



**CHALLENGES AND OPPORTUNITIES OF HIV POSITIVE ADOLESCENTS IN
ZVISHAVANE URBAN**

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I, Ngonidzashe Sesemani solely declare that, this thesis, being submitted to the Midlands State University in the Department of Development studies for the award of an Honours Degree in Development studies is my own original work, except where I have explicitly indicate otherwise, through referencing. This piece of work has not been submitted for any award at any University.

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DEDICATION

I dedicate this work to my mother Regina Muchechetere Sesemani who had a vision of me being where I am today. I treasure your guidance be it social, emotional, and spiritual. I also dedicate this piece of work to all young people born and living with HIV in Zimbabwe.

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ABSTRACT

The Human Immunodeficiency Virus and Acquired Immuno Deficiency Syndrome commonly known as HIV and AIDS have had negative consequences towards the well-being of young people in particular HIV positive Adolescents. In a country with high prevalence rate in Southern Africa, the number of adolescents born and living with HIV and AIDS is steadily increasing. As reported by the National AIDS Council (2011) there are more than 150 000 children born and living with HIV and AIDS who are below the age of 15 years. In the preceding years, this group of the population has been receiving little or no attention at all from the duty bearers. The study analysed the challenges and opportunities of HIV positive adolescents in Zvishavane Urban. The objectives of the study were to identify the challenges of HIV positive adolescents, to examine the role of Government and NGOs in promoting the well-being of HIV positive adolescents and also to explore opportunities available for HIV positive adolescents. The study mixed quantitative and qualitative research methods in order to mine adequate data for the study. Data collection included key informant interviews, focus group discussions and a questionnaire. A sample of 35 HIV positive Adolescents age between 10 and 19 years of age were selected through simple random sampling. The study revealed that HIV positive adolescents continue to face challenges which range from individual, family and community level and these were perpetuated at home, school, church and in the community as a whole. The study revealed that these adolescents faced problems which include stigma and discrimination, disclosure of HIV status, limited or lack of knowledge and skills on HIV and SRH, unfriendly health delivery systems and poor adherence to antiretroviral treatment. NGOs in particular Bethany Project were found to be working tirelessly in addressing the challenges of HIV positive Adolescents with support from Government line Ministries such as the Ministry of Health and Child Care. Opportunities for HIV positive Adolescents were explored in this study and were identified as the existence of community based structures established by the Government and NGOs, availability of youth friendly centres and the existence of policies that support programming for HIV positive Adolescents. The study concludes that despite the efforts being made by the Government and NGOs, the well-being of HIV positive adolescents is still being hampered. The study informs interventions that promote healthy coping and better quality of service delivery for adolescents that are struggling with the complexities of living with HIV and AIDS.

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ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
ART	Antiretroviral Therapy
ASRH	Adolescent Sexual and Reproductive Health Strategy
CCW	Case Care Workers
CPC	Child Protection Committee
CSOs	Civil Society Organizations
DAC	District AIDS Coordinator
DNO	District Nursing Officer
DSS	Department of Social Services
EFZ	Evangelical Fellowship of Zimbabwe
EGPAF	Elizabeth Glaser Paediatric AIDS Foundation
FGDs	Focus Group Discussions
HIV	Human and Immuno-Deficiency Syndrome
HTC	HIV Testing and Counselling
MACO	Midlands AIDS Caring Organization
MASO	Midlands AIDS Service Organization
MoHCC	Ministry of Health and Child Care
NAC	National AIDS Council
NAP	National Action Plan
NGOs	Non-Governmental Organizations

O.I	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PMTCT	Prevention of Mother to Child Transmission
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
STIs	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCRC	United Nations Convention on the Rights of the Child
UNICEF	United Nations Children`s Fund
WHO	World Health Organization
ZCC	Zimbabwe Council of Churches
ZDH	Zvishavane District Hospital
ZIMSTAT	Zimbabwe National Statistical Agency
ZIMVAC	Zimbabwe Vulnerability Assessment Committee
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan
ZNFPC	Zimbabwe National Family Planning Council
ZTC	Zvishavane Town Council
ZYC	Zvishavane Youth Centre

CHAPTER 1

INTRODUCTION TO THE STUDY

1.1 Introduction

This chapter is an endeavour to give an overview of the nature and purpose of the research to potential users. It will highlight the background of the study which shall provide the information concerning the area of study. The problem statement, research question, research objectives, the significance of the study and the hypotheses will also be outlined. This chapter is vital because it prepares the reader with an understanding of the topic and area under discussion.

1.2 Background to the Study

The development of this world, in particular sub-Saharan Africa is closely linked to the well-being of its young people. Globally young people aged 10 – 24 years constitute one third of the total population and this large number of young people provides an opportunity to hasten economic growth and reduce poverty, but only if nations make the right investments in current and future generations. Without premeditated and tactical investments, young people will continue to face social and economic challenges resultantly decelerating development efforts in the region.

The Human Immunodeficiency Virus (HIV) and the subsequent Acquired Immunodeficiency Syndrome (AIDS), hereafter to be referred to collectively as HIV and AIDS, remains one of the most significant public health challenges in our lifetime, and certainly one of the biggest obstacles to socio-economic development especially in developing countries (WHO, 2011). An estimate of 35.3 million people globally is currently living with HIV. In terms of Adolescents, it was estimated by UNAIDS in 2012 that globally there were 2.1 million

adolescents aged 10 – 19 years who were living with HIV. HIV infection was established long back for more than 30 years, with Sub-Saharan Africa continuing to bear the highest incidence of HIV of any region. The global epidemiology of paediatric HIV mirrors that of adults. The genesis of HIV epidemic resulted in the loss of gains recorded in child health outcomes in the 1970s and 1980, with the world child mortality rates a third to two-thirds higher than they would have been without HIV and AIDS (Dabis and Ekpini, 2002).

All nations across the world, particularly, low and middle-income countries are significantly affected by HIV and AIDS and Zimbabwe is no exception. Young people have not been spared by the HIV virus, some being born with it and some being vertically infected. It is well recognised that HIV and AIDS epidemic affects children in many ways including, making them orphans, increasing their vulnerability and threatening their survival. Adolescents born and living with HIV are faced with a number of challenges ranging from individual, family and to community level.

Despite the efforts being made to reduce the vulnerability of young people Adolescents aged 10 – 19 years continue to be vulnerable socially and emotionally including those young people aged 20 -24 years. In the year 2012 there were approximately 2.1 million people adolescents who were HIV positive and it is argued by UNAIDS 2013 that about one-seventh of all new HIV infections occur during adolescence.

Adolescents who are HIV positive have got their own unique problems which differ with those of adults. HIV testing and counselling (HTC) access and uptake for adolescents is lower than that of adults. A study conducted in Sub Saharan Africa revealed that only 15% of young women and 10% of young men knew their HIV status despite the fact that HTC access and coverage vary extensively across countries and regions. HIV related deaths for adults globally fell by 30% whilst for adolescents they increased by 50% (UNAIDS, 2013). Poor

prioritization of adolescents in national HIV plans, limited or absence of youth friendly centres that offers HTC and treatment services, limited or unavailability of care and support systems and adherence to ART are the reasons for such an increase.

Zimbabwe is one of the few countries in the world currently experiencing a general decline in HIV prevalence. With a total population of 13 million (1.1% population growth rate) (ZIMSTAT, 2012), Zimbabwe's HIV prevalence has gone down to 15% and this is a prevalence which is almost uniform in all the country's 10 provinces. Hot spots such as border towns, mining towns, growth points and resettlement areas where much higher rates are recorded because of heavy sexual activity continue to perpetuate new HIV infections in the country despite all the efforts being made. In addition to that the HIV prevalence for urban areas slightly higher in urban than in rural areas, and 1.5 times higher among women aged 15–24 years than among men of the same age. Despite the prevalence rate decline from 24% in the late 1990's is a tremendous success, the country still has a lot of ground to cover in order to meet the millennium development goals (MDGs). These targets are documented in Zimbabwe National HIV (and AIDS) Response Strategic Plan (ZNASP) – 2011 to 2015. Young people born and living with HIV including infants and Adolescents continue to feel the heat from the epidemic.

Mother to child transmission (MTCT) of HIV is a huge problem in Zimbabwe which has become the major cause of infant and child mortality (Mahomva, 2007). It is the most significant (90%) source of HIV infection in children below the age of 15 years. Without any PMTCT intervention, about a third of the HIV infected women passes the virus to their babies. Mother to child transmission of HIV can take place during pregnancy, delivery and breastfeeding but however with the PMTCT program in place, HIV positive mothers can now bear HIV negative children.

Located in the Midlands Province of Zimbabwe, Zvishavane District has a total population of 115372 people with more than 24 228 young people aged 15 -24 years thus indicating that the population is quite youthful in structure. According to the National AIDS Council annual report of 2014, the HIV prevalence for Zvishavane District stands at 16.7 % which is higher than the 16% of the Midlands Province and also the national one which stands at 15%. When the HIV and AIDS epidemic started in Zvishavane in early 1990s, it was concentrated among adult males and sex workers. Today however, the epidemic has further spread to be concentrated among the adolescents. The proportion of adolescents (10 to 19 years olds) living with HIV in Zvishavane Urban is also increasing. The Zvishavane District Hospital 2014 estimates, informs that there are 8 973 (3 399 male and 5 574 female) people living with HIV and AIDS in Zvishavane Urban. 644 (308 boys and 336 girls) are children of which 65 percent of that number represents adolescents.

Adolescents who are HIV positive are affected by HIV and AIDS, including being infected by the virus, being orphans and others made vulnerable because of HIV and AIDS in the family and community. A mini baseline survey conducted by a Zvishavane child and youth centred Non-Governmental Organization in 2013, revealed that adolescents who are affected by HIV and AIDS faced several problems including stigma and discrimination, disclosure issues, late initiation on antiretroviral therapy, shortage of food and nutrition support, lacked shelter, had insufficient protection, suffered psychosocial problems, and had less access to education and vocational training compared to children who were not affected. Adolescents continue to face the above challenges coupled with the socio-economic and political situation in Zimbabwe.

1.3 Study Area

Zvishavane district is located 400 km south of the City of Harare in the Southern extreme of the Midlands Province. The Great Dyke (West) and the gold belt cover the district resulting in gold, platinum, asbestos, chrome, diamonds and iron ore mining as major livelihoods. According to the ZIMVAC 2012 the District is in the semi-arid agro-ecological regions 4 (70% of the land area) and 5 (30% of the land area), which are prone to droughts and chronic food shortages. Dry spells used to occur after every 3 to 5 years, however since the year 2000 the dry spells are perennial. Major droughts occur every 10 years following this pattern 1971/72, 1981/82, 1991/92, 2001/02 (ZIMVAC, 2012). Every year, the agricultural season is characterized by severe food shortages particularly the southern and eastern parts of Zvishavane district. Food insecurity has always been an issue in the District.

According to the 2012 Population census, Zvishavane district has a population of 115372 (70047 rural and 45325 Urban). Population growth rates per annum are 0.3% for Zvishavane rural and 2.9% for Zvishavane urban. The urban population is growing at a much faster rate indicating the high rural to urban migration and high birth rates within the urban set-up. The majority of the population in the district is youthful, 45% aged 14 years and below and 21% aged between 15 and 24 years. About 42% of the population is sexually active in Zvishavane District. Demand for HIV and AIDS services is very high due to the huge populations of young people who migrate to Zvishavane urban in search of jobs and better income earning opportunities. The National HIV and AIDS prevalence rates have over the years declined significantly from a peak of 20,1% in 2005 to 15.7 in 2013 (National AIDS Council, 2014). However for a district like Zvishavane HIV prevalence rate is actually increasing.

The district has 16 clinics and 2 hospitals to service the above population. On average there are 6400 people per health facility in the district (Zvishavane District Hospital Report, 2014).

According to the District AIDS Coordinator (2014) all the health facilities offer HIV Testing and Counselling but there are no specialized services for young people living with and affected by HIV and AIDS as well as people with disability. Currently, the voices of young people living with and affected by HIV and AIDS plus people with disability are silent. Resultantly information regarding their special needs in terms of counselling, Anti-retroviral Therapy (ART), dietary and sexual and reproductive health needs is not available. According to the National AIDS Council Report (September 2013) there has been an increase in the number of people on ART from 6081 in the first quarter to 8138 in the third quarter. An estimated 15467 people are HIV positive. Despite the increase in the number of people on ART there are several problems affecting HIV positive Adolescents which were identified by Non-Governmental Organizations operating in the district which include poor adherence to treatment, limited or lack of disclosure of HIV status, late initiation on anti-Retroviral Treatment and limited family and community based support systems.

Figure 1: Location of Zvishavane District in Zimbabwe



Source: Google maps (2015)

Zvishavane District

1.4 Statement of the problem

Adolescents affected by HIV and AIDS are disproportionately impacted by the HIV and AIDS epidemic and its consequences as compared to adults. There are over 150 000 HIV positive children under the age of 15 years in Zimbabwe and due to improved treatment, the number is expected to increase as more young people will survive into adolescence and even adulthood (NAC, 2011). According to the World Health Organization, between 2005 and 2012 HIV related deaths globally fell by 30% for adults whilst for adolescents they increased by 50% (UNAIDS, 2013) and this is due to poor prioritization of adolescents in national plans. HIV positive adolescents find themselves with psychological and socio-economic challenges and these include the need to strictly adhere to intricate treatment regimen as well as handling HIV status disclosure, stigma and discrimination in the community among others. Undesirably there have been limited or no efforts directed to dealing with the needs of this target group in terms of programming in Zimbabwe, Zvishavane in particular. The needs of HIV positive adolescents are consequently emerging as distinctive and their situation requires prioritization by policy makers and service providers yet limited studies have been focused on how they are coping with their day to day lives. Against this backdrop, this study sought to explore the challenges and opportunities of HIV positive adolescents in Zvishavane Urban.

1.5 Significance of the Study

This study is significant in that it will provide useful information and skills for dealing with HIV positive Adolescents thereby enhancing their psychosocial well-being despite them being HIV positive. It will be useful in improving and revising government policy and legislation to support HIV positive Adolescents and it will determine the nature of intervention required in this district towards enhancing the well-being of HIV positive Adolescents. According to National AIDS Council (2013) a critical analysis into the plight of

young people born and living with HIV including those with disability is the first step in HIV and AIDS youth programming. A number of NGOs are operating in Zvishavane District therefore this analysis will be of significance also in improving their programming in mitigating the impact of HIV on HIV positive Adolescents in Zvishavane Urban.

1.6 Scope

This study seeks to investigate the challenges being faced by HIV positive adolescents in Zvishavane District Urban Area located in the Midlands Province of Zimbabwe and also to identify opportunities which are there and solutions to these challenges.

1.7 Objectives of the Study

The objectives of this study are outlined below:

1. To establish the challenges being faced by HIV positive adolescents in Zvishavane Urban.
2. To find out the role of Government and NGOs in promoting the well-being of HIV positive Adolescents in Zvishavane Urban.
3. To find out if there are opportunities that can be exploited by HIV positive Adolescents in Zvishavane Urban.

1.8 Research Questions

The questions for this study are outlined below:

1. What are the challenges being faced by HIV positive adolescents in Zvishavane Urban?
2. What is the role of Government and NGOs in promoting the well-being of HIV positive Adolescents in Zvishavane Urban?

3. Are there any opportunities that can be exploited by HIV positive Adolescents in Zvishavane Urban to enhance their psychosocial well-being?

1.9 Study Limitations

The limitations of this study are explained below:

- Zvishavane District was being assisted by quite a number of NGOs in food relief programs. Communities have been fully exposed to these donors and this has created a donor dependence syndrome. There is a possibility of respondents sensationalizing issues thinking that they will receive aid thus leading to falsified data being collected.
- HIV positive adolescents may refuse to disclose their status and to take part in the study.
- The political environment in Zvishavane is uncertain. It may happen that during data collection the political environment becomes unstable and this can affect the study.

