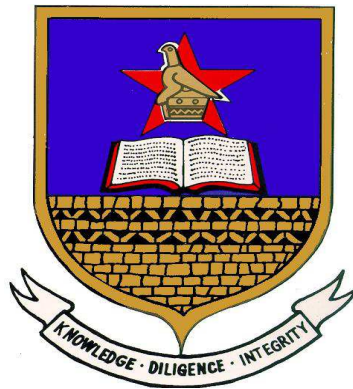


**AN EXPLORATION OF THE COPING MECHANISMS ADOPTED BY
ADOLESCENTS LIVING WITH HIV AND AIDS IN CHINHOYI : A CASE
OF ADOLESCENTS RECEIVING TREATMENT AT CHINHOYI PROVINCIAL
HOSPITAL, MASHONALAND WEST PROVINCE IN ZIMBABWE**

BY

RANGARIRAI FRANK



SUPERVISED BY

MR. CHARLES DZIRO

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DEDICATION

To all children and adolescents living with HIV and AIDS in Zimbabwe.

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ABSTRACT

In a country with a high prevalence rate of HIV, the number of adolescents living with HIV and AIDS is steadily increasing in Zimbabwe. The National AIDS Council (2011) reports that there are more than one hundred and fifty thousand children living with HIV and AIDS who are below the age of fifteen years. This emerging group of the population has been receiving limited attention in previous years. The study sought to explore coping mechanisms adopted by adolescents living with HIV and AIDS in Chinhoyi. The study recruited HIV positive adolescents who are receiving antiretroviral treatment was conducted at Chinhoyi Provincial Hospital, located in Mashonaland West Province. Data collection included semi-structured in-depth interviews, key informant interviews, and a questionnaire (Adapted adolescent version of KIDCOPE). A sample of 38 adolescents living with HIV and AIDS aged between ten and nineteen years of years were selected through simple random sampling from a possible one hundred and eighty six who receive antiretroviral therapy at the Provincial Hospital's Opportunistic Clinic. The results of the study indicate that adolescents living with HIV and AIDS still face a multitude of challenges in dealing with the demands that affect people living with HIV and AIDS. Stigma and discrimination were reported to be the major issues of concern. The majority of the adolescents have lost at least one parent. The majority have indicated that their families sometimes lack financial resources to meet additional medical needs that are not provided for free by public health institutions, and purchasing a nutritional food as well as paying school fees. Other challenges commonly experienced include fear of being attacked by opportunistic infections, anxiety due to possibility of shorter life expectancy, inability to handle disclosure issues in relationships with the opposite sex, as well as issues relating to marriage and having healthy babies. The study revealed that adolescents living with HIV and AIDS in Chinhoyi mainly use passive methods of coping, whilst active coping mechanisms are also utilized. Additional unique, situation specific coping mechanisms were also reported. It also came out from the study that there are various support mechanisms available to adolescents living with HIV and AIDS in Chinhoyi provided from state and non state actors. However, resources constraints, both human and final, have limited the effectiveness of these support mechanisms in addressing complex challenges that confront adolescents living with HIV and AIDS in Chinhoyi. It was interesting to note that these adolescents are developing skills and attitudes which assist them to cope with HIV and AIDS related demands in their social environments. The study concludes that although most adolescents are striving to successfully cope, a lot still needs to support them because the community environment is not yet fully appreciative of their needs. Improvement in the delivery of service and increased tolerance by the community has the potential to enhance the quality of life for adolescents living with HIV and AIDS. The study informs interventions that promote healthy coping and better quality of service for adolescents that are struggling with complexities of living with HIV and AIDS.

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LIST OF ABBREVIATIONS

- AIDS- Acquired Immuno-Deficiency Syndrome
- AMTO- Assisted Medical Treatment Order
- APA- American Psychological Association
- ART- Antiretroviral Therapy
- CDC- Centre for Disease Control
- CHBC- Community and Home Based Care
- DSS- Department of Social Services
- EGPAF- Elizabeth Glaser Pediatric AIDS Foundation
- FCH- Family and Child Care
- GoZ- Government of Zimbabwe
- HIV- Human and Immuno-Deficiency Syndrome
- I.E.C- Information, Education and Communication
- IRIN- Integrated Regional Information Networks
- MoHCW- Ministry of Health and Child Welfare
- NAC- National AIDS Council
- O.I- Opportunistic Infections
- STI- Sexually Transmitted Infections
- UNAIDS- Joint United Nations Programme on HIV/AIDS
- USA- United States of America
- VCT- Voluntary Counselling and Testing
- WHO- World Health Organization
- ZAPP- Zimbabwe AIDS Prevention Project
- ZNASP- Zimbabwe National HIV and AIDS Strategic Plan
- ZIMSTAT- Zimbabwe National Statistical Agency

CHAPTER ONE

INTRODUCTION

Introduction to the Chapter

Adolescents comprise one of the most invisible populations infected by HIV (Human and Immuno-Deficiency Syndrome) and AIDS (Acquired Immuno-Deficiency Syndrome). Adolescents living with HIV and AIDS encounter enormous challenges as they attempt to cope with the realities of living with HIV and AIDS in the community. This chapter briefly identifies the complex psychosocial issues that adolescents have to manage in relation to living with HIV and AIDS in a Zimbabwean setting. This chapter discusses the statement of the problem, the significance or rationale for conducting the study as well the research objectives, research questions and the conceptual framework.

1.2 Background to the Study

The first AIDS case was diagnosed in 1981 in the United States of America and the disease has since spread to epidemic proportions around the world (Joint United Nations Programme on HIV and AIDS (UNAIDS), 2011). By 1982, the Centre for Disease Control (CDC) in Atlanta, United States of America (USA) decided that enough was known about the disease to produce a provisional case definition (Hubley, 2002). In Africa, doctors were coming across patients with unusual symptoms. In Kigali (Rwanda) and Kinshasa (Zaire) there was by 1980 an increase in AIDS related symptoms (Hubley, 2002). In 1983 HIV and AIDS cases were reported in Zambia. According to the November 2005 **epidemiological update**, UNAIDS estimates that globally 40.3 million children and adults were living with HIV and AIDS while 4.9 million new infections and 3.1 deaths occurred in the year 2005 alone. Furthermore, there are regional variances in HIV prevalence globally. Sub Saharan Africa

bears the heaviest burden of the epidemic accounting for 28.5 million children and adults (about 64%) of those living with HIV and AIDS globally while about 97% of the AIDS related deaths in 2005 alone occurred in this region.

UNAIDS (2006) notes that HIV infection is regarded as a public health challenge that has disproportionately affected children from poorest parts of the world. Globally, it is estimated that the number of children living with HIV and AIDS rose to 3.1 million in 2011, while deaths among children below fifteen years declined (World Health Organization (WHO), 2013). About 1% lives in Europe and North America. Yet over 90% of HIV infected children live in Sub Saharan Africa, (UNAIDS, 2006). According to Prendergast, Tudor-William, Jeena, Burchett and Goulder (2007), an estimated 50 000 children are born with HIV every year in South Africa, as compared with around 25 per year in UK and 190 per year in the USA. In Zimbabwe, an estimated one million adults and children are living with HIV: the third largest burden in Southern Africa (National AIDS Council (NAC), 2010). The number of children (and adolescents) receiving antiretroviral therapy in Zimbabwe's public health institutions was 8627 in 2007 and increased to 13 287 in 2009. An estimated 15000 were newly infected with HIV in 2009; the majority was through mother to child transmission, (NAC, 2010).

HIV transmission to babies in Sub-Saharan Africa is the second most common mode of HIV transmission after sex between men and women. Ninety percent of infections in babies and young children are acquired through parent to child transmission, formerly known as mother to child transmission, while the remaining 10% is caused by sexual abuse, blood transfusion, and other exposure to infected blood. Elizabeth Glaser Paediatric AIDS Foundation (EGPAF, 2010) notes that without treatment and protection, roughly one third of children born with HIV will acquire the virus before or during birth or through breast feeding. Children under 15 account for more than 14% of AIDS-related deaths worldwide. More than 1,000 children

become infected with HIV each day – the vast majority through mother-to-child transmission, which can occur in the womb, during birth, or through breastfeeding. More than 90% of the 2.5 million children living with HIV were born in Africa (Elizabeth Glaser Paediatric AIDS Foundation, 2010).

Generally, the number of people receiving therapy has grown thirteen-fold, more than five million people in low- and middle-income countries, since 2004. Expanding access to treatment has contributed to a 19% decline in deaths among people living with HIV between 2004 and 2009 (UNAIDS, 2010). The results of such interventions have been remarkable because people living with HIV and AIDS, particularly children have lived longer lives than before. Orban, Stein, Koenig, Corner, Rexhouse, Lewis and LaGrange (2009) contend that with the combination antiretroviral therapy, HIV disease has been transformed into a manageable chronic illness. Long term survivors of vertical transmission of HIV have therefore survived to adolescence and even beyond. For this reason, society finds itself with adolescents living with HIV and AIDS, who become a special category of the population.

However, as they live in the mainstream society, adolescents living with HIV and AIDS face serious challenges on a daily basis as they grapple to have normal and fulfilling lives. The challenges they face include stigma and discrimination within the family and in society at large, burden to take medication, stunted growth, difficulties in accessing education, reduced school performance, hopelessness, low self regard and other mental health problems (Jackson, 2002). Frequent illness and hospitalization as well as separation have deleterious effects on HIV infected child's social, cognitive and communicative development. In addition, adolescents living with HIV and AIDS have to grapple with family conflict, fear of death, as well as instrumental problems in accessing health care services, transport, food, accommodation and other basic necessities. Bachanas, Kulgren, Schwartz, Lanier, McDaniel, Smith and Nesheim (2001) also contend that children with HIV are at particular

risk for psychological disturbance due to both direct effects of HIV infection on the brain structures involved in the regulation of emotion, behaviour, cognition and indirect effects related to coping with range of medical, psychological and social stressors associated with HIV.

Jackson (2002) further posits that the need to continuously take medication by the children poses challenges with regards to adherence. Moreover, these long term survivors of HIV face particular issues that affect young people generally, especially issues to do with sexuality. Jackson (2002) posits that young people easily find themselves in situations where it is difficult to adhere to strict sexual rules, even if they want to. Numerous pressures arise for girls and boys to engage in sexual activity, not the least being their emerging sexual desires. These pressures are thus biological, social and economic in nature. A cause for concern is the ability of the adolescents to cope with these demands, managing HIV disclosure when dating, safer sex, marriage and prevention of parent to child transmission (secondary prevention).

A significant number of these children have lost their parents to this deadly pandemic, leaving them as orphans. Such a situation has therefore complicated their circumstances and made their life more difficult and stressful due to the fact that they face enormous challenges in meeting the demands of life as well as having their basic needs met.

Coping with HIV and AIDS is a complex phenomenon involving multiple interacting variables. Paediatric HIV patients experience more subjective distress than their uninfected peers as a result of developmental skills and the many stressors associated with HIV infection (Trad , Kentros, Solomon and Greeblatt, 1994). The endeavor to cope with HIV may prompt social withdrawal, depression, loneliness, anger, confusion, fear, numbness, and guilt. However, some of the pediatric patients have developed cognitive and behavioral skills to

manage psychological stress and have therefore remained resilient in their attempt to cope with HIV and AIDS.

It is still imperative to develop empirical evidence with the view of getting a better understanding of the enormity of the challenges being experienced by these highly vulnerable children, especially in a resource limited setting like Zimbabwe. In addition, it is important to ascertain the children's feelings regarding their situation as well as their ability to cope, in response to their predicament. In this regard, getting an insight on the efficacy of the coping strategies being employed by adolescents with HIV gives room for the generation of new knowledge which culminates into more effective strategies which may enhance their coping capacities and psychosocial support interventions, subsequently boosting the quality of their lives for adolescents living with HIV and AIDS.

According to McLeod and Smith (2002), the psychological definition of coping is the process of managing taxing circumstances, expending effort to solve personal and interpersonal problems, and seeking to master, minimize, reduce or tolerate stress or conflict. Dewaal (1989) and Devereux (1993) also state that the concept of 'coping' and 'coping strategies' are derived from the responses to the famines of the 1970s and 1980s in Africa. UNAIDS (1999) has also posited that the term coping is now being commonly used in this era of HIV and AIDS pandemic, reflecting that individuals, families and communities have somehow developed the means to act in response to the adversities of the pandemic. Adler and Carlson (2009) note that it is the person who deals with these problems who define them as everyday problems or major life events. They also argued that coping and adaptation are linked to a range of psychological variables and social resources. Stress therefore results when the ability to deal with the events is not equal to the event or stimuli. It should also be noted that failure to cope may have serious health consequences at both physical and psychological level and that some strategies of coping seem to be inherently unstable or potentially self destructive.

It should be noted that besides the long term survivors of HIV and AIDS, there is also a cohort of adolescents or the behaviorally infected youths who acquired HIV later in life through sexual or drug risk behaviours (Orban *et al.*, 2012). Cases of child sexual abuse have also exposed some children to HIV infection. Despite the circumstances that led to the transmission of HIV, patients in all these categories are homogeneously referred to as adolescents living with HIV and AIDS.

Adolescents with HIV and AIDS are a special group which has been receiving less attention in the past. However, focus on this group is increasing as programmes to cater for adolescents living with HIV and AIDS are now being implemented. Furthermore, there is limited academic literature in this area, though academic interest and scholarly information in this subject is gradually evolving.

Adolescence is a developmental phase between childhood (under 10years) and adulthood (over 19 years). This is according to World Health Organization (WHO, 2010). This stage is characterized by the physical, psychological and social changes at the individual level. Once an adolescent's HIV status is known, they are usually subjected to stigma and discrimination by the community. Stigma comprises a complex web of affective, institutional and social forces that produce distress or other consequences that are detrimental to the adolescents' wellbeing. Yet stigma and discrimination intensifies the pain and suffering of adolescents living with HIV, their families and caregivers. The complex psychological and social challenges which adolescents living with HIV and AIDS and the extent to which they are coping with these challenges will be reviewed.

Chinhoyi Provincial Hospital is housed in Chinhoyi, under Makonde district. It is the largest hospital with modern facilities within Mashonaland West Province. The provincial is a referral health care centre for patients that are drawn from the six districts in Mashonaland

West. Mashonaland West province is head quartered in Chinhoyi town, which is located about 115km North-West of Harare. According to the national population census of 2012, the province has a population of 1 449 938, (ZimStat, 2012).

1.3 Statement of the Problem

NAC (2011) reports that there are over one hundred and fifty thousand children under fifteen years who are living with HIV and AIDS. This number is expected to grow as more children will survive into adolescence and even adulthood, due to improved access to antiretroviral treatment. Adolescents have composite developmental issues to deal with as they go through transition from childhood to adulthood. However, adolescents who are living with HIV and AIDS find themselves with more psychological and social realities as they gradually progress to assume adult roles. These include the need to strictly conform to a complex treatment regimen, as well as handling stigma and discrimination in the community among others.

Regrettably, there have been limited efforts directed to meeting the needs of this emerging group in terms of programming and service provision in Zimbabwe. This in part, is due to the fact that most community and health systems in Sub-Saharan Africa are not equipped to address a host of clinical and psychosocial needs for adolescents with HIV and AIDS. Furthermore, issues that affect adolescents living with HIV are complex and not fully understood in the Zimbabwean society and Chinhoyi in particular. Adolescents living with HIV and AIDS are therefore, emerging as a unique and unplanned population and their situation requires policy makers and service providers to prioritize their health and social support needs. Yet limited studies have been focused on how adolescents living with HIV and AIDS are coping with challenges they experience in their daily lives.

An appreciation of coping is important as it is a decisive point of intervention in the trajectory for adolescents who are living with HIV and AIDS. Unless a study is done to gain more

insight into the life experiences of adolescents living with HIV and AIDS, the situation cannot continue unabated. Against this background, this study explore the coping mechanisms adopted by adolescents living with HIV and AIDS in Chinhoyi.

1.4 Aim of the Study

This study aims to explore the coping mechanisms adopted by adolescents living with HIV and AIDS in Chinhoyi.

1.4.1 Objectives of the Study

- a) To understand the background circumstances of adolescents living with HIV and AIDS in Chinhoyi
- b) To examine the challenges that experienced by adolescents who are living with HIV and AIDS in Chinhoyi.
- c) To establish the extent to which adolescents living with HIV and AIDS in Chinhoyi are coping with their condition.
- d) To explore support mechanisms available to adolescents living with HIV and AIDS in Chinhoyi.

1.4.1 Research Questions

- a) What are the demographic characteristics of adolescents living with HIV and AIDS in Chinhoyi?
- b) What are the challenges that are experienced by adolescents living with HIV and AIDS in Chinhoyi?
- b) What are the coping mechanisms used by adolescents living with HIV and AIDS in Chinhoyi?

- c) To what extent are adolescents living with HIV and AIDS in Chinhoyi coping with their condition?
- e) What are the support mechanisms available to adolescents living with HIV in Chinhoyi?

1.4 Justification of the Study

Most studies in Zimbabwe on adolescents with HIV and AIDS have focused on the clinical aspects HIV and AIDS. A recent study conducted in Zimbabwe focused on chronic lung disease by adolescents with delayed diagnosis of vertically acquired HIV infection (Ferrand, Luethy , Bwakura, Mujuru, Miller and Corbett, 2012). Other studies focused on evidence-based intervention for providing community support to HIV positive adolescents in Harare (Mavhu, Berwick, Chirawu, Makamba, Copas, Dirawo, Willis, Laver, and Cowan, 2010).

The literature relating to how children cope with the demands of HIV infection is not available (Save the Children UK, 2002). Orban *et al.* (2010) add that little is known about coping responses of adolescents with HIV, the efficacy of coping strategies, or the aspects of illness perceived to be most stressful. Hence there is a knowledge gap relating to the coping mechanisms used by adolescents to adapt to HIV related challenges in Zimbabwe and in Chinhoyi in particular. The results of this study may add to the literature in the public domain pediatric HIV and AIDS issues.

