The caring practices, coping mechanisms and learning experiences of elderly caregivers of adolescent AIDS orphans in one residential area in Harare: Implications for Adult Education in Zimbabwe.

BY

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A Thesis submitted in fulfilment of the requirements for the degree of Doctor of Education in the School of Education, Faculty of Arts and Design at the Durban University of Technology.

August 2023

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DECLARATION

I, **ANGELINE PARADZAI,** declare that:

The work which I have presented in this document is my own effort and I confirm that it has not been offered for the award of a degree in any academic institution. There has been use of other authors' writings which I have appropriately recognised throughout the text.

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ABSTRACT

Recent studies (Kidman and Thurman 2014; Zvinavashe et al. 2015) have established caregiving in an HIV/AIDS context as a burden; however, the caring practices, coping mechanisms and learning experiences of the elderly caregivers of adolescent AIDS orphans have not been well documented. Being an elderly caregiver in this situation brings difficulties as far as the whole caring for an adolescent is concerned (Omotoso 2007; Zaky 2016).

This phenomenology research, whose dictates derive from the interpretivist paradigm and the qualitative approach, drew on a sample of twenty elderly caregivers. Snowball sampling, a subdivision of the purposive sampling method, within the non-probability type of sampling, was adopted. The study implemented a qualitative approach, where in-depth one-on-one interviews, observations of the home environments and focus group discussions were used for data generation. Data analysis utilised the six steps of Creswell (2014). Transformative Learning Theory (TLT) (Mezirow 2009), as well as the three models of the Transactional Model of Stress and Coping (TMSC) (Lazarus and Folkman 1984) were the theoretical lenses embraced for the study.

With regard to the nature of caring practice what emerged was that the process involved nurturing character development of the orphans. Approaches for character development were modelling adolescent behaviour, talking to and working with them, task delegation, and encouraging church attendance, among others. Provision of basic needs such as food, shelter, school fees and assistance from extended families were also evident as additional caring practices. Challenges faced in the caring practices were of a social, financial and psychological nature. In terms of coping, the more pronounced approaches were problem-centred and emotion-centred coping, with maladaptive coping having been minimally utilised. Coping strategies involved seeking counselling, cutting meal sizes and frequencies of eating the meals, and assistance from their extended families. The elderly carers indicated deficiencies in knowledge of how to look after adolescent AIDS orphans and, also, the resources to use during their care.

The new insights emerging from the study were that caring was age-sensitive and collaborative, bringing caregiver, clinic, school, community and extended family together. Elderly caregivers are now bound by the legal orientation in orphan care. Ways of knowing about these insights by the participants were primarily experiential – that is, learning as the processes unfolded. Nevertheless, print and electronic media, and observation also emerged. Educational implications are drawn on a number of issues, such as the need to conscientise caregivers on legal requirements, modern ways of child rearing, imparting entrepreneurial skills as the caregivers had no regular incomes and caregiving in a traditional thoughtful manner.

The elderly caregivers went through eight of the ten stages of the Mezirow theory in their learning, leaving out stages three and four which deal with a sense of alienation and relating discontent to others respectively. Not experiencing these two stages may be attributed to stigma and discrimination often associated with HIV/AIDS issues, so they were less likely to disclose their concerns as a means of further learning.

Elderly caregivers seemed to lack information on caring for the young in view of AIDS, as well as material resources. Failures of caregivers to join relevant groups like support groups seem to suggest denial of the HIV/AIDS situation they find themselves in. It is recommended that adult educational programmes be designed to reduce stigma and discrimination among the elderly living in HIV/AIDS circumstances.

DEDICATION

This piece of work is dedicated to my daughters, Lynnette and Peace. I challenge you to get inspired by this academic work and get motivated to engage in further studies.

ACKNOWLEDGEMENTS

I would like to sincerely recognise the following people:

- My study supervisors, Professor Tabitha G. Mukeredzi and Professor Julia Preece for providing their expert direction and positive criticism, which made me reach completion of my doctoral studies.
- All the elderly caregivers under study, the grandparents already burdened with adolescent orphan care in Epworth, who managed to participate in this research despite their daunting responsibility.
- The Epworth Local Board for granting permission for the study to be carried out in their area of jurisdiction.
- My family members, for enduring extended periods without me while I submerged myself in this research.
- My doctorate colleagues for the words of encouragement we used to give to one another. The journey was not all that easy as some of them appeared to have fallen by the way side. I wish to thank God the Almighty for seeing me through.
- All those who helped in one way or the other in a bid to make this thesis a success are honestly acknowledged.

LIST OF ABBREVIATIONS

AIDS:	Acquired Immunodeficiency Syndrome
BEAM:	Basic Education Assistance Module
ELB:	Epworth Local Board
ELM:	Kolb's Experiential Learning Model
ESAP:	Economic Structural Adjustment Programme
FGD	Focus Group Discussion
HIV:	Human Immunodeficiency Virus
SADC:	Southern African Development Community
TLT:	Transformative Learning Theory
TMSC:	Transactional Model of Stress and Coping
UNESCO:	United Nations Educational, Scientific and Cultural Organisation
WHO:	World Health Organisation

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CHAPTER ONE

SETTING THE SCENE

1.0 Introduction

Older people who now assume the duty of caring for AIDS orphans without prior training are growing in number (Nyasani, Sterberg and Smith 2009; HelpAge International 2017). The death of parents has, however, given rise to variations of care within households (Chazan 2014). Orphans in general used to be taken care of by extended kin such as elder brothers, sisters, uncles, grandparents and any other relative who would be willing to take charge of the caring role (Fauk, Mwakinyali, Putra and Mwantri 2017). It is evident that the HIV/AIDS pandemic has struck right at the core of the family system and the community at large, leading to variations in their structures (Malinga-Musamba 2015). Such changes force elderly caregivers to reluctantly embrace new roles in the caring of AIDS orphans seemingly without prior knowledge, despite the general expectation that these elders would also be looking forward to being looked after themselves because of frailty caused by aging (Zvinavashe et al. 2015; Tanyi 2018; Kidman and Thurman 2014). This burden of care for orphans often falls to the grandparent generation because those most at risk of dying are the working age population (HelpAge International 2017; Maronganye 2017, Mudavanhu, Segalo and Fourie 2008) and according to WHO (2016), those mostly dying of AIDS are between ages 15 and 49 years, also known as the productive years.

The usefulness of the extended family arrangements as safety nets for orphans seems to have been further challenged by natural, socio-economic and political factors that have perennially devastated Zimbabwe (Mhaka-Mutepfa, Mpofu and Cumming 2015; Mudavanhu, Segalo and Fourie 2008; Zvinavashe et al. 2015). These include droughts, floods, HIV/AIDS, inflation, and some unfriendly government policies like ESAP. Although in the past the elderly effectively cared for orphans (Bourdillon 1991), those of the present day seem to be facing formidable challenges due to changing times bedevilled with HIV/AIDS which continues to create orphans thereby challenging the elderly caregivers who do not seem to possess sufficient knowledge of caring (Schatz and Gilbert 2014).

In the African context grandparents have gradually become the principal caregivers of orphans including those whose parents died of AIDS (Chazan 2014; Kidman and Thurman 2014; Jongwe 2014; Maronganye 2015; Nyasani, Sterberg and Smith 2009). Instead of the elderly being able to retire from most of life's strenuous activities, they now find themselves having to re-start parenting roles due to AIDS (Fauk et al. 2017; Malinga-Musamba 2015). The caring of orphans by family members including grandparents is generally viewed as sustainable. Literature claims that children should continue to live with the extended families to retain ties of love and, most importantly, the emotional support brought by the familial relatives (Hong 2015; Jongwe 2014; Nyasani, Sterberg and Smith 2009), although their capacities as caregivers are often challenged (UNESCO 2016; UNAIDS 2017) by lack of caregiving knowledge in the context of HIV/AIDS (Kidman and Thurman 2014; Zvinavashe et al. 2015). In such situations the elderly caregivers are involuntarily embracing new responsibilities in AIDS orphan care apparently lacking prior knowledge. In this study, the elderly caregivers were understood as mature adults of at least 55 years as defined by HelpAge International (2017). I, therefore, wanted to understand these elderly caregivers' caring practices, coping mechanisms and learning experiences in their implementation of these caring roles, despite the general expectation that they would also be looking forward to being looked after themselves because of age. In the sub-heading below is the background to the study.

1.1 Study Background

HIV and AIDS remain a life challenge in view of the orphans whose fathers and mothers died of the disease and its allied sicknesses. The Southern Africa Development Community (SADC) countries and East Africa are recorded as the most affected by the pandemic (Gonese et al. 2020; UNAIDS 2018; United Nations Children's Fund (UNICEF) 2016; World Health Organisation (WHO) 2016 and UNAIDS 2017). The middle-aged generation seems to be absent after having been wiped out by AIDS (UNESCO 2015) leaving the elders and orphans to render support to each other (Nyasani, Sterberg and Smith 2009; WHO 2016; Zvinavashe et al. 2015). Although extended families seem to have taken over caring for orphaned children, at the same time they feel pressured in terms of the numbers of orphans, which is increasing (Fauk et al. 2017).

The related literature that has been reviewed emanated from studies carried out in Africa, particularly Botswana, South Africa and Zimbabwe which fall within the SADC region where HIV/AIDS is most pronounced (UNAIDS 2017). It is the African continent that shoulders the heavy brunt of the HIV/AIDS disease. UNAIDS (2018) reports that 6.2% of the global population resides in East and sub-Saharan Africa, with over 50% of the world's people living with HIV whose total figure is 19.4 million. Children under the age of 18 that lost either both or one parent are defined by WHO (2016) as double or single orphans respectively. In the reviewed studies, it seemed no research has focused on the caring practices, learning experiences and coping mechanisms of elderly caregivers of adolescent AIDS orphans, as they tend to concentrate particularly on the wellbeing of the orphans. The following shows the trend of deaths due to AIDS and related ailments in 2017 and 2020.

Table 1.1 Status of HIV/AIDS in 2021 and 2022 in Zimbabwe

Year	People living with HIV	Adult HIV prevalence	New infections	Deaths due to AIDS-related illnesses
2022	1.2m	11%	13.000	18.000
2021	1.3m	11.9%	25.000	22.000

Source: https://www.unaids.org/en/regionscountries/countries/zimbabwe

While the figures above show a downward trend in new infections, the responsibility of care is still heavy (Gonese et al. 2020) given the number of orphans (40%) reflected as being shared by South Africa, Uganda and Zimbabwe. In poor communities of Zimbabwe, the orphan scourge has put pressure on the caring kin in terms of psychosocial and economic support (Zvinavashe et al. 2015). The Joint United Nations Programme on HIV and AIDS (UNAIDS 2017) has reported that the present universal data has 16 million children who have lost one or both parents due to HIV/AIDS. Of these 16 million, 40% of them reside in Southern Africa and Uganda, while more than half of this 40% are said to be in Zimbabwe (Avert 2017). Literature reveals that there were 1.3 million people living with HIV in 2021 in Zimbabwe; with an adult prevalence of 11.9% being recorded the same year (UNAIDS 2022). It was, however, further noted that 25.000 new cases of

HIV infection were recorded in the same period (UNAIDS 2022), with a significant decrease of 12.000 in new cases in 2022. The drop in new infections is important and commendable. The figure of those who died due to AIDS related illness decreased in 2022; though, there is still a creation of orphans despite a fall in these figures. However, the situation did not show variation in terms of people living with HIV in the year 2021, though there has been a notable drop in new infections (Chingombe et al. 2022).

Despite this drop, the previous AIDS-related deaths had already created substantial figures of orphans whose guardianship is being spearheaded by their elderly relatives (HelpAge International 2017; Van Durme et al. 2012). The elderly have been compelled by situations to take on and endure the caring responsibility (Kidman and Thurman 2014; Maronganye 2017; Nyasani, Sterberg and Smith 2009), without knowledge of the most effective ways of doing it. HIV/AIDS has affected many, if not all, households in Zimbabwe prompting the elderly to move in to close the parental gap that the scourge has created, even though without any appropriate knowledge.

After losing their adult children to AIDS, the elderly suffer stigma and discrimination that is often associated with this disease (Makurumidze et al. 2020; Zvinavashe et al. 2015). It is on record that the stigma leads to noteworthy levels of segregation for both the elders and the orphans thereby causing loneliness and shame for both carers and orphans (Nyasani, Sterberg and Smith 2009). I am, therefore, keen to understand elderly caregivers caring practices, learning experiences and coping mechanisms in dealing with adolescent AIDS orphan care, given that the grandchildren are also trying to navigate into adulthood.

In the SADC region, the elderly constitutes a substantial proportion of people who are taking care of orphans and who are also living in poverty (HelpAge International 2017). The value of the extended family arrangements as safety nets for orphans seems to be further exacerbated by natural, socio-economic and political factors that have perennially devastated Zimbabwe (Madhavan 2004; Zvinavashe et al. 2015; Mhaka-Mutepfa, Mpofu and Cumming 2015). These include droughts, floods, HIV/AIDS, inflation, and some unfriendly government policies like the Economic Structural Adjustment Programme (ESAP). ESAP was presented in order to achieve objectives such as to inspire development and employment of the people of Zimbabwe, lessen government intervention in economic matters, and encourage growth in accessing foreign exchange, as well as the reduction of debt. However, during the era of this policy, numerous businesses closed shop, which increased the rate of unemployment. The anticipated growth was not realised and social services dwindled markedly causing a lot of suffering among the general population of Zimbabweans (Compagnon 2011).

Although in the past, the elderly effectively cared for orphans (Hawken, Turner-Cobb and Barnett 2018), those of the present day seem to be facing formidable challenges due to changing times bedevilled with the contemporary HIV/AIDS context which continues to create orphans, thereby challenging the elderly caregivers who do not necessarily possess any knowledge of caring in such a context.

Moreover, the elderly carers and the adolescent AIDS orphans are generations apart: their desires and aspirations are often not compatible and this is likely to cause friction in their relations. Deviance among adolescents is generally said to be rampant (Quas 2014). Disciplinary issues on the part of adolescents (Zaky 2016) were recorded in some studies as worrisome to the elderly, and is one of those experiences that the elderly suffer (Dolbin-MacNab and Yancura 2017; Jongwe 2014). Although caregiving must be effective in order to enhance raising adolescents to become better future adults and leaders (Hawken, Turner-Cobb and Barnett 2018), it is not clearly acknowledged in literature how these elderly carers, without acquisition of knowledge of caring for adolescent orphans in the era of HIV/AIDS, are managing in their responsibilities.

What is generally currently occurring in many households in Zimbabwe is that when a parent dies, the surviving grandparents close the parental gap by taking over the caring responsibility, although literature (Kidman and Thurman 2014; Zvinavashe et al. (2015) reveals that they are incompetent in executing this task in view of the HIV/AIDS era that they find themselves in. This is notwithstanding that these elderly caregivers may have experienced child rearing but not of HIV/AIDS children. In addition, some children or even the elderly caregiver may be living with the virus (Makurumidze et al. 2020). In times of illness, the elderly caregiver might not be competent enough to handle the situation without getting infected (Hawken, Turner-Cobb and

Barnett 2018; Zvinavashe et al. 2015). Epworth community may not be an exception to such situations.