1.10 Study Delimitations

Delimitations of the study are as follows:

- The Researcher will approach organizations that are working with HIV positive Adolescents in the District and seek help in terms of mobilizing these Adolescents so that they take part in the study. On top of that the Researcher is working in one of the NGOs in the District and will utilise that opportunity.
- The Researcher will be apolitical as the research will be carried out.
- Field observations will also be used also by the researcher so as to minimize the sensationalization of issues by the respondents.

1.11 Assumptions

The assumptions of this study are that the political environment will be stable thus the communities will be easily accessible to administer the research instruments. The other assumption is that the respondents will be willing to participate in the research. It is assumed that HIV positive Adolescents above 16 years will consent to participate in the research and also caregivers of those HIV positive Adolescents below 16 year will consent on behalf of their children to participate in the study since they are regarded as minors.

1.12 Chapter Summary

To sum up, this research purposes to be fruitful in improving the well-being of HIV positive in the urban area of Zvishavane District. Chapter One has introduced the study and gave a description of the area. The chapter has also presented the problem statement, research question, research objectives, the significance of the study and the hypotheses. It has also highlighted the challenges faced by HIV positive Adolescents. This chapter is essential because it prepares the reader with an understanding of the topic and area under discussion. The second chapter presents the theoretical framework and the review of literature related to the challenges and opportunities of HIV positive Adolescents.

CHAPTER 2

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

2.1 Introduction

In an endeavour to understand and analyse the challenges and opportunities of HIV positive Adolescents in Zvishavane Urban, this chapter will review literature on, the definitions of HIV and AIDS, Adolescent and Adolescence. The chapter will also give an overview of HIV in Zimbabwe and its response to the epidemic. It will also explain the link between HIV and Adolescents, the impact of HIV and AIDS on Adolescents, approaches on mitigating the impact of HIV on Adolescents. It is also the intention of this chapter to analyse the role of NGO's in mitigating the impact of HIV on Adolescents and policies in place to support Adolescents in Zimbabwe.

2.2 Defining HIV and AIDS

According to Sepkowitz (2001) and Wilhem (2008) Human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV and AIDS) is a continuum of conditions caused by infection with the HIV virus.

The abbreviation HIV stands for human immunodeficiency virus. The breakdown below assist in understanding what it means.

H: *human* - This clearly means that the virus can infect and survives only in humans.

I: *immunodeficiency* - HIV attacks the body's defence or immune system by destroying the important cells that fight against diseases and infections.

V: *virus* – this is a tiny organism that can only reproduce itself by taking over a cell in the body.

HIV can be transmitted through having unprotected sexual intercourse with an infected partner and according to UNAIDS 2013, 92% of people with HIV have contracted it through this method. The other method for HIV transmission is mother to child transmission (MTCT) during pregnancy, delivery and breastfeeding. 7% of people infected by HIV contracted the virus through this method. Mahomva (2007) argues that MTCT is the most significant (90%) source of HIV infection in children below the age of 15 years. According to Coutsooudis, Kwaan and Thomson (2010) without treatment, the risk of transmission before or during birth is around 20% and in those who also breastfeed 35%. They further argued that as of 2008, vertical transmission accounted for about 90% of cases of HIV in children. If appropriate treatment is administered, the risk of HIV infection can be reduced by 1% (Coutsooudis, Kwaan and Thomson, 2010). However with the introduction of the prevention of mother to child transmission of HIV program (PMTCT) a significant number of babies have been born HIV negative (UNAIDS, 2013). Other methods such as the use of unsterilized objects such as razors, needles, injections and blood transfusion accounts for the remaining 1% in the transmission of HIV.

HIV can be classified in the same category with other viruses including those that causes common colds and flu but there is an omnipotent difference which is that over time a person's defence system can clear most of the viruses out of the body. However this is not with HIV, the person's defence system cannot clear it but rather control it thus once infected by HIV it is incurable. The virus can be in the system for longer periods of time and attacks the T – cells and the CD4 cells. These cells are critical in order to fight against infections and diseases but when HIV invades these cells, it then replicate itself with those cells, make more

copies of itself and destroys them. Overtime, HIV then destroys so many of these CD4 cells in such a way that the body will no longer fight against infections and diseases anymore. When that happens, HIV infection can lead to AIDS which is the final or last stage of HIV infection

However with proper treatment called antiretroviral therapy (ART), not everyone who has HIV progresses to AIDS. ART refers to the use of HIV medicines to fight against infections and it helps to maintain the level of HIV virus in a person`s body low. ART suppresses the virus in order for a person with HIV to stay a longer, healthier life and reduce the risk of transmitting HIV to others. Long back in the mid-1990s, people with HIV could easily progress to AIDS just in a few years but today because of ART a person who is diagnosed with HIV and treated before the infections advances, can have a normal life expectancy. At the moment there is no safe and effective cure for HIV but however researchers and scientists are working tirelessly to find one, and remain hopeful.

The abbreviation AIDS stands for Acquired Immunodeficiency Syndrome. To understand what that means, let`s break it down:

- A :** *Acquired* – simply means that one acquires it from somewhere or from the environment.
- I :** *Immuno* – the person`s body immune system includes all the organs and cells that work to fight off infection or disease. Immuno simply refers to the body`s defence system.
- D :** *Deficiency* – a person get AIDS when his/her immune system is deficient, or isn't working properly.

S : *Syndrome* – A syndrome is a group of symptoms and signs of a disease. It is argued that AIDS is a syndrome, rather than a single disease, because it is a complex illness with a wide range of complications and symptoms.

There is huge difference between HIV and AIDS which some people may not seem to understand. HIV is virus which destroys the immune system and is incurable thus causing AIDS, and AIDS is a condition or a collection of disease caused by the HIV virus. AIDS is the final stage of HIV infection but however not everyone with HIV progresses to this stage. People who will be at this stage of HIV disease have badly damaged immune systems which then expose them to the risk of opportunistic infections commonly known as OI infections. When a person has one or more OIs, certain cancers or a very low number of CD4 cells, he or she is considered to have reached or advanced to AIDS.

2.3 Defining Adolescents and Adolescence

The World Health Organization defines Adolescents as persons between the ages of 10-19. Adolescence is a term commonly understood to describe the period of life between childhood and adulthood (Kaplan, 2004, p. 1). Adolescence varies considerably across cultures, over time, and within individual thus the age ranges 10 – 19 years doesn't only pronounce a very diverse veracity. To holistically or comprehensively define adolescence, the definition must encompass biological, psychological and sociological changes. Biologically the term adolescence keeps emphasis on the events of puberty that transforms the bodies of children into those of sexually and physical mature adults. Psychologically the term adolescence differentiate it in terms of the progressive tasks to be accomplished, each of which relays to the main assignment of achieving a personal uniqueness. Socially the term describes adolescence in terms of their status in society, particularly an intermediate period between childhood and adulthood.

According to MedlinePlus (2014) adolescence is an ephemeral stage human development (physical and psychological) which normally takes place during the time from puberty to legal adulthood which simply is the age of majority. This era of adolescence is mostly related with the teenage years and is usually a period of experimentation and engagement in high risk behaviors. It is during this period when adolescents face quite a number of challenges and that's when they begin to explore their bodies and the environment around them. HIV positive adolescents are also found in the same realm.

According to Erik Erikson's 1963 psychological development theory in Thom and Coetzee (2004) adolescence is the identity versus confusion stage which occurs between the ages of approximately 13 to 18. This stage is characterised by experiments and explorations where adolescents develop a sense of self and personal identity. Young people will be exploring their independence and developing a sense of self. As adolescence transcends from childhood to adulthood, they probably start to feel muddled or diffident about themselves and how they fit into the society. According to Erikson, this stage is important because it lays foundation of establishing a strong identity and developing a sense of direction in life. Adolescents who then receive proper guidance and reinforcement through personal exploration will rise from this stage with a strong sense of self and a feeling of independence and control. On the other hand those that remains unconfident of their opinions and longings become confused about themselves and the future.

2.4 Overview of HIV in Zimbabwe and the Country's Response to the epidemic.

UNAIDS (2013) reports that 35 million people globally are infected with HIV and 90% of these live in Sub-Saharan Africa where Zimbabwe is situated. With a total population of 13 million (1.1% population growth rate), Zimbabwe has a generalized epidemic, with a prevalence rate of 15% that is almost uniform across all its 10 provinces, although there are

hot spots such as border towns, mining towns, growth points and resettlement areas where much higher rates are recorded because of heavy sexual activity in these areas. In addition, HIV prevalence has been found to be slightly higher in urban than rural areas, and 1.5 times higher among women aged 15–24 years than among men of the same age. Although this prevalence rate is a major decline from around 24% in the late 1990's, the country still has substantial ground to cover in order to meet its targets of minimizing the impacts of the epidemic by 2015 (UNAIDS, 2013). These targets are documented in Zimbabwe National HIV (and AIDS) Response Strategic Plan (ZNASP) – 2011 to 2015. In this document, four impact areas for Zimbabwe's national response to HIV and AIDS are identified and targets to be attained by 2015 set as follows:

- i. HIV incidence among adults to be reduced by 50% from 0.85% (48,168) in 2009 to 0.435% (24,084) by 2015
- ii. HIV incidence among children from 30% in 2010 to less than 5% by 2015
- iii. HIV and AIDS mortality rate is reduced by 38% from 71,299 among adults and 13,393 among children in 2010 to 44,025 (adults) and 8,304 (children) by 2015, and;
- iv. National multi-sector response to the epidemic improved from 6.2 in 2010 to 9.0 by 2015.

Zimbabwe has registered meaningful progress in its response to HIV and AIDS, with the country's latest progress report (MoHCC, 2014) showing an increase in the number of deaths averted through antiretroviral therapy (ART) from 40,420 in 2011 to 45,700 by 2013, a decrease in HIV incidence rate from 1.29% (2011) to 0.98% (2013) and a reduction in HIV related mortality from 115,117 to 61,476 over the same period. The number of people tested of HIV and knowing their status rose 75% from 579,767 in 2007 to 2,274,328 by 2013,

according to the progress report, which also shows an increase in the proportion of adults and children eligible to receive ART who are accessing it (from 31.3% in 2007 to 76.9% by 2013, and from 9.7% in 2007 to 46.12% by 2013 respectively).

2.5 Adolescents and HIV

There is a strong link between Adolescence and HIV because Adolescence is that stage from childhood to adulthood which is full of experimentation and adolescents are at high risk of being infected by HIV. It is at this stage when adolescents begin to ask so many questions about life, they at this stage try to identify themselves with the environment surrounding them. The world that adolescents live today has got so many positive and negative things that can shape or destroy their lives and HIV and AIDS doesn't spare them.

Adolescent HIV and AIDS is a separate epidemic and needs to be handled and managed separately from adult HIV. The adolescents can be subdivided into student, slum and street youth; street adolescents being most vulnerable to HIV and AIDS. Among various risk factors and situations for adolescents contracting HIV virus are adolescent sex workers, child trafficking, child labor, migrant population, childhood sexual abuse, coercive sex with an older person and biologic (immature reproductive tract) as well as psychological vulnerability. The most common mode of transmission is heterosexual, yet increasing number of perinatally infected children are entering adolescence.

Despite the decrease in new HIV infections globally, young people continue to be the most infected and affected group in the world. More than 2 million young people aged 10-19 are living with HIV. Adolescents are especially vulnerable to becoming infected with HIV and to dying from HIV associated causes. For the first time, a WHO guideline offers advice on how to better tailor HIV services for this age group. Death rates among adolescents living with

HIV are not decreasing as they are in other populations. Although the global number of HIV related deaths fell by 30% overall between 2005 and 2012, HIV related deaths among adolescents increased by 50% during the same period.

2.6 Impact of HIV on Adolescents

The World Health Organization estimates that 10.3 million youth aged 15–24 years were living with HIV and AIDS in 2010 (most without knowing that they are infected) and half of all new infections are occurring among young people on a global basis (UNAIDS, 2013). Approximately 4 million people younger than 20 years are diagnosed with STIs including herpes, human papillomavirus (HPV), chlamydia, gonorrhoea, and the HIV. About 2.1 million adolescents between the ages of 10 and 19 were living with HIV worldwide. Adolescents account for about 6 per cent of all people living with HIV and about 12 per cent of new adult HIV infections. It is argued that Sub-Saharan Africa and South Asia Regions bear the highest numbers of young people living with HIV globally. Of the 2.1 million adolescents living with HIV, about 1.4 million (64 per cent) live in Eastern and Southern Africa. In countries where HIV prevalence among young girls is greater than 15 per cent, especially in Africa, girls (adolescent age) and young women are disproportionately affected by HIV and AIDS. In some of these countries, adolescent girls are two to three times more likely to be infected than boys of the same age group.

HIV infected adolescents are faced with recurrent and cumulative psychological stressors, such as illness and the death of their parents and siblings, responsibility for welfare of younger siblings or other ill family members, stigma and discrimination, the fear of being viewed as abnormal, and confrontation of mortality and an uncertain future (Nyamakupa et al, 2008). According to Petersen (2010) HIV and AIDS in the family affects the health and wealth of households, thus aggravating pre-existing poverty. The Orphanhood epidemic has

matured alongside the HIV epidemic. Thus, more than 50% of AIDS orphans are adolescents. Many adverse outcomes of being orphaned have been reported, including loss of effective guidance and supervision, inconsistent care, psychological distress and poor mental health, loss of educational opportunities, impoverishment, increased sexual vulnerability, and high rates of risk taking.

A total of about 13 million people are living with HIV in Zimbabwe and basing on the UNICEF (2011) report, adolescents in Zimbabwe constitute 24% of the overall population. The teenagers in Zambia are also faced with the same challenges with those that all adolescents around the globe face; but they also encounter other obstacles such as early sexual activity and parenthood, poverty, transactional and forced sex, and rigid cultural gender roles that can contribute to more teens contracting HIV. Adolescents with HIV are less likely than adults to take their medications regularly, putting them and their partners at risk. In addition, teens often face stigma in their communities because of their HIV-positive status, leading some teens to deny their status or avoid telling their partners. Adding to these challenges, many teens are orphans, having lost parents to HIV related diseases, and are living with extended family or other caregivers. HIV support programs often focus on HIV prevention rather than the needs of people, particularly adolescents who are already living with HIV.

HIV infected adolescents and young adults consistently have disproportionately higher rates of poor drug adherence and virological failure. In Uganda, children whose primary caregiver was the only one who knew the child's HIV status were three times more likely to be non-adherent to antiretroviral treatment (Nabukeera-Barungi, 2007). By contrast, good adherence to an antiretroviral regimen was associated with an adolescent's knowledge of their HIV status, valuable social support, and having a strong relationship with parents. However, even

for adolescents with these apparent advantages, structural barriers of stigma and poverty still affect adherence. The desire for conformity with peers during adolescence, and a fear of stigmatization, greatly affects treatment adherence. Antiretroviral treatment is a daily reminder of being HIV-positive, and drug fatigue can result in adolescents stopping the regimen.

HIV places multiple stressors on the life of the adolescent, including side-effects from medication, chronic illness, real or perceived stigma, and frequently the death of family members. Young people living with HIV may struggle to achieve mental health. North American research has described high rates of mental disorders among HIV infected adolescents, although it remains unclear whether these problems are associated with the virus itself or other environmental factors (Scharko, 2009).

HIV positive adolescents are also challenged by quite a number of diseases and infections. Skin disease is one of the most common manifestations of HIV infection, and adolescents are affected disproportionately. In a series of 301 young adults admitted to hospital in Harare, those with dermatological abnormalities were 37 times more likely to have HIV infection; furthermore, 70% of HIV-infected adolescents had two or more skin manifestations, a higher proportion than that reported in studies of HIV-infected younger children and adults (Love, Ferrand, Morris et al, 2010). HIV-infected adolescents typically report a history of non-specific recurrent rashes occurring throughout childhood. Common manifestations include papular pruritic eruption, angular cheilitis, molluscum contagiosum, herpes zoster, and common warts (*verruca vulgaris*).