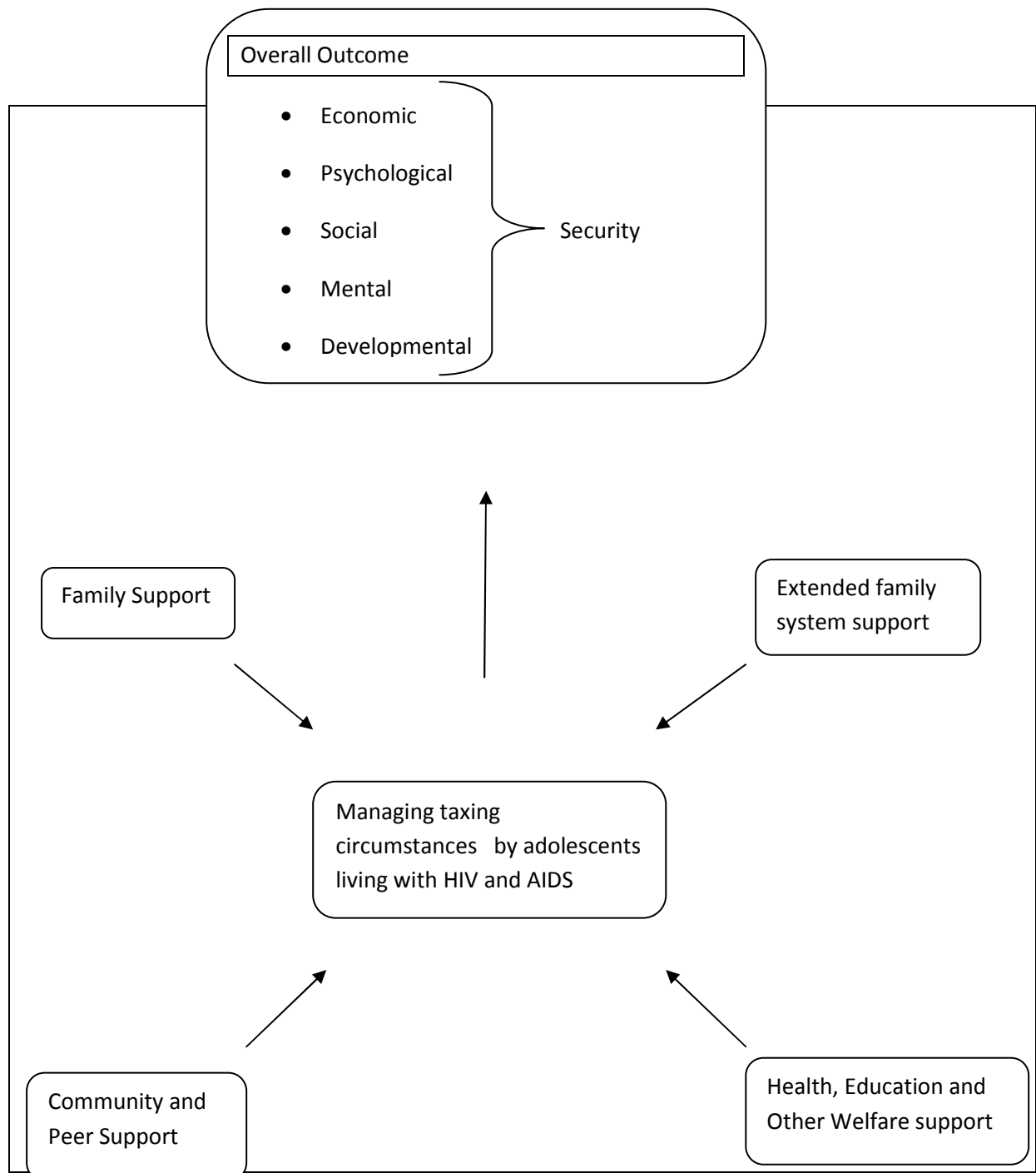
Furthermore, the information from this research may assist policy makers and other players such as the ministry of health to strengthen psychosocial support programmes for children and adolescents throughout the health system. Furthermore, adolescent patients would also benefit from prospects of adopting better ways of coping and managing complexities that are associated with HIV and AIDS. The study is set to benefit other nongovernmental

organizations as well as community based organizations that work with children and adolescents who are HIV positive.

1.5 Conceptual Framework

Coping must be understood as a process that builds on the strengths and weaknesses of an adolescent living with HIV and AIDS. It capitalizes on one's strength to absorb shocks, stresses and problems. According to McLeod and Davey (2002), the psychological definition of coping is the process of managing taxing circumstances, expending effort to solve personal and interpersonal problems, and seeking to master, minimize, reduce or tolerate stress or conflict. The following diagram conceptualizes coping mechanisms by adolescents living with HIV and AIDS in Chinhoyi:

Figure 1: Conceptual framework showing coping mechanisms adopted by adolescents living with HIV and AIDS.



1.6 Chapter Summary

This chapter shows that adolescents living with HIV and AIDS are a segment of the population which has been receiving minimal attention in the past. These adolescents have special needs considering complexity of challenges they face. It is therefore imperative to explore coping mechanisms adopted by adolescents living with HIV and AIDS in Chinhoyi and to ascertain the extent to which they are coping with stressful situations. The next chapter reviews the literature on coping mechanisms by adolescents living with HIV and AIDS.

CHAPTER TWO

LITERATRE REVIEW

2.1 Introduction to the Chapter

The previous chapter gave a brief background of the study area. This chapter provides an insight into the challenges experienced by adolescents living with HIV and AIDS as well as the strategies they use to adapting to these challenges. The concept of coping has also been examined. Case studies describing the circumstances and the coping mechanisms by adolescents living with HIV and AIDS are reviewed from selected countries. This chapter also critically looks at various publications that have been produced in the area under investigation by various researchers and scholars.

2.2 Theoretical Framework

2.2.1 The Stress -Coping Theory by Lazarus and Folkman

Coping mechanisms draws on various theoretical approaches. The stress-coping theory will be used to provide theoretical guidance in the study. It will serve as a foundation for the examination of the concept of coping as well as in the analysis and interpretation of data. According to Adler and Carlson (2009), the stress coping theory was originally developed by Lazarus (1981) and it is based on the social cognitive theory which proposes that human behaviour is influenced by the interaction between the person and the environment (Bandura, 1986; Lazarus and Folkman, 1984). Lazarus starts from the position that the social and (the biological worlds) are highly stressful. The degree to which this produces stress is determined by the extent to which these external stimuli are perceived to exceed the ability of the person to deal with them and, therefore, to endanger the well being. People have to appraise the extent to which the stimuli do this. They will then act and react accordingly. According to

Lazarus (1981) in Adler and Carlson (2009), when confronted by a stimulus that is potentially stressful, an individual engages in two processes of appraisal. These are called primary and secondary appraisal. Primary appraisal is the means whereby the person determines whether a stimulus is dangerous or not. If that person decides it is not dangerous, they may conclude that it is irrelevant to them. Alternatively, they may view it as benign or positive. If the stimulus is appraised as irrelevant, or benign or positive, it is not regarded as a stressor.

If the stimulus is regarded as stressful, this is because this is perceived to represent harm, loss or threat (anticipated harm or loss). The secondary process is about mastering the conditions of harm or threat. This can take several forms: seeking out information, taking direct action to confront the stressor, doing nothing and attempting to ignore it or worrying about it (Folkman and Lazarus, 1990).

Bandura (1999) adds a dimension that one's environment (including other people's behaviour), influences a person's behaviour emotions and cognitions. In addition, the environment is, at the same time, influenced by a person's reaction to it , as well as one's emotions and cognitions.

The importance of the stress coping theory is that it recognizes stimuli as not being stressful. It sees stress as arising from cognitive or thinking process which people bring to bear on particular stimuli (the appraisal processes) and on the extent to which they can control these stimuli by doing various things. Furthermore, when using this theory, the researcher is allowed to investigate stress and coping within a dynamic person-environment relationship. It is when the control factor fails due to internal and external factors that stress arises. This state of affairs affects the coping mechanisms.

2.3 A Global Overview of Coping Mechanisms adopted by Adolescents Living with HIV and AIDS

2.3.1 Developed Countries

The plight of people living with HIV has dramatically changed in the USA due to the advent of protease inhibitors, antiretroviral therapy and other life sustaining medications (Rowan and Honeycutt, 2010). However, a quarter of the new infections occur among those under twenty two years of age and over half of the new infections occur among those who are below twenty six years of age (Brown, Lourie, and Pao, 2000). Adolescents constitute one of the most invisible populations affected by HIV and AIDS in the U.S.A (Szekeres, 2000). Furthermore, of the HIV infected adolescents, approximately two thirds of them are from the African-American or Latino communities, which are minority groups in the country.

Hubley (2002) reported that studies conducted by some scholars in the USA revealed that children who are HIV positive and their care givers evidenced lower T-Scores on measures of distress than HIV negative children. Bachanas *et al.* (2001) attribute this curious scenario to the fact that families with HIV benefit from mental health care services available to them, whereas uninfected families rarely make use of such services. In a study conducted in the USA's three major cities by Orban *et al.* (2010), on a large and heterogeneous sample of adolescents living with HIV, results indicated that medication adherence and disclosure of HIV status are the major stressor for the adolescents under study. Most adolescents used resignation as a strategy to address adherence related stressors, while problem solving and social support were the least to be used, despite their efficacy (Orban *et al.* 2010). Furthermore, adolescents commonly used passive emotional regulation to deal with the challenge of disclosing HIV status, though this strategy may increase risk for sexual partners. Youths in the USA therefore, employ both active and passive strategies to address various stressors. They also use denial of the HIV disease as a coping mechanism, especially if they

are confronted with other pressing demands and pressure from school, work, chaotic home environments, homelessness, and substance abuse (Szeres, 2000). Hence these adolescents sometimes suspend focusing on the HIV issue until they address imminent issues, like finishing school.

Brown *et al.* (2000) also report that studies conducted in the USA show that adolescents accessing antiretroviral therapy in educational groups usually develop and share specific strategies for taking medication and adopt stress management techniques for coping with HIV in a supportive peer context, Lyon *et al.* (1998) cited in Brown *et al.* (2000). However, Szekeres (2000) notes that HIV positive adolescents may not receive care they need. In most cases, uninsured adolescents have little medical options except for accessing public clinics which may not always be youth friendly. Furthermore adolescents experience a challenge of navigating a complex health care system with they are unfamiliar and have limited experience with , coupled with mistrust of the medical system.

Brown *et al.* (2000) further posit that an integration of medical, psychological and social services, with primary clinicians and community based outreach staff would be the most ideal treatment model to address the needs of HIV positive adolescents. Hence the cooperation of medical doctors, social workers, psychologists, psycho-education assistants, and case managers is of paramount importance. Brown *et al.* (2000) give an example of Walden House in California which offers medical and psychological assessment, referral and coordination of care, therapy, counselling, transportation, peer education, legal information and long term management of adolescents living with HIV.

However, Rowan and Honeycutt (2010) argue that American society is tending more and more toward a purely medical perception, of HIV despite the multidimensional socio-economic and psychosocial components. Yet HIV is not only a medical, but also a social,

political, cultural, economic and personal issue. The new dispensation is reflected in the Ryan White Treatment Modernization Act of 2006 (RWTMA) which led to significant changes in the provision of health care services in the USA. The Act placed increased prominence on the medical aspects of HIV and AIDS at the detriment of psychosocial aspects of service provision. Under this Act, states are mandated to use not less than 75% of funding to provide core medical services that are needed in the state for individuals with HIV and AIDS (Rowan and Honeycutt, 2010).

In another developed country like Sweden, most adolescents suffering from HIV have acquired it vertically. They are treated by specialized paediatricians specialized in infectious diseases-usually in university based hospitals (Michaud, Suris, Thomas, Gnehm, Cheseaux, and the Swiss HIV Positive Mother, 2010). Michaud *et al.* (2010) also reports high levels of adherence medication by Swedish adolescents who are living with HIV and AIDS and this was attributed to adequate psychological adjustments and effective coping mechanisms, as well as the discussion and adoption of explicit medication taking strategies.

It should be noted that in developed countries, the comprehensive and better resourced health care services makes it fairly easy for adolescents to manage in dealing with HIV and AIDS related challenges. Brown, Schultz and Grag (1995) argue that active strategies of coping are mostly encouraged in western cultures. The health system in USA therefore promotes the use of therapeutic strategies adolescents living with HIV and AIDS in adapting to distress that is associated with their condition. The cultural beliefs, practices and values in the USA have an impact on the strategies that adolescents living with HIV and AIDS are encouraged to adopt.

2.4 A Regional Overview of Coping Mechanisms by Adolescents Living With HIV and AIDS.

2.4.1 Developing Countries

Despite being limited resource settings, countries in Sub-Saharan Africa have made significant efforts through comprehensive programmes for treatment, care and support for children and adolescents with HIV and AIDS. In Rwanda, support group services for HIV positive children and adolescents and their families are offered in line with a national policy that was developed by the Centre for Treatment and Research on AIDS, Malaria and Tuberculosis and other Epidemics (EGPAF, 2012). EGPAF has also been providing psychological and social services for children on antiretroviral therapy at twenty two different sites which offers treatment and care services for children and adolescents with HIV in Rwanda. Support services provided at these treatment sites include counselling, information dissemination, and life skills training.

These efforts are meant to help children to accept their HIV-positive status and cope with common challenges such as grief associated with loosing family members, treatment adherence and HIV-related discrimination. Uganda, a country with a young population with 55% of the 31 million people below fifteen years of age, has recorded an early age of sexual debut, with 14% of both men and women aged between 15 to 24 years of age reported having sex before 15 years (Bakeera-Kitaka, 2010). Similarly, 63% of young women and 47% of young men have reported having sex before eighteen years of age. However, there are limited purely adolescent services in Uganda that efficiently address the needs of this group. Health services targeting adolescents are often limited to Information, Education and Communication (IEC) on growth and development (Bakeera-Kitaka, 2010). Adolescents living within HIV have reported various challenges in seeking treatment at the public health

institutions in Uganda. They usually feel uncomfortable in adult clinic and wards, some adults are not friendly, adolescents get blamed for having HIV at a young age, and that some of the adults are their parents or close relatives (Bakeera-Kitaka, 2010).

Yet programmes in Rwanda also provide training for health workers to be able to help families with issues of managing disclosure of HIV status by families to children and to guide families on how to emotionally support. Furthermore, support groups for children and their caregivers are conducted monthly at various health care facilities with the intent of allowing children and adolescents and their caregivers to an opportunity to share their experiences and to be given important health information and reinforcement (EGPAF, 2010). In Uganda, psychosocial services are available in some health centers for adolescents with HIV, though family and caregivers are often involved (EGPAF, 2010).

Psychosocial support groups are usually based at health facilities and are facilitated by health workers and peer educators. Hence youths in Uganda are provided with a platform to receive information, share experiences, and receive mentorship from peer educators and also receive counselling which assist them to cope with the demands of living with HIV and AIDS. EGPAF is one of the agencies which are running support groups for HIV positive adolescents in Uganda. Specialized support groups known as Ariel Clubs have also been instituted by EGPAF, and these are called Ariel Clubs which are located at major health facilities providing ART (EGPAF, 2010). Children and adolescents are generally recruited into clubs through ART clinics or in some cases, through community referrals. These clubs provide life skills training, play therapy and counselling through various activities conducted by club facilitators. EGPAF (2010) also notes Center for Treatment and Research on AIDS, Malaria, Tuberculosis and Other Epidemics make a contribution to the HIV positive adolescents who are 13 years and older who are active members of support groups in Rwanda. Three day

camps are usually organized for adolescents with HIV to share experiences, feelings, know one another and learn about health and HIV.

Mulago Baylor-Uganda is another health institution which has registered over 900 youths living with HIV (10-24) since August 2003. Mulago Teens Club based at Baylor-Uganda provides psychosocial support services and promotes the wellbeing of HIV positive children, adolescents and young people, through various activities which include teen led focus group discussions. Furthermore, Makerere University hospital also provides services to over 620 registered children and adolescents with HIV (Bakeera-Kitaka, 2010). Similarly, in Botswana, a Teens Club was initiated in 2005 at Botswana Baylor's Children Clinical Centre with the intent of empowering HIV infected adolescents to build positive relationships, improve self esteem and acquire life skills through mentorship, adult role modeling and structured activities (AIDSTRA-ONE, 2012). This would ultimately lead to improved clinical and health outcome as well as a healthy transition into adulthood.

The Teen Club has also been spread out to five other sites throughout Botswana and the teen model had also been replicated in countries such as Lesotho, Swaziland, and Malawi among others (AIDSTRA-ONE, 2012). However, according to the Kenya 2008 country progress report to the United Nations Special Session on HIV and AIDS (UNGASS), the country with about 17 000 HIV positive adolescents has poor psychosocial support programmes to cater for this category of the population (UNGASS, 2008) Despite limited psychosocial support programmes, Kenya has made various efforts to increase the number of HIV positive children and adolescents in receiving treatment (EGPAF, 2010). Comparably, studies in Uganda have shown that adolescent friendly health settings have led to a significant increase in the uptake of sexual and reproductive health services. This has also enabled HIV positive adolescents to cope with sexual and reproductive challenges that confront young people, but being complicated by HIV infection, Agot and Onyongo, (2009).

In Tanzania, HIV infected adolescents have been reported to cope through various ways. Recognizing the limited capacity of the extended family to care for HIV positive adolescents, who are in most cases orphans, the concept of created kin has been adopted (Daniel, undated). The non blood relatives and humanitarian organization are increasingly taking roles that were previously played by the extended family. Service provided is usually more than providing material assistance, but care, when no kin are available to do so, among other things (Daniel, undated). Melissa and Fullem (2012) posit that South Africa and Botswana managed to adopt a family model in the delivery of HIV care and this yielded results in terms of promoting young people's self management in the context and their family. This has proved to be effective in adolescents' psychosocial adjustment as well as coping with medication adherence.

According to Parker (2009), despite the fact that peri-natally infected adolescents often become orphans while young, a study in Arusha region of Tanzania demonstrates that these adolescents demonstrate self resilient and self reliant coping mechanisms. The majority presented personal characteristics and adaptive responses that support emotional functioning. Parker (2009) adds that the adolescents in Tanzania recognized the challenges that are presented by illness, orphan hood, poverty and social stigma and they have developed ways to minimize their effect. They developed a strong sense of hope, better skills in self care and also a strong belief in God.

Gray and Rutter (2007) in Parker (2009) concur that developing coping mechanisms mitigated the effect of the meaning of chronic disease upon the physical functioning and the overall quality of life for adolescents. Mabala, Badcock-Walters and Anning (2009) posit that in Tanzania and Namibia, HIV positive adolescents who have cited personal and continuing experience of negative consequences of disclosure have emphasized greater safety in silence.

Education needs for HIV positive learners and orphans in both countries have also been catered for through reduced school fees and expanding feeding schemes.

According to Midtbø, Shirima, Skodav and Daniel (2012), studies in Sub-Saharan Africa have revealed disclosure on antiretroviral therapy help HIV infected adolescents cope with stigma. Disclosure has shown to improve adolescents ART adherence and that strong family support have enabled them to cope much better with HIV. Furthermore, adolescents in Sub-Saharan Africa have been reported to use knowledge about HIV to manage control own life and cope with stigma. Strategic disclosure of HIV status has been adopted as a coping mechanism, and also support group membership which has been seen a source of openness and nurturing self confidence. Disclosure, though has its challenges, has enabled HIV positive adolescents to seek support from family, friends, teachers, health care workers and has enabled them to resist internalized stigma by seeing themselves as better off than those who are untested and unaware of their HIV status (Midtbø, *et al.* 2012).

2.5 A Local Overview of Coping Mechanisms Adopted by Adolescents Living with HIV and AIDS.

Various attempts have been made in trying to address children and adolescents' issues in relation to HIV infection. A few organizations have emerged in the past few years with the intent of responding to the growing psychosocial support need of adolescents living with HIV and AIDS in Zimbabwe. According to Mavhu *et al.* (2010), Zvandiri support group programme was one such initiative to be introduced by Africaid. The support group was incepted to compliment clinic based services. These community based support groups were established at 20 urban centers in Harare and Chitungwiza .

In July 2009, child adolescent adherence supporters were introduced to enhance effective adherence strategies as well as life skills training, (Mavhu *at al.* 2010). Furthermore, eight

adolescent led training teams were set up, as well as the production of an adolescent led Information, Education and Communication (I.E.C) materials and also a community outreach team. Kapnek Trust is another agency which has been providing services for children with HIV and AIDS. It runs Early Childhood Development (E.C.Ds) centers focusing on preschool children in the Zvimba area in the Mashonaland West Province. It provides the children with food, health care and education interventions (Southern African AIDS Dissemination Service (SAFAIDS), 2010).