The new roles and responsibilities without acquisition of new knowledge are being undertaken in a situation where there are numerous sources of stress for the elderly (Maronganye 2017). The loss of their adult children through AIDS (the disease being a condition surrounded with stigma and discrimination), incompetence in caregiving in the context of this contemporary disease, the likelihood of some orphans and some caregivers living with HIV, and the problematic nature of children in adolescence may all stand as constant causes of stress for the elderly caregivers who sometimes lack basic provisions in the home (Foster and German 2002; Maronganye 2017; HelpAge International 2017; Zaky 2016). Although it is generally believed that the elderly may not often get any formalised training, it should be noted that since there are various domains of learning (formal learning, non-formal learning, incidental learning, and experiential learning), there are others which may be more appropriate for them to engage in learning new things. Adults want to tap into their own experiences, so experiential learning through critical reflection and conscientisation of problems and issues in their environments may be applicable for the elderly caregivers (Kolb and Kolb 2005; Mezirow 1978). The common belief that the elderly must be looked after during their elderly years is shattered as they struggle to care for their adolescent grandchildren who were orphaned by AIDS. It is against this background, therefore, that I undertook a study to explore the caring practices, learning experiences and coping mechanisms of the elderly caregivers of adolescent AIDS orphans in the Epworth community.

Epworth community, the research site for this study, which is discussed in greater detail below, is a settlement of diverse cultures (Gandidzanwa 2003). Numerous languages such as Shona, Ndebele and Ndau are spoken. It is characterised by both urban and rural settlements and the community has divergent socio-economic categories, with the poor being the greatest proportion as demonstrated by an endless number of squatter or unlawful settlements and the incidence of poorly constructed houses and fewer material belongings. Caregivers, mainly grandparents, are informally observed taking care of orphans and terminally ill patients, as AIDS has become pervasive in this area. For the adolescent AIDS orphans, such situations are predisposing factors to risky behaviour like drug abuse and prostitution, giving room for HIV and other sexually transmitted infections (Steinberg 2002) to thrive. In Epworth, there are many school dropouts as evidenced by school-going aged children roaming the streets and milling around shopping areas during school time. Thus the majority of people are uneducated (Mujere 2016). As most are not employed, they are observed embarking on projects such as vending and subsistence farming and herbal gardening for a living (Gandidzanwa 2003). Of the few who are formally employed, most are farm labourers, security guards, gardeners and truck drivers in Harare. Most people spend their leisure time in beer-halls and children spend their time playing football in open spaces during times they could be in school.

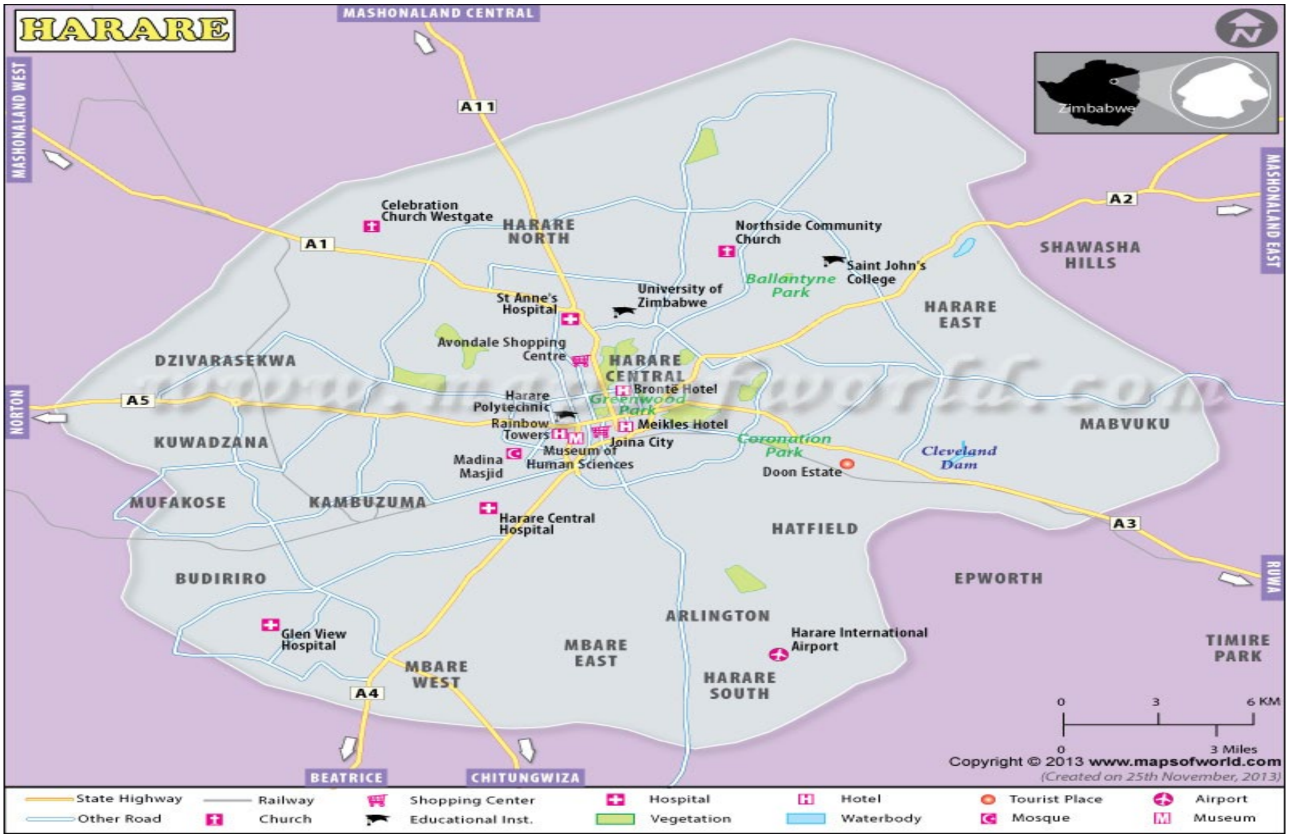
Investment in Epworth is not all that pronounced as demonstrated by the small and few business plants in this vicinity, save for minor crafts such as beer-halls and poorly stocked grocery shops (Mujere 2016). In my informal discussion with the Epworth Police I gathered that the rate of crime is high. In a Harare tabloid, Zindoga and Kawadza (2014) support these informal discussions and claim that Epworth is rapidly emerging as a new law-breaking location on the outskirts of Harare, with new armed muggers being associated with this area. Zindoga and Kawadza (2014) nevertheless posit that the law enforcement agency is progressively getting the upper hand in apprehending the criminals.

1.2 Background of Epworth Community

1.2.1 History and geography of Epworth

Epworth was established between the period 1905 and 1914 by the Methodist Church as a missionary area. It is a peri-urban informal settlement which is under the jurisdiction of a local government named Epworth Local Board (ELB). Epworth is located about thirteen kilometres in a south eastern direction of Harare. Its population grew during and after the liberation struggle of Zimbabwe (Chirisa 2009). According to the year 2012 census, the area is heavily populous, with at least 167 462 people packed in just above 35 000 hectares. The population of Epworth grew as a result of people escaping the Liberation Struggle in the rural areas and commercial migrants looking for employment in Salisbury (now Harare), (Zimbabwe National Statistics Agency 2012).

Figure 1.1 **Location of Epworth with Harare City**



Source: *https://www.google.com/search?q=Map+of+Epworth&tbm=isch&tbs=rimg*

1.2.2. Demography of Epworth

As alluded to above, the approximate population of Epworth of 167 462 from Census 2012 seems to be far below the actual. Due to the escalating number of informal households and cheap rentals, Chirisa (2009) estimates the Epworth population to be about 1 000 000 after 'Operation Restore Order', which was dubbed "Operation Murambatsvina" in 2005. The persistent monetary challenges ravaging Zimbabwe for about two decades now have seen many people moving to this area. The standard population progression is projected at 7.5 per cent per annum due to rural to urban migration. The population density of Epworth is pegged at 32.13 people per hectare (Chirisa 2013), with an average family size of around six people and most residents being aged below twelve years.

Table 1.2 Epworth Population from 1986 to 2012

YEAR	NUMBER
1986	27400
1990	62000
1994	84700
1998	91000
2002	113000
2012	167462
2022	189333

Source: National Statistics Agency, Zimbabwe (http://www.zimstat.co.zw)

The structure of the population is further distributed as follows:

Table 1.3: Epworth population size and structure

District	Male	Female	Per cent	Number	Per cent	Sex Ratio
Epworth	40.2	49.8	100	167462	7.0	101

The above figures are the only available latest official statistics which show that the population of Epworth is rising yearly. The sharp rise in the population which is estimated at 6.5 per cent has been attributed to a high birth rate and rural to urban migration (Zimbabwe Ministry of Health Annual Report, 2017).

1.2.3. Housing and facilities

The ELB laments the severe lack of housing in Epworth. According to their records there are 8 000 and 20 000 housing units in formal and informal settlements respectively. Most houses are too small for an average Epworth family which has six members. The number of squatters is apparently worrying, with most of them residing in an area popularly called New Gada in Epworth and they are not officially documented in the ELB records. The problem, according to the ELB, is further compounded by the fact that the Local Board cannot evict them without government approval (Chirisa 2009).

The Local Board has engaged in a combined undertaking with Shelter Zimbabwe to offer stands to middle income employees to improve the housing condition. Appropriate water and transport infrastructure are available in a small part of Epworth. According to Gandidzanwa (2003) water was basically delivered by the City of Harare, with some of it coming from Cleveland and Chikwari Dams. There is a conspicuous dearth of extensive sewerage structure. Accordingly, numerous homes use pit latrines, consequently exposing them to cholera and associated infections. In addition, the lack of water drainage arrangements results in the formation of ponds of motionless water which also escalate the dangers of malaria and bilharzia. Waste collection is normally done in the Domboramwari and Chinamhora sections only, although not on a regular basis (Gandidzanwa 2003). Domestic refuse is flung into shallow pits that are concealed with silt as they fill up.

Epworth comprises two secondary and eight primary schools, a far cry from the recommendation of the 1999 Nziramasanga Commission which had suggested five secondary and eighteen primary schools. Of the two clinics existing in Epworth, one of them is a polyclinic that the Local Board owns, while the other one belongs to the Methodist Church (Chirisa 2013). The sufficiency of these two health facilities is debateable as there are apparently always noticeably long queues of patients, which indicates a need for more such facilities to be established.

Given the issues that I raised in the background to the study related to elderly care-giving of adolescent orphans, coupled with the problems faced by Epworth residents, I wanted to develop an in-depth understanding of how the elderly caregivers in such circumstances practised caring, how they coped with this huge responsibility and what and how they learnt new ways of carrying out their caring roles. In the next section I discuss the focus and purpose of the study.

1.3 Focus and Purpose of study

The study focuses on both male and female elderly caregivers aged 55 years and beyond, who are looking after adolescent AIDS orphans. Adolescence is that stage of human life which exists between childhood and adulthood (Zaky 2016). According to Zaky (2016) adolescence is an interim phase in bodily and mental development that is usually restricted to the time between childhood and adulthood. The World Health Organisation defines an adolescent as a person falling between the ages of 10 and 19 years. A more detailed definition of adolescence is provided in Chapter 2. In this research, the ages of adolescents are understood as ranging between 10 and 19 years as defined by the WHO definition. Because of orphans created as a result of AIDS, men are also being observed looking after orphans, a societal duty that used to be done by women (Fauk, Mwakinyali, Putra and Mwantri 2017). The burden of care for orphans has generally fallen on the grandparent generation (Nyasani, Sterberg and Smith 2009; HelpAge International 2017). However, the generation lacks training in the execution of their new roles in an AIDS context (Chazan 2014; Maronganye 2017). As such, the study focuses on this generation in order to understand their caring practices, learning experiences and coping mechanisms in their day to day caring. Despite the fact that these elderly carers lacked caring knowledge and would have generally expected to be looked after in old age by their children, it seems the situation has forced them to embrace the new responsibility (HelpAge International 2017). As such, the purpose of the study was to explore the learning experiences and coping mechanisms of the elderly caregivers of adolescent AIDS orphans and draw educational implications from it. In the section to follow, I present the background of Epworth community in order to put my study into perspective.

1.4 Statement of the problem

Although new developments in terms of availing treatment have been on an upward trend, Zimbabwe continues to record new cases of HIV infection and deaths due to AIDS related illnesses (UNAIDS 2020). The figure of those who are succumbing to AIDS continues to be significant with a record of 22 000 deaths from AIDS-related ailments in the year 2020 (UNAIDS 2020) as indicated in the table below, thereby adding to the numbers of orphans, which places pressure on the elderly who would have retired from many household chores (Foster and German 2002; Small et al. 2017; Van Durme et al. 2012).

The middle-aged generation appears to have been wiped out by AIDS (UNAIDS 2017) exposing the elders to take over the caring of AIDS orphans (Nyasani, Sterberg and Smith 2009; WHO 2016; Zvinavashe 2015), without knowledge to care in this context.

Table 1.4: Trend of AIDS related deaths (2005 - 2021)

	2005	**2010**	**2017**	**2021**	**Totals**
All ages	120,000	60,000	22,000	22.000	226,000
Women (15+ years)	57,000	28,000	9,500	11,000	105,500
Men (15+ years)	48,000	24,000	10,000	9,900	91.900

Source: UNAIDS, 2020.

This trend shows that there has been a decrease in the number of adults dying from AIDS and its related illnesses from 2005 up to 2021, however, with a stabilisation in numbers in the year 2020. The reduction may be due to the scaling up of antiretroviral therapy. The 20 900 deaths recorded for men and women in 2021 were adults in the productive year age group who are likely to have left many orphans. Despite realising such a drop in the deaths, in 2017 the orphan crisis had already been created in the previous years where high figures in deaths were recorded. The crisis continues to burden the elderly in various communities up to this day (Kidman and Thurman 2014; Maronganye 2017; Mudavanhu, Segalo and Fourie 2008; Zvinavashe et al. 2015).

Historically, grandparents looked after their grandchildren while parents took up formal employment mainly in towns and cities (Bourdillon 1991). Though the elderly caregivers had been parents already prior to orphan caring, the contexts were now different and warranted acquisition of new skills, knowledge, and attitudes. The problem was that caregiving responsibilities were being undertaken by the elderly without any prior, appropriate adolescent HIV/AIDS caring knowledge. It seemed as if no educational programmes had targeted learning about and caring of AIDS orphans for the 55 years and above, notwithstanding that elderly carers had come back to parenting because of AIDS (Chepngeno-Langat 2014). Literature has also confirmed that the elderly caregivers lack competence in the execution of their caregiving obligations (Fauk et al. 2017; Maradik and Kim 2014; Zvinavashe et al. 2015). However, from the literature surveyed, there seem to be no studies that have focused on caring practices, coping mechanisms and learning experiences of the elderly caregivers of adolescent AIDS orphans. Hence, the current study which sought to understand the caring, coping mechanisms and learning experiences of the elderly caregivers of adolescent AIDS orphans as a contribution to this gap. I present the research questions of the study in the following sub-section.

1.5 Research questions

Drawing on Mezirow's transformative learning theory and the transactional model for stress and coping of Lazarus and Folkman, how do the elderly caregivers practice caring, learn about and cope with the disorienting dilemma of caring for the adolescent orphans in the context of HIV/AIDS? The study aimed to provide answers to this key question through the following two research questions, and to draw up implications for adult education programming:

1. What is the nature of caring practices and coping mechanisms that the elderly caregivers of adolescent AIDS orphans engage in?
2. How do the elderly caregivers learn to make new meaning out of their caregiving roles?