Side effects of ARVs are other challenges that HIV positive adolescents face. In their 2013 guidelines for treatment of HIV, WHO recommend earlier initiation of antiretroviral treatment compared with previous guidelines. Antiretroviral treatment is recommended up to

5 years of age, regardless of clinical or immunological stage of disease; however, in older children, adolescents, and adults, antiretroviral treatment is deferred until the patient develops WHO stage 3 or 4 HIV disease or the CD4 count drops below 500 cells per μL . Unlike adults, children are infected at a period when the immune system is immature. Compared with adult patients, HIV-driven chronic immune activation in children can lead to premature ageing of the immune system and cause more adverse outcomes on immune health. Delayed treatment also increases the risk of development and progression of end-organ complications in addition to compromising growth potential (Gspaner, Weigel, Davies et al, 2012). Although earlier access to HIV treatment might help to prevent these complications, antiretroviral treatment itself can lead to side-effects, such as lipodystrophy, hyperlipidaemia, and insulin resistance. Use of tenofovir is likely to rise now it is available as a fixed-drug combination for once-daily dosing. The potential risk of tenofovir- related renal and bone toxic effects have been highlighted as a concern by WHO, and recommendations for monitoring of children and prepubertal adolescents receiving tenofovir have been developed (WHO, 2013).

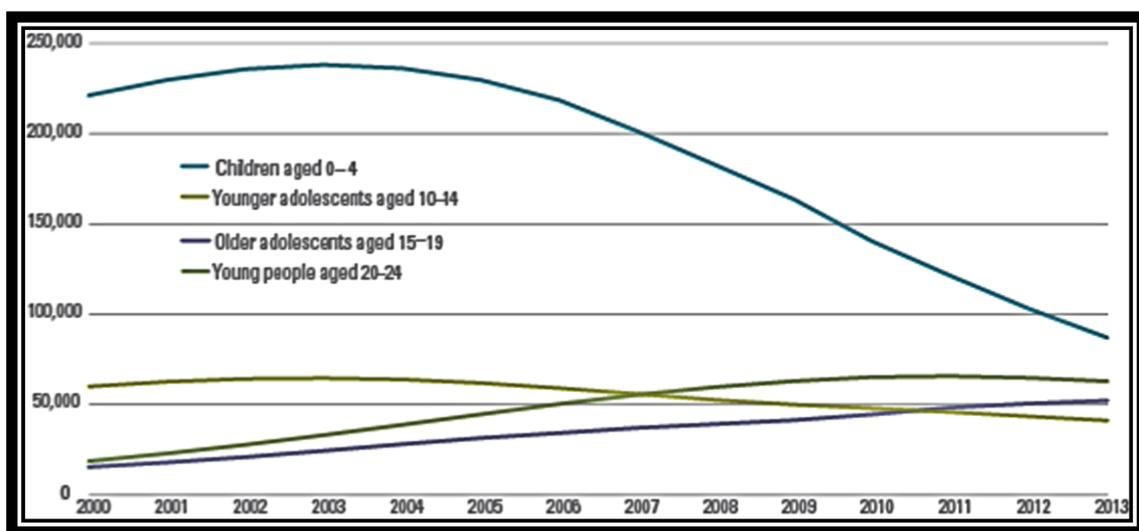
2.7 Addressing the needs of HIV positive Adolescents

A number of approaches have been employed in trying to deal with the challenges of HIV positive adolescents which ranges from prevention, treatment, care and support. To prevent the spread of new infections, adolescents and young people need accurate and relevant information about HIV, along with a safe environment in which they can talk openly about risk behaviour. This must be accompanied by access to voluntary counselling and testing, HIV education in schools, and the prevention of other sexually transmitted infections.

Greater emphasis must also be placed on reaching adolescent boys and girls with HIV preventive care and treatment programmes. Emerging evidence suggests that young people

living with HIV, especially adolescents are less likely than others to receive health care that can keep them healthy and alive. According to UNAIDS (2013) in fact, all other age groups except adolescents experienced a nearly 40 per cent decline in AIDS-related deaths between 2005 and 2013, while adolescents were the only age group in which AIDS-related deaths have not declined. AIDS-related deaths have declined in younger children and adults, but not among adolescents.

Figure 2: HIV and AIDS 2013 Estimates



Source, UNAIDS, 2013 HIV and AIDS estimates.

Estimated number of AIDS-related deaths among children (ages 0–14), younger adolescents (ages 10–14), older adolescents (ages 15–19) and young people (ages 20–24), 2000–2013 (aged 20–24), 2000–2012

Brown et al. (2000) 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.

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. A number of approaches are being employed by Organizations that deal with HIV positive adolescents such as the Bethany Project, Africaid, UNICEF and a few to mention. 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.

Africaid a non-governmental organization operating in Zimbabwe has got a Zvandiri (As I am) Model which seeks to enhance the right to prevention, treatment, care and support of young people living positively.

2.7.1 The Zvandiri Model

The Africaid Zvandiri Model comprises three components which are the community support groups, Training, Community Adolescent Treatment Supporters (CATS) and the Zvandiri House Training and Support Centre.

The Zvandiri Community Support Groups have been operating in 17 communities across Harare and Chitungwiza every month since 2005. They were established with the children, their families, clinics and communities and in particular, the support of the National AIDS Council in Harare Province. On average, 500 children, adolescents and young people attend the groups each month. The children and young adolescents who founded the groups back in 2004 are now leading the groups with support from an adult mentor, or have grown up and ‘graduated out’ of the Programme as they head off to employment, university and families of their own. The Zvandiri support groups provide a constant forum in the lives of the children where they can share, learn, feel loved and supported and have fun each month. Children are referred by clinics, hospitals, schools, churches, families and communities, once they have been told they are living with HIV. These groups are the ‘core’ of the Programme and through skilled, structured training, counseling and a lot of fun; children learn how to cope with the impact of their HIV status.

The Community Adolescent Treatment Supporters (CATS) have been trained and mentored since 2009 to provide community based adherence monitoring and counseling for their HIV positive peers. A team of 20 HIV positive adolescents provide daily support for their HIV positive peers and this has proved to be an extremely powerful approach for supporting children and adolescents with their daily, lifelong medication. It is also an opportunity for the adolescents to develop counseling skills and experience of which five of the original team have now moved on to further education including nursing, dental nursing and social work. The CATS are the foundation of the Zvandiri model. They really are setting the standard for the provision of appropriate, accessible, sustainable prevention, treatment, care and support services. Working within their own communities, they are creating a safety net with which their HIV peers can be supported through HIV testing and counseling, disclosure, starting treatment on ARVs, and difficulties with adherence, stigma and discrimination and

relationship challenges. They are doing phenomenal work and strengthening the capacity of local clinics

The Zvandiri House Training and Support Centre is a drop-in Centre where HIV positive children, adolescents, young people and their caregivers come for information, counseling, clinical assessments and sexual reproductive health services. Life skills training programmes are run here for children and adolescents from across Harare and young people come to use the library and IT lab where they are trained by their peers in IT skills. It is a very busy place with each room being filled with young people running their own training workshops, counseling sessions, IT training, creative arts programmes and team meetings.

Life skills training programmes are run for children and adolescents with the aim of assisting them to develop the knowledge, skills and confidence to cope with their HIV status and to live happy, health, fulfilled lives. Training programmes are also held for caregivers, health workers, teachers, churches, community members and other organizations. This work is planned and delivered by HIV positive children and adolescents themselves, and using a variety of media which they themselves have produced, they are striving to strengthen people's understanding and responses to the needs of HIV positive children and adolescents.

2.8 Policies and Frameworks in place for HIV positive Adolescents

2.8.1 WHO 2013 Guidance for HIV testing and counselling and care for adolescents living with HIV.

In November 2013, WHO issued HIV and adolescents: Guidance for HIV testing and counselling and care for adolescents living with HIV. The first ever guideline addressing the specific needs of adolescents living with HIV. It recommends that governments review their policies on consent to services in order to make it easier for adolescents to obtain HIV testing

without consent from their parents. The publication also provides guidance on how health services can improve the quality of care and social support for adolescents living with HIV.

The guidelines provide recommendations and expert suggestions, mainly for policy makers and national programme managers on prioritizing, planning and providing HIV testing, counselling and care services for adolescents. Designed to be used with the recent WHO consolidated antiretroviral guidelines, these new guidelines provide complimentary recommendations and guidance to support better provision of services to help adolescents remain in care and adhere to treatment. The guidelines were developed based on scientific evidence, community consultations with adolescents and health workers, field experience of health workers and expert opinion. WHO led the development of these guidelines in collaboration with the United Nations Children's Fund (UNICEF), the Global Network of People Living with HIV (GNP+), the United Nations Educational, Scientific and Cultural Organization (UNESCO), and the United Nations Population Fund (UNFPA).

One approach that has found particular success is provision of HIV treatment and care with additional support specifically for adolescents. A recent study in Zimbabwe, published in the journal AIDS, found that 1776 youths who received treatment in such a programme were no more likely to die from HIV-associated causes than adults, contrary to the overall trend in Southern Africa and worldwide. Young people responding to the WHO survey made it clear that being among their peers in a health care setting and interacting with health workers who understand the unique quandaries they face makes all the difference to them.

2.8.2 Zimbabwe National HIV and AIDS Strategic Plan (ZNASP)

The Zimbabwe National HIV and AIDS Response Strategic Plan (ZNASP II) – 2011 to 2015 guides all work on HIV and AIDS in the country including that of adolescents. In this

document, four impact areas for Zimbabwe's national response to HIV and AIDS are identified and targets to be attained by 2015 (UNAIDS, 2013) set as follows:

- i. HIV incidence among adults is reduced by 50% from 0.85% (48,168) in 2009 to 0.435% (24,084) by 2015
- ii. HIV incidence among children from 30% in 2010 to less than 5% by 2015
- iii. HIV and AIDS mortality rate is reduced by 38% from 71,299 among adults and 13,393 among children in 2010 to 44,025 (adults) and 8,304 (children) by 2015, and;
- iv. National multi-sector response to the epidemic improved from 6.2 in 2010 to 9.0 by 2015.

There are four thematic areas in the response against HIV and AIDS in Zimbabwe as enshrined in the ZNASP namely a). Prevention b.) Mitigation c). Treatment, care and support and d). Coordination. Adolescents with HIV are prominent under the Treatment, care and support thematic area where programs are implemented and coordinated through the National Coordinating board known as the National AIDS Council (NAC).

2.9 Critique of existing literature

All the discussed factors above ultimately affect an adolescent's access to HIV care and treatment adherence, undermining the success of antiretroviral regimens (Nyandiko et al, 2006 and Mellins et al, 2004). This research will fill in gaps in terms of coming up with other HIV support programs other than prevention which can be implemented in order to deal with the challenges of HIV positive adolescents.

The literature that has been reviewed indicates that many interventions to reduce sexual risk behaviors of HIV positive adolescents have been developed in high income settings, but they have had a scant applicability to African young people. To cover up that, this research will come up with practical solutions and interventions that are Adolescent driven and are applicable to Zvishavane Urban.

The reviewed literature also reflected that there is much focus on ensuring that HIV positive adolescents adhere to their treatment through the use of treatment buddies and capacity building programs such as training workshops on ART, stigma and discrimination. However the literature available doesn't speak more to disclosure challenges that HIV positive adolescents have. As HIV positive children reach the adolescence stage, they begin to have so many questions in themselves, like how do I disclose my status to my associates, girlfriend or boyfriend. They ask themselves questions on whether they are going to get married and bear HIV negative children. However the reviewed literature doesn't speak strongly on these issues of sexual and reproductive health rights (SRHR). This research is going to unearth disclosure related challenges and SRHR issues of these young people and inform advocacy work on policy formulation and implementation since the literature review also indicated that there are limited or no policies that specifically respond to the needs of HIV positive Adolescents.

2.10 Chapter Summary

The literature review has demonstrated how severe the impact of HIV on Adolescents is, especially on those that are already infected. An overview of HIV and AIDS has been discussed in depth from the global perspective down to local level. It is true as evidenced by the literature review that HIV positive adolescents have a mixed bag of challenges. However the fortunate part is that there is hope for the future for these young people as indicated by the

approaches being used by Governments and NGOs globally in trying to mitigate the impact of these challenges. This chapter is essential because it informs the reader about the impact of HIV and AIDS on Adolescents and also informs on the approaches in place to mitigate these challenges. The third chapter clearly explains the research methodology and design that is going to be employed in this study in order to harness data on the challenges and opportunities of HIV positive Adolescents in Zvishavane Urban.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

It is the purpose of this chapter to discuss the research design and methodology of this study. The chapter will describe the target population of this study, the sample size, data mining tools which include questionnaires, interviews, focus group discussions and observations. The chapter will also shed light on how data is going to be presented and analysed. The chapter is one of the critical chapters in this study because it gives direction on how the study is going to be carried out and thus influencing the kind of results that are going to be presented.

3.2 Research Methodology

It is the way of collecting data for research or inquiry project; the data may be collected either theoretically or practically. Methodology is a parameter arrangement for answering a problem, with specific mechanisms which include methods, techniques, tools, tasks and phases.

The research methodology that is to be employed in this study is a combination of both qualitative and quantitative research methods which is also referred to as the mixed method approach. The Mixed methods approach is an innovative approach which conglomerates qualitative and quantitative research designs in a single study (Bryman, 2008:1, Creswell 2003:1). It forms a combination of concepts from the two research designs. The advantage of using both methods in one study is that, the two will complement each other in achieving the best results. DFID (2005:1) argues that qualitative and quantitative designs are corresponding in that, the qualitative method captures feelings, testimonials and perceptions of the

respondents while the quantitative approach caters for the numerical inclinations and annotations. Glasow (2005) argues that the amalgamation of research designs is imperious for this study because; the plausible shortcomings and biases of using a single design method will be compensated by the other. Furthermore, the mixed method approach affords sufficient data which is demonstrative of both the topographical area and the subjects under study (Creswell, 2003 cited in Mutasa (2010:29).

3.3 Research Design

Gauch (2003) postulates that a research design is a plan, structure and strategy of investigation conceived so as to obtain answers to research questions and to control variance. Rocco (2011) argues that a research design is also defined as a framework for answering the research problem or question.

Due to time and financial constrains for analysing all the Adolescents in Zvishavane urban the study will employ a survey as a way of obtaining a true picture of the challenges and opportunities of HIV positive adolescents in Zvishavane urban area. Kraemer (1993) cited in (Glasow 2005:1) distinct a survey as a system of collecting data pertaining the physiognomies, sentiments, essentials, or activities of a large group of people. A survey makes use of a selected percentage of the population under study and the results can be universal for the whole population (Glasow 2005:1). Leedy and Omrond, (2005:148) postulates that, surveys are excellent vehicles that can be employed by researchers in quantifying attitudes and sensitivities predominant in large populations. The advantage of engaging a survey is that, it requires little investment to develop and to administer. A group of HIV positive and negative Adolescents and caregivers are going to be selected for the survey sample. The selection criteria will be random so that every respondent has an equal chance of being selected (Glasow 2005:1).

3.4 Population

All research questions address issues that are of great relevance to important groups of individuals known as a research population. According to Sullivan (2005) a population in research, is a group of individuals, persons, objects, or items from which samples are taken for measurement for example a population of presidents or professors, books or students. In this study, the target population refers to HIV positive adolescents that have disclosed their status, HIV negative adolescents, caregivers of both HIV positive and HIV negative adolescents, key informants which include the other Non-Governmental Organization, Faith Based Organizations, the Media, Child MP, Zvishavane Town Council, Government line Ministries which include the Ministry of Health and Child Care, Ministry of Primary and Secondary Education, Department of Social Services, Ministry of Youth, Ministry of Women affairs, Gender and Community Development and the National AIDS Council.