Furthermore, a study was conducted under the National Action Plan for Orphans and other Vulnerable Children NAP for OVC on 229 adolescents with HIV by Regai Dzive Shiri (RDS) a local nongovernmental organisation. The adolescents were drawn from support groups that are administered by Africaid. The study revealed that adolescents living with HIV and AIDS in Zimbabwe endured physical challenges associated with HIV and AIDS. They reported stunted growth, physical abuse, frequent illness and skin disfigurements. In addition, the study found the psychosocial challenges faced by children living with HIV as verbal abuse, stigma and discrimination at home, stigma and discrimination in the community, stigma and discrimination at school and depression. Mavhu *et al.* (2010) also reported that females in particular face additional challenges around forming relationships and disclosing their status.

While data showed that support group attendance was helpful, young people stressed that life outside the confines of the group was more challenging (RDS, 2010), for example, there was a lack of understanding of these young people's issues at home characterized by ignorance about antiretroviral drugs, safety of dating and possibility of future aspirations. Secrecy of a child's status was common and this hindered the ability of other household members to provide support.

Hence adolescents with HIV and AIDS in Zimbabwe cope with HIV and AIDS through various strategies which include attending support groups, support from the extended family, counselling, going to church, visiting traditional healers, school attendance, sport, engaging in income generation activities and many others.

2.6 Service Provision for Adolescents Living with HIV and AIDS in Zimbabwe

In Zimbabwe, there is a National Anti-Retroviral Programme whose aim is to provide access to antiretroviral therapy to all people who are living with HIV and AIDS who are in need of treatment (Buzdugan, Watadzaushe, Dirawo, Mundida, Langhaug, Willis, Hatzold, , Mugurungi, Benedikt, Copas and Cowan, 2011). In Zimbabwe, antiretroviral therapy provides comprehensive care and support packages that attempt to meet medical, social and emotional needs. Other services available include HIV voluntary counselling and testing (VCT), sexually transmitted infections (STI) management, opportunistic infections (O.I) / antiretroviral therapy (ART) management, quality of care in communities, psychosocial support and nutritional care. These services are available in public health institutions in all provinces. In 2008, about 196 000 were receiving HIV treatment, care and support in Zimbabwe's health care centres.

Though most people with HIV and AIDS need treatment for HIV and AIDS, there are still some gaps in service provision. HIV treatment is provided free of charge under the ART programme, but coverage is limited and expansion coverage is limited due to lack of funds (WHO, 2005).

Less than 300 000 of the 600 000 needing ART were receiving treatment, (Mutasa-Appollo, 2010). However, however, significant gains have been made in scaling up ART in Zimbabwe despite the unfriendly economic environment and resource constraints. Despite attempts to scale up services for adolescent with HIV and AIDS by the government, resource constraints

make continued expansion of services extremely difficult (Maruva, Keatinge., Miller, Foster, and Bwakura, 2009).

Kalichman, Heckman, Kochman, Sikkema, and Bergholte (2000) note that people who are living with HIV and AIDS are at risk for suicide, hence they require comprehensive mental health services, given the breadth and depth of their emotional distress and functional limitations. Such services may be integrated with available HIV care systems such as case management and multiservice agencies. Counseling, enhancing perceived support, and increasing coping resources for persons who have thoughts of suicide but are not yet in need of crisis intervention should be considered a priority in HIV-AIDS care services.

A study by Magaya, Asner-Self and Shreiber (2005) revealed that Zimbabwean adolescents generally use emotionally focused strategies more frequently than problem solving strategies. Hence the authors came to a conclusion that Zimbabwean adolescents may need to obtain a large repertoire of coping skills in addition to what they already possess, thereby highlighting the need to employ problem solving skills in dealing with highly difficult circumstances.

It should be borne in mind that there are complexities which should be considered when responding to the needs of adolescents who are HIV positive. Children and adolescents with HIV are not a cohesive group hence different circumstances as well as capacities to cope with the demands of HIV and AIDS (Strode and Grant, 2011). Hence this should be heedful of the fact that children evolve through distinct developmental stages including infancy (0-6years), early adolescents (10-14 years) and late adolescents (14-18 years).

2.7 Policy and Legal Framework for Dealing with Adolescents with HIV and AIDS in Zimbabwe

The absence of a comprehensive policy on paediatric HIV has led to a national situational analysis of the provision of services for children living with HIV and AIDS to be conducted in Zimbabwe between 2005 and 2006 to inform and catalyze policy and strategy development (Maruva, Keatinge, Miller, Foster, and Bwakura, 2007). The Ministry of Health and Child Welfare (2009) then crafted National Psychosocial Support Guidelines for Children Living with HIV and AIDS in an effort to standardize psychosocial support services to enhance children's and adolescents' capacity to cope with the demands of living with HIV and AIDS. The guidelines were also aimed at supporting health workers and other community based workers in the provision of psychosocial support services to children living with HIV and AIDS.

Other training manuals were also developed by the Ministry of Health and Child Welfare on palliative care and nutrition support for children living with HIV and AIDS in Zimbabwe. Furthermore, National Strategic Plan for PMTCT and Children Living with HIV and AIDS has since been completed. The purpose of the strategy is to focus on the provision of care and treatment services for mothers and children (Maruva *et al*, 2007).

The Zimbabwean government has also demonstrated relentless commitment towards fighting against HIV pandemic through the formulation and implementation of various national policies which had some contribution to adolescents living with HIV and AIDS. Hence various policies that institute a multi-sectoral response have been formulated by NAC, Zimbabwe's statutory HIV and AIDS governing body. NAC has since introduced a National HIV and AIDS policy in 1999 to give guidelines to programmes that are aimed at combating the spread of HIV and AIDS. NAC managed to make significant progress to put structures for

the creation of an environment conducive for HIV and AIDS multi-sectoral response. Among other policies, the government adopted and implemented the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP I) 2006 to 2010 and made several milestones. This strategic framework which was developed in line with the HIV and AIDS policy meant to give guidance in the formulation and implementation of programmes relating HIV and AIDS. This was intended to translate into improved services and programmes for HIV positive adolescents in terms of treatment and care in public health institutions.

NAC also made efforts to address issues of gender equality and stigma which also affected adolescents with HIV and AIDS in the community. Zimbabwe is currently implementing ZNASP II (2011-2015) whose main thrust is prevention and reduction of new HIV infections by 50% in 2015. Furthermore, the current strategic plan aims to reduce mortality rates of people living with HIV and AIDS by 38% by 2015, (NAC, 2010). This would translate to longer life span for HIV positive adolescents. The Zimbabwean government has also crafted a number of domestic HIV policy strategies guided by international and regional agreements that have been approved over the years.

Furthermore, the Government of Zimbabwe (2010) crafted a National Community and Home Based Care (CHBC) strategic plan (2010-2015). According to this strategic document, CHBC programme has evolved to ensure a continuum of care to adults and children with chronic and terminal illnesses such as cancer, hypertension, and its complications, diabetes, epilepsy, mental illness and HIV and AIDS, as well as the elderly. CHBC is also playing a significant role in response to HIV and AIDS in Zimbabwe and services provided usually include provision of nutritional support to clients, training of caregivers, assisting with access to HIV and AIDS related treatment. In this regard, CHBC programmes also assist adolescents living with HIV to cope with various demands that are required by their condition as well as societal challenges.

Zimbabwe has also been able to create an environment which led to the growth of networks for people living HIV and AIDS. There are now various networks for people living with HIV and AIDS, including support groups for HIV positive adolescents. This has assisted adolescents with HIV to share experiences with their peers as well as learn life skills which strengthen their capacity live positively with HIV and AIDS. Zimbabwe has also over the years enacted various bills that help to maintain the rights of vulnerable groups, for instance, the Criminal Procedure and Evidence Act of 1997 attempted to address the burgeoning cases of sexual abuse of minors. Furthermore, stiffer penalties (20years) are now included for rapists who infect their victims with HIV (Sexual Offences Act) of 2000. The Children's Act of 2006 also provides for the testing of children up for adoption.

With regards to sexual and reproductive health issues, national laws generally uphold the requirement for parental consent for adolescents below the age of 18 to access services and information on contraception, (The Center for Reproductive Law and Policy Child and Law Foundation, Undated).

2.8 The Concept of Coping

Lazarus (1993), an American psychologist, was very influential in the development of the concept of coping. He proposed that the concept of coping is not new, but has been with us for a long time, though it began to come into its own formally during the 1960s and 1970s, along with the burgeoning interest in stress. Rugalema (2000) further contends that the use of the notion of coping strategies, in attempting to explain household responses to disasters, gained currency in the 1970s and the 1980s when famine threatened and claimed lives of thousands of lives in North East Africa and Sahel region. Since then, the concept of coping has been used to explain the responses to famines (Devereaux, 2003).

In medical literature, the term coping has not been widespread, except in mental health, (Hodginson and Stewart, 1998). Rugalema (2000) further propounded that the advent of HIV

and AIDS, however, has given the concept of coping a new lease of life. Rugalema (2000) defined coping as dealing successfully with a difficult situation, and he assumed that coping is a process which is achieved through a strategy which, in turn, is a general plan or a set of plans intended to achieve something, especially over a long period of time.

Lazarus (1993) argued that coping may be regarded as a generic concept that includes ego defenses which deals with threats to one's psychological integrity. Lazarus (1993) also viewed coping as a process and as merely a combination of cognitive and behavioural efforts to manage psychological stress. From a process perspective, according to Lazarus (1993:235), the process of coping changes over time and in accordance with the situational contexts in which it occurs. He added that depends on the particular person and the specific type of encounter.

Tyre and Steinberg (1995) argue that learning, and practice of coping skills is generally regarded as very helpful to individual experiencing psychological distress. Hence sharing of learned coping skills with others is often beneficial. Welsh (2008) however notes that the overuse of coping mechanisms (such as avoiding problems or working obsessively) and defense mechanisms (such as denial and projection) may worsen one's problem rather than remedying it.

According to Lazarus (1993), when studying how a patient copes, it is necessary to specify the particular threats of immediate concern to the patient and treat them separately rather than broadening the focus of attention to the overall illness. Lazarus (1993) adds that in measuring coping, it is important to get a description of what a person is thinking and doing in an effort to cope with stressful encounters to be in a better position to assess the efficacy of coping strategies.

Brown, Lourie and Pao (2000) identify coping behaviors to include acceptance of responsibility, confrontive coping, planful problem solving, escape and avoidance, distancing, seeking social support, self control and positive re-appraisal. However, Folkman and Lazarus, (1993) put forward the argument that taking action against problems rather than reappraising the relational meaning seems more desirable.

2.9 Strategies of Adapting to Chronic Illness

According to Adler and Carlson (2009), a number of strategies have been observed in the way people cope with, adapt to and try to gain some control over chronic illness. The response is linked to the amount of threat their illness presents to them, and what they are able to do about the threat. These strategies, according to Adler and Carlson (2009:132-133), are normalizing, denial, avoidance, resignation and accommodation. Normalizing occurs when patients acknowledges the symptoms of their conditions, but redefines them as part of normal experience and hence as nothing to worry about.

With denial, the patient denies the existence of illness altogether. This may have profoundly beneficial effects, especially in the early stages of the knowledge of a worrying or threatening diagnosis. Denial may help the patient drawback, take stock and marshal help. In the longer run, however, denial prevents the patient from confronting the illness, particular difficulties for the health professionals and the close family members. Avoidance is another strategy. They set out to avoid those situations that might exacerbate their symptoms or lead to other problems. While, avoidance strategies are highly adaptive, they also contain within them certain maladaptive or potentially destructive elements, through potential social isolation.

Resignation is whereby a patient has totally embraced their illness and for whom the most important thing about their life is their illness. They resign themselves to their fate. The illness is designed in such a way that instead of being something threatening, it grants

psychological rewards. At certain times in a serious and grave illness resignation may be an entirely appropriate way to respond. However, in many less serious conditions, total resignation leads to invalidism. The problem that this type of a behaviour presents for health professional is that their best efforts to get the patient to attempt to take control over their own life is resisted because the patient works hard to maintain their dependence on others (Adler and Carlson, 2009).

Lastly, accommodation, according to Adler and Carlson (2009:133), is a strategy whereby a patient acknowledges and deals with a problem their illness produces- whether this is managing their symptom manifestations like pain or managing a self administered drug regime. The everyday work of handling the disease is seen as part of normal living. No attempt is made to build a special status out of the illness. Instead, the person tries to deal with other people in terms of his /her other characteristics, such as being a keen gardener, a football fan, a member of the church, and so on. They do not attempt to make their illness central to their life.

2.10 Coping with HIV and AIDS

According to Brown, Lourie and Pao (2000), most antiretroviral regimen is complex and challenging. Rigorous adherence to them is important and life prolonging. However, default in taking medication may lead to drug resistance and treatment failure. In adults and children, coping with HIV and AIDS is a complex phenomenon involving multiple interacting variables. Paediatric HIV patients experience more subjective distress than their uninfected peers as a result of developmental skills and the many stressors associated with HIV infection, (Trad *et al.* 1994). Such stressors often include disclosure of HIV status, social isolation, fear of death and family conflict.

In addition, there are often instrumental problems in accessing health care services, medication, transportation, clothing, counseling and recreation and housing, (Hansell *et al.* 1998). Repeated hospitalizations and isolation from peers are known to have adverse effects on HIV infected child's social, cognitive and communicative development. In addition, some stressors for the children living with HIV and AIDS include dysphoria, hopelessness, preoccupation with their illness, and poor body image. Some adolescents with HIV report more sexual risk-taking behavior and conduct or hyper-active disorders. Many individuals with HIV have a history of negative life events, such as forced disclosure, loss of a parent or a sibling due to AIDS, or abuse. In addition to increased distress, adolescents with HIV often experience greater physical pain, which is a frequent accompaniment to AIDS. Chest pain, head ache, oral cavity pain, abdominal pain, and peripheral neuropathy are commonly reported, (Holland *et al.* 1992). Almost 60% of the children with HIV experience pain which may negatively affect their quality of life.

Coping responses to HIV infection have been more extensively studied in adults than among children and adolescents. Studies by Grassi, Righi, Sighino, Makoui and Ghinelli, (1998) reveals that poor coping was associated with psychological stress, repression of anger, external locus of control, and low social support. This indicates that coping is a complex phenomenon.

Children and adolescents living with HIV may have to cope with multiple conflicts. They have to cope with emotional pain associated with social stigma, isolation and hopelessness, forced disclosure, anxiety about their medical prognosis, loss and bereavement, and physical appearance and body image due to wasting and dermatologic conditions (Lewis, 2001).

The multiple stresses and context of HIV appear to give rise to multiple nodes of adaptation and coping. For example, mothers of children with HIV infection have reported significantly

more wishful thinking than mothers of healthy children or children with cancer (Hardy, Armstrong, Routh, Albrecht and Davis, 1994). In the absence of a proven cure of HIV, wishful thinking may be an appropriate coping mechanism for mothers of infected children than those of children who have cancer. As might be expected, biological mothers experienced significantly more self criticism than did foster mothers. Parental adaptation to HIV may be an important factor in determining the child's adjustment and response.

Brown, Schultz and Gragg (1995) found that a significant degree of distress reported in response to HIV reminders even after years of knowing about their infection. A number of coping strategies were used with resignation, self calming, and distraction most commonly reported whilst self blame, engaging in risky behaviours, thinking about sex, and drug and alcohol use were used least.

Maes and Leventhal (1996) proposed that children and adolescent coping goes through four stages. Firstly, a stage of uncertainty, in which children try to conceptualize the disease, secondly, a stage of disruption, in which they realize they are plagued by something that may last the whole of their life, thirdly, striving for recovery, and lastly restoration of well-being.

Grassi *et al.* (1998) highlight that it is of paramount importance to come up with interventions that improve the coping styles that are utilized by HIV patients. Grassi *et al.* (1998) add that timely identification of HIV positive needing support and intervening early provides benefit for improved coping and this also enhances their quality of life. This can be achieved through support groups and other structured programmes. Researches that have been done on adults with chronic problems suggest that the use of active strategies such as problem solving and help seeking improves adaptation, as compared to passive strategies such as self blame or resignation (Brown *et al.* 1995).

2.11 The Role of the Family Environment in Coping with HIV and AIDS

According to Petersen *et al.* (2010) in Melissa and Fullem, (2012), the family environment has a significant influence on psychosocial adjustment for adolescents living with HIV. Poverty, parent history of drug use, and multiple losses are among the family and social factors that influence many children and adolescents with HIV and AIDS. In Africa, most HIV positive adolescent are orphans, a factor which makes adjustment difficult for these adolescents adjustment enormously difficult, (Petersen *et al.* 2010, as cited in Melissa and Fullem, 2012). Throughout the world, in both under developed and developed nations, poverty is the major barrier to prevention and treatment of HIV of those infected with HIV. The impoverished communities have limited access to information on best practices to prevent the spread of HIV. Furthermore, the poverty limits families' capacity to access available treatment as well as the adoption of recommended diets which improves health and well being of people living with HIV and AIDS.

Brown *et al.* (2000) also highlights the important of the social environment in coping with a chronic illness occurs. This is because coping is also related to the environment from family and friends (social network) and financial resources come into this category. Brown *et al.* (2000) adds that resources have an important mediating effect on difficulties, but cannot themselves prevent them. In the absence of social support, other life difficulties can be potentially damaging. Hence a combination of low self esteem, lack of financial resources and lack of social support make it difficult for HIV positive adolescents to cope with complex demands.

In addition, Lewis (2001) posit that although chronic illness can be a life stressor for children, the disease process itself does not appear to be the primary cause of behavioral adjustment problem for the chronically ill child. Most children show surprising resilience and regain a level of adaptive coping with minimal psychological intervention. Family resources such as

problem solving skills, level of cohesion, and adaptability to change, openness of communication patterns and so forth. In addition, the support system that available to the child family, include extended family networks, friends and community resources are also critical, (Lewis, 2001).

It should also be noted that developmental differences underscore the importance of evaluating coping behaviours within the developmental status of the child. In addition, coping is an ongoing process which can only understood only be by studying the individual as he or she interacts with the environment, especially understanding what children and their families do and think in specific situations in order to learn about their coping efforts with their illness.

2.11 Chapter Summary

This chapter reviewed literature on the psychosocial circumstances for adolescents who are living with HIV and AIDS. This includes challenges they encounter as well as coping strategies that are used to come to terms with various stressors that are associated with living with HIV and AIDS in a Zimbabwean context. The chapter also looked at the regional as well as the global overview of coping mechanisms by adolescents with HIV and AIDS. The legal and policy framework as well as service provision for adolescents living with HIV and AIDS were also reviewed. The implication of the literature that has been reviewed is that it has informed the researcher on the existing knowledge on the subject under study. This brings to the fore the research gap that this study seeks to address. The next chapter reviews the methodology for the study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction to the Chapter

The previous chapter highlighted theoretical framework as well as relevant literature on the existing knowledge on coping with HIV and AIDS by adolescents who are living with HIV and AIDS. This chapter addresses the research methodology that was used in gathering the data for this study. The issues to be covered include research design, scope of the study, population, data collection, data analysis, limitations of the study and ethical considerations.

3.2. Research Design

Research design refers to a blueprint for collection, measurement and analysis of data, (Nachmias and Nachmias (2008). There are two research designs namely, quantitative and qualitative. This study applied a mixed research design, comprising both qualitative and quantitative methods to explore the coping mechanisms adopted by adolescents living with HIV and AIDS in Chinhoyi. According to Creswell (2007), qualitative research seeks to identify a phenomenon for study and establish how people make sense of their own lives and experiences. “Qualitative research is oriented towards analyzing concrete cases in their temporal and local particularity and starting from the people’s expressions and activities in their local context”, (Flick, 2009:21). Qualitative design is suitable when exploring areas of sensitivity and emotional intensity (Padget, 2008).