In the next section I present my personal motivation in undertaking the study.

1.6 My Personal Context and Motivation for the study

My positionality in this doctoral thesis is vital. As an adult educator interested in being relevant to my communities, it took me a while to come up with a study that would be pertinent and contribute towards impacting their lives.

I am an individual currently engaged in Adult Education, occupying an administrative position in an academic institution. My interest in HIV/AIDS issues dates back to 2002 when my twin brother and his wife died a month apart from the disease AIDS. At that time antiretroviral drugs were not yet widely available and stigma and discrimination were rife.

In addition, at my work place I was involved in on-going HIV/AIDS research, generating data in communities around Harare. When I tried to engage with my brother when he was in hospital, applying the little knowledge I had from that research, he would not allow me to engage with such a subject as he was very much in denial. In fact, I was accused of spreading the ‘rumour’ that he and his wife were living with the virus. In a few months, my sister-in-law succumbed to AIDS, and my brother followed in a month’s time and left three double orphans. Many communities were ravaged by AIDS but people did not know how to help. These devastations created many orphans on the way, some of whom have become a burden on their elderly grandparents.

The above family deaths made us as siblings share among the three of us the orphans that were left behind in their infant years. This was not an easy task for me: I was still a young parent with my own children to look after. As I reflect on it, if I felt burdened with orphan caring in my youthful years, how did the elderly caregivers beyond fifty years of age cope? I have always imagined what it was and still is like for elderly caregivers who generally believed it was now their time to rest and be looked after by their adult children. I always wondered how they practised caring, how they coped with the many challenges of the orphan care crisis and what learning experiences these caregivers derived from their caring responsibilities.

It is from this background that motivation for studying HIV/AIDS issues developed. As I went around with data gathering exercises as a research assistant, I observed some of the elderly grandparents were looking after their ill children and sometimes also looking after grandchildren orphaned by AIDS. In 2014 I attempted to embark on doctoral studies with one of the SA universities to scientifically look into issues of my interest, but this fell by the wayside as the then supervisor allocated to me, swayed my line of thought from HIV/AIDS to cancer. Due to power dynamics between student and supervisor, I felt helpless to dispute his decision and eventually ended up quitting the programme because I did not have the slightest interest in cancer issues. This meant the single step which begins a thousand miles journey had gone back to zero.

However, my interest in AIDS issues refused to die down and I revived it after about five years. Surprisingly, the topic of my study does not seem to have been researched as researchers seem to focus on the orphans and not the grandparents looking after the orphans (Chazan 2014). I worked on my proposal with the help of my two supervisors and it sailed through in the Faculty Board, enabling me to embark on data generation. I came face to face with the cumbersomeness of analysing qualitative data which would have overwhelmed me had it not been for the guidance from my two supervisors. It is this sustained inquisitiveness that has kept me captivated on my research to explore the nature of caring, coping mechanisms and the learning experiences of the elderly caregivers of adolescent AIDS orphans.

The rationale of the study which corroborated the reasons for conducting it is discussed in the next sub-heading.

1.7 Rationale

In spite of the HIV/AIDS interventions that the Government of Zimbabwe Ministry of Health and Child Care, together with international humanitarian organisations, offered to the Epworth community, it seemed that caregivers of adolescent AIDS orphans were struggling to cope in looking after these orphans. Some Adult Education programmes that may have assisted these elderly caregivers targeted the child bearing age group, which is 15 to 49 years, without paying particular attention to the elderly who appeared to have come back to parenting (HelpAge International 2017).

Just like the education programmes, programmatic interventions that were normally put in place by government and NGOs seem to have prioritised the productive years of between 15 and 49 years in view of HIV transmission. As such, questions regarding how the elderly, some infected by the HIV and also in frailty condition and without any adolescent care knowledge, manage this hyperactive age group and how they feel about relapsing back to parenting because of the HIV/AIDS menace, needed to be answered. The various studies around the globe (Fauk et al. 2017; Hawkins 2013; Hong 2015; Maradik and Kim 2014; Maronganye 2017; Tanyi 2018) that have been carried out have focused on caring for orphans but none focused neither on caring for AIDS orphans nor on caring by the elderly. Apparently, it appeared as if there were no studies which addressed the nature of caring, learning experiences and coping mechanisms of elderly caregivers of adolescent AIDS orphans. It was, therefore, against this background that I intended to find out the nature of caring, ways of coping and learning experiences of the elderly caregivers of adolescent AIDS orphans. The findings of this study may inform discussions and decisions on Adult Education training programmes on caregiving of orphans.

The historical context of extended family roles is discussed in the next section.

1.8 Historical Context of extended family roles

Grandparenting is a worldwide phenomenon although it has changed face due to contemporary problems in society (Zagheni 2011). According to Dhal (2016), grandparenting was historically part of life across families. In the African context, the extended family care system used to be common across households (Zagheni 2011). In the instance that children were orphaned, they would be accommodated in the households of their kin such as grandparents, aunts, uncles and many more. According to Isiugo-Abanihe (1985), the word “orphan” was not even in existence in Zimbabwe before the advent of HIV/AIDS due to the well-knit, firm familial relations that were there. Children spent most of their time amongst their kin even when not an orphan. Even though caregiving alongside familial ties was solidly grounded in our African customs and beliefs (Bourdillon 1991), it did not seem to receive any form of maintenance from the government to try and make the elderly caregivers’ responsibilities more manageable (Zagheni 2011), particularly in view of the AIDS challenges.

Raising orphans within the kinship system is expected to strengthen the family connections that existed well before the child became an orphan (Bourdillon 1991) and the orphans would positively identify their kin carers as role models. Traditional Zimbabwean Shona and Ndebele communities were known to be established around a patrilineal relationship arrangement (Bourdillon 1991). People of like patrilineage were clustered together and the residential group could be multigenerational. Traditional life was characterised by friendship and brotherhood, a sense of belonging to a big household and by groups as opposed to personages (Isiugo-Abanihe 1985). Bourdillon (1991:26) says that:

> It used to be, and still is, the ambition of a man to gather around him a growing lineage of descendants and dependents who would act as a corporate body for

> economic purposes and also a united body in times of crisis or tension within the community.

The extended family offered safety and support and the participants shared numerous possessions (Foster and German 2002).

Customarily, marriage used to be not so much the connecting together of two individuals but of two families (Bourdillon 1991). When the unification of marriage was agreed upon, lobola or bride price, predominantly in terms of a certain number of cattle, was usually paid to the family of the bride. Hence by making this payment, the children born in this union would become the responsibility of the groom and his kinfolk. Payment of lobola would also form a strong link among brothers and sisters. The bride price that the family would have received from the groom assisted them to also pay the lobola of their own son(s) in the household. The son's offspring would, therefore, have a superior connection with the paternal aunt, who would have a distinctive role in their rearing also having contributed to the bride price of their mother. The expression of a 'social' orphan was not in existence in Zimbabwean cultures (Foster and German 2002).

Bourdillon (1991) further posits that the extended family was the customary social security system and its members were answerable for the protection of the vulnerable, care for the underprivileged and the sick and the communication of traditional societal norms and values, and education. In recent years, contemporary issues such as HIV/AIDS, the labour exodus, the monetary economy, formal education and Westernisation have transpired thereby debilitating the extended family system. For instance, Foster and German (2002) note that labour relocation and suburbanisation have caused a decrease in the incidence of interaction between kinsfolk and stimulated social and monetary independence with possessions belonging to the nuclear family as opposed to the wider extended family. The improved life expectancy, as well as the smaller sizes of families, have now eroded the possibility of multigenerational families staying together; and the lack of arable land has increased the problem for huge families' monetary freedom generated from subsistence farming (Zagheni 2011). Socialisation is being acquired from institutions such as schools, social media and communications of youngsters with peers as opposed to customary mechanisms. This has tended to diminish the capability of the elderly to apply discipline to the youth (Foster and German 2002).

Ordinarily, Zimbabwean children have looked after their ageing parents, but now, according to HelpAge International (2017), parents are far more likely to bury their children. During the final stages of their illness, many adult children return home to be cared for by their parents (Small et al. 2017), bringing their children, who will then remain with their grandparents after the parents die. It should be noted that the extended family organisation normally provides for the physical, emotional and social requirements of the orphans under their care (Dhal 2016). The provisions, however, include counselling the orphans, providing educational necessities, food and accommodation. The elderly caregiving roles to the adolescent AIDS orphans are performed out of the need that arises as a result of the deaths of these grandparents' adult children from AIDS (Chepngeno-Langat 2014). The activities they perform mainly comprise household chores, attending to the orphans' medical requirements, food and shelter provisions, monetary as well as emotional wants and educational needs (Chazan 2014). Being AIDS orphans, the adolescents may have other special needs that tend to intensify the strain on the elderly caregivers (Casale 2015). The next item is on the relevant policy statements that were made by the government of Zimbabwe.

1.9 Policy Pronouncements on Public Welfare

The Zimbabwean government adopted the Health for All policy in the year 2000 which came against the context of marginalisation of black Africans and the associated uneven provision and distribution of resources (Zhou and Zvoushe 2012). The government had subsidies in the health and education sectors to cater for the poor majority's needs whose infant mortality rates were 120 per 1000, compared to that of the white minority which was 17 per 1000 (Zhou and Zvoushe 2012). The 15% of the population who were white were consuming 44% of the budget allocated to social services in urban areas (Zhou and Zvoushe 2012). 70% of the poor majority lived in rural areas. These, together with the few black Africans who lived in towns, had no access to medical insurance; neither did they have access to the urban sophisticated hospitals (Zhou and Zvoushe 2012). For obvious reasons, the life expectancy for Africans was lower than that for white settlers and was pegged at 49.8 years for black males, 53.3 years for black females while that of European males and females was 66.9 and 74 years respectively (Zhou and Zvoushe 2012).

Goods and services in the health sector and many other social sectors of the country were normally consumed along both social class and racial lines, with the elites consuming most of them (WB 2012). It was against this background that the Zimbabwe Ministry of Health embraced Equity in Health as a national policy. The adoption of this policy saw the movement of resources to rural areas, with the establishment of better health facilities for both urban and rural folk (Zhou and Zvoushe 2012). Nevertheless, accomplishment of the policy aims faced hurdles due to financial constrictions, drought spells around the 1990s, as well as HIV/AIDS that was already ravaging the Zimbabwean communities (Mudavanhu, Segalo and Fourie 2008). Poverty amongst the black communities remained unabated and there was a sharp rise in deaths from ailments related to AIDS which, in the process, generated a lot of orphans (Zvinavashe et al. 2015)

Zimbabwe ratified some global and regional tools such as the United Nations Convention of the Rights of the Child (UNCRC) in 1990, International Protocol for Alternative Care in 2009 and the African Charter on the Rights and Welfare of the Child (ACRWC) in 1992. These instruments were amalgamated into a plethora of legitimate tools and guidelines with the major aim of upholding children's rights. As such, the Zimbabwe government is compelled by the ratification of these tools to institute mechanisms and resources to ensure that all children are protected. It is one of the countries hardest hit by the HIV/AIDS pandemic in the SADC region: it is estimated that there were around 1.6 million AIDS orphans in Zimbabwe in 2016 (UNAIDS 2017). Out of this number about 5000 were acknowledged as those who still needed care as required by the Children's Act 5:06 of Zimbabwe and these lived in Residential Child Care facilities which were established in response to parental mortality due to HIV and AIDS. In Zimbabwe these facilities are better known as Children's Homes (UNAIDS 2017). The provision of alternative care for children while efforts are made to trace their families for possible reunion and reintegration is highly pronounced in the children's rights. This duty was mandated to the Ministry of Labour through its Department of Social Services. Although placement in the residential child care facilities is important, in Zimbabwe it is regarded as a last resort as preference is given to growing up among kinships (Foster and German 2002) in the event that a child is orphaned.

Another instrument, as earlier mentioned, is the African Charter (AC) on the Rights and Welfare of the Children that was put in place in 1999 by the then Organisation of African Unity (now African Union [AU]). Although its provisions are similar to those of the Children's Rights, it should be noted that it further added the aspect of responsibilities of the child. In these responsibilities, children are required to render fulsome respect to their elders and help them when necessary; and be good citizens through serving national communities, being morally upright, promoting the achievement of unity in Africa and the reinforcement of national and social harmony (Dahl 2016). Like the Convention on the Rights of the Child (CRC), the AC has a provision that protects children from any type of abuse. It is a crime in Zimbabwe and Africa at large to expose children to certain harmful traditional practices such as genital mutilation thereby exposing them to infection and child marriages for both boys and girls below 18 years (Dahl 2016).

The Zimbabwe National Orphan Care Policy (NOCP) adopted in 1999 is another important tool whose main objective is to ensure the realisation of rights contained in the UNCRC, as well as in the AC. The importance of children to their immediate families and communities around them is highly pronounced in this instrument. In this policy, traditional leadership has the important role of protecting the community's susceptible members inclusive of children. The purpose of the Orphan Care Policy is manifold: it includes directing the courts' focus and development agents to the exact orphans' needs, and promotion of research in terms of training of people looking after orphans. Although the policy does advocate for training of those who look after orphans, it has been generally observed that such training mostly focuses on institutionalised care as opposed to kin-carers, such as the elderly, across households. Without the much-needed training of caregivers within the extended family the abuse of children such as exploitation tends to escalate. However, on losing parents the NOCP encourages the extended family to take over the protection and caring of the child but, alas, the training mentioned above seems to be rendered to institutionalised carers seemingly forgetting the elderly in the extended family setup. This, therefore, prompted me to try and understand elderly caregivers' caring practices, coping strategies and learning experiences.

The government of Zimbabwe in the year 1999 introduced an AIDS Levy in an effort to provide domestic monetary support for HIV/AIDS intervention programmes. The programmes involved paying school related support for the orphans and vulnerable children (OVC) through the basic education assistance module (BEAM) as well as the prevention and treatment strategies. AIDS

Levy was established to complement the AIDS financial assistance that comes from external humanitarian organisations. Three per cent of taxable earnings is deducted from individuals and corporates in an effort to build this fund. Bhat et al. (2016) acknowledge that income for the AIDS levy improved from the beginning to 2006 through 2008, marking the era of monetary uncertainty, characterised by runaway inflation in the Zimbabwean economy. Subsequent to the adoption of the multicurrency system in 2009, yearly income further rose to around US$38 million by the year 2014. Numerous monetary controls and auditing arrangements are well in place. Despite the improvement of income as noted in literature, the fund does not seem to embrace the kin elderly caregivers of adolescent AIDS orphans in its various programmes. Hence there was need to understand their stories of caring, coping and learning in adolescent AIDS orphan care. As this chapter draws to an end, following is its summary.