3.5 Sample Size

Webster (1985) contemplate that, a sample is a finite part of a statistical population whose properties are studied to gain information about the whole population. There is more accuracy in sampling than studying the whole population because it enables the researcher to have more control over the respondents. Sampling methods that are going to be employed in this research are simple random sampling and purposive sampling. A simple random sample is a subset of individuals that are randomly selected from a population. Purposive sampling represents a group of different non-probability sampling techniques. Also known as judgmental, selective or subjective sampling, purposive sampling relies on the judgement of the researcher when it comes to selecting the units that are to be studied. According to the National AIDS Council Zvishavane District there are 644 (308 boys and 336 girls) young people infected by HIV in Zvishavane Urban of which 205 are Adolescents, of the 205

Adolescents 47% of that number have disclosed their status. The study population shall comprise 90 respondents (55 adolescents and 35 adults) and they shall be drawn from Zvishavane Urban. The assumption being made by the study is that these could provide better insights into some of the challenges and opportunities for HIV positive adolescents. The population frame and size can be best summarized by table 1 below:

Table 1: Study population frame and size

Study Population: 90 respondents (55 adolescents and 35 adults)			
Study Population by type	Target	Total	Data Collection Method
HIV positive adolescents that have disclosed.	35 that have disclosed	35	35 Questionnaires and 6 interviews
HIV negative adolescents	12 negative adolescents	12	Focus group discussion
HIV positive caregivers	15 caregivers of those that have disclosed	15	Focus group discussion
Non HIV positive caregivers	8 caregivers on non HIV positive	8	Focus group discussion
Key Informants	Ministry of Health	2	Face to face interviews
	Ministry of Education	2	Face to face interviews
	Department of Social Services	2	Face to face interviews
	Non-Governmental Organizations	5	Face to face interviews
	National AIDS Council	1	Face to face interviews
	Faith Based Organizations	2	Face to face interviews
	Ministry of Youth	1	Face to face interviews
	Ministry of Gender	1	Face to face interviews
	Media	2	Face to face interviews
	Zvishavane Town Council Chairperson	1	Face to face interviews
	Child MP	1	Face to face interviews
Total		90	

3.6 Data Collection Tools

Hoffman (2003) defines research gathering tools as instruments that are used to mine or collect the required data to solve a research problem. The tools to be used for data collection in this study are interviews, questionnaires, observations and focus group discussions. Mouton (2001:100) supports the use of these data collection tools when he argues that, measuring instruments in human sciences refer to; questionnaires, interviewing schedules, observation schedules as well as psychological schedules.

a. Questionnaire

A questionnaire is a way of stimulating the feelings, beliefs, experiences, perceptions, or attitudes of some sample of individuals. The questionnaire is most frequently a very concise, pre-planned set of questions designed to yield specific information to meet a particular need for research information about a pertinent topic. Leedy and Omrond (2005:149) support employing questionnaires in research as they argue that, a questionnaire is a mutual domicile instrument for observing data beyond the observer. According to Hofstee (2006) questionnaires bring confidentiality to respondents and can be sent to more people in order to raise assurance in the sample. It is also the advantage of questionnaires that they can be sent to respondents who are a distant from the investigator in order to deliver the required data. Glasow (2005) alludes that a questionnaire shelters extensive range of issues, it allows contact to what the respondent, discerns, ponders, does and likes/dislikes regarding the topic under study. Additionally apart from jacketing a wider range of issues and offering a consistent and uniform measure of all respondents, the questionnaire offers guarantee for privacy.

The questionnaire that will be employed in this study will consist of both closed and open ended questions. Closed ended questions have been described by Glasow (2005:1) as

multiple choice or rating scales. Furthermore, closed ended questions are easy and less time consuming for respondents to answer. A number of open ended questions, sometimes called fill in the blank questions will also be employed. The open ended questions are necessary because they give room for comments and insights that are unforeseeable. They also provide richer and more descriptive facts as compared to closed ended questions.

In coming up or designing the questionnaire, certain guidelines listed by Cox (1996) cited are going to be considered and these include; warranting the use of diminutive and simple sentence structures instead of using unusual or bewildering words, expressions or phrases and avoiding questions that make respondents feel uneasy to answer. The questionnaires will be hand delivered to the respondents and will be collected soon after being completed. Only HIV positive adolescents are going to be reached by this tool.

b. Interviews

Knight (1999) argues that an interview is a direct face-to-face attempt to obtain reliable and valid measures in the form of verbal responses from one or more respondents. The advantages of interviews include, they permit the interviewer to clarify questions where they do not understand, they can be employed when also interviewing young children and the illiterate, they also permit the informants to answer in any manner they see fit, they allow the interviewer to observe verbal and non-verbal behaviour of the respondents, they are also a means of obtaining personal information, attitudes, perceptions, and beliefs, they also minimise nervousness so that potentially intimidating and sensitive issues and topics can be studied. However interviews have got their disadvantages which are that unstructured interviews often yield data which maybe too difficult to recapitulate or evaluate but the weaknesses of the interviews will then be addressed by other tools. Key informants and HIV positive adolescents are going to be reached by this tool.

c. Focus Group Discussions (FGDs)

Robson 1993 argues that focus group discussion (FGD) is a swift assessment, semi-structured data collecting system in which a purposively selected set of participants gather to discuss issues and concerns based on a list of key themes drawn up by the researcher. This qualitative method is very efficient because it provides a fast way to learn from a targeted group of people and also able to retrieve information easily. Caregivers of HIV positive Adolescents, caregivers of non HIV positive adolescents and non HIV positive adolescents are going to be reached through this tool.

d. Observations

The researcher will get involved in actual viewing of activities as they happen. The strong point of observations are that it is probable to have an understanding of the whole circumstance of the behaviour which is being investigated; if the period of investigation or assessment is long enough, all the aspects of a society or culture of a small community can be studied. Toolbox (1996) argues that field observations encompass undeviating observation and systematic gathering of what is transpiring all over the place. To authenticate the responses obtained from the questionnaires, interviews and focus group discussions, observations are going to serve that purpose. This method of data gathering will be used both officially with people knowing and sometimes with the people unaware that they are being examined or observed. This is necessary and critical because people normally have a habit of behaving differently if someone is watching their movements or actions. It is imperative to note that the researcher chose to employ four data mining tools in order to ensure that high volumes of data will be collected. The tools employed are going to complement one another so that the research findings are holistic.

3.7 Data Presentation and Analysis

Data analysis is defined as the process of examining, reviewing, cleaning and transmuting data into useful information for making conclusions and suggesting recommendations. In this study, both numerical which is referred to as quantitative and descriptive also referred as qualitative ways of construing and analysing data will be employed because of their mixed method approach. Basing on the arguments of Rubin and Rubin (1995) all data that has got one similar theme will be clustered into one classification and an evaluation of the data classes will be performed to determine connections between themes. Computer soft-ware that will be utilised includes Microsoft office excel and Microsoft word. Excel sheets will be used to code and analyse all the data that will be gathered. The results from the excel sheet will be pasted to a word document where conclusions are going to be drawn and recommendations made.

Some of the findings will be presented through tabulations, pie-charts, graphs and percentages for easy understanding. Graphs tell a story visually and this is supported by Crossman (2013), he further argues that they help the reader to easily comprehend and appreciate without querying or worrying him/her with the technical details behind the numbers. Allowance for adjustments, alterations and contingencies have been made for uncertainties or unforeseen matters to be met in carrying out this research.

3.8 Chapter Summary

To sum up, chapter three presents the research design and methodology which is critical in harnessing data on the challenges and opportunities of HIV positive Adolescents in Zvishavane Urban. This chapter is critical because it gave direction on how the research is going to be conducted. The fourth chapter informs the reader about the key findings and results of this study.

CHAPTER 4

PRESENTATION, INTERPRETATION AND ANALYSIS OF FINDINGS

4.1 Introduction

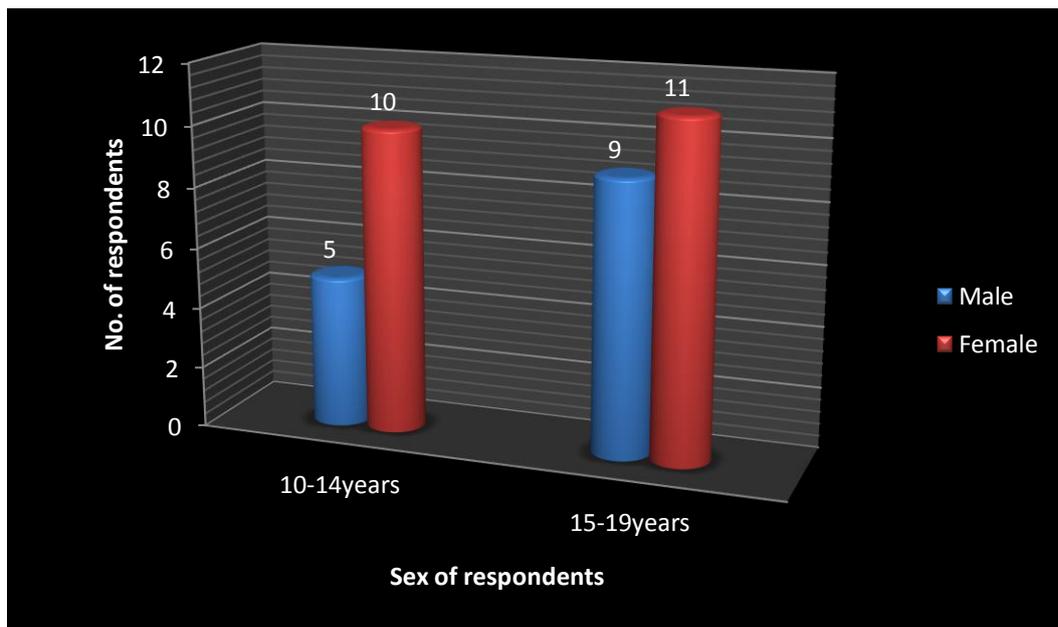
This chapter presents findings from the research, analyses and interprets them in relation to answering the research question and objectives of the study. The main thrust of this study was to analyse the challenges and opportunities of HIV positive Adolescents in Zvishavane Urban. The findings of this study will be analysed and equated to literature and to other scholar's research results. The process of data collection was a success since almost all the data needed for this research was obtained as scheduled. The findings presented in this chapter are based on views of 20 key informants reached through face to face interviews of whom three quarters were from Government ministries, FGDs with 12 HIV negative Adolescents, 15 primary Caregivers of HIV positive Adolescents and 8 Caregivers of non-HIV positive Adolescents. Quantitative information in this chapter was analysed from questionnaires that were orally administered structured questionnaires with 35 HIV positive Adolescents.

A. Demographics and Vulnerability Assessment

4.2 Age and Sex of Respondents

The results from the study indicate that 42% of the respondents were aged between 10 to 14 years and 58% were between 15 to 19 years age ranges. More girls were interviewed than boys, this was because of the fact that girls opened up more than boys. A study conducted by NAC in 2013 argues that more women in Zimbabwe are disclosing their HIV status twice than men do. There are more female adolescents than male adolescents living with HIV in Zvishavane Urban and this also contributed to having more female adolescents being interviewed. Figure 3 below clear disaggregates the study population by age group and sex.

Figure 3: Distribution of respondents by age group and sex



4.3 Parental Status of respondents by sex

As shown in table 2 below 22,5% of the respondents had both parents alive, 28,5% were double orphans, 40% single orphans, 6% didn't know about their father's whereabouts and 3% didn't know about their mother's whereabouts and this means that they were not sure whether they were dead or alive. Further analysis revealed that 60% of double orphans were females while 40% were males. 57% of the single orphans were females and 43 % were males. 100% of those who didn't know whether their mother was alive or not were females. Parental status has an implication on the quality of care provided to children as argued by NAP for OVC (2010), children with both parents alive receive quality or maximum care and support whilst those with one parent alive or both dead are at high risk of a compromised psychosocial wellbeing. There is a strong relationship between quality of care and parental status of a child. HIV positive Adolescents with both parents alive were found to be better off than those with only one parent or without any parent alive. The study also reflected that female adolescents were more vulnerable than male adolescents in Zvishavane Urban.

Table 2: Distribution of respondents by parental status and sex

Status	Male	Female	Total	Percentage
Both Parents Alive	3	5	8	22,5%
Double Orphan	4	6	10	28,5%
Single Orphan	6	8	14	40%
Father where abouts not known	1	1	2	6%
Mother where abouts not known	0	1	1	3%
Total	14	21	35	100%

4.4 Level of Education of respondents

The results from the study as indicated that 23,9% of the respondents were at primary school and 76,1% were either at secondary school or had reached secondary school education. Though statistical significance was weak, further analysis done through interviews with HIV positive Adolescents revealed that 22% of those at secondary level had written their O levels and didn't pass with five O level subjects and above. Also further analysis through interviews revealed that 25% of the Adolescents at primary level were not very illiterate since they struggled to write down their names correctly and they couldn't construct a single sentence with a vowel. No HIV positive adolescent reported that he or she was attending any tertiary education.

According to Ndlovu (2011) Education is an essential capacity indicator for dealing with stressors in life, it is considered to represent enhanced capacity because it enables people to make logical decisions about life, it facilitates access to information and technology and it makes people able to easily understand new knowledge and skills to improve their livelihoods. As such, with the high literacy level that was noted in this study, HIV positive adolescents have the capacity to deal with their challenges. However having such capacity doesn't automatically translate into practice.

4.5 Household Size and Age of household head

The study as indicated by figure 4 and 5 below found out that 68% of the respondents had a household size of 3 to 5 people, 29% reported that they had 6 to 10 people whilst 3% reported that they had 11 and above people in their households. In terms of the age of the household head, 14% of the respondents were being cared for by head of household between the age ranges of 40 to 49 years, whilst 52% were being cared by head of household aged between the age ranges 50 to 64 years and 34% by those aged 65 years and above. According to World Bank (2012) people who are between the age ranges 18 to 55 are more economically productive. They have the capacity to work, gain new knowledge and skills to deal with any vulnerabilities and risks as compared to those below 18 or above 55 years. Skirbekk (2003) supports this idea by saying that, with old age comes less production, decreased cognition abilities and a slower pace of learning new skills and knowledge. As such, as reflected by the study, more than 55% of the respondents were being cared for by head of households aged 55 years and above thus this exposes them to social and economic vulnerabilities. On top of that the household size also being on average 5 people.