It should be noted, however, that although qualitative design is criticized for providing subjective data, it gives an enhanced insight into a participant’s experience at a given time on the subject matter under study (Padget, 2008). These direct encounters assist social work

practitioners and researchers to understand experiences of people in difficult circumstances, particularly adolescents living with HIV and AIDS.

Quantitative research refers to an objective process whereby numerical data are from a participant sample for purposes of making on generalized inferences on the population being studied (Flick, 2009: 296).

It should be noted, however, that s issues in social sciences research are not addressed by one research methodology. Black (1993) put forward the argument that triangulation, a combination of both qualitative and quantitative methods, is more useful in conducting social science research. Quantitative and qualitative research studies are combined to produce a general picture of the subject under study.

3.3 Scope of the Study

The study was conducted in Zimbabwe, Mashonaland West Province in Chinhoyi Urban under Makonde District at Chinhoyi Provincial Hospital. Mashonaland West province has a population of 1 449 938 people (ZimStat, 2012). The province consists of six districts namely Chegutu, Hurungwe, Zvimba , Kadoma, Kariba and Makonde. The prevalence rate of HIV in Mashonaland West Province is 15% (ZimStat, 2011). The provincial hospital is located in Makonde District which is about 115km North-West of Harare, the capital city. The hospital is run by a medical superintendent, with the assistance of the hospital administrator.. The study focused on evaluating adolescents who are living with HIV and AIDS who receive antiretroviral therapy at Chinhoyi Provincial Hospital.

3.4 Population

A research population is generally a large collection of individuals or objects and it forms the main focus of a scientific inquiry, (Yates, 2004). One hundred and eighty six HIV positive adolescents aged between ten and nineteen years who receive ART at Chinhoyi Provincial

Hospital were the main target population of this study. The researcher also considered five key informants for this study. The key informants included the District Social Services Officer, a health care worker from Chinhoyi Provincial Hospital, secondary care giver and a guidance and counselling teacher from a local school (Chikonohono secondary school). The researcher also considered and interviewed the Director of Pamuhacha as a key informant because the organization provides psychosocial support and life skills training to adolescents who are living with HIV and AIDS.

3. 4 Sampling

A sample is defined as a proportion of a large population (Creswell, 2007). Generally, there are two types of sampling, namely probability sampling and non probability sampling, (Bryman, 2004). Probability sampling includes simple random, systematic random, stratified random, cluster and multi-stage sampling, (Bryman 2004). Non probability sampling includes quota, convenience and purposive sampling.

In this study, the sample of thirty eight was drawn from a possible one hundred and eighty six adolescents living with HIV and AIDS aged between ten to nineteen years of age, who are receive antiretroviral treatment at Chinhoyi provincial hospital, thereby representing about 20% of the target population. Simple random sampling was used in respondents to participants using a sampling frame (Hospital registers. Key informants were also selected using judgmental sampling. Judgmental sampling was deemed appropriate because it was assumed that the selected key informants had adequate and expert knowledge on the area under study because the nature of their work has a direct bearing on the service provision for the unit of analysis for this study.

3.5.1 Data Collection Techniques

The study used questionnaires, in-depth interviews, and key informant interviews. Questionnaires were administered by the respondents immediately after interview sessions. Separate appointments were set with key informants.

3.5.2 Data Collection Instruments

The study made use of three sets of instruments namely Indepth interview guide (Appendix I), key informant interview guide (Appendix III) and a questionnaire (adolescent version of KIDCOPE, Appendix II). The instruments that were used to collect qualitative data contained open-ended questions. The instruments were designed to make an assessment of the challenges being experienced by adolescents who are living with HIV and AIDS as well as to explore the coping mechanisms adopted by adolescents living with HIV and AIDS to these challenges.

The researcher administered a key informant interview guide in order to solicit authoritative and expertise data from five key informants. These key five informants closely work with adolescents living with HIV and AIDS in Chinhoyi. Key informant interviews were conducted because they enable researcher to solicit useful and authoritative data which validated that which were collected from study participants. The researcher acquired invaluable specialist knowledge as well as key informants' experiences of working with adolescents living with HIV and AIDS.

An adolescent version of KIDCOPE was used to establish and measure coping mechanisms that are frequently adopted by adolescents living with HIV and AIDS in Chinhoyi. The adolescent version of KIDCOPE was adapted from Orban *et al.* (2011) who conducted a similar study at various treatment sites in the USA. The questionnaire was in the form of a likert-type scale with two sections. The first section required the adolescent to indicate the

extent to which they used a given set of coping mechanisms. The second section required respondents to indicate how effective a certain mechanism is in addressing challenges they face in their daily lives. The limitation of the scale is that it only measures eleven broad categories of coping mechanisms, thereby not capturing unique or specific coping methods that respondents adopt depending on the situation at hand.

Quantitative was collected using an adolescent version of KIDCOPE to used to establish and measure coping mechanisms that are frequently adopted by adolescents living with HIV and AIDS in Chinhoyi. The adolescent version of KIDCOPE was adapted from Orban *et al.* (2011) who conducted a similar study at various treatment sites in the USA. The questionnaire was in the form of a likert-type scale with two sections. The first section required the adolescent to indicate the extent to which they used a given set of coping mechanisms. The second section required respondents to indicate how effective a certain mechanism is in addressing challenges they face in their daily lives. The limitation of the scale is that it only measures eleven broad categories of coping mechanisms, thereby not capturing unique or specific coping methods that respondents adopt depending on the situation at hand.

A pilot study was done prior to engaging a full scale data collection. Denscombe (2010: 106) defines a pilot study as “a small scale trial run that a researcher can use as a means of checking how well their proposed research designs work”. The instruments were pre-tested at the Alaska Clinic, 15km away from Chinhoyi town. The clinic is one of the two treatment centres in Makonde district which has recently initiated the administration of ART. Five HIV positive adolescents and one health worker from the clinic participated in the pre-test. The improvements to the data collection instruments were made accordingly. The pretesting was done in December, 2012.

3.6 Data Analysis

According to Bryman (2004), data analysis aims to describe discuss and explain context of data that is generated in a study. Qualitative data generated in this study were analyzed thematically together with content analysis. Data were split into manageable themes, patterns and trends. According to King and Horrock (2010:150), “themes are recurrent and distinctive features of participants’ accounts, characterizing particular perceptions or possible reasons behind these experiences”. Padgett (1998) also argues that themes that emerge should highlight the pattern of human experiences and possible reasons behind these experiences. Data were also analyzed in accordance with the research objectives. Quantitative data generated from the adolescent version of KIDCOPE were coded and entered into the Statistical Packages for Social Sciences (SPSS). Descriptive statistics were used to analyze the quantitative data to address objective number two.

3.7 Limitations of the Study

Limited resources and time constraints narrowed the researcher’s focus on studying adolescents living with HIV and AIDS who are receiving treatment patient from one public health institution, which is a provincial hospital. If resources permitted, the study could have covered adolescent patients from other provincial hospitals, district hospitals, referral hospitals, as well as local and mission hospitals.

3.8 Ethical Considerations

Research ethics were observed, with the guidance of the American Psychological Association Code of ethics, [American Psychological Association (APA), 2002]. Before each data collection session, the researcher clearly explained to the adolescents, their guardians and care givers and also key informants of the background and purpose of the study. Voluntary consent was sought from each participant prior to each session. Since the majority of participants were minors, voluntary consent was sought from parents, guardians and care

givers of adolescents who are below the age of sixteen. Upon agreement to take part in the study, voluntary consent forms were signed by the participants. The researcher emphasized the importance of confidentiality, non judgmental attitude and the maintenance of privacy during sessions. Furthermore, identities of respondents were not recorded, except for the biographic data such as age, sex, and school status.

The researcher also made a commitment not to inflict any form of harm to respondents during data collection process. Their personal, professional and moral eminence was preserved in interview sessions, home visits and in group discussions. Counselling sessions as well as other psychosocial support services were arranged within the hospital set up for six adolescents who seemingly presented some difficulties in coping with living with HIV and AIDS. Referrals were also made to relevant agencies that could best assist them to deal with their challenges.

3.9 Feasibility of the Study

The medical superintendent granted the researcher permission to carry out the study at Chinhoyi Provincial Hospital. It was possible to reach out to twenty HIV positive adolescents as they visited the O.I clinics for treatment or to get a supply of antiretroviral drugs. In addition, key informants also participated in the study.

3.10 Chapter Summary

This chapter describes methodology that was in gathering the data for the study. Sampling procedures as well as the data collection methods were highlighted. Data analysis was also discussed. The chapter also discussed the ethical consideration. The next chapter covers data presentation, discussion and analysis of findings.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF FINDINGS

4.1 Introduction to the Chapter

The previous covered issues relating research methodology. This study seeks to explore the coping mechanisms adopted by adolescents living with HIV and AIDS in Chinhoyi. This chapter shows detailed findings from an adapted version of KIDCOPE questionnaire, focus group discussion and key informant interviews. The information has been organized according to the main themes and data from interviews focus group discussion transcripts were used to support the findings. The themes identified were as follows:

Theme 1: Challenges experienced by adolescents living with HIV and AIDS in Chinhoyi

Theme 2: Coping mechanisms adopted by adolescents living with HIV and AIDS in Chinhoyi

Theme 3: Support mechanisms available for adolescents living in Chinhoyi

The findings were broken down into smaller subsections to ensure that findings that were made during analysis were logical and structured. Particular quotes by respondents were highlighted using italics. Respondent in the focus group discussion has been assigned a number; for instance, respondent two is identified as respondent 2. Key informants have also been assigned numbers to identify quotations that they have made.

4.2. Results

4.2.1 Demographic Background of Study Respondents

Table 1: Demographic background of study respondents

| Age group | Gender | | School status | | | | Sub-total |
|--------------|--------|--------|---------------|---------------|-----------|---------------|-----------|
| | | | Male | | Female | | |
| | Male | Female | In School | Out of School | In School | Out of School | |
| 10-15 | 10 | 12 | 10 | 0 | 10 | 4 | 22 |
| 16-19 | 6 | 10 | 4 | 2 | 4 | 4 | 16 |
| Total | 16 | 22 | 14 | 2 | 14 | 8 | 38 |

4.2.1.1 Sex and Age of Respondents

As shown by Table 1 above, the study had a total of 38 participants (n=38). Sixteen of them were male whilst 22 were female. Of the 38 respondents, 22 of them are aged between 10 to 15 years, whereas 16 were aged between 16 to 19 years.

4.2.1.2 Education Status of Respondents

The table 1 above indicates that 28 out 38 respondents reported that they are still in school. The findings also indicate that more of girls than boys who participated in the study are no longer in the school system. In terms of highest levels of education reached, 30 respondents (n=38) have reached up to or are currently enrolled for secondary education, whilst the remaining 8 (n=38) are still in primary school or have not proceeded to secondary education.

The table 1 above indicates that only 8 female respondents out of total 22 respondents aged between 10-15 years are not in school. This suggests limited access to education mostly affecting young girls than boys. This age group is expected to be receiving basic education some in primary schools (lower end of the age range) and some secondary schools (upper end of the range). Table 1 above has indicates that none of the adolescents have gone above form four which most adolescents in Zimbabwe complete at the age of sixteen. However, table 1 show that 6 males and 10 female respondents are in the 16-19 age groups. This indicates that some HIV positive adolescents complete their studies slightly later than the average at which Zimbabwean pupils complete their primary and secondary studies if there are no disruptions. This could be a result of illness which can disrupt HIV adolescents' normal progression with their studies.

4.2.1.3 Orphan Hood Status of Respondents

Results indicate that most HIV positive adolescents who participated in the study are orphans or having lost one or both parents. Fourteen respondents (n=38) reported that they lost both parent, whilst 12 adolescents (n=38) have lost their fathers. In addition, 6 respondents (n=38) are maternal orphans, whereas 6 adolescents said both parents are surviving.

4.2.1.4 Religion of Respondents

Thirty five respondents in this study (n=38) reported that they are Christians, while 2 respondents stated that they are affiliated with the Muslim region. One respondent reported a non affiliation to any religion.

4.3 Theme 1: Challenges experienced by adolescents living with HIV and AIDS in Chinhoyi

4.3.1 Sub Theme 1: Social Challenges

4.3.1.1. Stigma and Discrimination

Stigma and discrimination were described as major challenges that confront adolescents living with HIV and AIDS in Chinhoyi. The majority (n= 32) of respondents have reported having experienced stigma and discrimination at some point in their lives in the family and in the community. It was also reported that stigma is most prevalent in the school environment from peers if your HIV status gets known to them. One respondent shared her school experience of stigma and discrimination when she said:

(R2): *“my school mates used to tease me and would not want to play with me because they say I am sick”*

One respondent (R25) highlighted that he has been given nicknames at school dubbed *“Better nhasi”* (He/ she is better today) - signaling that they frequently get ill. He also added that:

(R25) *“My school mates also tease me by calling me “Muondi-ondi” (the slim one)”*.

Another adolescent who experienced a similar situation also expressed concern over how he was once teased during sporting activities by other children calling him *“Ndombokura”* (One who sometimes grows) -as this signals stunted growth that is exhibited by the adolescent.

Another participant narrated how he was denied the chance to participate in sporting activities at his school despite his willingness to do sports:

(R18): *“The coach always denies me a chance to play in competitive soccer matches despite the fact that I play better than other students who are selected into the team. Being HIV positive does not mean that I can’t do well in sport”*

Stigma was also reported in the community, especially by neighbours spreading rumours about issues that relate to HIV status of adolescents who are living with HIV and AIDS.

Another adolescent (R7) explained how neighbours made fun of him taking pills on daily basis. He said that:

(R7) My neighbours once passed a comment that saying “kamukomana aka kanojusa”-(that lad juices/recharges). I always remember this statement everytime I drink my pills.

In showing how community can be insincere to adolescents who are living with HIV and AIDS, one respondent described an incident between him and his neighbours. He said:

(R3): “I asked for water to drink from a neighbour. However, when I finished drinking, I was asked to wash it, before they further washed it and rinsed it several times and that made me feel very uncomfortable embarrassed”.

A respondent reported an incident where he overheard some women making comments as they bypassed them when they were approaching a treatment centre where they attend support group meetings. He heard them say:

(R9): “ndivo vaya ve AIDS, vavekuenda kwavanosangana” (There comes the AIDS people, they are going for their usual meetings).

One adolescent confirms fear and anxiety of being stigmatized and discriminated against when she said that she would not want to experience what she has witnessed happening to people who are living with HIV and AIDS in the community, especially issues to do with labels and being called names which constantly remind one of their health condition.

Key informant from Pamuhacha also indicated that the general community continues to stigmatize people living with HIV and AIDS. She said that a lot of derogatory terms are used to describe adolescents who are living with HIV and AIDS. She also added that:

(KII): “adolescents showing visible physical symptoms of illness are more vulnerable to stigma and discrimination. Unfriendly reactions are exhibited by community members in instances where an adolescent fails to observe proper coughing etiquette”

Discussion

The findings show that the Chinhoyi still stigmatizes people, particularly adolescent living with HIV and AIDS. This may be attributed to a number of reasons, chiefly, fear of being associated with AIDS as a chronic disease, as well as lack of adequate information issues pertaining to HIV and AIDS. This happens despite vociferous efforts by government and other stakeholders on issues pertaining to HIV and AIDS in school and in the community. Another reason is lack of sincerity on the demands and need for adolescents living with HIV and AIDS as epitomized by teasing by peers in school as well as use of offending and derogatory statements by neighbours and community members.

These findings support Campbell, Skovdal, Mupambeyi and Greyson, (2010) who proposed that children (and adolescents) with HIV and AIDS are likely to be stigmatized by peers, family and community members through their association with HIV and AIDS. The fact that stigma and discrimination are most rife in schools suggests that Chinhoyi community has not adequately prepared its young people to accept people (adolescents) who are living with HIV and AIDS. This causes the psychological and emotional damage and also negatively impact on the psychosocial development of these adolescents. Unfriendly communication to adolescents living with HIV and AIDS in Chinhoyi represents an attack on their psychological integrity despite the fact that they strive to improve their physical, psychological and social wellbeing. This makes life much difficult for adolescents living with HIV and AIDS as they would constantly live in fear of being labeled. This is also explained by Goffman’s labeling theory.

The findings also point out to the fact that stigma and discrimination has a physical / physiological dimension to stigma and discrimination. This is due to the fact that community can easily diagnose that an adolescent is suffering from AIDS. This calls on the need for enhanced palliative care which can assist in the management of symptoms that are associated with AIDS related. Jackson (2002) also reports that HIV positive adolescents experience stigma and discrimination in the family and in the society at large. Mavhu *et al.* (2010), in a study conducted in Harare on children living with HIV and AIDS, also concluded that although stigma and discrimination is going down, it still remains rife in Harare.

Rather, society should be more empathic and supportive to adolescents living with HIV and AIDS as this would make them feel loved, cared for and accepted in society, despite the fact that they are living with HIV and AIDS. Change of attitude towards these adolescents can create a better environment which understands the needs of these adolescents. Social workers need to play an active role to concertize community on the needs of adolescents living with HIV as well as educating community of the importance of treating these adolescents with dignity and respect they deserve.

Stigma and discrimination against adolescents living with HIV and AIDS in Chinhoyi poses a challenge to social work, a profession which seeks to reduce human suffering as well as promoting social justice. Social work profession needs to intervene from household to community level to conscientise community to accept people adolescents and promote to their growth and development. This includes providing them with an equal opportunity to partake in all community activities.

4.3.1.2 Community integration challenge

It emerged that adolescents living with HIV and AIDS in Chinhoyi experience difficulty in being integrated with the community, particularly, the extended family structures.

Adolescents indicated that they lack wider opportunities for being integrated to society due to fear of disclosure of their HIV statuses. The majority of the respondents (N=20) stated that they are barely visit extended family members, while the majority actually experiences fewer restrictions as they stay with their relatives. One respondent reported that:

(R20): "I stay home during most holidays; my mother does not want us to visit relatives even when schools are closed". Another respondent in an interview added that:

(R30): "My uncle only allows me and my older to visit grandmother who is also aware of their HIV status. He is reluctant to let us visit our cousins who live in Harare and other relatives, though I like to stay in a different environment from the one I am used to."

A secondary caregiver commented that parents deprive their children the opportunity to visit other relatives for more than one day because they wish to conceal their own HIV statuses. She said:

"Parents would want to avoid situations where children are seen taking ARV and eventually disclose their HIV positive status. They prefer they keep their HIV status and that of their children a secret".

One parent to an adolescent living with HIV indicated that she was not ready to disclose her own HIV positive status as well as that of her children for fear of societal stigma and discrimination. She added that she prefers keeping HIV status and taking of medication are usually kept as a secret. As a result, she avoids situations whereby her children would visit relatives for days as this has implication on taking medication and in some cases, disclosure of HIV status. Hence one mother stated that:

(P1): "When I visit my husband's relatives, I make sure that I don't leave my daughter behind. I may leave younger children who are not on medication. However, she visits my

mother who is aware of my HIV status, and she takes her drugs with her. But the situation is different with my in-laws as they may not fully understand my situation”.

Discussion

The findings show that living with HIV and AIDS in Chinhoyi have limited chances of being integrated with their extended families. It seems visiting extending family members is surrounded by complex issues which families need to resolve before they expose their children and condition to other members of the family. Unwillingness by caregivers to allow children visiting extended families may be explained the fact that question regarding HIV will be raised if their children are seen taking medication, as they do not want to have their own HIV status or that of their children known to other members of the family, possibly for fear of stigma and discrimination. As a result adolescents living with HIV and AIDS are isolated from the broader family networks. Despite their willingness to be integrated, invisible barriers still persist.