1.10 Overview of Theoretical Framework

The study used two theories in its theoretical framework because of the variables in the topic which could not be addressed by a single theory. The transformative learning theory (TLT) propounded by Jack Mezirow (1978) addressed the caring practices and learning experiences of these elderly caregivers. “Learning is about transformation, it’s about change, it’s about seeing yourself in relation to the world differently” (Apte, 2009:168). This quotation basically summarises the fundamental idea of the transformative learning theory. In Mezirow’s view, learning is a journey that a learner embarks on to alter their previously held frames of reference by understanding the experience. This understanding would thus direct one’s actions and allow the individual to provide a basis for these actions. According to Mezirow (1978), learning is a shaping of people’s views of the world because it enables one to reflect upon those procedures of verifying certain concepts that may not be in harmony with suppositions carried forward by an individual learner through previous knowledge. Learning, therefore, changes from being prescriptive and turns out to be more integrated into the learner’s life, as opposed to simple facts and figures which are rehearsed in such a way that it is extrinsically evaluated. As such, this theory is appropriate for this study as it provides a lens to get a better understanding of the caring practices and learning experiences of elderly caregivers in looking after their adolescent AIDS orphans.

The transactional model of stress and coping (TMSC) proposed by Lazarus and Folkman in (1984) looked at how these elderly carers cope with their situation of caring for AIDS orphans. TMSC suggested that people get stressed up only if their coping mechanisms were judged to be insufficient to overcome the present demand. An individual and the situation were perceived as if they were in a dynamic, equally reciprocal, multi-directional association. Hence, the central point of TMSC is the relationship between a person's demands and the ability to deal with these demands in the environment. I was interested to see if the elderly caregivers in the study engaged in the approaches to coping as identified by Lazarus and Folkman (1984).

In the following heading I give an overview of the methodological approach for this study.

1.11 Overview of Methodological Approach

The study aimed to explore the caring practices, learning experiences and coping mechanisms of the elderly caregivers of adolescent AIDS orphans. As such, my choice of methodology was already dictated by what the study purpose was, which must be in line with the dictates and rules of the selected theoretical standpoint (Guba and Lincoln 2005). This research adopted the interpretivist paradigm, whose essential effort is to interpret the subjective world of the researched's experiences (Creswell and Creswell 2017). This view endeavoured to generate understanding of what participants thought about a certain phenomenon and the meanings they might attach to their contexts (Searle 2015). In the present study, there was a need, therefore, to attempt to understand the elderly caregivers' caring practices, ways of coping and learning experiences from their own standpoint as opposed to my own perspective. In the interpretivist paradigm, prominence is on the participants and how they interpret their own world (Patton 2002).

The study also adopted a qualitative approach to research, whose principles are compatible with those of the interpretivist paradigm (Searle 2015). The principles view social realities as being entrenched in social settings (Best and Kahn 2016; Creswell and Creswell 2017; Leung 2015). It is assumed that reality be interpreted through a sense-making process, contrary to testing hypotheses in the positivist paradigm where suppositions are that reality is somewhat autonomous of the context (Gutterman, Fetters and Creswell 2015; Searle 2015). Social reality in my study was the truth that elderly caregivers were taking care of adolescent AIDS orphans without previous training to perform such a huge role.

The phenomenology design, whose essential purpose is to describe and interpret the views and insights of the participants, and study how these can be linked to people's lived experiences of their, was adopted for this study (Creswell 2014). The choice of this design was influenced by things like study purpose, theoretical frameworks, approach, analysis and interpretation of the data (Creswell 2014). The design also dealt with how some people have experienced a particular phenomenon. There should be conformity of all these aspects with the principles of the selected paradigm (Patton 2002). Whatever I did was consistent with the commands and guidelines of the interpretivist paradigm which shelters the methodological aspects that I have chosen. Phenomenology was, therefore, adopted because of its appropriateness in exploring learning experiences and coping ways of elderly caregivers in looking after adolescent AIDS orphans.

1.12 Chapter summary and Structure of the thesis

This study was a qualitative inquiry which adopted the phenomenology design, all which is consistent with the dictates and principles of the interpretivist paradigm. It sought to investigate the caring practices, learning experiences and coping mechanisms of the elderly caregivers of adolescent AIDS orphans in Epworth, Zimbabwe. Thus, the nature of caring, coping mechanisms and learning experiences of elderly caregivers in the context of AIDS were presented as a fundamental issue meriting research.

Chapter One was the preamble to this investigation containing strategic features such as the background, central questions which the research intended to answer, statement of the problem, rationale for the study and other pertinent supplementary components. Key points were that elderly caregivers were undertaking caring responsibilities without prior learning in regards to the AIDS context. Overviews of the theoretical framework, literature around the globe and methodological aspects were also made.

Chapter Two discusses related literature reviewed internationally, regionally, and nationally. In the global arena, and in relation to Research Question One, the nature of caring practices for caregivers was supported by monetary assistance from NGOs and the central and local governments. There was provision of basic needs of these children and a low child-carer ratio was safeguarded. Caregivers had regular incomes, with periodical assessment and parenting consultation from the associate NGOs. Regionally, and in relation to Research Question Two, the learning which emerged from past research is that caregiving is a heavy burden and that caregivers were incompetent in executing caring responsibilities. Their chief strategy in responding to the orphan crisis was engagement in subsistence farming of vegetables and maize. The previous research looked at coping ways of caregivers and not specifically their learning experiences and without a theory to illuminate their coping strategies.

Chapter Three presents the theoretical framework, comprising two theories as highlighted above: transformative learning theory (TLT) (Mezirow 1978), and transactional model of stress and coping (TMSC) (Lazarus and Folkman 1984). Use of two theories was necessitated by the different variables in my topic which could not have been fully addressed by a single theory. While the TLT addressed the caring practices and learning experiences of the elderly caregivers, the TMSC addressed their coping strategies. The historical developments and critiques of the two theories were also discussed.

Chapter Four discusses the methodological issues embraced for this research, under the headings Research Paradigm, Design, Population and Sample. The procedures of data gathering and analysis are further discussed; ways of enhancing rigour are also discussed under trustworthiness and ethical issues observed throughout the research.

Chapter Five presents and analyses data that was generated in response to Research Question One. Research Question One focused on the caring practices and coping mechanisms of the elderly caregivers in their execution of orphan care in the context of AIDS. The Chapter also discusses the challenges that the elderly caregivers faced in the practices of care which emerged from the data.

Chapter Six presents and discusses findings on the two themes which emerged in answer to Research Question Two, focusing on the new learning that the elderly caregivers gained in their caring practices.

Chapter Seven first reflects on the theoretical framework, methodology and the study itself. The discussion of findings, and lessons and contribution of the study follow next, with implications for adult education, recommendations and conclusions coming last.

The definition of terms in the following section brings Chapter One to an end.

1.13 Definition of Terms

1.13.1. Adolescence

Zaky (2016) defines the term adolescence as a physical and psychological development phase that happens from puberty to the age of maturity. For the purpose of this study the age range 10 and 19, as defined by WHO, applies. It is a transitional period that stretches from childhood to adulthood. Naturally, adolescence covers the stage between the onset of puberty until the completion of bodily growth. Adolescents are interested in assuming adult roles and tend to experiment with their bodies that will be rapidly growing (Quas 2014; Wagner et al. 2017) and at this age they are often emotional as a result of hormonal changes. The transition signifies challenges to everyone who has anything to do with human conduct or behaviour and these include parents, as well as the elderly caregivers of AIDS orphans, clinical psychologists and psychiatrists (Jorg et al. 2016). More elaboration on adolescence is in the literature review chapter.

1.13.2 **Orphan**

Traditionally, an orphan is someone who no longer has any parent living in order to be looked after. However, the United Nations Children's Fund (UNICEF) and the Joint United Nations Programme on HIV and AIDS (UNAIDS) tag individuals under 18 years of age who have lost single or both parents, as orphans. If one has lost both parents they call him/her a double orphan. A maternal orphan is a child who has lost his/her mother and, similarly, a paternal orphan is someone whose father is dead, while a double orphan has lost both mother and father. This is contrary to the traditional usage of the word 'half-orphan' to describe youngsters who have lost particularly one parent. In this study, the UNICEF definition has been adopted.

1.13.3 Caregiver

This is an individual, such as a parent, grandparent, foster parent, or head of a household, who attends to the needs of a child or dependent adult. It is a person who takes care of someone requiring close attention, as a young child or an invalid (Webster's New World College Dictionary 2010). In this study, the elderly persons were those people aged 55 years and beyond, who happened to be caregivers of adolescent AIDS orphans. The WHO has defined an elder in an African context as someone from 50 or 55 years upwards.

1.13.4 AIDS

Acquired immune deficiency syndrome (AIDS) is an infectious disease triggered by the human immunodeficiency virus (HIV). It was originally documented in the United States in 1981. AIDS is the advanced form of infection with the HIV disease that does not cause noticeable sickness for a long period after the original exposure (latency). Currently, all forms of AIDS treatment are fixated on refining the quality and length of life for people living with AIDS by slackening or stopping the duplication of the virus and treating or preventing infections and malignancies that benefit from a patients' deteriorating immune system (http://www.medterms.com/scriptlmain/art.asp?articlekey=3769).

1.13.5 HIV

Human Immunodeficiency Virus is the one that causes the disease AIDS (http://www.medterms.com/scriptlmain/art.asp?articlekey=3769).

1.13.6 Extended Family

An extended family is a collection of people comprising of more than double generations of kinsfolk living either in the same household or actually nearby to one another. These might comprise the kin of an individual, both by blood and by marriage, besides its close family, like grandparents, elder siblings, aunts and uncles (http://glossary.adoption.com).

1.13.7 Household

A household is a set of people staying or residing together under the same roof sharing foodstuffs from the same pot, whether or not they are related by blood (http://glossary.adoption.com).

1.13.8 Coping mechanisms

Lazarus and Folkman (1984:112) define coping mechanisms as a person's "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are considered as taxing or exceeding the resources of the person". According to Hawken, Turner-Cobb and Barnett (2018:22), the coping concept is used "in general terms to include defence mechanisms, active ways of solving problems and methods of managing stress". It was observed that crisis occasions happen from time to time in the course of human life. For example, caring for adolescent AIDS orphans might present crises predominantly for the extended families who already have their nuclear family needs to attend to. UNICEF (2016) reported that there is a need to strengthen families through resource mobilisation so that people cope with the effects of the disorienting dilemma that was encountered as a result of AIDS.

1.13.9 Transformative learning

Conceptualised by Jack Mezirow (1978), transformative learning describes how adults learn and make sense or meaning out of situations or occurrences which they encounter in their lives. Having been influenced by the works of Freire on critical consciousness, Mezirow (1978:167) focused on the process by which adults develop perspective transformation, which term he described as "the process of becoming critically aware of how and why our assumptions have come to constrain the way we perceive, understand, and feel about our world; changing these structures of habitual expectation to make possible a more inclusive, discriminating, and integrative perspective; and finally, making choices or otherwise acting upon these new understandings." The current study, drawing from Mezirow's ideas, explored how the elderly caregivers learned and coped with the disorienting dilemma of caring for adolescent AIDS orphans.

1.13.10 **Learning**

Conventionally, research on learning has mainly concentrated on children and adolescents. Nonetheless, it is now acknowledged that learning is an unceasing process that starts from birth to death (Nisbet and Shucksmith 2017; Revans 2017). Learning is an activity through which people utilise their lived experiences to handle new circumstances in order to improve on lives (Boud, Keogh and Walker 2013; Mezirow 1978). As such, most of our learning happens deliberately and/or sub-consciously within the life course. Hence, people can also learn from new experiences such as disorienting dilemmas (Mezirow 1978). According to Cranton (2006), learning encompasses more facets than just thinking. This means that the whole person with his/her values, attitudes, beliefs, perceptions, feelings, as well as a will to learn, must be involved in the process of learning. Without the will to learn, an individual does not do any learning, and if we learn there is bound to be change of some sort (Mezirow 1978). Above all, if our learning does not make any difference in the circumstances we encounter in our lives then it will be insignificant. In the case of elderly caregivers in the study, if they were to engage in learning, the learning must be able to positively change their circumstance in the realm of caring for adolescent AIDS orphans.

1.14 Chapter Summary

Chapter one set out the scene, making the chapter a prelude to the study. Strategic structures like the study background, research questions, statement of the problem, significance of the research and other appropriate accompanying elements were all dealt with in this chapter. The important points to draw from these features were that the elderly caregivers were deficient in requisite knowledge, skills and attitudes in adolescent AIDS orphan care. The chapter also made some synopses of the theories that informed the study, literature reviewed for the research, as well as issues to do with methodology.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The study aims to explore the nature of caring practices, coping mechanisms and learning experiences of elderly caregivers of adolescent AIDS orphans in Zimbabwe, and draw up implications for Adult Education. Having set the scene in Chapter One, this literature review chapter examines the domains of learning, learning of adults, characteristics of adult learners, critiques of Knowles in his principles of adult learner, adolescence, and what other writers have said in relation to the aims of this study. As learning is a central issue to this study, it is important that it gets some foregrounding at the initial stage of this chapter.

2.1 Domains of learning

2.1.1 *Formal learning*

This is the learning that normally happens in a classroom situation (Colardyn and Bjornavoid 2004). It is characterized by a hierarchical structure where a teacher is in control of the learning activity, following pre-set curriculum and learning objectives whose outcomes are chronologically graded, with the award of certificates at the end of a programme (Freire 1970). This type of learning is associated with schools or institutions, academies and other training establishments whereby the learning is not for immediate application to solve current problems.

This is the banking concept of education which Freire (1970) defined in his criticism of traditional educational systems. Learning here is done without reference to the experience of the learner, despite adults having accumulated it in abundance; and whatever is learned is used in the future. This banking concept refers to the metaphor of students being vessels into which the teacher deposits knowledge as if depositing money in the bank. Such learning, however, supports the absence of critical thinking and instead strengthens oppression. Formal learning cannot be ideal for the elderly caregivers who are experiencing caregiving problems in the context of HIV/AIDS. This leads me to discussing non-formal learning.

2.1.2 *Non-formal learning*

Non-formal learning is a planned scholastic activity that is carried out outside the formal arrangement (Colardyn and Bjornavoid 2004). According to Coombs and Ahmed (1974), non-formal education is any planned, intentional learning activity that is conducted outside the background of the formal system, to provide chosen kinds of learning to specific subcategories of people. This includes both adults and children. In the same vein, non-formal education is defined by Yasunaga (2014) as that education which is institutionalised, deliberate and planned by authorities in the educational field. Its essential feature is that it complements formal education in the course of an individual's life-long learning (Ainsworth and Eaton 2010). Non-formal learning does not end up with the learner having to obtain a recognised certificate, besides a certificate of attendance. Examples of such learning are generally more pronounced in formalised work places where activities like workshops and seminars are administered to improve workers' performance. It can also be done in community-based programmes such as agricultural extension, health education and youth clubs to improve performance in their various activities. Non-formal learning comes with its curriculum tailor-made to suit a situation in the workplace and other organisations implementing it. As such, it could be a potentially useful form of learning for my orphan carers where the curriculum may be tailor-made to appropriately respond to their situation. This takes me to the domain of informal learning.