Figure 4: Distribution of respondents by Household size

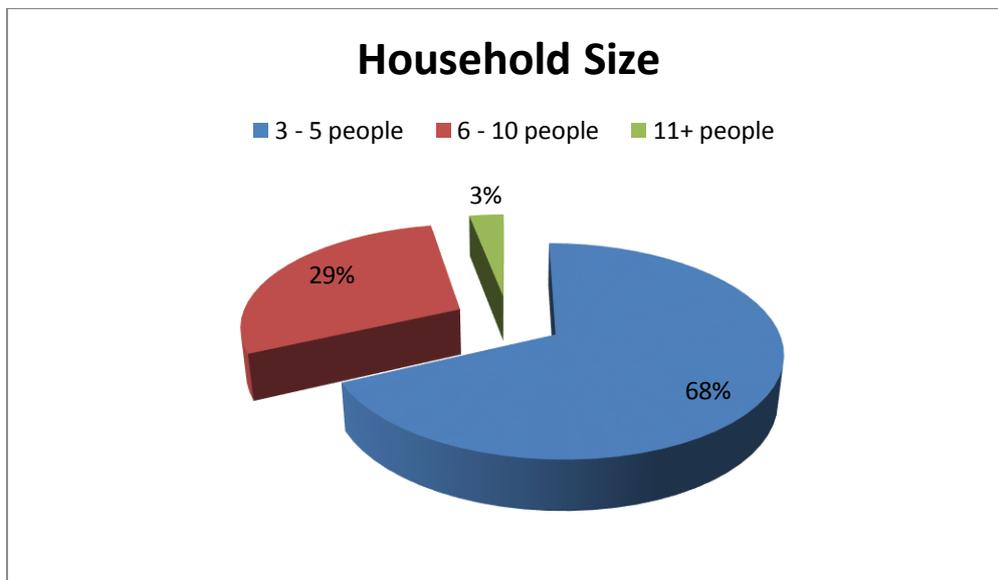
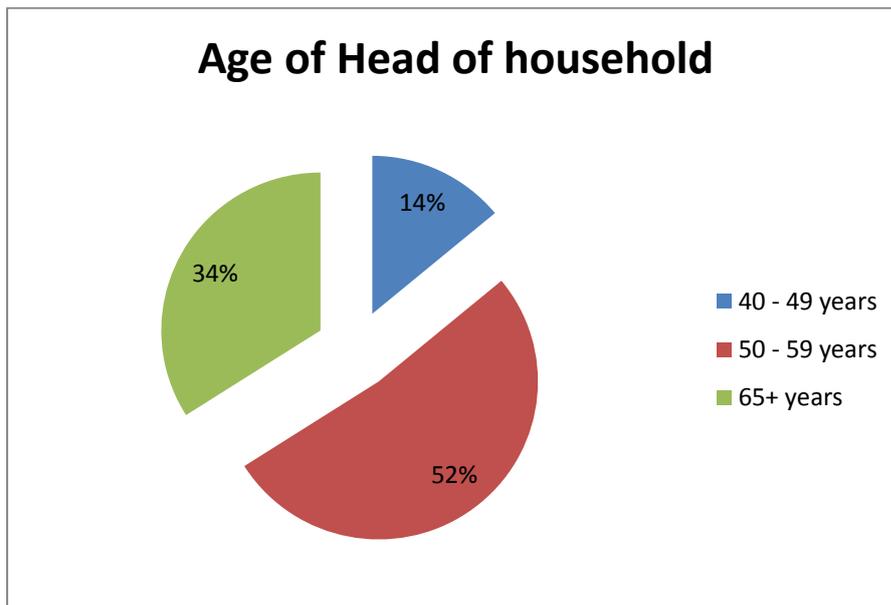


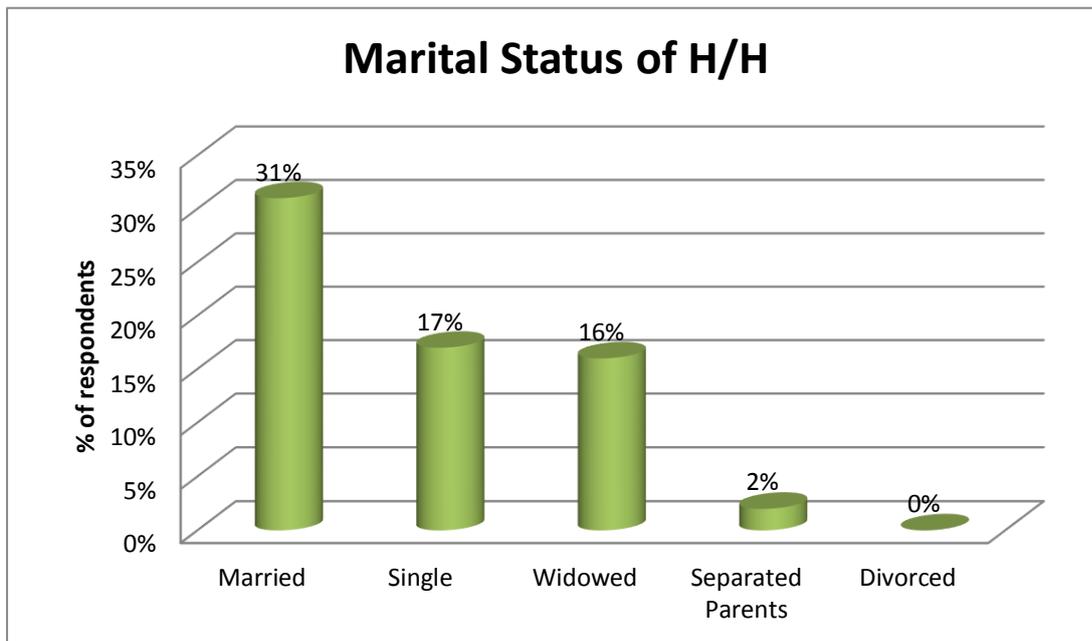
Figure 5: Distribution of respondents by age of head of household



4.6 Marital Status of respondent`s head of household

Results from the study indicated that 31% of the respondents were staying with married head of households, 17% with single head of households, 46% with widowed head of households and 6% with head of households who had separated with their spouses. Of all the respondents` head of households, 76% were women who were either a grandmother, aunt, biological mother or a community caregiver/volunteer to the respondent. No respondent was found to be staying with a divorced parent/guardian. Oxfam (2013) argues that women are heavily burdened with unpaid care work of caring for children, cooking for them, taking them to school and ensuring their whole wellbeing. The study found out something interesting that there was a relationship between the two variables of head of household which is marital status and employment status of which most women are in the informal sector as will be discussed in 4.8. Marital status has a bearing on the quality of care that HIV positive adolescents receive. Figure 6 below shows the marital status of respondents` head of household.

Figure 7: Distribution of respondents by marital status of head of household



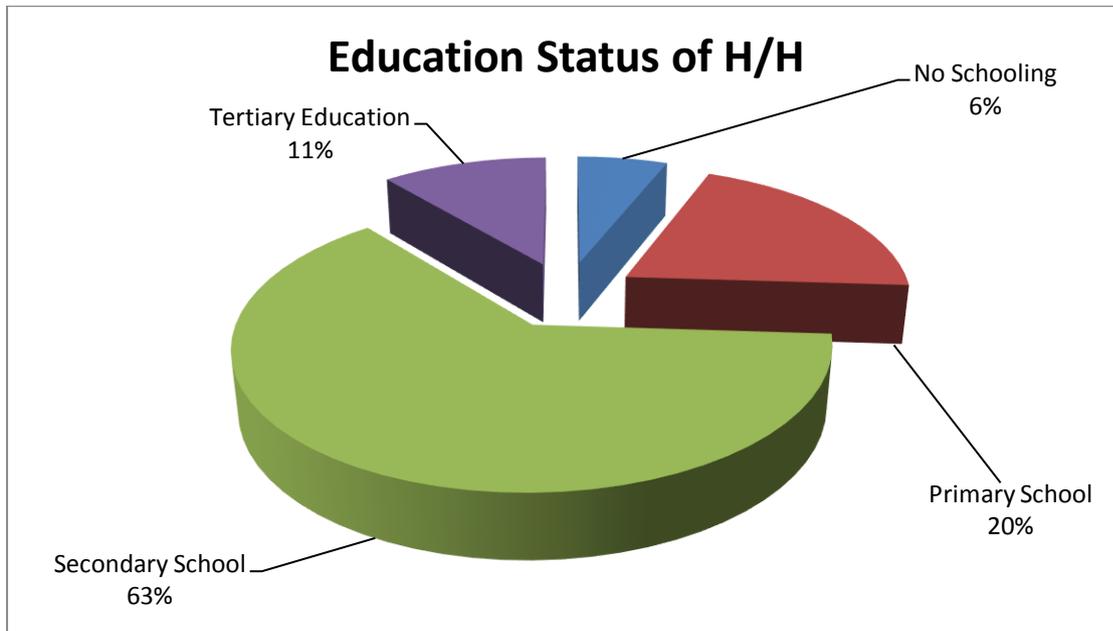
4.7 Highest level of education of respondent`s head of household

As indicated by the pie chart on figure 7 below, 20% of head of households reached primary school, 63% secondary level and 11% tertiary education. 6% had never been in any school setting which speaks a lot to literacy levels of this category of head of households. As alluded earlier by Ndlovu (2011) education is an essential capacity indicator for dealing with stressors in life, it is considered to represent enhanced capacity because it enables people to make logical decisions about life, it facilitates access to information and technology and it makes people able to easily understand new knowledge and skills to improve their livelihoods.

The study found out that a total of 94% head of households were literate and 6% were not but however literacy levels didn't automatically spoke to the quality of care provided to respondents in terms of taking their medication. Though literacy levels of caregivers were high, administered interviews and focus group discussions revealed that respondents had

problems in adhering to their medication thus leading to defaulting. However high literacy levels of caregivers can be an entry point of ensuring adherence to antiretroviral treatment by respondents.

Figure 7: Distribution of respondents by education status of head of household



4.8 Employment status of head of household

In terms of employment status of respondent's head of household, 11,4% of respondent's head of households were formally employed majority being those working for local Mining Companies such as Mimosa and Shabanie Mine. 80,6% of respondent's head of household were self-employed in the informal sector. Self-employment was in the form of cross border trading, weaving of baskets, vending, welding and piece jobs. 8% of head of households were not involved in any type of employment but it was reported that they had other means of survival such as receiving aid from family members, relatives and friends. Interviews and focus group discussions administered with HIV positive adolescents revealed that more female respondents were staying with a head of household who was self-employed as

compared to their male counterpart thus increasing the girl child`s vulnerability to shocks and stressors.

Cutter et al (2003) argues that without employment, one`s level of vulnerability is high, unemployment exacerbates dependency on second parties such as family and community members and locally based resource extraction sources. He further argues that unemployment leads to self-employment which in most times is not sustainable and dependable hence affecting people`s entitlements and income. The study therefore reveals that HIV positive Adolescents were at risk since most of their caregivers were found to be self-employed.

Employment status has got a relationship with household size and marital status. The study found out that 46% of respondents` caregivers were widowed and 76% of respondents` caregivers were women. The above information vis-à-vis the employment status of caregivers depicts a bad picture for HIV positive Adolescents. The study found out that on average each household had 5 dependents thus increasing the burden of care work on the part of caregivers and women being the majority of them. Since most of the caregivers were found to be self-employed, their burden was found to be high also.

B. HIV knowledge, practices and attitudes

4.9 HIV Knowledge

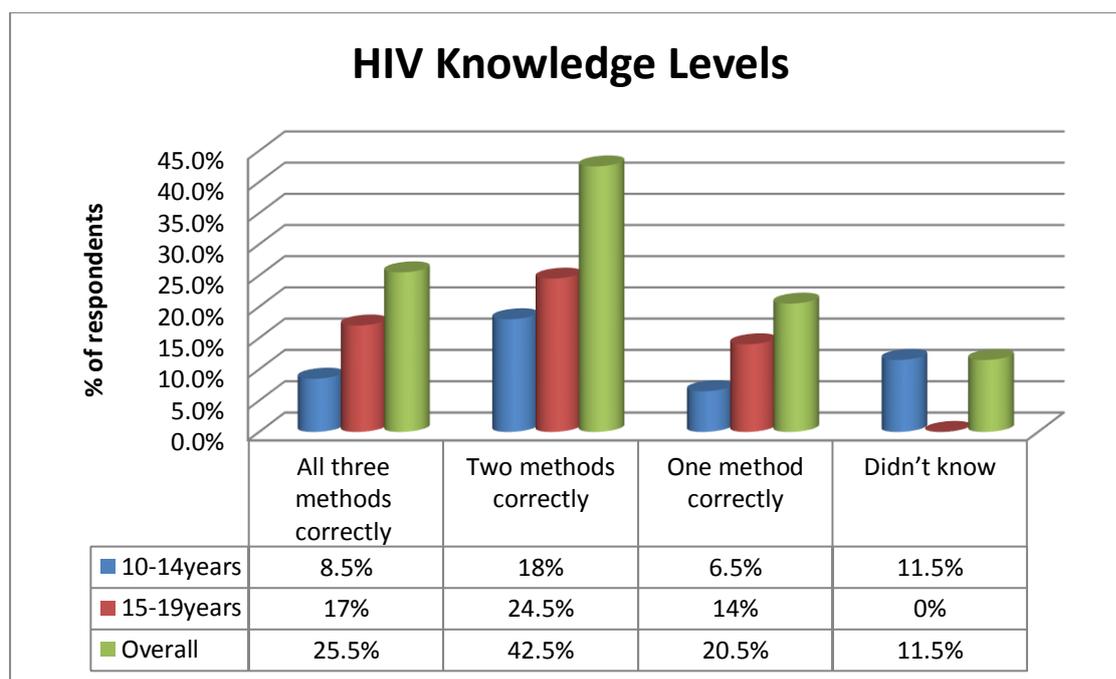
The study revealed that 63% of the respondents managed to define HIV and AIDS but only 22% of those managed to accurately define HIV and AIDS. 19% moderately defined HIV and AIDS, 11% didn`t have an idea of what HIV and AIDS is and 8% didn`t respond to the question. An observation made was that most respondents had basic information on HIV and AIDS, which was good but however couldn`t clearly distinguish the difference between the two.

Respondents who were able to identify at least three methods of HIV transmission and/or three methods of HIV prevention were considered to possess comprehensive knowledge of either or both while those who identified two methods possessed “moderate” knowledge, and those who mentioned one method were considered to have “limited” knowledge. Respondents who failed to identify at least one HIV prevention or transmission method were said to have no knowledge.

Figure 8 shows that 25,5% of the respondents were able to identify at least three correct methods of HIV transmission, while 42,5% identified only two correct methods of HIV prevention, 20,5% identified only one and 11,5% did not know any correct HIV transmission method. Disaggregated by age, young people aged 15 to 19 as expected demonstrated better knowledge than any other group with the younger age (10-14 years) demonstrating the least knowledge thus showing a significant statistical relationship between age and knowledge level.

Key informants interviewed in this study unanimously attributed low levels of HIV and AIDS knowledge among the 10–14 years age group to the government’s slow pace in formalizing and developing syllabi for the uniform and intensive teaching of HIV and AIDS in primary and secondary schools. However, it was the shared experience of NGOs which are Bethany Project, Midlands AIDS Caring Organization (MACO) and Midlands AIDS Service Organization (MASO) that the process for NGOs to get government clearance to take HIV and AIDS education to primary and secondary schools was challenging, if not discouraging. There was no significant statistical difference on HIV transmission knowledge between males and females.

Figure 8: HIV prevention and transmission knowledge among HIV positive respondents



4.10 Sexual practices and attitudes among HIV positive Adolescents

The study used an analysis of respondents' inclination to use condoms as both a measure of sexual practices and a proxy indicator of their readiness to disclose one's HIV status. The study revealed that 4 out of 35 HIV positive respondents (11,4%), had had sex before; Table 3 below shows the pattern and it is concluded that sexual practices is significantly related to age.

Table 3: Sexual experience of HIV positive respondents by age

Age of respondent	Status related to sexual experience					
	N ^o of that had sex before			N ^o of that had no sex before		
	Male	Female	Total	Male	Female	Total
10 – 14 years	0	1	1 (2,8%)	5	9	14 (40%)
15 – 19 years	2	1	3 (8,7)	7	10	17 (48,5%)
Totals	2	2	4 (11,4%)	12	19	31 (88,5%)

The results from the table above reflect that adolescents of the 21st century are engaging into sexual encounters at a very tender age than it was before. Focus group discussions conducted with both HIV positive and non HIV positive adolescents revealed that young people in Zvishavane urban are having their first sexual encounter as early as 12 years. This is due to the fact that there are very few youth friendly centres in Zvishavane hence young people end up resorting into sexual intercourse as a way of occupying themselves. It was also noted that there are a lot of minerals in the district hence a lot of gold panners come in search of gold. Resultantly young girls engage into promiscuous activities with these gold panners. FGDs with caregivers of HIV positive and non HIV positive adolescents also supported the above ideas also citing reasons that it has become normal for young people today to engage into sexual relationships.

Coupled with that, the Zimbabwean traditional culture is said to be treating any discussion of sex-related subjects as taboo, especially if involving parents and their children or in-laws, discussing sexual and reproductive health matters can be very challenging to some people hence young people end up indulging into sexual relationship because they are not well capacitated.

The study also revealed that condom usage among the sexually active was found to be irregular. Of the four HIV positive respondents who reported to have had sexual intercourse, 3 of them (75%) reported that they did not use one during their last sexual encounters. These three who did not use a condom for their last sexual encounter, include two females and one male. Failure to use a condom in a sexual encounter among Adolescents who knew their positive HIV status was treated in this study as a symptom of one's reluctance to disclose their status to a partner, and boys displayed that behaviour more than girls. These findings point to not only a high rate of unwillingness to indulge in protected sex among Adolescents living with HIV, which constitutes risky sexual behaviour, but also a low rate of willingness

to disclose a positive HIV status. When asked during face to face interviews, on disclosing their status to their partners, about 80% of HIV positive Adolescents indicated that they would not disclose their status which implies that they had greater fear of losing their intimate partners because of their status especially male Adolescents.

