationality*. Peoria, IL: Bennett and McKnight.

Wilson, D. *et al.* (1990). A pilot study for HIV prevention programme among commercial sex workers in Bulawayo, Zimbabwe. *Social Science and Medicine Journal*, 31(50), 609-618.

Wilson, D., Wilson, C., Greenspan, R., Sibanda, P. & Msimanga, S. (1989). Towards an AIDS strategy for Zimbabwe. *AIDS Education and Prevention*, 1(2) 96-104.

Wilson, W. J. (1987). *The truly disadvantaged: The inner city, the underclass, and the public policy*. Chicago: University of Chicago Press.

Winn, M. (1984). *Children without childhood*. New York: Penguin.

Wolf, J. G. (Ed.). (1989). *Gay priests*. New York: Harper & Row.

Woodlands Conference on Growth Policy. (1981). J. C. Coomer (Ed.). *Quest for a sustainable society*. New York: Pergamon Press.

Wyckoff, P.M., & Erickson, M.T. (1987). Mediating factors of stress on mothers of seriously ill, hospitalized children. *Children's Health Care*, 16(1), 4-12.

Yogman, M. (Eds.) (1986). *Theory and research in behavioral pediatrics*. New York: Plenum, 147-205.

Zimbabwe Demographic and Health Survey (1994). Central Statistical Office (Zimbabwe) and Macro International Inc. Calverton, Maryland, USA.

Zimpher, N., & Ashburn, E. (1985). Studying Teachers: How conceptions of the world inform the research agenda. *Journal of Teacher Education*, 36(6), 16-26.

Zimpher, N., & Howey, K. (1987). Adapting supervisory practices to different orientations of teaching competence. *Journal of Curriculum and Supervision*, 2(2), 101-127.