This also suggests that these adolescents lack adequate opportunities for socialization, so that they fully learn about the culture, values and societal expectations. It can also be seen that people still face challenges in disclosing HIV status to extended family members despite potential benefits. This is contrary to Midbo *et al.*'s (2012) assertion that HIV disclosure helps to cope with stigma and also improves adherence to treatment, thereby prolonging life expectancy of people living with HIV and AIDS. Although, restricting visits to extended family may improve address to treatment and maintain confidentiality, it also leads to isolation on these adolescents. In the end, they miss out on developing strong bond with distant relatives, as well as fully appreciating dynamics within families, as well as getting an insight on the generational traditions and general family expectations. Yet Serra (2009) posits that African children have traditionally spent large parts of their childhood away from their

parents in an effort to kinship ties. Serra (2009) adds that this promotes an early sense of responsibility, belonging and collective responsibility. However, this challenges of integrating adolescents living with HIV and AIDS in the community has not been adequately addressed by literature, hence the need to the need for further investigation in the issue.

4.3.1.3 Socio-economic challenges

The majority (n=7) who participated in the in-depth interview expressed concern that their families sometimes experience financial difficulties, thereby fail to meet some of their basic needs. Adolescents living with HIV and AIDS in Chinhoyi depend on their guardians or care givers for financial support. The major challenge cited is inadequate food supplies and this poses more challenges for adherence to treatment. Adolescent respondents reported that:

Table 2: Responses from participants on socio-economic challenges

| Respondent | Remark |
|-------------------|--|
| R11 | <i>“ARVs increase my appetite, such that food should be readily available. However, I sometimes get tempted to skip taking my medication when food is inadequate”.</i> |
| R16 | <i>“When there is no food in the morning, I just simply take my drugs and dash to school”</i> |
| R1 | <i>“I live with my elderly grandmother who sells vegetables to look after me and my young brother. However, she sometimes runs out of money to buy certain types food that would have been recommended by the doctors to improve my health”.</i> |
| R33 | <i>Living with HIV and AIDS is really a challenge if you do not have adequate</i> |

| |
|--|
| <p><i>resources. You need to be financially stable to afford all the necessities that can keep you healthy and strong. However, money is not always available and that is a fact of life we, as adolescents living with HIV and AIDS have to live with</i></p> |
|--|

The majority (N=23) of respondents said that they live under the care of guardians who are either unemployed or do informal enterprises and unsecure piece jobs.

It also emerged financial constraints also negatively impact on access to education and other learning material by adolescents living with HIV and AIDS. The majority (n=20) highlighted challenges in affording school fees, or to have it paid in time. Some adolescents have their school fees paid for by Basic Education Assistance Module (BEAM) (N=9) which covers tuition fees and levies. This may pose difficulties in acquiring school uniforms, text books and other learning material by some families.

A key informant (guidance and counselling teacher), highlighted that she has worked with adolescents living with HIV and AIDS in Chinhoyi who come from disadvantaged backgrounds who were not being catered for by BEAM due to limited number of children put on the programme at each school.

It also came out that when faced with financial difficulties, certain families may not prioritize sending children living with HIV to school. The District Social Welfare Officer reported having intervened in cases where children and adolescents living with HIV and AIDS had dropped out of school after the legal guardians refused to pay school fees for an HIV positive child who learns at a local school. The district officer elaborated that:

(KI 4) *“The department of social service had to address the case of a child who was denied the chance to go to school because of her HIV positive status. The uncle was of the views that*

since his funds were limited; sending an HIV positive child to school would be a waste of money because the child may not live long”.

Discussion

The results show that adolescents living with HIV and AIDS are vulnerable to economic problems that affect their families. Financial challenges by their families tend impact negatively on their health and wellbeing if some of their basic needs are met. Lack of adequate food supplies reduce the effectiveness of ARVs, thereby exposing them to health. This is illustrated by R11 and R16. Financial constraints also limit them from accessing education. These results match the findings by Jackson (2002) contends that HIV positive adolescents face difficulties in accessing education, food, accommodation and other basic necessities.

Economic challenges experienced by adolescents living with HIV and AIDS and their families are a reflection of the difficult economic situation in the Zimbabwe, which is characterized by low capacity utilization in industry and unprecedented levels unemployment. Another possible explanation for vulnerability to economic pressures is the fact that most adolescents living with HIV and AIDS are orphans who live under the care of extended family members who may be struggling to contain the burden of looking after larger families. This supports Coscia *et al.* (2001) who found that families affected by HIV and AIDS face accompanying social issues which include impoverished home environment, insufficient access to medical, social and educational resources. This scenario can be explained by the conservation of resources theory which states that one’s personal, social and economic resources influences one’s ability to cope with stress as they help to cushion people from distress. In this present study, the significance economic resources for households

caring for adolescents living with HIV and AIDS are highlighted. These help to improve the wellbeing of adolescents.

A significant issue emerging from the findings is the fact that adolescents living with HIV and AIDS are sometimes left out from government education assistance programmes such as BEAM, despite the fact that they need assistance. This could be caused by limited funding to include all the deserving clients on the Module. Furthermore, this could also point to inefficient assessments or selection criteria which may leave out individuals who best the limited services that are available. Hence the needs for social workers to advocate for a social policy which guarantees the provision of social services which meet the needs of the vulnerable and people in society.

The findings also indicate that families that experience financial may choose not to prioritize education requirements of adolescents who are living with HIV and AIDS. Such thinking may be motivated but the possibility of a lower life expectancy by adolescents living with HIV and AIDS. Such misconceptions result in the violation of a child's right to education, yet they have the right be given equal opportunities which can promote their psychosocial development.

This shows that families may choose to violate fundamental right of children and adolescents living with HIV and AIDS. This calls for the intervention of the social work professionals so that families prioritize the needs of these children and that they do not discriminate against children or adolescents when it comes to making decisions which have a bearing into the future of their families. However, organizations like Capernaum Trust and Batsirai Group have been assisting some small proportion of HIV positive adolescents in Makonde district with school fees, school supplements and food handouts whenever they have available funding.

4.3.2 Sub Theme 2: Emotional Challenges

4.3.2.1 Fear and anxiety

Adolescents living with HIV and AIDS in Chinhoyi expressed various fears and anxiety over an uncertain future (n=18). The respondents also feared disruptions in supply of medication (N=16), fear of finding a future marriage partner who is willing to accept their HIV positive status (N=14) and fear about falling ill or being attacked by opportunistic infections (N=14). Some adolescents feared death, particularly, the possibility of having a very low life expectancy. However, the study found additional complexity by older adolescents who are struggling to come to terms with the reality of living with HIV and AIDS as well as the development of personal identity. Key informant from Pamuhacha explained that:

(KI 1): "Adolescents living with HIV and AIDS are striving to develop a personal identity as well as to identify with people of their age. However, the growing consciousness about the demands of living with HIV as well as the desire to be like their peers in all spheres of life present problems from these older adolescents. There is a general tendency towards changing attitude and behavior towards adherence to treatment, defaulting treatment is very high with this category. Furthermore, they often skip attending support group meetings."

The key informant also added that the desire "fit in" and to be accepted by their peers have led to some adolescents abandon some recommended healthy practices as they may expose their HIV status to their peers.

Discussion

A significant aspect that emerged is that adolescent living with HIV and AIDS have to deal with emotional challenging emotional issues. Fears that are presented by demonstrate practical challenge that they need to resolve as they grow up. A sense of insecurity is derived from worrying about the possibility of not accessing medication possibly due to shortages in

public health institutions. This has a direct impact in their physical and health as well as life expectancy. In addition, finding a future marriage partner who will accept to live with a person living with HIV and AIDS remains a practical challenge respondents would need to resolve in the future, because people living with HIV and AIDS are still stigmatized in Chinhoyi, hence their fear of experiencing challenges in looking for prospective partners. Such emotional issues, if not addressed well, have the potential to negatively impact on their emotional and psychological wellbeing. Furthermore, adolescents living with HIV and AIDS need parental and professional support for them to be able to manage this transitional period of adolescents as well as help them allay fears that they may have regarding realities of living with HIV and AIDS. Fear and anxiety that are experienced by adolescents living with anxiety are best explained by the stress-coping theory by Lazarus and Folkman(1984) who proposed that anxiety as an external stimuli which individuals may have to deal with.

4.3.3. Sub Theme 3: Behavioural and Disclosure Challenges

4.3.3.1 Sexuality Issues

Adolescent respondents reported challenges in dealing with the opposite sex. Fourteen adolescents indicated that they have started dating. Adolescents who indicated that they are too young to date or not being ready for relationships with the opposite sex formed the minority (n=6), whereas the remaining adolescents cited challenges in forming relationships (n=4). Some of the adolescents interviewed were either too young or not ready to form relationship with the opposite sex though some older adolescents indicated that they avoid dating because they are not ready or they do not know how manage disclosure of HIV status to the opposite sex. One respondent actually said that:

(R12): I am afraid of starting a relationship with a girl because I don't know how I will tell about my HIV status. You never know if she would accept that, because people are afraid of people with HIV"

Other adolescents indicated that maintaining stable relationship was made difficult as relationships were prematurely terminated whenever HIV issues are discussed. One respondent reported that:

(R11): *“I opted out of the relationship with my previous boyfriend when he insisted on taking an HIV test. I was not prepared for an embarrassment as I had not disclosed my HIV positive status to him”.*

Another respondent stated that his partner had a general attitude towards people who are living with HIV; hence he doubted the wisdom of counting with such a relationship. Terminating the relationship was perceived to be a better option than to disclose the HIV status:

(R8): *“She had a negative attitude on people who are HIV positive, hence I doubt if she was going to accept a person like me. So being on my own would make life much easier”.*

The same respondent (R8) recounted how he lost girl he loved dearly after she discovered that he is on antiretroviral therapy:

(R8): *“I lost my first girl friend after she found some pills in my bag. That is when I finally disclosed to her that I am taking medication. She was disappointed and she opted to break away from the relationship.”*

Key informant (Pamuhacha) indicated that the issue of disclosing HIV status to a prospective marriage partner is a big issue adolescents living with HIV and IADS in Chinhoyi struggle to deal with. The majority (n=10) of the respondents indicate that they have not disclosed or they would not disclose their HIV status to any time soon. Only two respondents indicated that they might disclose their HIV status to their partners/ prospective partners so that they can make informed decisions in good time.

Discussion

Jackson (2002) predicated that children living with HIV and AIDS experience sexuality challenges. Findings from this study reveals that issues regarding forming relationships with the opposite sex are associated with issues pertaining to stigma and discrimination of people living with HIV and AIDS in society. The findings suggest a lack of skill by adolescents in handling such sensitive sexuality issues with sexuality issues. As a result they are subjected to stress when they think about or attempt to deal with such issues. Furthermore, the results also point to the fact that sexuality issues are not discussed with parents or caregivers as this would also help in addressing concerns about sexuality. Mavhu *et al.* (2010) conclude that females in particular face additional challenges in forming relationships and disclosing HIV status to partners.

This confirms findings by Mavhu *et al.* (2010) who discovered that there is limited knowledge about safety in dating and prospects of forming functional families by adolescents living with HIV and AIDS as well as by community members. Furthermore, the majority of adolescents displayed a lack of information methods that could be used to prevent secondary transmission of HIV to sexual partners and children. This is consistent with Mavhu *et al.*'s (2010) previous findings in Harare that there is general lack of understanding of issues young people with HIV and AIDS.

4.3.4 Health Challenges

Various health care linked challenges were reported. Delays in given medical attention at health centres emerged. One adolescent complained said that:

(R34): *“I usually may spend as much as six hours when go for clinics to get all the necessary procedures completed.”* Another respondent added that

(R27) *“Sometimes queues are long and nurses take long to serve patients. This why I dread going to the hospital”*

Regular visits to the hospital to get treatment and replenishment of medication was cited as a stressor to the respondents: One study participant said:

(R9): *“I feel overburdened by just going to the hospital every now and then. I sometimes miss school so because I will at the hospital. I go there because I do not have any choice”*.

Issues of adherence to medication were also as adolescents living with HIV and AIDS expressed concern over stress associated with taking medication at regular intervals daily.

(R10): *“I take my pills at 5am and 5pm respectively. I sometimes miss my evening doses when I delay getting home from school; sports or when I would have travelled and came in late”*.

Key informants (health worker) revealed that has handled cases where adolescents would have defaulted taking their medication for various reasons. She said:

(KI 2): *“Here we have handled numerous cases of drug resistance in adolescents who are on treatment. We have also noted older adolescents form the majority of those cases and this is largely caused by defaulting taking of medication”*. She also added that:

(KI1) *“Older adolescents present adherence problems which emanates from challenges in dealing with the development of a personal identity. They would have reached a stage where they want to identify with their peers. It is at this stage they find it difficult to accept reality that they are living with HIV and AIDS and that they have to be on medication for life. They tend to default treatment and frequently miss clinic visits. It is only when they are around 21 or older that they begin to adhere to recommended treatment practices.”*

Discussion

The findings show that respondents encounter numerous challenges during their encounter with the health system. Delays in service provision at the health centre is an indication of a health system with limited capacity to promptly deal health issues that confront adolescents living with HIV and AIDS in Chinhoyi. This could be a result of limited resources including human resources. Such challenges lead to frustration by those who access services. Regular visits to hospitals have been observed to inconvenience respondents as they sometimes miss school. This calls for the need to introduce flexible timetables which accommodates adolescents who are still in school.

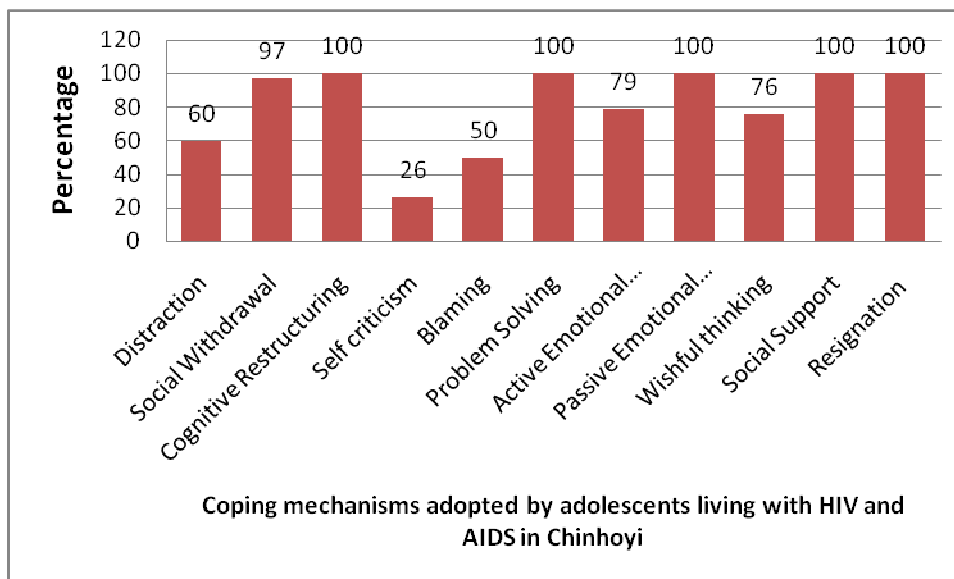
These findings are consistent with those made by EGPAF (2010) that health services in Sub-Saharan Africa lack the capacity to deal with complex needs of children living with HIV and AIDS. Agot and Onyong (2009) argue that health services should be youth friendly. The findings also suggest challenges associated adherence in taking medication. This in line with Trad *et al.* (1994) found that adolescents living with HIV and AIDS experience subjective distress in taking antiretroviral drugs. However, the factor older adolescents develop problems in dealing treatment and health issues suggest a relationship between age and health seeking behaviour. In addition, this is also indicative transitioning of care which is not properly managed because adolescents are likely to assume a certain degree of independence in managing their own affairs including medication and accessing health services as they grow older.

4.5. Theme 2: Coping Mechanisms adopted by adolescents living with HIV and AIDS in Chinhoyi

Results from an adolescent version of KIDCOPE questionnaire shown on the diagram below indicate that adolescents living with HIV and AIDS use a combination of both active and passive methods of coping with stress and challenges they experience in their daily lives. All

the adolescents (100%) have used cognitive restructuring, passive emotional regulation, problem solving, seeking social support and resignation, whereas 97% have reported the use of social withdrawal.

Figure 2 Percentage distributions showing the coping mechanisms adopted by adolescents living with HIV and AIDS (N=38)



Respondents have also indicated the adoption of other coping mechanisms such as active emotional regulation (79%), wishful thinking (76%), blaming (50%), self criticism (26%) and distraction 60%. The use of several coping mechanisms by respondents' points to the dynamism of coping and also that coping is a process not an event. This may be due to the fact that individuals may cope with one method or another or a combination of more than one strategy, depending on the situation at hand. This can be explained by Maes and Laventhal (1996) who suggested that adolescent coping goes through four different stages, namely stage of uncertainty, stage of disruption, striving for recovery and restoration of wellbeing. In this regard, use of some coping strategies may correspond with certain methods of coping adopted by adolescents living with HIV and AIDS in Chinhoyi.

Though various coping strategies have reportedly been used, the frequency or the extent of to which they have used vary considerably. The table below shows the mode, mean and standard deviation of these strategies on scale of 0-3, with 0 reflecting non use of a coping mechanism, 1 being somewhat used, 2 being moderately used and 3 reflecting using a specific coping strategy a great deal.

Table 3: Summary of the coping mechanisms adopted by respondents (N=38).

| Coping Mechanism | Mode | Mean | Std Deviation | N |
|--|-------------|-------------|----------------------|----------|
| [Distraction] I thought about something else; tried to forget it; and/or went and did something like watch TV or play a game to get it off my mind. | 1 | .63 | .541 | 38 |
| [Social Withdrawal] I stayed away from people, kept my feelings to myself, and just handled the situation on my own. | 2 | 1.66 | 1.072 | 38 |
| [Cognitive Restructuring] I tried to see the good side of things and/or concentrated on something good that could come out of the situation. | 1 | 1.50 | .604 | 38 |
| [Self Criticism] I realized that I brought the problem on myself and blamed myself for causing it. | 0 | .32 | .574 | 38 |
| [Blaming] I realized that someone else caused the problem and blamed them for making me go through this. | 0 | .66 | .781 | 38 |
| [Problem Solving] I thought of ways to solve the problem; talked to others to get more facts and information about the problem and/or tried to actually solve the problem. | 2 | 2.24 | .714 | 38 |

| | | | | |
|--|---|-------------|------------|----|
| [Active Emotional Regulation] I talked about how I was feeling; yelled, screamed, or hit something | 1 | 1.08 | .712 | 38 |
| [Passive Emotional Regulation] I tried to calm myself by talking to myself, praying, taking a walk or just trying to relax. | 3 | 2 | .683 | 38 |
| [Wishful thinking] I kept thinking and wishing this had never happened; and/or that I could change what had happened. | 1 | 1.03 | .716 | 38 |
| [Social Support] I turned to my family, friends, or other adults to help me feel better. | 2 | 2.32 | .662 | 38 |
| [Resignation] I just accepted the problem because I knew I couldn't do anything about it. | 1 | 1.50 | .604 | 38 |
| TOTAL SCORE | | 15.3 | 7.7 | |

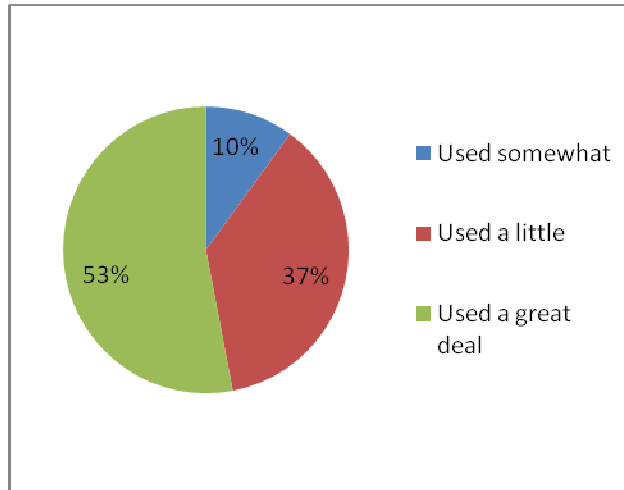
From the table 3 above, it can be seen that passive emotional regulation was the most frequently used strategy with a mean of 2.4 (SD=0.68), followed by seeking social support with a mean of 2.3 (SD=0.66), problem solving (mean, 2.2; SD=0.71); Social withdrawal (mean, 1.66; SD=1.07), whilst cognitive restructuring and resignation have mean of 1.5 (SD=0.6). Distraction, blaming, active emotional regulation are not frequently used by adolescents living with HIV and AIDS in Chinhoyi. These coping mechanisms are discussed in detail.