C. Impact of HIV on Adolescents

Adolescents have not been spared by HIV. Unlike adults, adolescents feel the impact of HIV more. Their challenges are complex and dynamic; they range from individual level to family level and from family level to societal level. The administered tools in this research analysed challenges of HIV positive in five areas that is at home, school, church, clinic and in the community.

4.11 HIV status disclosure

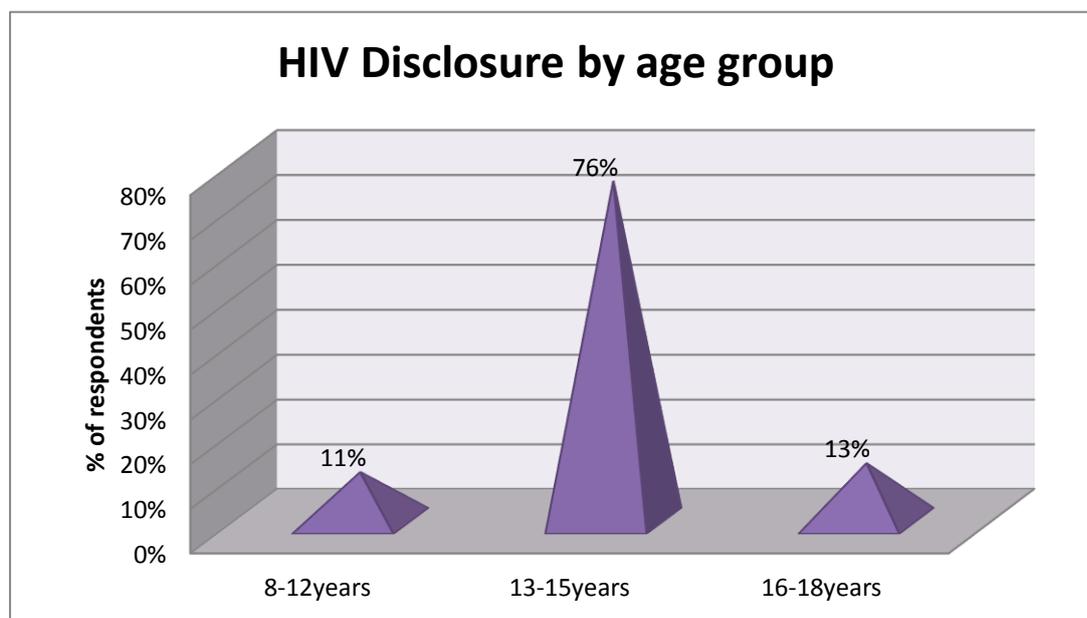
HIV status disclosure was found to be one of the biggest challenges HIV positive adolescents face and in this study it is analysed in two facets which are: caregiver disclosing to the adolescent and the adolescent disclosing to a peer or intimate partner. In terms of the caregiver disclosing to an adolescents, this was identified as a problem coming from home since it is the duty of the caregiver to disclose the HIV status according to the Ministry of Health and Child Care policy yet they were found to be incapacitated.

As indicated by figure 9 below, the study revealed that 11% of the respondents were informed of their HIV status when they were between the age ranges 8 to 12 years which is regarded as timely disclosure, 76% when they were between 13 to 15 years which is close to the timely disclosure definition and 13% when they were between 16 to 18 years which is late disclosure. These findings reflect that generally fewer respondents received timely disclosure; majority of them received late disclosure of their status. FGDs and Key informant interviews

reflected that Caregivers disclosed late the HIV status because they were afraid of causing psychological harm to the child, they were also afraid to be asked so many questions which they would not find answers and they were also found to be incapacitated in terms of the disclosure process. They noted that there were no simple disclosure literature/materials be they booklets which they could ride on in order to execute that process. 90% of the respondents felt bad after being told of their HIV status whilst 10% felt nothing. The study also revealed that 85% of the respondents were told of their status by a woman who was either the biological mother, grandmother or an aunt. This finding indicates that women are bearing the burden of care work as compared to their male counterparts.

It was noted through interviews with HIV positive adolescents that most of them had received partial disclosure not full disclosure which then left them with a number of unanswered questions in their minds. 25% of the respondents indicated that they were not formally told of their HIV status but they knew through, either accidental/unintentional disclosure, implicit/silent disclosure or secondary disclosure, or when they went for male circumcision. The lack of disclosure is against the World Health Organization HIV Testing and Counselling, Treatment and Care for Adolescents Living with HIV guidelines (November 2013) which recommend that young people should know their HIV status and their parents. Box 1 below is a story of Isabel (pseudo name) which clearly shows the impact of the unavailability of timely disclosure of HIV status as narrated by one the key informant from Bethany Project.

Figure 9: HIV disclosure of respondents by age group



Box 1: Isabel’s story showing the impact of late disclosure

The following is a story of Isabel (pseudo name) who received late disclosure.

Isabel is a 17 year old girl who resides in Mandava with her grandmother. She is a double orphan who finished her form four at Mandava High in 2014 but she didn't managed to score 5 O level subjects and above. Isabel is an adolescent who was born and is living with HIV. She only gets to know her HIV status accidentally when she fell pregnant in 2014. Isabel was taking her medication unknowingly; she was only told by her grandmother that she was taking treatment for Asthma. In 2014 her boyfriend John had a severe cough for about two weeks and he took some pain killers but it couldn't work. Both Isabel and John concluded that it was Asthma so Isabel took her ARV medication and gave it to her boyfriend. After a month Isabel fell pregnant and went to the hospital where it was also discovered that she was HIV positive and already on antiretroviral treatment. That's how Isabel came to know her HIV status and she was very bitter about her granny who had not disclosed to her in time. The clinic encouraged her to bring John who had impregnated her so that he may be tested as well. When this news came to John's ears, he quickly ran away and went to South Africa. John was initiated on antiretroviral treatment unknowingly by Isabel, at the moment he is in South Africa and no one knows what he is doing there, maybe he is HIV positive or not, there is high probability that he has infected someone or some other people there in South Africa. All this was caused by non-disclosure of HIV status by the caregiver.

Source: Bethany Project Key Informant (2015)

All the respondents indicated that disclosure should be done at a very early stage in relation to the stages of child development. It was noted that disclosure is a process not an event or a once of thing. Disclosure as indicated by the respondents should be done between age ranges 7 -13 years since it's a process. Interviews with key informants indicated that NGOs in the District in particular Bethany Project encourages the disclosure process to start at 7 years when a child can comprehend issues and also not later than 14 years. However the study

found out that majority of the respondents (76%) were told of their status when they were between the age ranges 13 – 15 years which is late disclosure according to the definition of disclosure.

The other facet of HIV status disclosure which poses a challenge to HIV positive adolescents was that of an adolescent disclosing to a friend or intimate partner. In this study this problem was taken as an individual challenge. 86% of the respondents indicated that they were not in a position to disclose their status to their friends and intimate partners. The reasons for not disclosing to a friend were that of stigma and discrimination and low self-esteem and confidence. The reason for not disclosing to an intimate partner was fear of losing that partner. The other reason leading to lack of disclosure by adolescents was that they were not capacitated to handle the process when telling a partner.

4.12 Stigma and Discrimination

Link and Phelan (2001) argues that stigma takes place when metamorphoses are labelled, interconnected to stereotypes that are negative, and people are branded as separate, such that it results into discrimination. Parker and Aggleton (2003) argue that HIV and AIDS stigma is a social and cultural phenomenon that is entrenched and embedded in social conditions. In their stigma framework, Parker and Aggleton argues that stigma forms part of a multifaceted social struggle used to generate and prolong social imbalances such that it is through understanding and acting on these social processes that the problem can be tackled.

The study revealed that stigma and discrimination is another biggest challenge HIV positive adolescents. Stigma and discrimination was found to be coming from the community (44%), church (18%), school (23%) and at home (15%) but much of it was coming from the community. Stigma came in form of social labelling and actions that hurt the respondents. 44% of the respondents revealed that in the community much of the stigma they face is in the

form of names such “chibetter nhasi” (you are only well today), “chimufiria” (inferior) and sometimes they were being shouted at by community members especially by other children saying “zidumbu rizere macotri” (a stomach full of contrimoxazole tablets).

Stigma and discrimination was also found to be rampant in churches were adolescents living with HIV reported that they are not given equal opportunities to participate on equal basis with others. 18% of the respondents revealed that stigma in the church also came in form of sermons that are delivered by Pastors and Church leaders during services. One respondent shared that she felt very bad when the Pastor was preaching about sin linking it to HIV positive people where he quoted the bible verse which says for the wages of sin is death. Focus group discussions with caregivers and HIV positive and non HIV positive Adolescents revealed that in many churches HIV is regarded a sin, if not a demon. Two interviewed key informants from the Zimbabwe Council of Churches (ZCC) and the Evangelical Fellowship of Zimbabwe (EFZ) revealed that about 80% of their churches have a component of HIV and AIDS. However further analysis through focus group discussions and interviews with other key informants indicated that HIV and AIDS is not a priority issue in many churches and in churches where it is spoken, only basics are discussed but real life issues are left out.

Stigma and discrimination was also found to be fecund in schools in the urban area and 18% of the respondents alluded to that. Stigma at school was found to be perpetuated heavily buy other students and partly by staff members (teachers). Students attach names, drawings on chalkboradand quotations to HIV positive adolescents such as “ARV”, “adhakwa nemapiritsi (he/she is drunk because of ARVs, a few to mention. Resultantly this reduces self-esteem and confidence of HIV positive adolescents therefore leading to poor performance in class. 8,6% of the respondents also revealed that they were forbidden by their teachers to participate in sporting activities and were ordered to clean the classrooms whilst others were doing sporting activities. This is against the child`s right to play as enshrined in the United Nations

Convention on the Right of the Child (UNCRC) and the African Charter on the Rights and Welfare of Children (ACRWC). The respondents further reported that teachers would discriminate them saying, “hamuite ma sports nekuti mungatifira” (you can’t participate in sporting activities because you may die in front of us). Also respondents pin pointed out that they also found it difficult to take their medication to school whenever they will be going for camping for some days in the event that they were participating in school activities such as music, traditional dance or sporting activities. All this was due to stigma and chances of poor drug adherence were high.

However FGDs with the key informants in the Ministry of Primary and Secondary Education revealed that the Ministry has an HIV and AIDS workplace policy which guides their work with people living with HIV including children. Despite having this policy in place, the study found out that having a policy in place doesn’t automatically translate into practice. However the study revealed that the Ministry was encouraging all parents and guardians with children who had any health related problem to let the school authority know about it so that the child is treated with dignity and given special attention if need be. 26% of the caregivers reached through focus group discussions revealed that there is such a provision in the Ministry they were using that.

The study revealed that at home stigma and discrimination was not very rampant but culminated through the calling of names either intentionally or unintentionally but mostly unintentionally. Caregivers would talk to neighbours and/or community members saying “mugwere wangu” (my sick child) and in that way it becomes a form of stigma and also in another

Box 2: A list of names given to HIV positive adolescents

- Chimufiria – an inferior someone
 - Cotri – an antibiotic pill
 - Mugwere wangu – my sick child
 - Akupengesa – crazy because of ARVs
 - Ari mubhazi – he/she is passing through
 - Moving grave
 - Go slow
 - Aku juicer – he/she is taking ARVs
-

way it then becomes accidental disclosure since the word “mugwere” in this 21st century is associated more with HIV positive people.

Through FGDs, the study went on to analyse the reasons for stigma and discrimination and it tried to analyse whether it was because of the lack of knowledge or it was because people have the knowledge but doesn't put it into practice. 80% of the respondents indicated that only two in every ten people stigmatise HIV positive adolescents because they have limited or don't have knowledge on HIV transmission and eight in every 10 people stigmatise knowingly. One HIV positive respondent indicated that school children have the information on HIV but they do not believe that HIV cannot be transmitted through playing together, eating together or sitting on the same bench. This interesting finding supports the notion that having information doesn't automatically translate into practice. Though the research indicated that the majority of people stigmatise HIV positive people knowingly, it also revealed that some are not informed consequently they need capacity building in terms of HIV knowledge and skills.

Stigma and discrimination has been described by WHO, UNICEF and UNAIDS (2013) as a silent killer to people living with HIV and AIDS because of its devastating consequences. Box number 3 clearly explains the effects of stigma and discrimination.

4.13 Limited or lack knowledge on HIV and SRHR

The study revealed that HIV positive adolescents have got challenges to access of information on HIV and AIDS and Sexual and Reproductive Health (SRH). The study revealed that 63% of the respondents managed to define HIV and AIDS but only 22% of those managed to accurately define HIV and AIDS. 19% moderately defined HIV and AIDS, 11% didn't have an idea of what HIV and AIDS is and 8% didn't respond to the question. An

observation made was that most respondents had basic information on HIV and AIDS, which was good but however couldn't clearly distinguish the difference between the two.

Interviews administered with HIV positive adolescents shows that they did not understand what HIV means especially those that were between the age ranges 10 – 12 years. Yes they had been disclosed of their status but they seem not understand what it means or what entails to be HIV positive. Focus group discussion with caregivers of HIV positive adolescents revealed that 85% of the caregivers had been asked so many questions by their adolescents regarding HIV transmission and prevention. One of the key informants from MACO alluded to the fact that young people born and living with HIV have got so many unanswered questions where they wonder whether they are going to be married or not, whether they are going to bear HIV negative babies or not and how they were going to disclose such.

The study revealed that 65% of the sexually active Adolescents were already on puberty stage and had received no information about it and this is a critical component of sexual and reproductive health as argued by the Zimbabwe National Family Planning Council (ZNFPC). NAP for OVC (2010) argues that HIV and AIDS destroyed the safety nets for young people and left them vulnerable especially in Africa. In the African context, it is the duty of the tetes (aunts), sekurus (grandfathers), mbuyas (grandmothers) and the uncles to teach young people about sexual related matters when they reached puberty stage. But this has since disappeared because of many reasons, HIV and AIDS being the biggest problem then also other issues like modernisation. HIV has destroyed the child's support systems and children are left with no one to deal with their sexual related matters. Also families have disgruntled due to issues like poverty, modernisation and migration. As such young people are left vulnerable with no one to attend to their psychosocial needs.

With the African culture, Zimbabwean traditional culture in particular is said to be treating any discussion of sex-related subjects as taboo, especially if involving parents and their children or in-laws, discussing sexual and reproductive health matters can be very challenging to some people hence young people end up indulging into sexual relationships without any knowledge and skills on how to prevent that. However 55% of the caregivers reached with FGDs indicated that they were talking to their adolescents about SRH issues nevertheless further analysis reflected that they only talk basic issues and they don't go deep to real information issues that affect HIV positive adolescents. Majority of the caregivers of HIV positive adolescents reached through FGDs indicated they were not capacitated themselves to address knowledge gaps which their adolescents had.

The problem of information gap was not only found to be perpetuated by caregivers only, but also by duty bearers which is the state. It was noted that there were no youth friendly centres where these young people can access information regarding HIV and AIDS and SRH which is going to be explained more in the next challenge identified.

4.14 Poor adherence to Antiretroviral Treatment (ART)

The study revealed that adherence to ART was an issue for HIV positive adolescents. Many factors were pin pointed as hindrances to drug adherence to ART. 24% of the respondents pointed out that they had a problem of food at home were they would only eat either one or two meals per day which is against the nutritional guidelines as laid down by the Ministry of Health and Child Care (MoHCC) resultantly this contributes to poor health of the adolescent.

Poor adherence was also perpetuated by limited family and community based support systems. The family and community units are important systems in the provision of care and support for the well-being of human beings. The study indicated that in general families and communities do not support people living with HIV to take their medication rather they

stigmatise them which sometimes end up leading them not to take their medication. It was found out that only 25% of the reached caregivers monitor their children when they took their medication which is an indicator that there was limited support from the family. Also because of the lack of disclosure to other family members, adolescents had difficulties in taking their medication properly whenever they were changed a caregiver. Another minor issue pointed out was child abuse in form of neglect where the caregiver doesn't care or check whether the child has taken his/her medication.