2.1.3 *Informal learning*

This type of learning encompasses all learning that occurs without any curriculum to be followed (Colardyn and Bjornavoid 2004; Kaziboni 2018). It can take place within formal and non-formal educational situations; however, such learning is spontaneous and autonomous in nature and frequently not contributing to the outcomes of the set syllabus (Schugurensky 2015). Informal learning – also known as incidental learning – is, therefore, viewed as a process of meaning-making where individuals strive to understand and interpret the vast experiences they have accumulated during the course of life (Ainsworth and Eaton 2010; Knowland and Thomas 2014;

Knowles, Holton III and Swanson 2014). As we continue to informally learn in our daily activities, we tend to critically reflect on our prior experiences or frames of reference making necessary revisions, thereby generating new meanings in view of new experiences (Mezirow 2000). Most of the learning that occurs throughout life is, thus, acquired by way of informal learning (Kaziboni 2018). This domain of learning sits at the margins of other activities given its spontaneous nature: for example, carers may bump into each other and start sharing experiences because whenever people gather, opportunities to learn from one another are amplified. This study would try to establish whether caregivers in this study also experience such a type of learning where they meet and discuss by the way side with other community members thereby learning from such sharing. This type of learning is likely to be appropriate for the elderly caregivers of adolescent AIDS orphans in their quest to learn and to cope with this new responsibility. Below is a discussion on experiential learning.

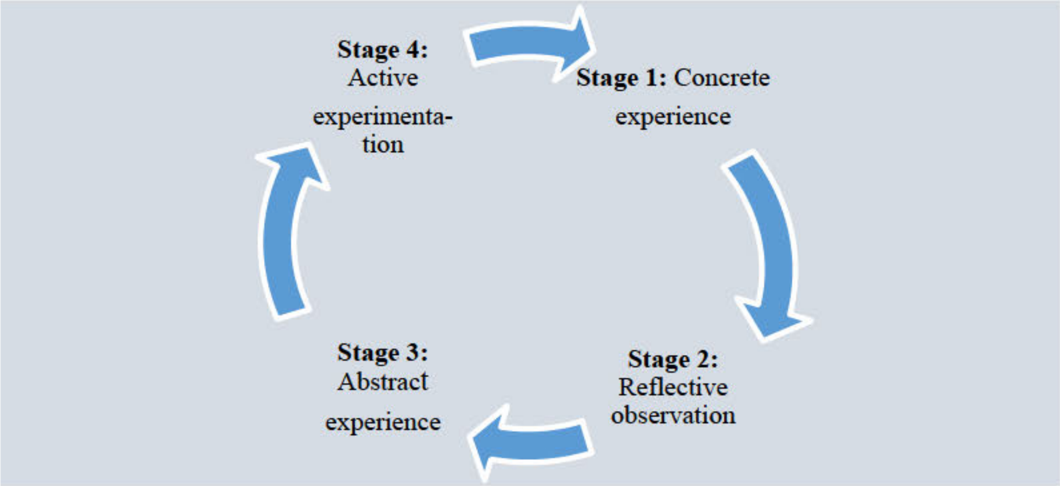
2.1.4 *Experiential learning*

Experiential learning is defined by Bassett and Jackson (1994) as that process of learning through lived experiences. Kolb (1984:4) says it is the process by which "knowledge is created through the transformation of experience". In other words, this is mainly a knowledge construction process of the individual's experience which is done through hands-on experiences (doing) and reflection on the experiences. In Lewis and Williams's (1994:5) words, "experiential learning means learning from experience or learning by doing". In these definitions, the central point is that experiential learning involves a hands-on way to learning which moves away from the concept of rote learning. The elderly caregivers were initially faced with giving care to the adolescent AIDS orphans which then may stimulate some reflection on their lived experience in order to change to new knowledge, skills, attitudes and new ways of thinking and doing things. The way they looked after their own children in the past may not necessarily be the same as what they may be required to do with the AIDS orphans. Because of contextual differences now, they needed to reflect on their frames of reference with a view to transforming some of their practices, knowledge, skills and attitudes.

Learning through experience entails that the learner takes charge of his/her own learning, as opposed to being told what to do, how and when (Moon 2011). Much of the responsibility to learn is, therefore, vested in the learner. Throughout the learning, the learner keeps on reflecting on their learning. An effective experiential learner has a readiness to rearrange their idea of a problem facing them. The learner may now reason out issues for themselves and effectively describe their own situation. Thus, the elderly caregivers' problems may have triggered some readiness to learn so that they effectively performed the caregiving responsibilities. They may reflect upon their previous vast experiences in looking after orphans in order to learn to make meanings out of the new situation.

Kolb (1984) has proposed a model of experiential learning whose figure is presented below:

Figure 2.1: Kolb's Experiential Learning Model (ELM)



Source: McCarthy (2016)

2.1.4.1 The stages of ELM are elaborated on below:

Stage 1: Concrete experience: This is when the learner encounters a new experience or maybe could make a reinterpretation or a new understanding of an existing experience (Kolb 1984). The elderly caregivers encountered a new situation of providing care for adolescent AIDS orphans although they seemed to lack prior training to perform the responsibility.

Stage 2: Reflective observation: The learner reflects on and extracts knowledge from their prior experience in an analytical way (McLeod 2013). It is fundamental that there exist some inconsistencies between experience and how the learner interprets the experience. The elderly caregivers reflect on how they cared for their children in the past and compare that with caring now and may learn to transform certain ways of caregiving.

Stage 3: Abstract conceptualisation: By reflection, new ideas emerge, or an amendment of some existing abstract ideas (Kolb and Kolb 2005; Mezirow 2000). Thus, learning from experience has occurred. The elderly caregivers may now be able to come up with new concepts of caregiving in view of the AIDS background after critical reflection.

Stage 4: Active experimentation: The learners try out the learned conceptions on their situations to see if they can solve their problem (Kolb 1984; Mezirow 2000). The elderly caregivers may use the learned new ideas and assess their effectiveness in solving the caring dilemma they currently have.

In view of the above stages, it is important to also outline the main features of adult learning through the ideas of Knowles (1980).

2.2 Learning of adults

As this study explores caring practices and learning experiences of elderly caregivers, it is prudent to assign a section that holistically looks at adult learning, specifically focusing on elderly caregivers who are the participants in my research. According to Coombs and Ahmed (1974), Jarvis, Rabusicova and Nehyba (2015), and Pappas (2013), learning refers to the changes that happen in our behaviour resulting from experiences. The learning of adults is dependent upon various internal and external factors (Knowles, Holton III and Swanson, 2014).

Significant to this learning are driving forces that intrinsically and extrinsically trigger learning (Pappas 2013). The motivation becomes strong if adults realise that the learning satisfies their basic requirements, such as being accepted in a community or family, gaining the respect of others around, achievement, and being able to solve personal problems (Knowles, Holton III and Swanson, 2014). The elderly caregivers in their contemporary disorienting dilemma may be motivated to learn so that they achieve the goal of effectively caring for adolescent AIDS orphans in their households. Other extrinsic motives (Knowles, Holton III and Swanson, 2014), such as financial rewards, provision of household supplies to both elderly caregivers and orphans, recognition and earning titles after caring for the orphans in a manner that is admirable to community may trigger further learning in an individual.

The idea of critical reflection in these motivating factors, a main tenet of transformative learning, is dominant (Mezirow 2000). The cornerstone to transformation is rooted in critical reflection. If the elderly caregivers critically reflect on and interpret their experiences, particularly those that came as a disorienting dilemma, then they have adopted transformative learning (Kucukaydin and Cranton 2013). Through the notion of critical reflection, my participants may transform their perspectives about how they produce practical knowledge, and in the process can improve their ways of caring for adolescent AIDS orphans.

In the learning process, one reviews past experiences in order to come up with a new meaning making of experience to guide subsequent learning (Mezirow 2000). According to Boggs, Mickel and Holton (2007), learning is grounded and occurs out of our past learning, thus, our prior experiences. That which we have already learned tends to formulate the foundation from where additional learning happens and it is upon this ground that an individual makes new steps (Christie et al. 2015). Adults always build on what they already have, because previous experience continues to live on in them in the form of recollection, experience, as well as capabilities. In the absence of the previous experiences being active in the current situations, adults may not acquire additional learning (Christie et al. 2015). In this view, Kolb (1984) perceives learning as a result of functional environmental interface that an adult interprets through meaning making. The scope of knowledge, skills and attitudes that an adult holds contributes to learning, regardless of the situation in which it has occurred (Colardyn and Bjornavold 2004). Hence, these authors propose types of learning to be formal, informal, non-formal and experiential as discussed above, which when combined constitute lifelong learning.

Lifelong learning entails that all the learning that has occurred in the past in the various situations that adults found themselves in be connected together (Findsen and Formosa 2011). Since learning occurs in the now it, therefore, becomes constantly rooted in the strain between what is and what ought to be (Pappas 2013). It is interesting to find out how the elderly caregivers relate their prior experiences to the learning that is in the present, where the present as a moment embraces both past and future (Colardyn and Bjornavoid 2004). These elderly carers already have experience in looking after children of all age groups, so in view of the contemporary issues in our society, they should learn to construct new meanings and cope with the disorienting dilemma of AIDS orphans.

The characteristics of adult learners as propounded by Knowles are discussed in the following section.

2.3 Adult learners' characteristics

Adult life is fraught with complexities due to contemporary issues that one encounters (Knowles, Holton III and Swanson 2014). These difficulties call for adults to be able to think independently or as individuals in order to let them make sense of the world around them, free from imposed pre-suppositions such as beliefs, norms, values, religion etc. (Mezirow 2000). As such, it is necessary that adult learners' characteristics are discussed.

2.3.1 *Sense of the self*

Knowles (1980) posits that the adult has a sense of self that is already well established. During childhood, an individual models him/herself on parents and siblings (Wagner et al. 2017). From adolescence, we become inclined to pull away from parents to imitate peers around us (Omotoso 2007). And by adulthood we will have picked and selected frames of reference from the two phases to form a whole entity called the 'self', and become really attached to it (Mezirow 2000). In view of the self, an adult is aware of his/her distinction from others surrounding him/her and this tends to impact on decision-making and behaviour thereafter (Knowles, Holton III and Swanson 2014). As such, adult learning is self-directed, where learners take charge of their own learning, initiating activities that are self-governing, and self-dependent. It is important that their teachers understand these characteristics and use experiential methods of teaching, guiding only when required and helping them achieve goals set prior to learning (Knowles 1980). The learning can be deliberate because it is motivated by a specific purpose. Any learning that is imposed on them by others may face resistance (Knowles 1980; Schugurensky 2015). It was, therefore, essential to find out if the elderly caregivers critically reflected upon their prior experiences with a view to learning new information, given the new caregiving responsibility they now had to carry out. The study would reveal how the 'self' impacted on their sense-making of the contemporary disorienting dilemmas in their household.

2.3.2 *Role of prior experience*

When identifying themselves adults mainly draw from the vast experiences they have accumulated throughout life (Knowles, Holton III and Swanson 2014). This world of experience can be both social and academic. Any endeavour to have adults learn in an effective manner should tap from what they know already going into new ideas (Knowland and Thomas 2014). The past, thus, helps as a reserve to make learning more meaningful. My participants may critically reflect upon their vast experiences in order to find a rooting of the new experiences. By so doing, transformational learning would have occurred.

2.3.3 *Purposeful learning*

The learning of adults has a specific purpose as they need to know why they must learn something (Knowles 1980). Hence, they want to learn if what is to be learned has relevance in solving their immediate problems. Theirs is goal-oriented learning. The caregivers may engage in learning if its practical utility immediately makes them better caregivers of orphans, thereby alleviating this disorienting dilemma they are currently experiencing. In view of the fact that they assumed this social role without any form of training, the most powerful motivating factors are the internal pressures that they experience in executing their caregiving roles (Mezirow 2000).

2.3.4 *Readiness to learn*

Closely linked to the practical utility of the learning is the adult's readiness to engage in learning (Colardyn and Bjornavoid 2004). Adults become ready to learn if the learning experience assists in dealing with their life situations, such as performing tasks relevant to their social role. On being faced with the disorienting dilemma of orphans, and upon critical reflection on past experience (Mezirow 2000), the elderly caregivers might find themselves ready to learn in order to be able to effectively perform the social role of caring for the AIDS orphans.

2.3.5 *Orientation to learn*

According to Knowles, Holton III and Swanson (2014) the learning of adults revolves around real life issues. In the same vein, my participants felt the drive to learn if the learning would help them to practically respond to their disorienting dilemma of losing adult children through AIDS and having to care for the adolescent orphans created by these deaths. Despite the ideas of Knowles having assisted in structuring most adult educational programmes around the world, they have also been widely critiqued. Following are some of the critiques of Knowles identified in literature.

2.4 Critiques of Knowles' Adult Learners' Characteristics

The idea of andragogy has its own share of critics. Brookfield (2000) claims that the theory is blind on culture. He argues that self-directed learning and the notion of learner and teacher creating a non-intimidating relationship to enable learning may disregard certain races and cultures which value the instructor as the principal source of information and guidance.

The validity of andragogy as a theory of adult learning came into question around the 1970s to 1980s. In their account for the debate around this validity, Davenport and Davenport (1985:157) argue that andragogy was classified "as a theory of adult education, theory of adult learning, theory of technology of adult learning, method of adult education, technique of adult education, and a set of assumptions" leading Hartree (1984) to query if there existed any theory at all. Hartree (1984) suggested that maybe these were simply explanations of what adult learners must look like and not necessarily naming these as theories.

Another criticism emanated from the degree to which Knowles' assumptions are features found only in adult learners. Merriam, Mott and Lee (1996) argue that there are some adults who are greatly dependent upon the instructor for structure, while the opposite is also true that some children are autonomous and engage in self-directed learning. Knowles later conceded that the two concepts may be appropriate for either adult or child depending on the context.

This led Knowles (1980:112) to eventually agree that andragogy was "a model of assumptions about learning or a conceptual framework that serves as a basis for an emergent theory". The critique leveled against the assumptions of andragogy and pedagogy provoked Knowles to review his thinking about whether andragogy and pedagogy were just for adults and children respectively. It was around the 1970s and 1980s that he shifted his position of having the two standing at opposite ends, claiming that they represent a continuum that ranges from teacher-directed to learner-directed learning. Although I used some of these critiqued ideas of Knowles in my study, the use of two different theories in my findings may have minimised the impact of the weaknesses highlighted in the literature. In the next paragraph, I discuss the term ‘adolescence’ to put the challenges of elderly caregivers of adolescents into perspective.

2.5 Adolescence

Since the term adolescence has already been introduced in the background chapter and briefly defined, I now move on to giving more detail about it, elaborating on its various stages. Transitions at the adolescent stage are multiple (Omotoso 2007), affecting living conditions, education, employment or lack of it (Quas 2014). It is a crucial phase that is characterised by multiple rapid developments including moral, sexual, social, physical and emotional (Zaky 2016). Being a fundamental stage, the adolescent requires considerable care from parents or guardians, with proper direction or guidance by people who exercise empathy with them (Quas 2014), which may not be easy if the caring is provided by elderly caregivers who normally lack prior knowledge in view of the HIV/AIDS situation.

In some parts of the African continent today, some parents turn to their own experiences of how they were brought up in dealing with their adolescent children (Omotoso 2007). However, this does not automatically mean they care positively for their own adolescents (Jorg et al. 2016), and in terms of AIDS orphans, we are now living in a contemporary context that would require the acquisition of relevant knowledge by elderly caregivers to effectively perform caregiving responsibilities. Sometimes parents lack adequate time for adolescents due to ever-busy schedules in life, whereas others just lack understanding and knowhow in resolving any emerging issues (Zaky 2016). Some with little knowledge about this stage of development tend to use inappropriate ways of disciplining the adolescent, using methods such as house arrest and prohibition from engaging with friends (Omotoso 2007).