4.5.1. Passive Emotional Regulation

All the adolescents reported that they use passive emotional regulation and frequency of its use is much higher than any other coping strategy identified, mean (2.24; SD= 0.71). The

modal value of 3 suggests that the most common response was that passive emotional regulation as a coping strategy is used a great deal.

Figure 3 Percentage distribution of the frequency in the use of passive emotional regulation as a coping mechanism (n=38).



As indicated in the figure 3, above 53% frequently used passive emotional regulation to a greater deal. This supports Orban *et al.*'s (2010) multisite study of 166 HIV infected adolescents in three major cities in the USA. Orban *et al.*'s (2010) found passive emotional regulation as the most popular and effective coping strategy with the youth under study.

Spirituality and involvement in church emerged as a coping strategy used which falls under passive emotional regulation. Spirituality and involvement activities play a big role in helping adolescents living with HIV and AIDS to cope with demands they come across in life. The majority (n25) indicated that this assists them to envision a future of promise. One adolescent stressed that

(R6): My pastor always reminds me that God loves me despite my illness and he has a plan for my life. This somehow uplifts my spirit; I get strength and hope to move on despite numerous problems I encounter.

Another respondent added that:

(R3): *“I am youth leader at church, I do décor, I sing the choir and I also teach Sunday school”*. Another respondent added that

(R38) *“When I am down and low, I fall on my knees and pray for divine intervention. God is on my side”*

Use of spirituality has been supported by various studies. Folkman (1997) identified use of faith as an effective in assisting gay caregivers in coping with loss of their partners. In this study, the findings indicate that belief in God can provide strength and motivation to move despite the multifarious challenges they encounter in their daily lives. German (2004) in studying HIV affected children in Bulawayo, found seeking spiritual support as a mechanism used to cope with stressors.

Key informant from Pamuhacha also however reported that spiritual faith has had damaging to some adolescents whose have strictly adhered to some of the doctrines being preached so that they could receive blessings and deliverance. She added that some adolescents living with HIV and AIDS follow strict church rules which include fasting, though this is not recommended as this limits effectiveness of medication. Its effective may only be compromised when message preached in contrast with HIV positive adolescents’ medical requirements. One respondent stated that:

(16) *“I once defaulted from taking medication after being assured at church that they have been will be well after taking holy water and through prayer and fasting”*.

It can be seen although Christian faith as a coping mechanism can have negative consequences, despite benefits that are associated with it. This may be due to limited knowledge of the implication of fully relying on faith whilst neglecting taking of medication

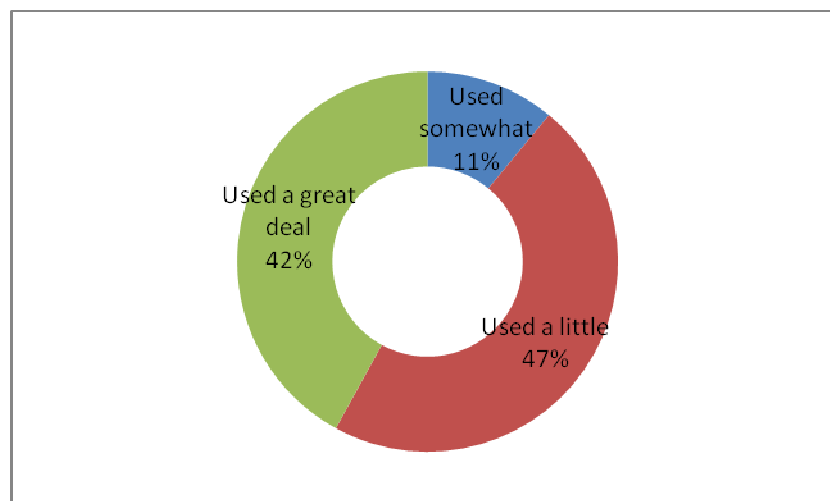
the These findings contradict Parker (2009) who identified a strong belief in God as an effective coping mechanism by used adolescents living with HIV and AIDS in Tanzania and Namibia.

Generally, although passive emotional regulation is commonly used as a coping mechanism adopted by adolescents living with HIV and AIDS in Chinhoyi, it is generally considered a passive method of coping (that which do not directly deal with the problem), though they assist in managing distress associated with a problem (Lazarus and Folkman, 1984).

4.5.2 Seeking social support

Seeking social support is another coping strategy adopted by adolescents living with HIV and AIDS in Chinhoyi when they are confronted with challenges. All respondents(n=38) reported use of social support to cope with challenges. However, the frequency of use of this strategy differs among respondents, as shown by figure 4 below.

Figure 4 Percentage distribution of the frequency in the use of seeking social support as a coping strategy (N=38).



The results indicate that that social support is fairly or moderately used to deal (mode=2).

It also emerged that that adolescents who seek or who receive unconditional social support from family members enable them to cope better with issues such as possible stigma and discrimination and other various fears. Key informant (DSS) emphasized that:

(KI 4): *“Biological parents, and in most cases, extended family members happen to be the pillars of support for these adolescents living with HIV and AIDS here in Chinhoyi.”*

Most of the adolescents highlighted that support they received from their family was necessary for them to lead happy lives, whilst taking their medication. Though the majority(n=36) valued support they received from family, two adolescent said that their families are not very cooperative when it comes to giving him the support he needs, he said he often reports to the secondary caregiver who intervenes who when he encounters various challenges.

Respondents of the study indicated that that the support they sometimes receive range from meeting basic needs to financial support through paying school fees, providing money for bus fares and procuring further medication. One respondent remarked that:

(R18): *“My grandmother always keeps a reminder of the hospital review dates and she makes sure that I do not miss any scheduled appointments”*

It also emerged that, care and reassurance boost confidence of these adolescents. Hence one respondent, a double orphan, reiterated that:

(R22) *“I am managing because my stepmother does her best to care for me. When my father was alive he used to tell me that despite being HIV positive, I am a special girl..... I am special”*.

One adolescent explained that:

(R1): I manage to take my medication on a daily basis because of the encouragement and supervision from my niece. She makes sure that I eat meals in good time so that they are able to take their medication at stipulated intervals. She also makes sure that I do not skip taking my drugs because it is good for my health”

R14: “If it wasn’t for my lovely parents, I would have died long back. They have taught me to live with my condition and I am happy just like any other child. I will continue following my doctors’ advice, and I know I will make it”

Key informant (health worker) emphasized that adolescents take seriously what they are told by health workers and family members. She added that:

(KI1): “Words of reassurance by family give a sense of hope, especially on issues to do with their future. They allay their fears and anxieties. She added that those who receive positive reassurance tend to cope much better as they believe that one day they will realize their dreams and their heart’s desires, if they continue to take their medication as prescribed.

It also come into view that adolescents living with HIV and AIDS in Chinhoyi seek emotional and moral support from support groups. The majority (n=33) of adolescents interviewed were members of a support group. They acknowledged that support groups are playing significant roles in their lives. This is what some of their views pertaining support groups:

Table 4 Summary of respondents on support group as a coping mechanism

| Respondent | Remark |
|-------------------|---|
| R13 | <i>“Tichararama support group is my source of strength”</i> |
| R25 | <i>“ At the support group I meet other teenagers who are living with HIV and we share our concerns”</i> |

| | |
|------------|--|
| R8 | <i>“We get professional assistance and counselling at the support group”</i> |
| R29 | <i>“Support group is very helpful. We are encouraged to my peers from the group used visit me at home when I got sick last year”</i> |
| R34 | <i>“I don’t think I would do without my support group because there I get all support I need.</i> |
| R11 | <i>“Meeting with other HIV positive young people gives me hope, because If others are surviving with HIV then I can also do it”</i> |

The key informant also further explained on the benefits for attending support group meetings by the adolescents:

(KI 2) *“They hold various discussion, play sports, quiz, debate and many other activities which occupy their minds as well as giving them the opportunity to experience a pleasant childhood. Issues of treatment adherence are also heavily emphasized at support group meetings”.*

Key informants (District Social Services Officer, Health worker) also observed that support groups for adolescents living with HIV and AIDS are not so widespread as compared to those for adults. This is despite the effectiveness of support groups in strengthening the capacity of HIV positive adolescents to cope with demands of living with HIV and AIDS. The secondary care giver also weighed in on support groups by saying that:

(KI 3) *“Unlike adults, adolescent lack the capacity to organize them to run their own support groups, hence the need for committed cadres to organize this special group.*

Several studies that have been done show the significance of receiving support from the family and the community in general. Studies by Mellisa and Fullem (2012) in Botswana and

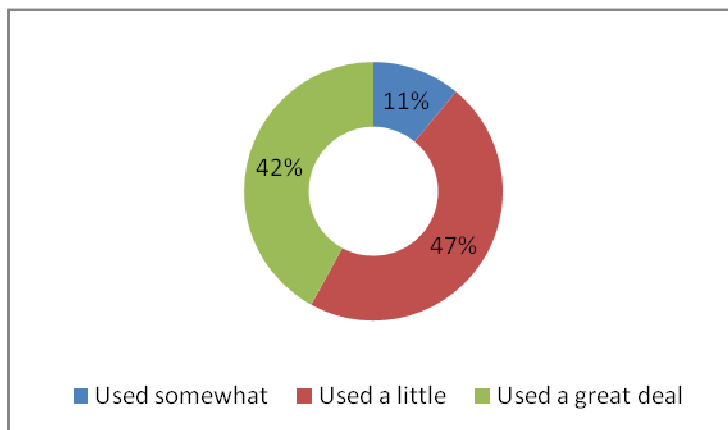
South Africa revealed that a family model in the delivery of HIV care has been effective in psychosocial adjustment as well as coping with medication adherence by HIV positive adolescents. The importance of family support was identified by Midbo *et al.* (2012) who argued that strong family support improves adherence and coping. In the present, results suggest that support from family (and community) empower adolescents to deal with numerous demands that confront people living with HIV and AIDS. Furthermore, findings point to the fact that social support makes HIV a manageable condition as adolescents living with HIV and AIDS in Chinhoyi get assistance and reassurance when they are in need of help. This has helped to ensure a healthy lifestyle for adolescents. The extended family system has absorbed the majority of these adolescents as most of them have lost one or both parents. Family support is highly effective as a coping strategy. Inadequate family support therefore makes it difficult for HIV positive adolescents to cope with HIV and AIDS.

Support groups also provide a strong source of social support that helps adolescents living with HIV and AIDS to cope with numerous stressors. Studies done in Botswana on teen clubs revealed that support groups have a positive effect in building positive relationships, improvement of one's self esteem and gaining life skills through mentorship and structured activities (Aidstra One, 2012). Lewis (2001) also found that support system available, including extended family; friends and community resources play a pivotal in assisting adolescents living with HIV and AIDS to effectively cope. In line the stress and coping theory, social support becomes a mediating factor interaction between individuals and their environment. It can therefore be concluded that family, community peer support contributes toward managing taxing circumstances by adolescents living with HIV and AIDS in Chinhoyi.

4.5.3 Problem solving

Problem solving as a strategy has been used at some point by all the respondents in this study. However, the frequency of the use of the coping strategy is shown by the figure 5 as follows: The mode of 2 indicates that problem solving is used a little (or moderately).

Figure 5 Percentage distribution of the frequency in the use of problem solving as a coping mechanism (N=38).



As a coping strategy adopted by the adolescents living with HIV and AIDS in Chinhoyi, problem solving was generally regarded as a effective in dealing with challenges they encounter in their daily lives, (Mean, 2.13; SD=0.81). A modal value of 2 indicate that problem solving is used in moderation by adolescents living with HIV and AIDS in Chinhoyi.

Other specific problem solving coping strategies emerged during in-depth interviews which include sending proxies to collect medication; antiretroviral treatment, counseling, health education (seeking information) and selective dating. These strategies are perceived as effective in providing some solutions to specific stressors.

It came out that sending proxy to collect medication on their behalf from Chinhoyi Provincial Hospital proved to be very widespread (n=18). One adolescent responded enunciated that:

(R5) *“When I fail to get money for bus fare to go to the hospital from Alaska, I normally give my hospital cards to a close friend from the support group who goes to hospital on the same days as mine for review and collection of drugs so that she can bring my pills. This way, we are all assured of getting their drugs as long they are available at the hospital”.*

This demonstrates use of an ingenious method of dealing with lack of money for bus fare to go for clinics. This has limited stress on adolescents and their families. This strategy could be useful in assisting adolescents to continuously replenish their supplies. However, the limitation of this strategy is that they miss opportunities for physical examinations; CD4 counts tests to check effectiveness of treatment as well as counseling from health care workers.

Antiretroviral treatment (and healthy eating habits) has been cited adolescents as a way of improving their physical health in response to drugs have restored hope to live by most HIV positive adolescents. This helps them to deal with challenges associated with physical health. Most adolescents (N=31) reported a significant improvement in their physical health because of adherence to antiretroviral treatment. This is what one respondent had to say pertaining to sticking to ART to help manage his physical health:

(R9): *When I was young I used be in and out of hospital. I once dropped out from school due to recurrent illness in childhood. I finally got tested and put on medication, after a secondary care giver in my ward advised my grandmother to take me to the New Start Centre or hospital. When I was put on treatment, my health improved tremendously. I no longer have numerous headaches as I used to do and I have since gained weight and now look much better. I will continue to eat well and take my medication so that I will live a healthy and longer life.*

Another respondent remarked that:

(R12): *“I am coughing as much as I used to do since I was put on treatment. I feel much better these days longer experiencing much pain”.*

One key informant also highlighted the importance of ART in helping adolescents living with HIV and AIDS in Chinhoyi:

(KI 3): *“Some of the look children look very healthy, unless you are told; you may not know that one is living with HIV. The fact that they look healthy reduces their chances of being stigmatized by community. The fact that antiretroviral drugs are provided to them free of charge gives them a sense security as they are likely to live longer with these drugs. Antiretroviral therapy helps a lot of improving health and well being these children”.*

The key informant (health worker) also indicated that most adolescents respond well to antiretroviral treatment as compared to adults. The significant improvement in physical health as well as the fear of being attacked by Opportunistic Infection has prompted the adolescents living with HIV and AIDS to strictly adhere to their treatment regimens.

Antiretroviral treatment has been effective as a coping strategy. Findings point out to the fact that taking action to take life prolonging medication helps to cope with challenges to relating to physical health for the adolescents. It also came out that effective taking of medication has social implication, as this helps to reduce stigma and discrimination among adolescents living with HIV and AIDS in Chinhoyi, among other challenges. These results are consistent with Medley (2009) who found that antiretroviral treatment plays a key role in addressing health challenges of women living with HIV and AIDS, as the treatment make them physically stronger and less vulnerable to opportunistic infections and recognizable symptoms of HIV infection.

Adolescents living with HIV and AIDS in Chinhoyi pointed out that utilizing counseling services help them to cope with challenging problems. They all concurred that they sometimes cope with the demands of their illness as well as other societal challenges through counselling. One respondent said that:

(R8): "I value counseling that I receive from Pamuhacha it helps me to accept things I can't change in my life and to identify solutions for problems that worry me day and night. Whenever I face problems at home, whenever I needed someone to talk to, these guys have been there for me".

Though, some adolescents still have some emotional issues to deal with, most adolescents have accepted their situation and are prepared to live with it as long as medication and professional support services remain available to them.

The usefulness of counselling has also been confirmed by study that was conducted in Mabvuku and Tafara in Harare by Tarwirei (2005). The study revealed concluded that seeking counselling and joining support groups are common coping behaviours used by HIV positive clients. Counselling is a highly effective coping method that is used by HIV positive adolescents.

Adolescents living with HIV and AIDS in Chinhoyi seek information as a strategy that help them cope better with challenges associated with living with HIV and AIDS. According to key informant (Health Worker), adolescents who are adequately equipped with information in relation to their condition tend to cope better with their condition. She added that, Information dissemination education about health issues is mainly done in support groups and in counselling sessions and clinic visits. One adolescent clearly articulated her view towards receiving about health issues:

(R7): *“When I visit the health care centre, I make sure that I get as much information as possible about HIV. I also ask the sisters to explain the every procedure that they do on me so that I have a full appreciation of what is going on.”*

Another participant added by saying that

(R6): *“I get all the information on dangers of stopping taking my pills, CD4 counts, drug resistance as well as information of food I am supposed to eat so that I stay healthy and well. This education helps me to take precautionary measures against falling ill and this helps maintain my good health”.*

Indications from another key informant (secondary caregiver) were that proper explanation to adolescent on the why certain procedures are being done helps them to understand their conditions better. She said giving necessary information leaves little room for anxiety. Health education has empowered adolescents to have a certain degree of empowerment and be actively involved in their treatment. This finding highlights the value of seeking information relating to HIV and AIDS. This makes respondents understand their nutritional and other needs, as well as technical aspects of their care.

This can be explained by the conservation of resources theory which by Hobfoll (1989) which propounds that people makes every effort to increase their resources such as income, employment and education. In this study, seeking health information plays a vital role in protecting adolescents living with HIV and AIDS in Chinhoyi against distress. Adler *et al.* (2009) also proposed an argument that seeking out information is one of the strategies that are used in coping with chronic illnesses.