According to the Ministry of Health and Child Care key informant, the number of adolescent defaulters was increasing where they would receive an average of 4 to 5 defaulters per month. The other reason pinpointed by the Ministry was that caregivers and adolescents thought that one should first of all eat something before taking their ARVs however that was not the case. The Ministry pointed out that ARVs can be taken before eating even if there is no food at home or if food is not ready by the time of taking medication, one can take his/her medication so that he/she maintains his/her time for taking ARVs which is critical. 86% of caregivers alluded to the fact that they were not aware of that and would make their children wait for food even if it was time for them to take their medication resultantly contributing to poor adherence to ART.

Churches were found to be perpetuating poor drug adherence of HIV positive adolescents. Focus group discussions revealed that 2 in 10 churches in Zvishavane urban view HIV and AIDS as sin, rather a demon if not. The study found out that some of these churches forbade people of ART to take their ARVs citing reasons that they would pray for them and get healed. The informant from the Ministry of Health and Child Care pointed out that they were receiving cases of patients defaulting after stopping taking medication at the advice of Prophets and Apostles. Some churches which include the Johanne Marange Apostolic Church discouraged its congregants to go to any health centres to seek for medical help citing reasons

that it was useless since they can provide the healing at their church. Some Pentecostal churches were found to be classifying HIV as a demon hence there was no need for someone with HIV to take ARVs but to seek healing and prophetic guidance from the spiritual fathers and prophets. HIV positive adolescents who had their caregivers attending to such religious sects were also found to be trapped in that dilemma.

4.15 Unfriendly health delivery systems

The study found out that limited or unavailability of youth friendly centres in Zvishavane urban health centres was also a great challenge for HIV positive adolescents. The unavailability of such a facility culminated into stigma and discrimination, adolescents standing in long queues to collect their medication and also a reduction in health seeking behaviour of services by HIV positive adolescents. Respondents revealed that they took their medication at the health centres in the same queue with adults which then increases stigma and discrimination. About 95% of the sexually active adolescents indicated that there were not free to collect their monthly ARV supplies in the same queue with adults. Reasons being stigma and discrimination mostly and also fear that they would meet parents/guardians of their loved ones in that same queue which might then result in them losing an intimate partner. All the sexually active HIV positive adolescents pointed out that they required youth friendly corner in all health centres, where they can access services freely.

Through FGDs with non-HIV positive adolescents, the study also found out that all young people require a specialised facility of a youth friendly corner in all health centres in Zvishavane urban area. They cited that some young people were afraid to get tested for HIV or seek services for sexually transmitted infection (STIs) treatment because there was no privacy in the health centres and also the personnel in these institutions were not age appropriate and friendly to young people thus they find it difficult to share their problems

with them. Adolescents also revealed that, because of that, young people in Zvishavane were shunning health centres and would opt to go to traditional healers to seek STIs treatment popularly known in the area as “siki”.

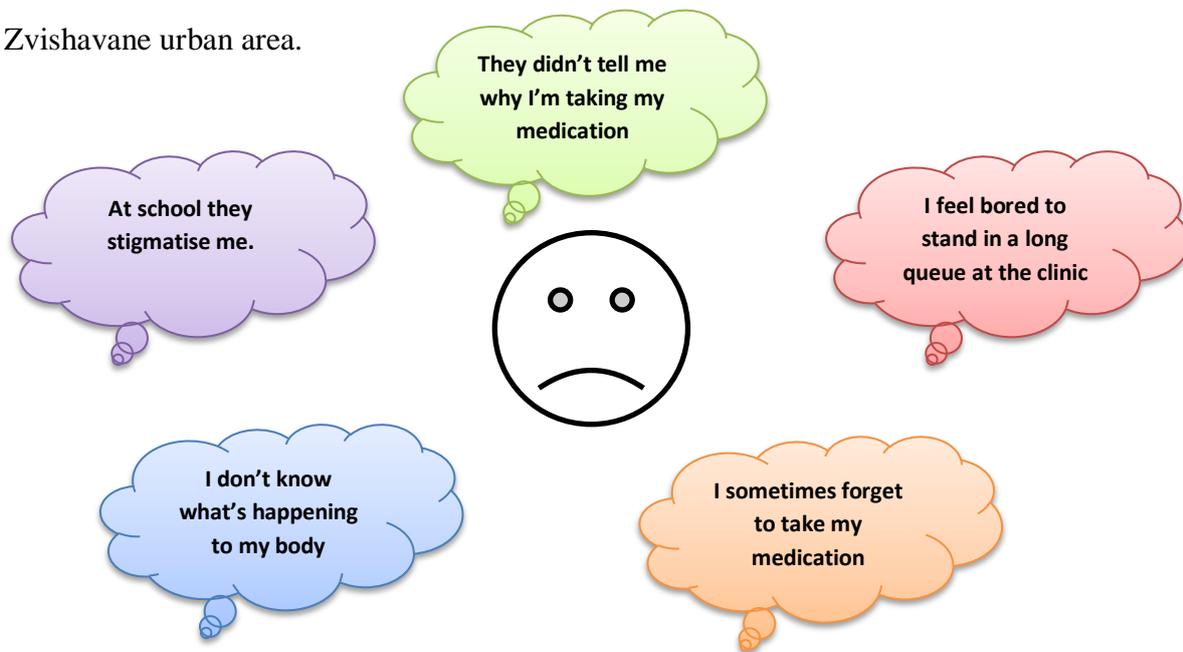
However it was noted through key informant interviews from NGOs that Midlands AIDS Caring Organization (MACO) and Bethany Project had youth friendly centres but they were not providing clinical services but were providing information and recreational facilities for the youth only. Bethany Project key informant pointed out that they were overwhelmed by large numbers of young people who came to their centre seeking HIV testing and counselling (HTC) service citing reasons that health centres were not free.

In terms of access to information by HIV positive adolescents, the problem was not severe but moderate. The Bethany Project youth centre was reported to be well resourced but the biggest challenge was that of its vicinity. It was pointed out that the centre offers information and skills to young people in form of in and outdoor games, internet facilities and sporting facilities which was good for the adolescents but its location was found to be not strategic. Adolescents reported that they would travel at most 3kms to get to the centre which then ended up discouraging them to get there to access the available services.

It was found out that MACO youth centre was no longer functioning since three years up to the time of the study. The centre used to offer information of HIV to all young people under the support of UNICEF's young people we care (YPWC) program but had no clinical services too. It was found that there was another centre established in 2014 for young people called Zvishavane Youth Centre (ZYC) but was itself also incapacitated even in terms of information and skills on HIV and SRH. FGDs with both HIV positive and non-HIV positive adolescents revealed that there was limited government commitment to support HIV positive adolescents. The Zimbabwe National Family Planning Council (ZNFPC) which was

mandated by the government of Zimbabwe to roll out a program on Adolescents Sexual and Reproductive Health (ASRH) have two youth friendly centres in Zvishavane rural that is Murowa and Mabasa but intriguingly it was noted that there were low HIV prevalence rates in the rural area than the urban area of Zvishavane District.

Coupled with all these challenges some adolescents it was noted that it leads to stunted growth or delayed physical development. It was learnt and revealed in this study that HIV and disability are the two sides of the same coin since some adolescents with HIV developed some types of disabilities such as hearing or visual impairment and slowness in learning at school. The diagram below summarises the impact of HIV on HIV positive adolescents in Zvishavane urban area.



D. Opportunities

4.16 Institutional Support for HIV positive Adolescents

The study indicated that there were quite a number of players in the HIV and AIDS sector including NGOs and the Government. NGOs were found to be doing a lot of work on HIV and AIDS but however work around adolescents living with HIV was very minimal. An interview with the District AIDS Coordinator (DAC) of the National AIDS Council (NAC)

Zvishavane indicated that there were more than five NGOs operating in Zvishavane Urban area working on health issues but there was only one Organization known as the Bethany Project which was specifically dealing with young people born and living with HIV including those with disability. Other NGOs had a component of HIV and AIDS but not specifically for HIV positive adolescents. However through networking and coordination NGOs would work together including the Government in order to promote the well-being of young people.

The government through its ministries and department was also making efforts to address the challenges of HIV positive adolescents but however resources were the greatest hindrance thus they partnered with NGOs and Civil Society Organizations (CSOs). Key informants from different ministries indicated that they were doing something for instance; the Department of Social Services (DSS) indicated that they facilitated the provision of shelter and food for abused and vulnerable HIV positive adolescents while the Ministry of Health and Child Care (MoHCC) provided clinical services for these adolescents.

Intriguingly the study found out that there were quite a significant number of mines in Zvishavane District but they were not doing much in terms of improving the well-being of HIV positive adolescents. Mimosa Mining Companies renovated the Zvishavane District Hospital (ZDH) which was good but found to be not directly linked to the special needs of HIV positive adolescents. FGDs also indicated that the local authority, Zvishavane Town Council (ZTC) had mandate of ensuring the well-being of its community but surprisingly the study indicated that the council had done nothing for this vulnerable group. The key informants from the Ministry of Primary and Secondary Education (MoPSE) indicated that the ministry's curricular had a component of HIV and AIDS but however further analysis indicated that it was not being religiously implemented as argued by 65% of the respondents. The table below shows different key players involved in mitigating the impact of HIV on adolescents in Zvishavane Urban Area as identified by the respondents. The

ranking of the service was done by the respondents themselves and it was like this: 1 = excellent, 2 = good, 3 = satisfactory 4 = poor and 5 = very poor

Table 4: Institutions working on health programs

Institution	Role	Ranking
Bethany Project	Empower communities to care and support for young people living with HIV, those with disability and those vulnerable.	1
Midlands AIDS Caring Organization (MACO)	Works with HIV positive people mostly adults in trying to promote their well-being.	2
Midlands AIDS Service Organization (MASO)	Works with communities promoting behaviour change and creating a demand generation on health services.	2
Zimbabwe National Network for People Living with HIV (ZNNP+)	Works with HIV positive adults promoting their psychosocial well-being.	2
National AIDS Council (NAC)	Coordinating the multisectoral HIV and AIDS responses in the District	2
Department of Social Services (DSS)	Ensuring the welfare of the communities in the District including children	3
Zvishavane Town Council (ZTC)	Providing social services to the community	4
Ministry of Education	Proving quality education (academic and extra-curricular)	3
Ministry of Health and Child Care (MoHCC)	Ensuring the well-being of the communities in the District	2
Local Mining Companies	Provision of Corporate Social Responsibility (CSR)	4

The ranking in table 4 above indicates that there were quite a significant number of institutions that were doing health related programs in the district but were not doing as expected by the respondents (communities). This indicates that there is an opportunity for advocating on these institutions to work together in promoting the well-being of HIV positive adolescents. From the above rankings, it is clear that only NGOs especially Bethany Project, are working tirelessly to improve the well-being of HIV positive adolescents. On the side of

the government, it is only the Ministry of Health and Child Care (MoHCC) performing better in promoting the health being of the communities including HIV positive adolescents.

Another institutional support for HIV positive adolescents found out by this study was the use of support groups. The study found that 11 (31,4%) out of 35 respondents were members of a support group, most of them being female mostly aged between 12–16 years. Assessing the role of support groups through FGDs, questionnaires and interviews, the study revealed that:

Box 3: Impact of support groups for HIV positive Adolescents

- a) *Support groups are a platform for the exchange of information among HIV positive adolescents where experts with essential information, including on the importance of disclosure, can access them to educate them.*
- b) *Through support groups HIV positive adolescents get to appreciate that there are many others in the same or worse situations, which gives them comfort in numbers. This comfort was said to be key in one's fighting of stigma: "I think stigma will always be there, but through support groups we get the strength to withstand it" (FGD participant).*
- c) *Members of the support groups become a united force that can be very powerful in lobbying and advocating for the protection of their interests. They fight together, not as individuals, for their common interests, which is effective (ZNNP⁺ official).*
- d) *Support groups with memberships that include the HIV-positive and HIV-negative are effective in demystifying HIV and AIDS. All NGO partners are implementing programs that centre on promoting these kinds of support groups.*

4.17 Opportunities

Much of the opportunities identified were pin pointed out by key informants from Government Ministries, NGOs and Faith Based Organizations (FBOs). The first opportunity which was identified in this study was the availability of NGOs operating in the area. This was seen as an opportunity that all HIV positive adolescents can exploit especially those that had not joined support groups yet. The availability of NGOs means that there was an opportunity to carry out more advocacy work on issues that affect HIV positive adolescents

from an individual, family and community level. Bethany Project key informant indicated that they had trained community volunteers and mentors on ART, disclosure, treatment adherence and disclosure hence HIV positive adolescents in the urban communities can make use of those people to gain more knowledge and skills on issues surrounding HIV and AIDS. They also indicated that they trained PMTCT champions and peer educators who are also sources of adequate information on health related matters.

The study revealed through FGDs that the availability of youth friendly centres being facilitated by the Bethany Project and Zvishavane Youth Centre (ZYC) was seen as opportunity HIV positive adolescents can exploit to enhance their knowledge and skills on SRH and HIV and AIDS. The District Nursing Officer (DNO) at the Zvishavane District Hospital (ZDH) alluded to the fact that the Hospital was in the process of coming up with a youth friendly corner at the hospital and plans were at an advanced stage. The centre was said to be going to offer ART, STIs treatment, male circumcision, HIV testing and counselling (HTC) for all young people including those with disability. The Zimbabwe National Family Planning Council (ZNFPC) developed the Adolescent Sexual and Reproductive Health (ASRH) strategy together with stakeholders which is a roadmap for implementing SRH related programs for adolescents and that alone is an opportunity to promote the well-being of adolescents.

Key informants from the Ministry of Health and Child Care (MoHCC) indicated that the availability of the World Health Organization (WHO) HIV Testing and Counselling, Treatment and Care for Adolescents Living with HIV guidelines of 2013 which recommend that young people should know their HIV status and their parents in another opportunity the guidelines help both the Ministry of Health and its partners in the health sector to program effectively for HIV positive adolescents. They assist also in coming up with programs that enhances treatment adherence and timely disclosure.

The Ministry of Health key informant also indicated that the Ministry in 2013 rolled up a program called option B+ which promotes the Prevention of Mother to Child Transmission (PMTCT) of HIV. The program initiates every HIV positive pregnant woman on antiretroviral treatment (ART) so that she delivers an HIV negative baby. This is an opportunity that adolescents who wish to bear HIV negative children can exploit and this brings hope to the hopeless HIV positive adolescents in Zvishavane urban.

The Department of Social Services indicated that they had trained Case Care Workers (CCW) together with Child Protection Committees (CPCs) to deal with child abuse and child protection issues in all the wards in the district. They alluded to the fact that HIV positive adolescents can make use of these channels to report issues that will be affecting them therefore this stands as an opportunity for them. MACO and MASO indicated also that they had trained the Behaviour Change Facilitators (BCF) on sexual and reproductive health (SRH) so adolescents can exploit that opportunity to enhance their knowledge and skills.

The study indicated that of the 35 interviewed HIV positive adolescents, 67% were positive about life and they indicated that they saw a bright future in their lives despite that the challenges they face especially stigma and discrimination. One of the respondents who were in the Bethany Project support groups indicated that she was at some point stigmatized by the community members that she couldn't do anything because of her HIV status. She felt challenged by that and composed a song titled, "I'm living my life, extra ordinary life". In that song she indicated that she doesn't matter what people were saying about her status as long her life goes on well. At that moment (2014) she had become a prominent local artist in Zvishavane despite her status. This was seen an indicator that being HIV positive doesn't translate to inability and the above story reveals the impact of support groups.

4.18 Summary of findings

In a nutshell, it is incontestable that HIV and AIDS has had devastating consequences on the lives of adolescents as revealed by the findings in chapter four. Challenges of HIV positive adolescents range from stigma and discrimination, unavailability of friendly health delivery systems, limited or lack of knowledge on SRH and HIV and AIDS issues, disclosure of status and poor adherence to treatment. These problems culminates other challenges such as low self-esteem and confidence, isolation and poor comprehension of concepts since HIV and disability are the two sides of the same coin.