Moreover, elderly carers and adolescent AIDS orphans are generations apart: their interests may not be harmonious and, therefore, likely to create conflict and tension between them. Deviance among adolescents is generally said to be rampant (Quas 2014). Disciplinary issues on the part of adolescents (Zaky 2016) were recorded in some studies as worrisome to the elderly and this is one of those experiences that the elderly suffer (Dolbin-MacNab and Yancura 2017; Jongwe 2014).

2.5.1 *Early adolescence*

At this stage adolescents are faced with remarkable bodily changes in growth and development which normally occur prior to puberty and throughout adolescence (Omotoso 2007). It is at this time that major physical growth takes place, with marked increase in height and weight (James 2013). The growth is rapid and sometimes gives some youths discomfort as the growth varies from one person to the other. Boys will develop deep voices while girls start their periods or menses (Jaworska and MacQueen 2015; Wagner et al. 2017). This stage is characterised by conflict between the adolescents and their parents or guardians because they (adolescents) develop the reasoning that their parents/guardians are not perfect as they see good or bad in concrete terms (Zaky 2016). The adolescents become irritable and demand more secrecy from their parents (Quas 2014). The age ranges for these growths is between 10 and 13 for females, while it is 12 and 15 for males. These are the age groups which are transitioning to secondary education after completing the primary level of education. However, for my elderly caregivers' orphans this stage has already passed and this section is mainly for the reader to understand the nature of adolescent stages. With adolescent behaviour, it remained to be seen in this study how the elderly caregivers handled the orphans and coped with such situations.

The hormonal changes in this stage are also known to cause skin problems emanating from the increase in the production of sebum (which is the skin oil) thereby creating an oilier look to one's skin (Jorg et al. 2016; Kalat 2016; Wagner 2017). It is common knowledge that majority of teenagers struggle to fight spots that are created by acne; and they worry about their perspiration which is fairly unpleasant (Omotoso 2007). Some authors posit that it is crucial that the adolescents maintain a healthy lifestyle which comprises balanced nutritious diets, with sufficient peaceful sleep (Jaworska and MacQueen 2015), and adequate physical exercise (Kalat 2016). However, literature has revealed that elderly caregivers are usually struggling to make ends meet for survival, let alone managing the provision of balanced nutritious foods enabling a healthy adolescence. Important questions which the study addressed are, therefore: How then do they learn to make sense out of this situation? What is the nature of their caring? How do they respond to the dilemma? After early adolescence, the following paragraph addresses middle adolescence.

2.5.2 *Middle adolescence*

This stage is for those aged between 14 – 18 years (Quas 2014). A major feature here is generally the completion of puberty (Zaky 2016), with adolescents now embarking on abstract and relativism thinking (Omotoso 2007). This kind of thinking is essential in the youths' formulation of individual identities that are normally distinct from their guardians or parents (Kalat 2016). Their cognition has developed and enables them to consider their own future thereby designing clear goals and objectives about it (Heider 2013; Jaworska and MacQueen 2015). The middle adolescent defines his/her own identity, norms, values, and attitudes in terms of peers and not parents/guardians (James 2013; Quas 2014; Wagner et al. 2017). Love feelings start to develop and this often tends to interrupt prior peer groups and other relationships (Jaworska and MacQueen 2015). The stage marks the completion of high school learning to transition to college studies (Omotoso 2007). Other central features for this phase are mood fluctuations, rebellion and irritability. These are often punctuated with disobeying parental prescriptions so as to conform to peer group principles (Jaworska and MacQueen 2015; Omotoso 2007). It was also my intention in this study to establish whether the elderly caregivers dealt with such adolescent behaviour in their caring practices, the coping strategies that they adopted and what knowledge they gained therefrom.

Although elderly caregivers may have past experience in looking after adolescents, the context is now varied in view of HIV/AIDS with its associated challenges such as stigma and discrimination. It, therefore, calls for the acquisition of new skills, knowledge, and attitudes to be effective in the social role of caregiving. When they looked after their own children as adolescents, the elderly caregivers were probably still in their youthful years and would cope with some of the problems associated with adolescence. Now that they are frail, poor, and some of them living with HIV (HelpAge International 2017), I wondered whether they would be able to face up to the task of adolescent orphan care. This brings me to the late adolescence stage.

2.5.3 *Late adolescence*

The late adolescence period runs from 19 – 21(+) years, with the adolescent now being considerate of other people's emotions (Wagner et al. 2017). The relationships with peers are still taken as key (Quas 2014), although a sense of self that is independent of peers and guardians tends to develop (Jorg et al. 2016). Adolescents at this third stage make more serious and long-lasting associations (Jaworska and MacQueen 2015). Their socialisation becomes important, giving a reflection of their initial personality as part of their wider identity (Omotoso 2007). The adolescent keeps on setting clearly and more realistically defined goals for the future and also ensures that he/she thinks like an adult. According to Omotoso (2007), an adolescent at this stage can reflect on a problem and come up with numerous variables impacting on the result. Thinking like an adult then is when the adolescent is able to evaluate the most likely to work solutions if more than one result is brought to the fore (Zaky 2016).

The late adolescence stage seems to have no marked problems compared to the two previous ones. Would this mean that the caregivers had no challenges with adolescents in this phase? If they faced any challenges, I would be drawing on the theoretical framework to provide insight on how they learn from and cope with the disorienting dilemma. In this study I was targeting all the stages of adolescence. Literature has identified the following problems in the adolescent years.

2.5.4 Some behavioural problems during adolescent years

Adolescence is described as having numerous problems mostly emanating from the need to become independent from parents or guardians (Jaworska and MacQueen 2015; Zaky 2014). Development of autonomy gives rise to the growth of an inquisitive mind on the part of adolescents as they tend to critically reflect on some of the parent rules and put them to question, thereby occasionally breaking them (Omotoso 2007). In some families, such adolescents can be viewed as being stubborn and argumentative but, alas, they will be determined to stand up for what they think is right (Zaky 2016). The cognitive growth changes make teens temperamental and problematic to deal with (Jaworska and MacQueen 2015; Omotoso 2007), hence boys often have physical battles with peers and become more interested in listening to noisy music (Heider 2013).

With their newly established autonomy, experimentation is generally rife leading to engagement in risk-taking, thus causing some thoughtless behaviour (Quas 2014; Zaky 2016). Examples of such behaviour can be absenteeism, drug and substance use, incidents of physical fighting, engaging in unprotected sexual intercourse with various partners and many others (Jorg et al. 2016). The need to conform to the dictates of certain groups as peer pressure may lead the adolescent into behaving in specific ways and adopting habits that may not be easy to disrupt (Omotoso 2007). It is quite disheartening for a parent to experience their own children associating with known problematic adolescents that one as a parent may not want to accept. Teenagers are in the habit of lying (Jaworska and MacQueen 2015) and sometimes they do it as a way of escaping conflicting encounters with the parents (Omotoso 2007).

Parents can experience difficult challenges in the adolescence phase, although it should be noted that this is an ordinary transitory period which every adult has experienced (Zaky 2016). However, literature suggests some resolutions to these problems which, when followed may go a long way in alleviating conflicts that normally arise between adolescents and their caregivers (Omotoso 2007). It is important to create a platform to regularly talk to adolescents and get to listen to and understand them without necessarily judging and criticising them as this may likely degenerate into even worse behaviour and ruined relations between the parent and the adolescent (Jaworska and MacQueen 2015). Talking to adolescents regularly is also known to gain the guardians/parents their children's trust, which is an important ingredient in assisting them with behavioural problems (Omotoso 2007).

The caregiver or parent should ensure that there is provision of accurate and sufficient information on the subject of interest. Adolescents should be assured of the parent's love and encouraged to be true to self without essentially adopting certain traits in order to satisfy other people. The parent is supposed to maintain privacy and confidentiality with the adolescent's issues; however, there must be interference if they notice their adolescent linking up with bad-mannered individuals. It should be noted that these children are really sensitive during this stage and may sometimes not view criticism in a positive way (Zaky 2016). It has to be remembered that at adolescence one is not fully autonomous to handle one's sensations and one requires the parent to continuously support one through discussion. If this does not work, a professional counsellor can be engaged (Wagner et al. 2017). In some contexts, youth friendly services are established to give adolescents a platform to discuss issues such as reproductive health which most parents particularly in an African setting are not comfortable to discuss with their children (Omotoso 2007).

Having outlined the challenges that adolescents face during their transitional period; my research sought to reveal the nature of caring practices, learning experiences and coping mechanisms of the elderly caregivers of AIDS orphaned adolescents. In view of these challenges, and the attendant problems surrounding AIDS issues, the study hoped to discover the elderly caregivers' understanding of the dilemma of orphans and to see if their caring practices and learning experiences were in line with what is suggested by the literature above. In an African context it is generally the work assigned to aunts and uncles to sit down regularly with their nieces and nephews educating them on social issues as they approach adulthood. But the case might be different now in view of the mortality that HIV/AIDS has presented to people in productive years. In the subsequent paragraphs I examined what other authors have said in relation to my topic.

2.6 Review of relevant Literature

The few studies which were identified and reviewed for this research were indicative of experiential, incidental and non-formal learning domains. The types of learning domains are discussed in the following sections on what other writers have reported. Formal learning in relation to understanding caring practices of adolescents appeared to be lacking in the reviewed literature, and it would have to be seen if it may emerge as an aspect of the current study.

2.6.1 The nature of caring practices and coping mechanisms of elderly caregivers of AIDS orphans

In the international domain, a rural Chinese study undertook a series of ethnographic observations, FGDs and in-depth interviews in Henan province which is one of the areas hard hit by AIDS to identify and evaluate suitable care arrangements for AIDS orphans in community-based family-style group homes. According to Hong (2015), it seemed group homes had steady and safe living atmospheres for AIDS orphans. Sufficient monitory assistance from NGOs and both central and local governments has guaranteed provision of basic needs of these children and also safeguarded a low child-carer ratio. The caregivers received regular remuneration, with periodical assessment and parenting consultation from the associate NGOs which was characterised by good health and education. A recommendation was made to replicate this care arrangement for AIDS orphans particularly in poor resource backgrounds for the best interest of children. It was deemed critical for the caregivers and communities to be capacitated so that their provision of care became sustainable. The need for capacitation might imply the need for caregivers to learn caregiving responsibilities, an issue which is fundamental to my study.

There seem to be more dissimilarities than similarities between Hong's (2015) study and the current one. Contextually, the settings of the two researches are absolutely varied, with the Chinese one being financially stabilised through the intervention of NGOs and governments in the remuneration of caregivers and provision of basic needs in the homes. We also differ in terms of methodological aspect of design. The comparison is the care for AIDS orphans, although this care was administered in community-based family-style group homes. Hong (2015) may give my study a feel of how caregivers of AIDS orphans in the global domain are experiencing and coping with AIDS orphans. However, Hong (2015) did not address the learning and coping strategies of the carers which is central to the present research. With periodic assessment and parenting consultations from the associate NGOs, the caregivers in Hong's (2015) study may have also utilised experiential learning as espoused by Kolb (1984), non-formal learning, as well as incidental which usually happens within the other domains (Kaziboni 2018; Bretuo 2018). The use of these learning domains was also explored in my study.

In the regional context, Oosthuizen (2014) conducted a doctoral study in rural South Africa to look at older people's experiences of care in relation to adolescents in a poor resource setting. Thirteen volunteers comprising 11 women and 2 men were recruited into the study whose data was generated through the Mmogo-method that was described as a culturally-sensitive data generating technique.

It was revealed that this care relationship is under stress impacting on the social structure and the psychological wellbeing of both the elderly persons and the adolescents. This situation is further compounded by a dearth of financial and psychological resources. Care was described as happening in specific reciprocal interactions, characterised by both tangible and intangible activities being directed towards the general wellbeing of the adolescents. The elderly showed care for adolescents by way of teaching and disciplining them, while the adolescents would be expected to accept and obey the teachings. Nevertheless, the elderly caregivers expressed displeasure with the adolescents' inability to demonstrate care, which could be described by the limited understanding they have of caregiving and care receiving. In their teaching and disciplining of the orphans it is highly likely that the experiential learning domain was in use as they may have reflected back on the way they had reared their own children. Experience, therefore, stood as the foundation of any new learning and meaning making they encountered in their caring activities (Kolb and Kolb 2005). This obviously must have included the incidental learning which happens spontaneously wherever people are (Schugurensky 2015; Knowland and Thomas 2014). These two domains of learning were explored for my elderly caregivers in relation to the character formation of their adolescent orphans.

Having been interpreted by Self-Interactional Group Theory (SIGT) as the philosophical lens, it was found that care involved the interaction between the two generations under study. As an educational implication, the study suggested that its contributions could be utilised in the development of relevant programmatic interventions targeting intergenerational relations because of the critical role they play, particularly in poor resource-settings such as SADC.

Although the study did not mention anything about AIDS orphans, the current study benefits in the intergenerational interactions between the older persons and the adolescents. My study was keen to find out if the nature of care demonstrated in the South African study would have any variation in terms of the different contexts and theoretical frameworks with my study. The adolescents in the previous study were not AIDS orphans so in view of the impact of AIDS on communities, it was expected that my study would produce different insights in terms of caregivers' caring practices, learning experiences and coping mechanisms in the caregiving responsibilities. Epworth community was a poorly resourced area; the same applied to the context of this South African study. I believed that my study would perhaps be informed by the former research.

Fauk et al. (2017) did an exploratory study to understand the coping strategies and impact alleviation undertakings engaged by families that adopted AIDS-orphaned children in the Mbeya rural district of Tanzania. Their focus was on the families that had adopted AIDS orphans. The method used was one-on-one in-depth interviews, yielding the results that adoptive families encountered various challenges such as finance for house provisions, school fees for the orphans, and health care expenses. Work opportunities for the families dwindled with limited time to address the problems. In mitigation of the challenges, the adoptive families engaged in poultry farming. Farming seems to remain a backbone of most economies in Africa (Foster and German 2002), and many families engage it at subsistence level. The adoptive families in the former study may have developed poultry farming through experiential learning. They also sold family assets and rented out portions of arable land to get extra income. Tasks were reallocated and children de-enrolled from school so that they could enter the labour force in order to supplement the family income. The poultry farming got support from a local NGO called Isangati Agricultural Development Organisation, as well as from the local government. In conclusion, Fauk et al. (2017) acknowledged the requirement for focused interventions in order to address the fundamental social causes of HIV/AIDS in the affected people so as to curb additional enforcement of socio-cultural and economic drawbacks on households offering care to AIDS orphaned children.

Connections of Fauk et al.'s (2017) study with mine are that the focus is on caregivers of AIDS orphans, so it provides me with insights on caregiving in the context of HIV/AIDS. Challenges were identified although learning issues were not addressed in Fauk et al.'s (2017) study. In fact, they concluded that targeted interventions to deal with social causes of HIV/AIDS were necessary, but did not deal with caring practices, learning experiences and coping of elderly caregivers as they move in to assume new responsibilities of caring in HIV/AIDS context. Some of the coping strategies in Fauk et al. (2017), such as dropping children out of school to enter the labour force and selling family assets to get income, are counter-productive. It exposes the already vulnerable children to various forms of exploitation. Drawing on Carver, Scheier and Weintraub's (1989) type of coping, such coping falls into the harmful category of coping.