4.5.4 Social Withdrawal

Social withdrawal was regarded as a fairly used strategy by all the adolescents living with HIV and AIDS in Chinhoyi, (mean, 1.66; SD=0.66). In terms of the perceived effectiveness of social withdrawal as a strategy, the 82% regard it as an effective strategy, though the extent of its effectiveness as a strategy varies among respondents. This is illustrated by the table 5 below:

Table 5 Percentage distribution showing effectiveness of coping method adopted (social withdrawal)

| Effectiveness of Coping Mechanisms used | Percentage |
|--|-------------------|
| Not effective | 18 |
| Somewhat effective | 24 |
| Quite effective | 37 |
| Very Effective | 21 |
| Total | 100 |

However, social withdrawal was fairly rated as an effective strategy (mean 1.61; SD=1.03). Despite social withdrawal being widely used and widely rated as a coping method by adolescents living with HIV and AIDS, it is generally regarded as a passive style of coping with HIV and AIDS. Adler and Carlson (2009) posits that while avoidance strategies of coping produce some positive outcome, they also contain within them, maladaptive or potentially destructive elements through social isolation. Some of the strategies social withdrawal strategies reported by respondents during in-depth interviews include relocation and non disclosure (selective disclosure) of HIV status,

4.5.4.1 Relocation

Adolescents reported that they are frequently transferred to live with another relative another relative in a different town or city after incidences where adolescents are exposed to much stigma and discrimination in the community. In most instances, the adolescents may get an opportunity to live in an environment where their HIV status is not thereby being spared from damaging consequences of stigma and discrimination. Once child narrated that:

(R15) *“When I got sick, everyone knew about it at the mining compound and it was the widely talked about it. The situation was very embarrassing for the family. When my condition improved, my uncle transferred from Shurugwi to Chinhoyi (Shackleton) where no one is aware of my HIV status. I have started a new life here in Chinhoyi where no one knows or bothers about my HIV status.”* Key informant (Secondary caregiver) also added that:

(KI 3) *“It is a common practice for adolescents to move from one place to another to escape from stigma and discrimination in the community”*

The findings show transferring to a new place, or moving a relative in a new locality provides some relief to adolescents living with HIV and AIDS from various stressors, mainly stigma and discrimination. The stress coping theory of Lazarus and Folkman (1984) hold that stress is determined by the extent to which external stimuli are perceived to exceed one’ s ability to handle. This may result in threatening their wellbeing and end up taking necessary action. in this study, relocating may be perceived as running away from stigma and discrimination. Adolescents living with HIV and AIDS may have limited capacity handle complex issues of stigma and discrimination when it is accompanied by poor physical health. It has worked for adolescents who experienced stigma and discrimination. However, change of environment is not fully effective because it does not address the upstream challenges that may precipitate adolescents confront problems they experience (confrontive coping). This strategy may need

to be complimented with empowering the adolescent deal with such challenges, should they recur in the future.

4.5.4.2 Non disclosure (Selective Disclosure)

All the adolescents interviewed indicated that they have not disclosed their HIV positive status to their peers and colleagues. They all perceive non disclosure to a very useful strategy to cushion them from stigma and discrimination. Most adolescents have highlighted that they have not experienced much stigma as long as look healthy and they disclosure to community members and peers. Health workers and encourage them not to disclose their HIV statuses. Some respondent adolescents remarked that:

R36: *“I will never disclose my status to anyone who is not a member of my family; otherwise they would move around and spread the word about my HIV positive status in the compound”.*

(R4) *“If I disclose my status, I may lose all my friends and I will be on my own. “*

(R13) *“I am afraid of disclosing my HIV status to my friends, because they may mock me using this information in the event of an argument or a misunderstanding”.*

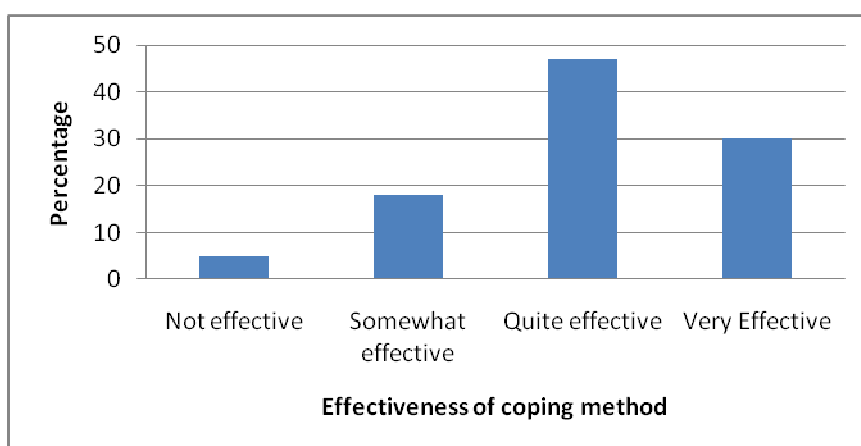
Selective disclosure of HIV status is perceived by respondents as a strategy that can cushion them from being stigmatized by the community. This is also motivated by fear of rejection. However, these finding in an Ugandan study by Obare, Birungi, Katahoire, Hannington, and Kibenge (2009), indicated that 56% of study participants had disclosed their HIV positive status to school friends, whereas 47% had disclosed too school teachers. This disparity could be attributed to reduced stigma against HIV positive students in Ugandan schools, as compared to Zimbabwe’s school system. This suggests that it is still in the culture of the people of Chinhoyi to conceal things that they regard as sensitive. Furthermore, this may be

indicative of the fact that the stigma and discrimination are still rife in society, hence the reluctance of adolescents living with HIV and AIDS to disclose HIV status despite the documented benefits of doing so (Orban *et al.* 2012). Mabala *et al.* (2009) in a study conducted in Tanzania and Namibia observed that HIV positive adolescents who experienced negative consequences of disclosure have realize greater safety in silence. Lazarus (1993) concludes that indiscriminate disclosure of HIV status is suggestive of failure to cope with HIV and AIDS. Midbo *et al.* (2012) also confirms that strategic disclosure is a useful strategy. There is general consensus that is selective disclosure is a useful strategy that is used by adolescents living with HIV and AIDS in Chinhoyi.

4.5.5 Cognitive restructuring.

All adolescents (n=38) reported the use of cognitive restructuring as they endeavor to cope with demands of living with HIV and AIDS. Though all adolescents have used this strategy, it is not used widely (mode=1). The table below shows respondents' view towards the effectiveness of cognitive restructuring whenever it is used.

Figure 6 Percentage distribution showing effectiveness of coping method adopted (cognitive restructuring)



Previous researches demonstrate that use of cognitive restructuring is associated with passive coping, hence no efforts are made to directly deal with a problem, (Lazarus and Folkman,

1984). However, use of cognitive restructuring was regarded as effective whenever it is used. This finding suggests that adolescents living with HIV and AIDS encounter certain situations where the neither have control over difficult circumstancer nor the capacity to address the challenge and change the situation. Hence the use of this strategy entails changing one's way of viewing a problem so that it becomes more manageable and less threatening. Adler and Carlson (2009) noted that individuals define challenges as evryday problems or major life events.

4.5.7 School attendance

Key informants have highlighted going to school was very helpful for most HIV positive adolescents. It helps them to cope. When they are in the school system they also feel like they are like other children. This also helps them to experience normal socialization and a pleasant childhood just like other children. They also get an opportunity to participate in community activities. Furthermore, they start planning their future. However, they may be bad days as children refuse to go to school if they experience stigma in the school environment. Furthermore, if they are sick, they tend to drop out of school until they are feeling and looking much better.

Teacher intervention has greatly assisted HIV positive adolescents to experience much challenge in the school system. Furthermore, teachers in school now have better understanding of the needs of HIV positive adolescents; hence protection measures are now in place in some schools. In addition, all children in school environments are being taught to be friendly and accommodative to everyone in the school. Schools also run various social clubs which help children to develop necessary social skill and these clubs are also attended by HIV positive adolescents. All these efforts being put are remarkably improving the school to be a safe environment for adolescents with HIV to experience normal growth and develop to the fullest of their potential. In this regard, school attendance is a highly effective

mechanism to cope with demands of living HIV and AIDS, provided that child protection systems are in place and that all students in schools receive sensitization to accept and tolerant with every child in the school.

4.5.8 Traditional beliefs and practices

A very limited number of adolescent's families adopt traditional beliefs, practices and values as way of coping with demands of HIV and AIDS. Some respondents' families claimed to have consulted traditional healers to try and address some of the challenges that adolescents face. This has however had damaging effects as certain belief systems have acted as a barrier for adolescents to access treatment for some time. For instance, children are meant to believe that chest pain they experience could a result of being used by witches to plough in their fields at night, yet the heaviness of the chest may be a symptom of untreated tuberculosis.

Though very few, some families believe the frequent illness may also be attributed to witchcraft, hence need to address the possible or control such illnesses through traditional medicine and traditional healing procedures .Some have at some stage failed to strictly adhere to their medication. Some traditional herbs are known to have some healing effects, though issues of dosage are not clearly defined. Turning to traditional practices are effective, but to a lesser extent, on if their use do not interfere with HIV positive adolescents' treatment regimens and dietary requirements.

4.6 Sub Theme 2: The Extent to which Adolescents Living with HIV and AIDS are coping with the condition

Results shown on table 6 below show that adolescents living with HIV and AIDS are generally coping with challenges they encounter with the demands for living with HIV and AIDS. These general variability of responses (mode ranging from 0 to 3) on each coping

method point to on each the fact that other adolescents individuals see things differently, depending on their individual experiences concerning the coping method in place.

Table 6 Summary of the Effectiveness of the coping mechanisms adopted by adolescents living with HIV and AIDS in Chinhoyi.

| Effectiveness of Coping Mechanisms Adopted | | | | |
|---|-------------|-------------|-----------------------|----------|
| Coping Mechanism | Mode | Mean | Std. Deviation | N |
| [bDistraction] I thought about something else; tried to forget it; and/or went and did something like watch TV or play a game to get it off my mind. | 1 | .84 | .754 | 38 |
| [bSocial Withdrawal] I stayed away from people, kept my feelings to myself, and just handled the situation on my own. | 2 | 1.61 | 1.028 | 38 |
| [bCognitive Restructuring] I tried to see the good side of things and/or concentrated on something good that could come out of the situation. | 2 | 2.00 | .838 | 38 |
| [bSelf Criticism] I realized that I brought the problem on myself and blamed myself for causing it. | 0 | .66 | .815 | 38 |
| [bBlaming] I realized that someone else caused the problem and blamed them for making me go through this. | 0 | .58 | .722 | 38 |
| [bProblem Solving] I thought of ways to solve the | 2 | 2.13 | .811 | 38 |

| | | | | |
|---|----|-------|-------|----|
| problem; talked to others to get more facts and information about the problem and/or tried to actually solve the problem. | | | | |
| [bActive Emotional Regulation] I talked about how I was feeling; yelled, screamed, or hit something | 2 | 1.37 | .970 | 38 |
| [bPassive Emotional Regulation] I tried to calm myself by talking to myself, praying, taking a walk or just trying to relax. | 3 | 2.39 | .679 | 38 |
| [bWishful thinking] I kept thinking and wishing this had never happened; and/or that I could change what had happened. | 2 | 1.29 | .927 | 38 |
| [bSocial Support] I turned to my family, friends, or other adults to help me feel better. | 2 | 2.03 | .716 | 38 |
| [bResignation] I just accepted the problem because I knew I couldn't do anything about it. | 1 | 1.82 | .766 | 38 |
| TOTAL SCORE | 17 | 16.72 | 9.026 | 38 |

Passive emotional regulation was regarded as a very useful strategy in coping with HIV and AIDS as compared to all other strategies (mode=3). Strategies like social withdrawal, cognitive restructuring, problem solving, active emotional regulation, wishful thinking and social support were moderately rated in their efficacy (mode =2). Resignation and distraction were lowly rates (mode=1), whilst self distraction and blaming were regards as ineffective (mode=0). The total score of modal score of 15 indicate moderate coping by adolescents

living with HIV and AIDS with HIV and AIDS. Furthermore, although a combination of coping methods are utilized; passive ways of coping with stressors seem to be preferred. Asked, whether adolescents living with HIV and AIDS are managing to cope with their demands, various responses came from the key informants:

Table 7: Summary of responses on the extent to which adolescents living with HIV and AIDS in Chinhoyi are coping

Key Informant Remark

| | |
|------|---|
| KI 1 | <i>“Adolescents living with HIV and AIDS have developed skills to cope with their challenges, but let me say that they need a lot support”.</i> |
| KI 2 | <i>“By and large, these adolescents are somehow coping, but with challenges”.</i> |
| KI 3 | <i>“Yeah, they are managing to carry on with life, though I believe more needs to be done to enable them to experience the best out of life. Society needs to be tolerant to these kids”.</i> |
| KI 4 | <i>Those who have received professional care and support are coping, though service provision needs to be enhanced to be able to meet their needs. I would not know about adolescents who have not been reached or who are not accessing treatment care and support”.</i> |
| KI 5 | <i>They are coping to a lesser extent because services available are not able to fully address their needs.</i> |

Discussion

Findings from the study show that generally, adolescents living with HIV and AIDS are coping with some of the challenges they encounter in their daily lives. Though there is a general tendency towards the use of passive ways of coping, both active and passive methods of coping are used depending on the person and the situation at hand. This finding is matches

results obtained by Orban *et al.* (2012) that both passive and active styles of coping are utilized. In a study by Parker (2009) on perinatally infected adolescents (who are orphans), the majority presented personal characteristics that support emotional functioning. Gray and Putter (2007) came to a conclusion that developing mitigates the meaning of chronic illness upon physical functioning. Though it has been reported that adolescents living with HIV and AIDS in Chinhoyi are coping with their challenges, it should be borne in mind that not all adolescents are managing to effectively deal with their challenges.

It also came out that there could some other adolescents who have not yet been reached, hence they cannot access services. From a process perspectives, coping changes over time and in accordance with the situational context, depending on the particular person and encounter. There is, therefore a general consensus that adolescents living with HIV and AIDS are coping with taxing circumstances to a limited extent, as much work still needs to be done to make the world a better place for them to live, despite their difficult circumstances. The social work profession upholds the principle of individuality which recognizes the uniqueness of every individual, hence the need to accept them for what they unconditionally. This calls for social workers to address individual differences in their quest to work for the promotion of interests of adolescents living with HIV and AIDS.

Theme 3: Supporting Mechanisms available for Adolescents living with HIV and AIDS in Chinhoyi.

It emerged from the key informants that the government provides various services which are accessed by the HIV positive adolescents in living with HIV and AIDS in Chinhoyi. Various nongovernmental organizations also complement government in provision of social services.

The health worker indicated that health services are available in Chinhoyi which seek to address their physical and psychosocial needs:

(KI 2) *“There are three treatment sites in Makonde district for adolescents, including Chinhoyi provincial hospital. At Chinhoyi provincial hospital, services that are offered to HIV positive adolescents include voluntary counselling and testing, ART initiation, including physical examination, drug resupply (ART) and psychosocial support. An adolescent comes into contact with professionals like medical doctors, nurses and primary care counselors among others. At the hospital, children up to the age of fifteen are seen at the family and child health where paediatric antiretroviral therapy is administered. At FCH, there is a child support group is called “Tichararama” (We shall live) which meets every last Saturday of the month. Adolescents who are over fifteen years receive their antiretroviral therapy and treatment from the O.I clinic which deal with adults. However, At the O.I clinic, there is a support group which is operational, but it is, however, dominated by adults, although young people who are in their mid twenties actively participate. This excludes adolescents who are in their late teens.”*

The district social service officer indicated that social (welfare services are available to adolescents living with HIV and AIDS in Chinhoyi. He explained that

(KI 5) *“At the department of social services also indicated that they provide services to all vulnerable groups which can also be accessed by HIV positive adolescents if they are eligible. The department of social services regards HIV positive adolescents as children in need of care. In the absence of parents or caregivers, the social welfare system encourages the children to seek voluntary counselling and testing and ART. The department also provides Assisted Medical Treatment Orders to children whose families have challenges in raising money for medical expenses for the adolescents living with HIV and AIDS.*

He also added that the department of social services also engages in family casework, where family problems are reported. He said this usually happens when there are there are family

adjustment problems which may compromise the health and nutrition needs of the adolescents living with HIV and AIDS.

The director of Pamuhacha indicated that her organisation also provides services to adolescents with HIV and AIDS which include life skills training (that encompass reproductive health), income generation, skills identification, nutrition education, psychosocial support activities among others. The organization works in collaboration with volunteers who are based in the community who identify and report on HIV positive adolescents in the community including those facing psychosocial adolescents.

She added that they work with Child Protection Committees in various wards in Chinhoyi, whenever they are functional. These committees are involved in investigation and intervention on cases of emotional, physical and sexual abuse of children (including those who are HIV positive).

Treatment services for HIV positive adolescents were reported to be available and accessible though not very comprehensive. Adolescents are not required to pay for user fees for services provided at O.I clinic and at the family and child health, including supply of ARVs. However, there may be other medical procedures which may require cash payment upfront. The district social service officer stated that department of social services has been playing a role by assisting those who cannot afford other services by providing AMTOs which cover comprehensive services and medical procedures available at the provincial hospital, except for blood transfusion.

However, some adolescents (n=13) have reported ignorance of services offered by DSS or lack of concern by caregivers to visit social services offices for assistance. DSS indicated that for they try to make services available for HIV positive adolescents as no strict means testing is done for them when they need medical and other forms of assistance. Secondary care

volunteers have providing support in some communities to adolescents and adolescents living with HIV and AIDS. They work in selected wards in Chinhoyi. It was also reported that adolescents often receive support from these community caregivers usually when they experience challenges in the home set up, usually, emotional abuse. These community care givers are somehow trusted by the adolescents because they are viewed as independent, neutral outsiders who are willing to help them when they are in difficult circumstances.

The health worker also said that at Chinhoyi Provincial Hospital's Family and Child Health, there is a child support group is called "Tichararama" (We shall live) which meets every last Saturday of the month. She added that adolescents who are over fifteen years receive their antiretroviral therapy and treatment from the O.I clinic which deal with adults. It was indicated that, at the O.I clinic, there is a support group which is operational, but it is, however, dominated by adults, although young people who are in their mid twenties actively participate. This excludes adolescents who are in their late teens.

Key informant from Pamuhacha indicated that a limited number of adolescents who come from poor background have received support from organizations like Batsirai Group and Kapnek Trust (school fees). Some local churches have been assisting primary school HIV positive adolescents with meals before or after school. These adolescents visit their premises on their way to school (when they are hot sitting) or after school (if they have morning classes).

Of the adolescents interviewed a few (n=8) confirmed receiving support in various ways from charitable organizations, while the majority are not benefiting from such initiatives. This has gone a long way in complementing nutritional needs of these adolescents.

However, it came out that there are some structural challenges regarding support mechanisms available to adolescents living with HIV and AIDS in Chinhoyi. All key informants raised

issue of resources limitations. The health worker indicated that nurses in the FCH sometimes make personal contributions to buy refreshments to be used for support group meetings as no funds are allocated for such by the hospital. Pamuhancha director indicated that it has limited funding, hence it cannot cater for many adolescents who needs it services. Furthermore, operations can be suspended when there is no funding. In addition, lack of coordination was cited between department of social services and the provincial hospital when it comes to cases that need cooperation of both institutions. It came out that limited resources may limit the capacity of the department of social services to follow up on every case. This situation has also been exacerbated by the unavailability of a social worker at the provincial hospital, who can act as a link between the patients and the social services delivery system.

Key informant from the Department of social services proposed that adopting some traditional models of care can also bring fruitful results as managing issues related HIV and AIDS need community effort.

Discussion

The findings from the study indicate that a variety of services from medical, psychosocial and social services are available to adolescents living with HIV and AIDS. Various initiatives are being done by government and non government players to reach out to this vulnerable group. However, shortages of resources (financial and human) compromise the quality of service that is provided to adolescents living with HIV and AIDS in Chinhoyi This has also been noted by Government of Zimbabwe (2010) through its National Community Home Based Care Strategic Plan (2010-2015). This results in hospital based support groups catering for large numbers of children, thereby limiting the groups' capacity to address individual concerns.

An issue of concern which emerged is the need to tailor make services which suit the developmental needs of the adolescents living with HIV and AIDS. This find is consistent

with AIDSTAR-ONE(2012) which proposed that services which suit transition needs of adolescents should be introduced, as well as the integration of adolescent health services various levels.