This chapter also analysed the role of Government and the third part actors in promoting the well-being of HIV positive adolescents. Organizations which include Bethany Project, MACO, MASO and ZNNP+ were found to be working tirelessly to promote the well-being of adolescents especially Bethany Project which had established support groups for HIV positive adolescents in the Zvishavane urban. The Ministry of Health and Child Care as the mother ministry of all health programs was founding to be performing satisfactorily and was partnering with other players. Other relevant governmental departments and authorities were found to be performing below expected standard, reasons being lack of resources and limited commitment. The local companies were found to be nowhere in the promotion of the well-being of HIV positive adolescents in the urban area. Opportunities for HIV positive adolescents were also discussed in this chapter and they were found to be available only needing to be tapped.

4.19 Chapter Summary

To sum up, the chapter has presented interpreted and analysed findings from the research. The findings of this study have been discussed and evaluated vis-à-vis scholarly views and other relevant literature on the impact of HIV on adolescents. The chapter has thus shaded

more light on the challenges that HIV positive adolescents face in this 21st century and has also analysed the role of Government and the third part actors in addressing the challenges of HIV positive adolescents.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The purpose of this chapter is to present the supposition of this study. It is also the intention of this chapter to make practical recommendations for addressing the challenges of HIV positive adolescents and on building their capacities. These recommendations made are based on the findings and interpretation of the challenges that HIV positive adolescents in Zvishavane urban area face.

5.2 Conclusion of the study

In summing up, the study discovered that it is proven beyond reasonable doubt that HIV and AIDS impacted negatively on adolescents in Zvishavane urban area. HIV and AIDS created an array of challenges which ranges from individual, family and community levels. These challenges emanated from schools, community, health centres, and churches and at home. Key challenges pointed out by HIV positive adolescents in this study were as follows:

Disclosure of HIV status

The study found out that HIV status disclosure was a difficult subject to deal with for both HIV positive adolescents and their caregivers. Caregivers found it very difficult for them to disclose the HIV status to their children and youths hence leading to late or untimely disclosure which was against the disclosure definition. Late disclosure led to the genesis of other problems such as poor adherence to ART, further transmission of the virus, among many others. HIV positive adolescents themselves, found it very hard to disclose their HIV status to their intimate partners fearing that they would lose them and also fearing the stigma and discrimination associated with HIV and AIDS. Failure to disclose one`s status led to

oneself indulging into sexual relationships without any means of protection such as condoms. Practising safe sex was considered by respondents as disclosing one self's HIV status indirectly.

Stigma and Discrimination

Stigma and discrimination was found to be the silent killer destroying the well-being of HIV positive adolescents. Stigma and discrimination was found to be rampant at home, in the community, schools and churches. The research revealed that stigma and discrimination came in many forms such as name calling, attaching names to certain objects, forbidding adolescents to participate in developmental programs such as sporting activities. Resultantly it led to negative impacts such as low performance at school, low self-esteem and confidence, self-stigma and depression.

Limited or lack of knowledge on HIV and SRHR

The study indicated that HIV positive adolescents had limited or no knowledge at all on issues surrounding HIV and AIDS and SRHR which is then critical in enhancing positive human development. Older adolescents (15-19 years) were found to be better off than younger adolescents (10-14 years) in terms of basic information on HIV and SRH. However the study revealed that as early as 12 years, some HIV positive adolescents had started engaging in sexual relationships and of which they had limited information on HIV transmission and prevention. The study also revealed that HIV positive Adolescents had so many unanswered questions concerning whether they were going to get married and bear HIV negative babies.

Unfriendly health delivery systems

The health delivery systems in Zvishavane urban were found to be unfriendly to HIV positive adolescents and further analysis revealed that they were unfriendly to all young people in the district. It was indicated in this study that HIV positive adolescents would be standing in the same queues with adults whenever they were collecting their monthly supplies of ARVs. This then increases stigma and discrimination and also compromises adherence to treatment since HIV positive adolescents received little support in terms of counselling on treatment literacy and SRH issues. Also personnel at the health centres were found to be inappropriate in dealing with health related issues of adolescents due to the generational gap. It was also noted that there were only three youth friendly centres that were only offering HIV and SRH information and skills without providing clinical services to HIV positive adolescents.

Poor adherence to Antiretroviral Treatment (ART)

Adherence to antiretroviral therapy was one of the biggest issues pointed out in this research by the respondents. Reasons surrounding poor adherence were: myths surrounding the taking of ARVs without taking any food, availability of food for consumption at home, limited family and community based support systems to treatment and also myths and misconceptions on HIV and AIDS which were propagated by some religious sects. The study also indicated that poor adherence to treatment led to some HIV positive adolescents defaulting to ART.

The study also explored on the opportunities which were available for HIV positive adolescents in Zvishavane urban area and were pin pointed out as follows:

- ✓ It was noted in this study that there were quite a number of key players working in the area of HIV and AIDS mitigation and these included Government line ministries, NGOs and partly the corporate world. The availability of these players was an opportunity for

carrying out more advocacy work on mitigating the impact of HIV on adolescents living positive with HIV.

- ✓ The availability of local/community based structures established by NGOs and the Government was seen as an opportunity that can be exploited by HIV positive adolescents to access more information HIV and SRH.
- ✓ The availability of the three youth friendly centres in the area namely Bethany Project, MACO and ZYC was also an opportunity for HIV positive adolescents to again acquire more information on health related issues.
- ✓ The Zvishavane District Hospital (ZDH) was in the process of coming up with a youth friendly centre where adolescents were going to access all clinical services including receiving their ARVs without adult interference and this was another opportunity.
- ✓ The existence of policies, guidelines and instruments such as the WHO guidelines on HTC and ART, the Zimbabwe Adolescents Sexual and Reproductive Health (ASRH) strategy and the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) created opportunities for effective programming on programs that address the challenges of HIV positive adolescents in the area.
- ✓ The rolling out of the Ministry of Health's option B+ program which initiates on ART every HIV positive pregnant woman, in order to prevent mother to child transmission of HIV (PMTCT) was seen in this study as an opportunity for HIV positive female adolescents who would want to bear HIV negative babies.

5.3 Recommendations

Recommendations are drawn from responses made by HIV positive adolescents, non HIV positive adolescents, caregivers of HIV and non HIV positive adolescents who participated in this study and from field observations and interpretations of the challenges that HIV positive adolescents face. The following are the recommendations made from this study.

- a. The study recommends the formulation and implementation of sustainable interventions targeted at building the capacity of HIV positive adolescents to deal with stigma and discrimination issues, disclosure, treatment adherence, HIV and SRH issues and this includes capacity building workshops, sessions and experiential learning.
- b. Advocacy and lobbying on issues of stigma and discrimination, effective private sector support and state accountability on the HIV and AIDS discourse should be carried out through awareness campaigns, mass media and dialogues.
- c. Establishment of youth friendly corners/centres that are easily accessible should be prioritised by the state in partnership with the third sector.
- d. It is important that HIV positive adolescents are not taken as passive recipients towards their development in the community consequently the study recommends the establishment and support of advocacy teams specifically constituted by HIV positive adolescents in order for them to raise and report their issues to relevant authorities.
- e. The study also recommends the establishment of support groups for HIV positive adolescents. Support groups are a platform for HIV positive adolescents to share their problems and support one another.
- f. The study also recommends capacity building of caregivers through dialogues, awareness campaigns and workshops in order for them to effectively deal with disclosure, nutrition requirements, treatment adherence and SRH issues of HIV positive adolescents.

g. Recommendations are also being made for the development of a simple disclosure booklet or guide that can be used by HIV positive adolescents and caregivers when disclosing the HIV status.

5.4 Area(s) for further study

The researcher recommends the following areas to be studied:

- An analysis on the merits and demerits of the Health Practitioner disclosing the HIV status to adolescents of minor age rather than the caregiver.
- An analysis on the impact of religion in the fight against HIV and AIDS.

5.5 Chapter Summary

In a nutshell, this chapter clearly expounded the conclusion that was drawn from the study. The supposition elucidated the challenges of HIV positive adolescents which are mainly HIV status disclosure, poor adherence to ART, stigma and discrimination, unfriendly health delivery systems and limited/lack of information on HIV and SRH. The chapter also laid down some recommendations which are aimed at reducing the vulnerability of HIV positive adolescents in Zvishavane urban area. The recommendations are mainly focused on strengthening the family and community based support systems which include the adolescent him/herself, the caregiver and the surrounding institutions. In view of the conclusions that have been drawn from the study and the corresponding recommendations, it is imperious that responsible authorities, Civil Society Organizations, NGOs, the corporate world and all community members combine their efforts in promoting the well-being of HIV positive adolescents in this area.

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APPENDICES

Appendix A: Questionnaire

QUESTIONNAIRE FOR HIV POSITIVE ADOLESCENTS

Challenges and Opportunities of HIV positive Adolescents in Zvishavane Urban

QUESTIONNAIRE No.....

My name is Ngonidzashe Sesemani an Honours student in Development Studies at the Midlands State University (MSU). I am conducting a research in Zvishavane Urban area as part of my study requirements. The study focuses on the challenges and opportunities of HIV positive adolescents.

Participation is voluntary and no personal information will be revealed. All the information gathered will be used for academic purposes only and data gathered will be treated as confidential. This questionnaire will take at most 10 minutes to complete. Please complete the questionnaire as honestly as possible and if you do not feel comfortable taking part in the research, you are free to withdraw or not even participate. Please put an **X** in the box provided and complete in your own words in the spaces provided.

A. Demographics and vulnerability assessment

1. Age and sex of respondent and sex.....
2. Status of respondent.....
 1. Both parents alive
 2. Double Orphan
 3. Single Orphan
 4. Father whereabouts not known
 5. Mother whereabouts not known
3. Level of education.....
 1. No schooling
 2. Primary School Level
 3. Secondary School Level
 4. Tertiary Level
4. Household size.....
5. Age of head of household.....
6. Marital Status of head of household.....
 1. Married
 2. Single
 3. Divorcee
 4. Widowed
 5. Other (specify)

7. Highest level of education of head of household.....

1. No schooling 2. Primary School Level 3. Secondary School Level 4. Tertiary Level

8. Employment status of head of household.....

1. Formally employed 2. Self-employed 3. Other (Specify)

9. If the Head of household is involved in any type of employment, please state the nature of employment

.....

B. HIV knowledge levels, practices and attitudes

10. What is your understanding of HIV and AIDS

.....

.....

.....

11. List any three (3) ways of HIV transmission that you know

.....

.....

List any three (3) ways of HIV prevention that you know

.....

.....

.....

12. Have you ever had sexual intercourse

.....

13. If yes, did you use a condom?

.....

14. At what age did you know that you are HIV positive and do you think that was the proper time for you to be disclosed your status?

.....

.....

15. Who disclosed that to you?

.....
16. How did you feel after knowing that you are HIV positive?

.....
.....
.....

C. Impact of HIV on Adolescents.

17. What challenges do you face as an HIV positive Adolescent at the following areas?

Home.....
.....
.....

Community.....
.....
.....

School.....
.....
.....

Clinic/Hospital.....
.....
.....

Church.....
.....
.....

D. Opportunities and Solutions.

18. Are there any key players (Government, NGOs, or community members) working with HIV positive adolescents in your area?

.....

19. If yes to question 18, who are these key players and what are they doing?

.....
.....

.....
.....
.....

20. Are you in any support group or social club for HIV positive adolescents?

.....

21. If yes to question 20, what do you do in that group and how has the group assisted you?

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.....
.....
.....

22. Are there any available opportunities that can be exploited by HIV positive Adolescents to enhance their well-being?

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.....
.....
.....

23. What do you think can be done to deal with the challenges that HIV positive Adolescents face?

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.....
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24. Do you see any bright future for HIV positive Adolescents in your area? And if yes why and if no why again?

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.....
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.....
.....

End of Questionnaire

Thank you for your time!!!!!!

Appendix B: FOCUS GROUP DISCUSSION GUIDE

Challenges and Opportunities of HIV positive Adolescents in Zvishavane Urban

This tool will be administered with Caregivers for HIV positive Adolescents, Caregivers for non-HIV positive Adolescents, HIV positive and negative Adolescents.

My name is Ngonidzashe Sesemani an Honours student in Development Studies at the Midlands State University (MSU). I am conducting a research in Zvishavane Urban area as part of my study requirements. The study focuses on the challenges and opportunities of HIV positive adolescents. Participation is voluntary and no personal information will be revealed. All the information gathered will be used for academic purposes only and data gathered will be treated as confidential. This focus group discussion will take at most 20 minutes to complete. Please feel free to contribute to the discussion as honestly as possible and if you do not feel comfortable taking part in the research, you are free to withdraw or not even participate.

Objectives	Key Questions
Assess the HIV knowledge levels, practices and attitudes.	<ul style="list-style-type: none"> • What is your understanding of HIV and AIDS? • How is HIV transmitted? • How is it prevented? • What's your societal perspective towards people living with HIV and AIDS?
Assessing the impact of HIV on HIV positive Adolescents.	<ul style="list-style-type: none"> • How does it feel to be living with HIV positive? • Do we have in our families and communities Adolescents who are HIV positive? • What challenges do these Adolescence face? (Home, School, Clinic, Church and Community)
Unearthing the opportunities and solutions.	<ul style="list-style-type: none"> • Are there any key players (Government, NGOs, or community members) working with HIV positive adolescents in your area? • If yes who are they and what are they doing? • Does their work seem to be yielding positive results in addressing the challenges of HIV positive Adolescents? • Are there any available opportunities that can be exploited by HIV positive Adolescents to enhance their well-being? • What do you think can be done to address the challenges being faced by HIV positive Adolescents?

Appendix C: KEY INFORMANTS INTERVIEW GUIDE

Challenges and Opportunities of HIV positive Adolescents in Zvishavane Urban

My name is Ngonidzashe Sesemani an Honours student in Development Studies at the Midlands State University (MSU). I am conducting a research in Zvishavane Urban area as part of my study requirements. The study focuses on the challenges and opportunities of HIV positive adolescents. Participation is voluntary and no personal information will be revealed. All the information gathered will be used for academic purposes only and data gathered will be treated as confidential. This interview will take at most 10 minutes to complete. Please feel free to respond to the interview questions as honestly as possible and if you do not feel comfortable taking part in the research, you are free to withdraw or not even participate.

Objective	Key Questions
General	<ul style="list-style-type: none"> • Name and type of Organization (whether NGO, government etc.) • What are your strategies or approaches of working with HIV positive Adolescents? • In what ways do your strategies or approaches address the challenges of HIV positive Adolescents in a holistical manner?
Assessing the impact of HIV on HIV positive Adolescents.	<ul style="list-style-type: none"> • What common trends have you observed in your work regarding knowledge, attitudes and practices among HIV positive Adolescents? • According to your experience, what do you think are the challenges of HIV positive Adolescents?
Unearthing the opportunities and solutions.	<ul style="list-style-type: none"> • What can be done to or address the challenges of HIV positive challenges? • What services are available to increase knowledge of HIV positive Adolescents? • What are the gaps in services and how do you suggest these should be filled? • What benefits would your Organization enjoy if challenges of HIV positive Adolescents are addressed?

Appendix D: 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.

My name is Ngonidzashe Sesemani an Honours student in Development Studies at the Midlands State University (MSU). I am conducting a research in Zvishavane Urban area as part of my study requirements. The study focuses on the challenges and opportunities of HIV positive adolescents. Participation is voluntary and no personal information will be revealed. All the information gathered will be used for academic purposes only and data gathered will be treated as confidential. You (or your child) have (has) been chosen to participate in this research as a respondent. 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: Ngonidzashe Sesemani

Contact Details: 904 Mandava, Zvishavane, Zimbabwe (0773784421)

Declaration of Consent:

I.....consent to take part in this research are 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:.....