However, there are various dissimilarities between the two studies which the current study sought to address. While Fauk et al.'s (2017) study was done in a rural district of Mbeya province in

Tanzania; the current research was carried out in the peri-urban setting of Epworth in Zimbabwe. Though the previous study looked at adoptive families, it did not give a cut-off point of the ages of participants. Instead, my study investigates only the elderly caregivers of adolescent AIDS orphans. The previous research does not seem to have used a philosophical framework. I exposed my study to the theoretical framework of transformative learning (Mezirow 1978) and the transaction model of stress and coping (Lazarus and Folkman 1984). The former theory provided a lens through which to look at the caring practices and learning experiences of the elderly caregiver, while the latter helped in explaining their coping mechanisms.

From the national arena in Zimbabwe, Mhaka-Mutepfa, Mpofu, and Cumming (2015) explored the effect of protective factors, health, and well-being on the resilience of grandparents caring for orphans. A survey tool containing the Resilience Scale and World Health Organisation Quality of Life Questionnaire (WHOQOL-BREF) was administered to 327 grandparents. It was found that the protective factors that were interrelated to resilience were individual assets such as high self-esteem, capacity to solve problems and social assets such as social linkages and religion. The grandparents with characteristics of greater coping skills, younger age and higher socio-economic standing had greater individual capabilities for resilience than their peers with lower self-esteem personal attributes. The optimistic feelings and good health that resilient elderly caregivers experienced tend to work as defensive factors to diminish the extent of hardship to people and support them to manage well with caregiving responsibilities.

While Mhaka-Mutepfa, Mpofu, and Cumming (2015) looked at protective factors of grandparents of orphans, I looked at caring practices, learning experiences and coping mechanisms of elderly caregivers of adolescent AIDS orphans, aspects which are not addressed by this previous study. However, the protective factor issues of resilience such as self-esteem, capacity to solve problems, social linkages and religion were pointers I looked out for in my study. Mhaka-Mutepfa, Mpofu, and Cumming (2015) used a quantitative approach administering the standardized WHOQOL-BREF instrument, while mine qualitatively generated data through in-depth one-on-one interviews and FGDs. In Zimbabwe it is documented by Mhaka-Mutepfa, Mpofu, and Cumming (2015) that there is a lack of state-sponsored social welfare arrangements which can alleviate the hardships of elderly caregivers. Other studies held in Zimbabwe (Mudavanhu, Segalo and Fourie 2008) revealed that the elderly required grief counselling, social support, as well as knowledge in terms of HIV/AIDS. The current research, thus, would extend from this knowledge base, through the mentioned twin lens of theories to find out how my participants experienced learning and coped with the disorienting dilemma. The grief counselling would probably trigger some experiential learning through self-introspection, a pointer from this prior study, which led me to look at whether caregivers in the present study used counselling from clinics and the community to cope with their disorienting dilemmas. The social linkages with clinics and communities would probably have made them experience some non-formal learning through workshops organised around the HIV/AIDS context where they could discuss matters of interest.

2.6.1.1. *The coping mechanisms of elderly caregivers with the disorienting dilemma*

Hawkins (2013) in Thailand conducted a phenomenological study to investigate the religious, social and familial experiences of the elderly caregivers of AIDS orphans. Erickson's theory of the eight ages of man was used as the theoretical lens to illuminate the study which administered in-depth interviews with 14 elderly caregivers who took part in the Grandma Cares Partnership Programme. The data analysis utilised Creswell's six-step process to come up with themes and patterns.

The results of this research showed that the caregivers were comforted and strengthened by the teachings of Buddhism, as well as their cultural canon, to be able to continue with the maintenance of their homes, although they indicated a need for more support from government. These findings have shown how the caregivers responded to the dilemma of orphans. Their reaction was mainly divine intervention which is a form of emotional coping (Lazarus and Folkman 1984). In terms of learning domains, this appropriately falls into experiential learning as they tapped into their cultural canon and also non-formal learning whereby Buddhism would strengthen them with its teaching (Bretuo 2018). Workshops, discussions, and even prayers could probably be arranged by the church to enhance the caregivers learning.

The major connection of this study to the current one is that the focus was on elderly caregivers of AIDS orphans, although my research trimmed the scope to include only those elderly caregivers looking after adolescent AIDS orphans. It is important to compare the caregivers in the Thailand study with my participants and see if their coping mechanisms with the AIDS orphan crisis or the disorienting dilemma could be similar, given the contextual variations of our study settings. The magnitude with which Zimbabwe was hit by HIV/AIDS is greater than and different from what was experienced in Thailand. Other noted dissimilarities are that Hawkins' (2013) elderly caregivers were participating in the Grandma Cares Partnership Programme which could also be providing them with a buffer zone in terms of their coping with the AIDS orphans, whereas those in my study did not belong to any programmes. The Hawkins (2013) study did not address caring practices and learning experiences of caregivers, although one type of coping (emotional coping) came out of the study.

Although the two studies may be diverse, I still benefitted from Hawkin's (2013) successful use of Creswell's six-step process of data analysis in the qualitative approach to research, as well as the phenomenology design. I considered the same frameworks for my study as they fall within the same approach and paradigm.

In a South African study Chazan (2014) sought to understand the distresses, collective responses and mobilisations of older women in four communities of KwaZulu Natal (KZN). The methods used for generating data were FGDs, interviews, and participant observations. The results showed that the older women were organising themselves in reacting to the collective devastating and varied impacts of HIV/AIDS, poverty, violence and illness. Associations were formed to generate incomes, fight stigma and link up with wider support systems, as well as to provide care to several others in their respective areas.

Chazan's (2014) study had relevance with the current study in terms of elderly caregivers for vulnerable children in the era of HIV/AIDS.

In contrast to Chazan's (2014) research, my study context was a peri-urban settlement called Epworth in Zimbabwe, which was totally different from the setting of KZN. The issue of how the elderly learn to and cope with the carrying out of the caring responsibility did not seem to have been addressed in the previous study. While delimitation was made along gender lines, my study recruited both males and females. Nowadays, males are observed taking care of orphans probably due to the devastation of HIV/AIDS: their views in my study are crucial. The SA study seems to be quiet on the theoretical framework. Our methodological aspects are slightly different as Chazan (2014) included participant observation further to the interviews and FGDs that I utilised. As the caregivers in the prior study organised themselves in groups in order to deal with the numerous devastations of AIDS, they might have been engaging in non-formal learning where learners would discuss and present issues at hand freely, tapping from their experiences as well (Preece 2009). These ideas influenced me to find out whether my elderly caregivers grouped or collaborated with people in similar situations. However, they may have learned useful things in collaboration with the clinic staff, the schools to which their orphans were going and the community surrounding them because wherever people assemble there is an opportunity to learn (Bretuo 2018). The learning may have been non-formal, characterised by discussions about issues of interest to the discussants; and as they discussed some incidental learning may have crept in as well (Bretuo 2018).

Maronganye (2017) in his doctoral thesis investigated the experiences of caregivers raising HIV/AIDS orphans in the rural area of Bulilima district in Zimbabwe. Using a non-probability purposive sampling, semi-structured interviews became the method of data generation from the 15 caregivers that were sampled. The study found that the kin orphan care support system was not collapsing as stated in other circles, but somewhat aggressively improving the structural challenges of the HIV/AIDS endemic, coupled with severe economic situations and persistent droughts in Zimbabwe. Maronganye (2017) also acknowledges that the capacity to care and the caregivers' experiences should be viewed as a continuum as the kin capability may be subject to change at any time and in any place. In Marongonye's study experiential learning was pronounced as the caregivers tapped into their prior experiences to care for the orphans, while the infusion of incidental learning may also have been engaged since its occurrence is intentional and/or unintentional (Bretuo 2018; Kolb 1984). As a way of coping with the orphan crisis the extended families developed adaptive ways of caring despite being plagued with financial problems and the burdens created by the HIV/AIDS disease. It was noted that in rural Zimbabwe orphans, over time, develop into active family members whose contribution to their subsistence way of life is essential.

Although the two studies concur in aiming to study caring experiences of caregivers of AIDS orphans, my study added the learning aspect and coping mechanisms to see how the caregivers managed the new responsibility of caring. Being an elderly caregiver looking after adolescent

AIDS orphans was my inclusion criteria. I also had age delimitation for both the elderly caregivers and the AIDS orphans they looked after, a feature which is not in the Maronganye (2017) thesis. The adolescent phase of the AIDS orphans was one of the important aspects of my research as adolescence is characterised by challenges. I wanted to understand better how the elderly caregivers learned and coped with them. The current study would find some insights in the previous research because it looked at experiences of caregivers looking after AIDS orphans. Although there are differences in contexts, such as rural and peri-urban, I would draw on the previous study findings for the sake of comparisons on the nature of the caregivers' reactions in handling the orphan crisis.

Summary of the nature of caring practices and coping mechanisms of elderly caregivers of AIDS orphans

The main issue being revealed in these studies is capacitation of caregivers to be able to sustain their households, especially lack of money to finance their obligations, such as provision of the basics in the home and school fees for the orphans. Coping was reported to be mainly subsistence poultry farming, selling family assets, renting out arable land, dropping out orphans from school to join the labour force and also high self-esteem, use of social linkages and religion. No study in this category researched caring practices and learning experiences. Coping was investigated, though I looked at it through the lens of the transactional model of stress and coping which the prior studies did not use.

In Hawkins's (2013) study participants drew comfort from Buddhism and their cultural canon as a way of coping with caregiving roles, with an indication of the need for more support from government. Chazan (2014) says older women were uniting in reacting to the combined devastating and varied impacts of HIV/AIDS: poverty, violence and illness. Associations were formed to generate income, fight stigma and link up with wider support systems, and to provide care to numerous others in their particular areas. In Zimbabwe Maronganye (2017) acknowledges that capacity to care and the caregivers' experiences be viewed as a continuum as the kin capability may be subject to change at any time and in any place. Caregivers developed adaptive ways of caring despite financial problems and the burdens associated with HIV/AIDS disease. Over time, orphans grew into active family members whose contribution to their subsistence way of life was important.

2.6.2 **Making new meanings out of caregiving roles**

In Vietnam Maradik and Kim (2014) examined the skipped-generation caregivers who were looking after their AIDS orphaned grandchildren. The challenges facing this population and their ways of handling them were investigated. Maradik and Kim (2014) inquired into the sense-making of their caregiving roles, and how the meanings informed their choice of coping strategies. The sample comprised 21 elderly caregivers and 7 key informants whose data was generated through in-depth interviews; and 5 caregivers who were selected from the 21 to complete the participant observations. The findings of the study were that participants understood that coping should be problem-centred because they considered a set of caregiving-related activities such as childcare, generating money, borrowing money, cooking, and doing other household chores, all of which fall in the three learning domains, namely, experiential, non-formal, and incidental.

Although there are contextual variations in Maradik and Kim (2014) and the current study, I got insights into what other elderly caregivers of AIDS orphans were experiencing in the global arena. The caring practices and learning experiences of caregivers of AIDS orphans, a responsibility my elderly respondents appeared to have assumed without acquiring necessary caregiving knowledge, skills and attitudes, was not addressed in the previous research. In view of Lazarus and Folkman's (1984) reference to types of coping, the caregivers in the previous research cited one type of coping, which was problem-focused. There was no mention of emotion-focused and Carver, Scheier and Weintraub's (1989) maladaptive coping, which they termed harmful coping. The transformative learning theory of Mezirow (1978) and the transactional model of stress and coping propounded by Lazarus and Folkman (1984), with Carver, Scheier and Weintraub (1989) further adding the harmful coping dimension, would further illuminate my findings.

In a quantitative study conducted by Kidman and Thurman (2014) the purpose was to investigate the caregiver burden among adults who were caring for orphaned children in South Africa. It was noted that as the AIDS pandemic has generated high numbers of orphans, this has created an additional responsibility for caregivers. The idea of caregiver burden embraces numerous dimensions: physical, social and psychological. Using the 12-item Zirit Burden Interview instrument 726 caregivers were surveyed. The results indicated that 40% of the caregivers reported that orphan caregiving was a high burden for them. The carers in the earlier study tapped into their experiences and made comparisons between caring for children before and after the HIV/AIDS situation to come up with the result of labelling the task as a high burden (Knowles, Holton III and Swanson, 2014). There was evidence of experiential learning in the former studies, which became pointers for me to look for in the current study. The caregivers had feelings of stress and incompetence regarding the caregiver obligations. Anger towards the orphans was said to be common among the caregivers. The burden of caregivers was further compounded by food uncertainty in most of the households, as income was also scarce. Kidman and Thurman (2014) also revealed that caregivers were economically susceptible and some often worry about their personal AIDS-linked ailments thereby feeling most overstretched. The learning which these caregivers derived from the caregiving responsibilities is that it is a heavy burden. In my study it would be prudent to determine whether caregivers would also view their caring responsibility as a burden.

Kidman and Thurman (2014) highlight the caregivers' incompetence in executing their responsibilities, thereby exposing the learning gap that exists among elderly caregivers. Although there is a similarity to my study in that these were caregivers of AIDS orphans, the issue of learning and ways of coping of the elderly caregivers remained unaddressed. Without learning new skills, knowledge and attitudes, how would elderly caregivers manage the dilemma of AIDS orphans? We also differ in terms of methodological issues. While Kidman and Thurman (2014) used a quantitative approach, which engages probability sampling methods and standardised measures, the current research utilises a qualitative approach, with an interpretivist paradigm characterised by interviews and FGDs to generate data phenomenologically. Kidman and Thurman (2014) conducted their study in South Africa; mine took place in Zimbabwe in a peri-urban community and there were bound to be contextual variations.

Zvinavashe et al. (2015) carried out a study in Zimbabwe to investigate coping approaches of caregivers of HIV/AIDS orphans in the rural areas of Bikita. The focus of the study was caregivers of AIDS orphans. Face-to-face structured interviews were administered to the conveniently sampled 30 caregivers. The results revealed that 73% of the participants were in their elderly years and this meant they also had to be cared for. The research also discovered that the caregivers lacked information on caring for the young in view of AIDS. The caregivers also required money but it was scarce. The caregivers' chief strategy in response to the orphan crisis was engaging in subsistence farming where vegetables and maize were grown, with any surplus being sold to raise some income. These caregivers may have embraced some experiential learning because even in the past they could rely on subsistence farming in looking after their own children (Moon 2011). The research recommended the need for the provision of income generating activities by the local authorities and also of vocational skills to the caregivers which may have further strengthened their learning in a non-formal way (Widen et al. 2020).

The likeness of Zvinavashe et al.'s (2015) enquiry to my study is the issue of caregiving for AIDS orphans, however, without attending to the caring practices and learning experiences in view of assuming a responsibility in the context of a fairly modern disease HIV/AIDS without prior learning. The previous research looked at coping of caregivers and not specifically at their caring practices and learning experiences. The caregivers in the earlier study were looking after any children, some still in infancy whose parents had died of AIDS, whereas I recruited elderly caregivers of adolescent AIDS orphans from a peri-urban context. Having been done in Zimbabwe, I would make some comparisons with Zvinavashe et al. (2015) and be able to investigate the learning and coping of elderly caregivers in looking after AIDS orphans through the mentioned theoretical framework. Non-formal education is documented as offering educational prospects for people who have missed out on the formal type of learning (Kaziboni 2018; Ngozwana 2014) and in the current study it would have to be seen if the elderly caregivers may be benefiting from non-formal and incidental learning in their orphan care.