Of paramount is the development of programmes which empower adolescents living with HIV and AIDS people to with the necessary skills to be able to manage their condition and cope better with their illness. This is best explained by the theory of learned resourcefulness by Rosenbaum (1990) which states that cognitive strategies are useful in deal addressing future stressful situations that can be acquired by a person from learning that occurs as a result of current learning experiences. Brown, Lourie and Pao (2000) suggest the inclusion community based outreach staff as part of an integration of medical, psychological and social services, coupled by the cooperation of multi-disciplinary professionals concerned. Habbib and Rahm (2010) share the same sentiments when they postulated that social workers should be a liaison between the adolescents living with HIV and AIDS and their families, medical personnel, other health care providers and social services agencies.

4.10 Chapter Summary

This chapter presented findings from the study. The findings were structured as demographic characteristics of respondents, challenges faced, coping mechanisms by respondents and support mechanisms available for adolescents living with HIV and AIDS in Chinhoyi. The discussion and analysis of the findings of the study was covered in this chapter. Based on these findings, the next chapter draws numerous conclusions and recommendations.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction to the Chapter

The findings from this study led to various conclusions. The previous chapter presented findings from the study. This chapter aims to summarize, draw conclusions based on these findings and to make recommendations.

5.2 Summary of Findings

The study sought to evaluate the coping mechanisms that used by adolescents living with HIV and AIDS in Chinhoyi. The results of the study indicate that HIV positive adolescents are stressful situations due to various challenges encounter in their lives. Stigma and discrimination remains a major challenge that adolescents living with HIV and AIDS may have to deal with. Stigma is experienced in family set up, in the school environment and in the community. Other challenges include health related challenges, community integration, fear and anxiety, emotional and behavioural challenges. Adolescents living with HIV and AIDS were found to utilize both active and passive styles of coping, though passive styles dominated. Furthermore, adolescent used endogenous ways of coping which reflect their situation in Chinhoyi.

It was also discovered that various support mechanisms exist to assist adolescents living with HIV and AIDS in Chinhoyi from state and non state actors. Though they play a key role in ameliorating suffering by the adolescents, lack of resources poor coordination by among various professional and service providers for adolescents living with HIV and AIDS limited the effectiveness of the support mechanisms to adequately address the needs of these adolescents. Furthermore, the absence of an enabling policy framework which provides for

the harmonization and provision of services which specifically target the adolescents living with HIV and AIDS limits the effectiveness of available services in meeting the complex needs of adolescents living with HIV and AIDS.

5.3 Conclusions

Based on the results presented in the previous chapter, the following conclusions were made:

5.3.1 Psychosocial and economic challenges are pose barriers to effective coping.

Adolescents have experienced stigma, or fear to experience stigma and discrimination. Stigma and discrimination against HIV positive adolescents is still prevalent in the community. Financial challenges in the family, unsupportive family and community pose barriers to adolescents to effectively seek treatment and support as well to cope with the demands of living with HIV and AIDS. This also negatively affects their capacity to develop to the fullest of their potentials.

5.3.2 Provision of health and social services makes HIV and AIDS more manageable by adolescents living with HIV and AIDS.

The improved provision of medical and social services has reduced suffering for adolescents living with HIV and AIDS. The introduction of ART has dramatically changed the physical health of adolescents that they lead near normal lives provided that support is available. Gaps in service provision reduces effective coping by adolescents.

5.3.3 Health and social service provision is fairly comprehensive but not fully adequate to address the complex and emerging needs of adolescents who are living with HIV and AIDS.

Health and social services address the majority of the needs of the HIV positive adolescents. However, the shortage of resources such as finance and human resources has led to other

needs of these adolescents unmet. Community resources are therefore needed to fill the gap in terms of service provision by government.

5.3.4 Lack of effective coordination by stakeholders in responding to the needs of HIV positive adolescents.

Ineffective coordination and cooperation by health workers and social services officers has compromised quality of services that are needed by clients. Resources constraints have also limited department of social services to effectively intervene in situations where adolescents are experiencing abuse or being denied access to treatment. Such cases take long to conclude or they may never be concluded.

5.3.5 HIV positive adolescents are developing skills to cope with various demands that confront people living with HIV and AIDS.

HIV positive have learnt to accept their HIV positive status. Furthermore, they are developing skills to confront adversities that they go through in their daily lives, including resiliency. They are gradually developing cognitive abilities which enable them to cope with regard to taking medication on a daily basis, loss of parents, as well as living in a community which is not sensitive to the needs of people living with HIV and AIDS. The existing services and community structure have been of use to the adolescents overcome adversities that are associated with living with HIV and AIDS in a Zimbabwean context. This suggests that adolescents who have been reached are managing to cope, though with difficulties.

5.3.6 Adolescents with HIV and AIDS are utilize both active and passive coping methods, and passive methods are mainly preferred.

Results have shown the use both active and passive methods of coping with stress related to living with HIV and AIDS. Passive methods are mostly favoured, despite their detrimental consequences if their over used.

5.3.7 Adolescents living with HIV and AIDS are coping with their condition to a moderate/ lesser extent.

Adolescents are coping with challenges to a limited extent, though coping ability varies from one person to another, depending on the social circumstances.

5.6.8 Older adolescents need adequate support to manage the developmental pressures and still adhere to medication.

Older adolescents having fully internalized societal attitudes towards people who are HIV positive, they are tempted to dissociate themselves from having HIV, subsequently leading to defaulting treatment, missing clinic appointments and support group meeting. The process of developing an identity and the need to have a sense of belonging to their peers has interfered with their quest for independence, even in managing their own health demands.

5.3.9. Extended family remains critical for the care and support for HIV positive adolescents.

This suggests that they still depend on the extended family for their basic necessities. This also includes finances to meet their medical needs as well as supervision for adherence to treatment as well as provision of emotional support. Provision of economic resources and emotional support by family system for the treatment, care and support of HIV positive adolescents is critical in promoting their physical, mental, psychosocial wellbeing.

5.3.10. Coping with HIV and AIDS is not individual, but community responsibility.

Coping with HIV and AIDS related challenges should not be abdicated to the adolescents but should be a community responsibility. The community involvement in removing barriers that prevent effective coping may strengthen help improve the quality of life for HIV positive adolescents

5.3.11 Decentralization and Transition of Treatment Care and Support has potential for better health outcomes.

Provision of ART in local clinics has the potential to increase adolescents' access to treatment within their communities. Furthermore, if support groups for HIV positive adolescents are widespread in communities, that can also reduce barrier to accessing opportunities to for receiving psychosocial support which will, in turn strengthen their coping with HIV and improve their physical and psychosocial well being. Health care services for adolescents living with HIV and AIDS should be systematically adjusted to meeting changing needs of adolescents as they strive towards independence of their own affair, including health care.

5.3.12 Empowerment and building confidence in adolescents promotes better coping.

Creating better confidence in adolescents has the potential to boosts their self esteem, and strengthens their potential to overcome stigma and discrimination as well as being resilient in sight of various adversities.

5.4 Recommendations

Based on the above conclusions made in this chapter, the following recommendations are being made:

5.4.1 Sensitize community to combat stigma and discrimination against adolescents living with HIV and AIDS.

The community should be conscientised to be sensitive to the needs of adolescents who are living with HIV and AIDS. Community should be taught accept and be tolerant to adolescents who are in difficult circumstances because of their health problems. The community should be engaged in a bit to eliminate stigma and discrimination against HIV positive adolescents.

5.4.2 Introduce livelihood programmes that strengthen economic situation of families looking after HIV adolescents living with HIV and AIDS.

Developmental organizations should also include families caring for HIV positive adolescents in the livelihood programmes which boost food security. This would enhance the nutritional status of HIV positive adolescents who are on medication.

5.4.3 Improve allocation of resources for programmes and services that specifically target HIV positive children.

Improvement in the provision of resources leads to better programmes and services that are tailor-made to address the needs. HIV positive adolescents should be recognized as a special group because which needs a lot of financial support. Critical personnel to deal with HIV positive adolescents should be made available.

5.4.4. Improvement policy and legal framework provide for the harmonization of service provision for adolescents living with HIV and AIDS.

The government should improve the existing laws and policy so that they provide for the harmonization of service provision for adolescents living with HIV and AIDS. Furthermore, policy should also clearly articulate the role that is played by various stakeholders in the multi sectoral approach in responding to the complex health and social needs of HIV positive adolescents in a resource limited setting like Zimbabwe.

5.4.5 Introducing structured programmes to train HIV positive adolescents and their families to adopt better and effective methods of coping with demands of HIV and AIDS.

Structured programmes should be implemented to equip adolescents with more skills of dealing with various challenging situations and circumstances that they may come across in the family, in schools and in the community at large. Parents or caregivers should be given

professional advice by trained professionals on ways on handling disclosure of the child's HIV positive status. This would result the child receiving information at the appropriate time, thereby promoting better adjustment.

5.5.6 Creating conditions for equal opportunities for HIV positive adolescents.

The government should create conditions which promote equal opportunities for HIV positive adolescents. They should have access to employment and also skills to make them economically self sustaining in future as well as to develop to their fullest potential.

5.5 Areas for Further Study:

The researcher recommends the following areas to be studied:

- The experiences of HIV positive adolescents in rural settings.
- Coping strategies for HIV positive children living in institutions or residential places of safety.
- Challenges experienced by families in addressing the needs of children who are HIV positive.
- The adoption of traditional models of care in dealing with children living with HIV and AIDS
- The role of culture in promoting better coping
- The psychosocial circumstances of children with AIDS who are not accessing treatment.

5.6. Chapter Summary

The difficult circumstance that surround adolescents who are living with HIV and AIDS needs attention of the social work profession, a profession which aims to enhance people's problem solving and coping capacities. Therefore social workers have to advocate for the adoption of policies as well the creation of an environment which protects the health and social needs of adolescents living with HIV and AIDS. This will not only improve their quality of life, but reduce morbidity and improve life expectancy for this special group. This will promote the attainment of the millennium development goal number six. If some of the proposed recommendations are adopted, with treatment access, longer and fulfilling lives for HIV infected children and adolescents becomes a reality.

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APPENDIX I

INTERVIEW GUIDE FOR ADOLESCENTS

This study seeks explore the coping mechanisms adopted by adolescents living with HIV and AIDS in Chinhoyi.

DEMOGRAPHIC DATA:

Age.....

Sex:.....

Level of Education Attained:.....

Indicate whether or not you are still in school.....

Relationship to your guardian/ primary care giver.....

Occupation of your guardian.....

Are your biological parents still alive?.....

Any other relevant Details:

CHALLENGES EXPERIENCED BY ADOLESCENTS LIVING WITH HIV AND AIDS.

What challenges do you face in accessing treatment or medical care?

Indicate challenges you encounter when taking medication

What challenges do you experience at School?

What challenges do you encounter in the community?

TESTING AND DISCLOSURE

How old where you when you were told of your HIV status?

Indicate your relationship with people you have disclosed your status

What is the people's usual reaction after knowing your HIV status?

How do you feel about disclosing your HIV status to your friends and peers?

SEXUAL AND REPRODUCTIVE HEALTH ISSUES

Tell me about your (prospective) relationship with the opposite sex (dating, sexual behaviour)

How do you feel about disclosing your HIV status to your boyfriend/girlfriend or future partner?

What challenges have you encountered in dating/ courtship because of your HIV positive status

What are your future wishes about dating, marriage and child bearing?

What do you know about secondary prevention of transmission of HIV and AIDS?

What methods do you use to cope with sexuality issues?

How effective are these coping methods?

PSYCHOLOGICAL ADJUSTMENT/ COPING WITH HIV AND AIDS

How are you managing to deal with stigma and discrimination at home and in the community?

How do you deal with disclosing your status to your friends and peers?

How do you respond to pressures within the school environment?

How do you feel about the need to take medication on a daily basis? How do you feel about frequent hospitalization and medical attention?

How do you manage stresses that are associated with living with HIV and AIDS within your community?

Do you think you are able to effectively deal with various challenges that face adolescents living with HIV and AIDS in society?

What are your future aspirations?

Do you think you have the capacity to attain your future aspirations?

What keeps you going in the face of adversities in your life?

COPING MECHANISMS

What methods do you use deal with challenges you face in the community?

Which methods do you think are effective in addressing your challenges?

What methods do you think are less effective in addressing your challenges?

Who gives you the greatest social and psychological support in your life?

What level of support do you receive from the family?

SUPPORT MECHANISMS

What forms of support do you receive from the community?

What sort of support do you receive from your peers?

Do you find support group membership being useful in handling challenges that you encounter?

Do you receive any support from the department social services (upon request)?

What do you think should be done to help you improve your quality of life? Any other comments:

-THANK YOU-

APPENDIX II

ADOLESCENT VERSION OF KIDCOPE QUESTIONNAIRE

This study seeks explore the coping mechanisms adopted by adolescents living with HIV and AIDS in Chinhoyi.

To respond to statements on this questionnaire, you must have specific challenges/ stressful situations which you have gone through in your life. The situation should be reflective of challenges you encounter as an adolescent living with HIV and AIDS in the community. Reflect on what really transpired, how you acted and why these situations are important to you.

Not Used **Used Somewhat** **Used Quite A Bit** **Used A great deal**
 0 1 2 3

| ITEM | FREQUENCY IN THE USE OF STRATEGY | | | |
|---|---|----------|----------|----------|
| 1. I thought about something else; tried to forget it; and/or went and did something like watch TV or play a game to get it off my mind. | 0 | 1 | 2 | 3 |
| 2. I stayed away from people, kept my feelings to myself, and just handled the situation on my own. | 0 | 1 | 2 | 3 |
| 3. I tried to see the good side of things and/or concentrated on something good that could come out of the situation. | 0 | 1 | 2 | 3 |
| 4. I realized that I brought the problem on myself and blamed myself for causing it. | 0 | 1 | 2 | 3 |
| 5. I realized that someone else caused the problem and blamed them for making me go through this. | 0 | 1 | 2 | 3 |
| 6. I thought of ways to solve the problem; talked to others to get more facts and information about the problem and/or tried to actually solve the problem. | 0 | 1 | 2 | 3 |
| 7. I talked about how I was feeling; yelled, screamed, or hit something | 0 | 1 | 2 | 3 |
| 8. I tried to calm myself by talking to myself, praying, taking a walk or just trying to relax. | 0 | 1 | 2 | 3 |
| 9. I kept thinking and wishing this had never happened; and/or that I could change what had happened. | 0 | 1 | 2 | 3 |
| 10. I turned to my family, friends, or other adults to help me feel better. | 0 | 1 | 2 | 3 |

| | | | | |
|---|----------|----------|----------|----------|
| 11. I just accepted the problem because I knew I couldn't do anything about it. | 0 | 1 | 2 | 3 |
|---|----------|----------|----------|----------|

Not effective **Somewhat Effective** **Quite Effective** **Very Effective**
 0 1 2 3

| ITEM | EFFECTIVENESS OF STRATEGY USED | | | |
|---|---------------------------------------|----------|----------|----------|
| 1. I thought about something else; tried to forget it; and/or went and did something like watch TV or play a game to get it off my mind. | 0 | 1 | 2 | 3 |
| 2. I stayed away from people, kept my feelings to myself, and just handled the situation on my own. | 0 | 1 | 2 | 3 |
| 3. I tried to see the good side of things and/or concentrated on something good that could come out of the situation. | 0 | 1 | 2 | 3 |
| 4. I realized that I brought the problem on myself and blamed myself for causing it. | 0 | 1 | 2 | 3 |
| 5. I realized that someone else caused the problem and blamed them for making me go through this. | 0 | 1 | 2 | 3 |
| 6. I thought of ways to solve the problem; talked to others to get more facts and information about the problem and/or tried to actually solve the problem. | 0 | 1 | 2 | 3 |
| 7. I talked about how I was feeling; yelled, screamed, or hit something | 0 | 1 | 2 | 3 |
| 8. I tried to calm myself by talking to myself, praying, taking a walk or just trying to relax. | 0 | 1 | 2 | 3 |
| 9. I kept thinking and wishing this had never happened; and/or that I could change what had happened. | 0 | 1 | 2 | 3 |
| 10. I turned to my family, friends, or other adults to help me feel better. | 0 | 1 | 2 | 3 |
| 11. I just accepted the problem because I knew I couldn't do anything about it. | 0 | 1 | 2 | 3 |

APPENDIX III

KEY INFORMANT INTERVIEW GUIDE

This study seeks to evaluate the coping mechanisms of adolescents living with HIV and AIDS in Zimbabwe.

This interview shall endeavor to collect data as close to the following aspects as possible:

1. BACKGROUND INFORMATION OF KEY INFORMANT

a. Name of key informant

.....

b. Institution's name

.....

c. Title

.....

d. Summary of work

.....

e. Years of Experience

.....

f Any other details

.....

2. DISCUSSION QUESTIONS:

a) Can you comment on the psychosocial challenges that are faced by adolescents living HIV and AIDS in Zimbabwe?

b) How have adolescents been able to deal with challenges relating to stigma and discrimination in society?

c) How are adolescents managing to handle issues of adherence to treatment and disclosure?

d) What strategies have been used by the adolescents to cope with challenges associated with living with HIV in Zimbabwe?

e) What are the useful coping strategies mostly used by HIV positive adolescents?

f) What are the less useful coping strategies employed by adolescents with AIDS?

g) What are the factors that make it difficult for adolescents to cope with the demands of adolescents living with HIV and AIDS?

- h) What are the health and social services available for use by adolescents living with HIV and AIDS?
- i) Are there health and social services specifically designed to meet special needs of adolescents living with HIV and AIDS?
- j) How satisfactory / adequate are these services?
- k) What do you think should be done by relevant authorities to improve the quality of life for adolescents living with HIV?
- l) Can you comment on the legal and policy framework for dealing with ALHIV?

Thank You

APPENDIX IV

CONSENT FORM FOR RESPONDENTS

**This form should be filled in duplicate. One form should be given to interviewee or interviewee’s guardian and the other form remains with the researcher.*

Introduction: Good morning/afternoon. My name is

I am carrying out a study on an exploration of coping mechanisms adopted by adolescents living with HIV and AIDS in Chinhoyi. You (or your child) have (has) been chosen to participate in this research as a respondent. Details of the research and researcher are given below:

Title of Research: An exploration of the coping mechanisms adopted by adolescents living with HIV and AIDS in Chinhoyi, A Case of adolescents receiving treatment at Chinhoyi Provincial Hospital, Mashonaland West Province in Zimbabwe.

Interview details: The interview will take approximately 45 minutes and you are free to reject taking part or terminating the interview at any time. Your responses as well as observations made in this interview will be used for the purposes of this study only and will not be released to anyone.

The interview procedure involves me asking you questions and I will record your answers/us discussing issues I have on my list. You are free to seek clarification, expand your responses or ask questions. There are no risks or direct benefits associated with this study but your accurate contributions will help build knowledge that will be used to shape future interventions.

Name of Researcher and Contact Person: Mr. Rangarirai Frank

Contact Details:

734 Rudland Avenue, Orange Groove, Chinhoyi Telephone Numbers: 0772307983

Declaration of Consent:

I.....consent to take part in this research under the terms stated above. I have appended my signature below in the presence of my witness who will also sign below:

Interviewee’s signature:..... Date:.....

Witness’s signature:..... Date:.....

Interviewer’s signature:..... Date:.....

I.....consent on behalf of, who is under my care, to take part in this research under the terms stated above. I have appended my signature below in the presence of my witness who will also sign below:

Interviewee’s signature:..... Date:.....

Witness’s signature:..... Date:.....

Interviewer’s signature:..... Date:.....