Summary of learning to make new meanings out of caregiver roles

In summary, the caregivers in Vietnam understood that coping should be problem-based as they considered a set of caregiving-related activities such as childcare, generating money, borrowing money, cooking, subsistence farming and doing other household chores (Maradik and Kim (2014).

In South Africa orphan caregiving was reported as a high burden, with feelings of stress, anger towards orphans, and incompetence on the part of the caregivers (Kidman and Thurman 2014). Zvinavashe et al. (2015) in Zimbabwe revealed that the caregivers' burden was aggravated by lack of food and income. Caregivers lacked information on caregiving in view of HIV/AIDS. The provision of income generating activities and vocational skills by the local authorities were recommended. All three studies reported lack of money to finance their caregiving obligations, with the two regional ones citing incompetence of the caregivers in conducting their caregiving roles. Maradik and Kim (2014) and Kidman and Thurman (2014) suggest experiential learning of the elderly caregivers; my study will examine whether similar learning took place in the context of the two theoretical lenses. These theories were not used in the former studies. This leads me to discuss the nature of the caring practices of my participants.

2.7 Chapter Summary

This chapter reviewed literature in specific areas: domains of learning, learning of adults, characteristics of adult learners, critiques of Knowles's principles of adult learner, adolescence, and what other writers have said in relation to caring practices and learning experiences and coping mechanisms of elderly caregivers of adolescent AIDS orphans. All the reviewed literature yielded the following major findings at a glance:

Globally, coping was believed to be problem-centred as caregivers engaged in activities to reduce or alleviate the stressful conditions. They had the necessary resources available to run their households as they got remuneration from NGOs and the local government, hence, experienced good health and managed the education of orphans. They also coped emotionally through their religion and culture. Regionally, caregiving was experienced as a high burden, characterised by incompetence, lack of basic resources to run their households and dwindled work opportunities due to caregiving responsibilities. The burden normally caused the caregivers to be stressed and express anger towards the orphans. Coping was mainly through subsistence farming of maize and vegetables, with children dropping out of school to join the workforce. Nationally, caregivers were mostly the elderly, who lacked information about and knowledge of executing their new roles. There was also a dearth in resources to be able to manage their homes. Despite lack of resources, caregivers engaged in adaptive ways of coping such as engaging in a subsistence way of life, with the older orphans contributing to the work around the homes.

It looked like there were no studies on caring practices and learning experiences and coping mechanisms of elderly caregivers of adolescent AIDS orphans that had been done nationally, regionally, and internationally. Hence, conducting the current study became justified. In the next chapter I describe the theoretical framework used for the study.

CHAPTER THREE

THEORETICAL FRAMEWORK

3.0 Introduction

This chapter discusses two theories, namely, the Transformative Learning Theory (TLT) of Mezirow (2000) and the Transactional Model of Stress and Coping (TMSC) conceptualised by Lazarus and Folkman in (1984) as lenses through which the caring practices, coping mechanisms and learning experiences of elderly caregivers of adolescent AIDS orphans were explored and described. On analysing the two theoretical lenses in this study, it is evident that they have overlaps in that both refer to how the person relies on his/her past experiences whenever a dilemma strikes. The meaning of coping frequently encompasses discovering the implication of the disorienting dilemma with a view to engaging in effective ways of coping. Issues such as religious opinions and being humorous are often utilised in circumstances of prolonged stress (Lazarus and Folkman 2015). However, the rationale for using both theories in this study was to be able to fully address the variables in the research topic, which are caring practices, coping mechanisms and learning experiences. Use of only one of these theories may not have sufficed to fully address all issues under study. In the following section I explain transformative learning theory and how it related to my study.

3.1. Historical background of TLT

The evolution of Mezirow's transformative learning theory is well articulated by Kitchenham (2008) in his article presented in the Journal of Transformative Education. In 1978 Mezirow came up with the initial theory of transformative learning, after having been influenced by ideas of other authorities such as Freire (1970), Habermas (1971), and Kuhn (1962). Since 1981 the theory has undergone various expansions. It initially adopted the three learning domains of Habermas (1971) which are technical, practical, and emancipatory. Habermas (1971) claims that the above mentioned three parts of human interest are where knowledge develops from.

In 1985 the theory was extended to embrace instrumental, dialogic and self-reflective learning (Kitchenham 2008). Kitchenham (2008) tells us that in 1991 another update was made in terms of stressing the significance of changing current relationships and building new ones. The prominence of critical self-reflection in perspective transformation was made in 1995. As further revisions continued to be made, Mezirow emphasised the importance of critical self-reflection of suppositions which involved objective and subjective reframing.

In the year 2000 Mezirow revised the theory, reviewing his terminologies. In the revision he acknowledged the significance of the social and emotional parts of his theory, leading to the introduction of the habits of mind and points of views. By these revisions Mezirow was able to provide a strong definition for his philosophy in 2003 and extended it further in 2006 as it relates to constructivist theory. The following sub-heading examines the central tenets of Mezirow's theory.

3.2 Transformative Learning Theory – Mezirow

Transformative learning theory was generated by Jack Mezirow in the early 1970s when he conducted a study of women in the United States who had decided to go back to learn at a community college. This is an exclusively adult learning theory which Mezirow (1990) utilised to define how people mature and use their self-reflection in critical ways in order to consider their experiences and beliefs around them. Over some time of critical thinking, people tend to alter their ways of viewing their world. Transformative learning usually happens if an individual comes across perspectives that are not harmonious with his/her present viewpoint. Mezirow's major interest was, therefore, in the worldviews of people and what motivates them to change their specific ways of viewing the world around them (Cranton 2006).

As a means of provoking critical self-reflection in the adult learner the theory refers to disorienting dilemmas. For adults to change their ways of seeing the world around them they must face what Mezirow (1990) calls 'disorienting dilemmas'. These are problems or experiences that are not attuned with their beliefs of their world, for which a reconsideration of these experiences is sought in a way that will change their view of the world (Preece 2003). Adults engage in dialogue with their own minds, as well as with other people, so that critical self-reflection is provoked (Cranton and Taylor 2012). For example, in most cultures people's belief systems or frames of references were generally unquestionably imposed on them by society but may no longer be compatible with this contemporary global village due to new problems people now face. However, as adults have inquisitive minds, they typically do not cease to interrogate all that surrounds them until they come up with changes of attitudes, beliefs and values about their worlds (Mezirow 2000). Through being caregivers of adolescent AIDS orphans the elderly caregivers in this study probably continued to question their lives and engaged in experiential, non-formal and incidental learning in order to allow the much needed alteration to their frames of references as was necessary for their situation (Kolb 1984; Mezirow 2000). Experiential learning probably enabled my caregivers to take on the caring responsibility in the context of HIV/AIDS even if they lacked some necessary information. A solid base on which new knowledge emerges is argued as being constructed from past experience (Knowland and Thomas 2014). This study explored the extent to which that happened for the elderly carers.

Similar to concepts of both John Dewey's self-development and participation and Paulo Freire's awareness and critical dialogue, Mezirow acknowledges that learning is rooted in the subjective experiences and the knowledge emanating from individual contexts (Keagan 2000). Mezirow's idea of 'habits of mind' and the 'points of view' that build up the individual's frame of reference has been observed as an addition to Dewey's (1981) and Freire's (1970) ideas. The frames of reference comprise points of view and habits of mind that are grounded in "cultural, social, educational, economic, political, or psychological" experiences which are then articulated through gathering norms, values, attitudes, feelings etc. to form a specific understanding. Mezirow (2012:77) explains that an individual's "cultural canon, socioeconomic structures, ideologies and beliefs about ourselves, and the practices they support often conspire to foster conformity and impede development of a sense of responsible agency."

Cultural canons according to Mezirow (2012) are the frames of reference that people commonly hold. Hence, altering one's habit of mind requires an alteration of viewpoints in a similar fashion to Freire's (1970) model of critical consciousness through which dialogue and critical reflection lead to critical awareness. This is evidenced by Mezirow when he highlights the importance of contextual interpretation, critical reflection on traditions and the justification of meanings through evaluation of reasons.

Mezirow's theory captured the attention of various academics and experts in the field of adult education (Baumgartner 2012) eventually causing a decline in popularity of studies related to the concept of andragogy, which is described as the art and science of teaching adults (Knowles 1980), and the more radical notion of conscientisation (Freire 1970), which is the capacity to critically identify reasons for socio-economic and political repression for which people engage the necessary actions against repressive components of humanity. In the USA the dominant concept of andragogy (Knowles 1980) was replaced by contemporary transformative learning theory (Benham and Desjardins 2013a).

3.2.1 **Stages of transformative learning theory**

According to Mezirow (2000), the ten-staged process of perspective transformation is identified and explained as follows:

1. <u>Disorienting dilemma</u>: This is a stage where one encounters ideologies, values and beliefs that are different from previously held ones. As people work through their experiences that tend to challenge earlier paradigms, the internal conflict will lead to what Mezirow (2000:22) calls "disorienting dilemma". The disorienting dilemma typically emanates from major life changes, transitions in roles and responsibilities or interactions and severe individual or communal crisis, such as bereavement of family members (Cranton 2006). This theory was appropriate for this study as all the elderly caregivers studied had experienced the deaths of their loved adult children leaving the orphans who then became the grandparents' crisis. After facing this crisis, the study sought to explore their caring practices, learning experiences and coping mechanisms in caring for adolescent AIDS orphans, in view of the fact that they had reached a stage where they generally would have expected to be cared for by their adult children.

2. <u>Self-examination</u>: The disorienting dilemma then causes one to question previously held values. It would be vital to understand whether the elderly caregivers in this study relooked at their frames of references and found any possible changes to their previously held viewpoints as a way to positively impacting on their caring practices, learning experiences and coping with new caregiving roles. Among the AIDS orphans, it was

highly probable that some were living with HIV, which might have prompted the acquisition of new caring skills to avoid further possible infection in the caring process. HIV/AIDS is a stigmatised and discriminated disease where people generally developed a negative attitude towards the affected and infected. It might have been, therefore, necessary for the elderly caregivers to also self-examine their attitudes towards AIDS issues in critical ways in order to alter their perspectives and enhance positive caregiving.

3. Sense of alienation: These are feelings of isolation and being segregated. AIDS is a highly stigmatised condition which the elderly caregivers may not be able to handle. Having lost their adult children to this disease may have led to isolation and segregation by their communities and families. It was necessary for the elderly caregivers to adopt positive attitudes towards caring for AIDS orphans if their caregiving would have a constructive impact on these children. The present research explored how they learned and coped with such issues in the course of their new roles of caring.

4. Relating discontent to others: After facing the disorienting dilemma, the individual knows that their condition is common to others. As the caregiver's role was common to others in their communities, how would they learn to collectively manage the crisis? We have generally heard of people living with HIV forming support groups, where diverse information pertaining to this disease is shared. I was curious to find out if their learning would include the formation of such structures with similar people in order to impart pertinent knowledge to one another. If they could belong to a support group, this would be linked to Lazarus and Folkman's (1984) problem-centred coping strategy and they might have critically reflected on their cultural canon and it might have helped them learn that the problems they faced required sharing with others in similar crisis, through which process transformative learning would have occurred.

5. Explaining options of new behaviour: This is a phase when one discovers new ways of behaving. It is important for one to ask one's self 'what now' so that the next necessary move is contemplated. This step also addressed the coping mechanisms of the elderly caregivers.

This phase might be considered when the elderly caregivers had insight into their problems and examined their frames of references with a view to learning certain aspects of their new roles, as we are always experiencing changes in life.

6. Building confidence in new ways: The significance of this stage is the construction of abilities and self-assurance in contemporary roles and responsibilities. An individual should realize the need to acquire skills, knowledge and attitudes because life is not stagnant. Life is troubled with challenges requiring people to continuously critically reflect back to previously gathered experiences and learn as necessary (Mezirow 2009). The research explored elderly caregivers' need to acquire further skills, knowledge and attitudes in order to build up their confidence in the execution of these contemporary roles and responsibilities.

7. Planning a course of action: Developing capabilities and self-confidence leads to planning strategies to make necessary modifications to one's life. The plan of the next course of action for the elderly caregivers was necessary because it pointed them to caring practices, learning experiences and positive ways of coping with the disorienting dilemma. It was, therefore, important to note how they learned or built capacities to deal with the orphan crisis. Did they critically reflect on their previous frames of reference with a view to learn to effectively execute the new responsibility; and what coping mechanisms did they normally engage in?

8. Knowledge to implement plans: There is a need for the acquisition of knowledge, skills and attitudes in order to implement the new behaviour. The development of a plan to adopt new perspectives frequently leads to the requirement for additional information, knowledge, skills and attitudes. The study sought to find out if the elderly caregivers considered it important to come up with ideas of learning new ways of caring for AIDS orphans, and applying the new worldviews to their daily caregiving roles.

9. Experimenting with new roles: After attainment of new learning, it should be tried out through new roles and responsibilities, while evaluating its utility in solving life problems. The present study sought to understand whether the elderly caregivers applied any new learning and assessed its usefulness to their daily caregiving activities. It was important that

they relooked at their frames of reference and get into dialogue with the self and the others to see how they could possibly learn and change. It is generally believed that elders have no need to acquire new skills as they are considered to be too old for that. However, in adult education, learning is a life-long process because we are faced with a lot of contemporary issues such as diseases, both man-made and natural disasters, which require us to continuously learn (Findsen and Formosa 2011).

10. Reintegration: The new learning, as well as the reformed perspectives, is then brought back into the daily life of society. The result of this study may reveal new learning which may enable elderly caregivers to engage others in similar situations in dealing with the disorienting dilemma of AIDS orphan caring.

The purpose of this study was to explore the caring practices and learning experiences of the elderly caregivers of adolescent AIDS orphans. Did the elderly caregivers engage in reflective learning as described by Mezirow (2009) above? In analysing these caring practices, learning experiences and the coping mechanisms, transformative learning theory was the lens for explaining how the elderly interpreted the meanings of their experiences and how these influenced the new learning that they encountered in their caregiving responsibilities. It was important to see if the elderly caregivers went through Mezirow's stages of learning and how they attached meaning to their experiences. In fact, this theory was appropriate for my study because it exclusively focuses on the experiences of adults. Learning starts from the known to the unknown whereby the adult interprets his/her own world and sees how best to proceed to the unknown or the new learning.

In this theory reference is always made to the already accumulated experiences, beliefs, attitudes, values etc. that were inculcated in people by society and how they attempt to interpret the validity of these so as to impact on new learning (Mezirow 2000). Meaningful learning is, therefore, said to have taken place when the knowledge learned has significance to the learner, is satisfying and applicable to the learner's solving of problems. Ideas and interpretations that normally worked for people in childhood or in yesteryears might not be as useful in adulthood or current situations. Similarly, as the elderly caregivers already had experience in looking after children, this past experience would probably not be sufficient for caregiving responsibilities in the context of

HIV/AIDS and its attendant challenges, like the growing number of orphans. The elderly may lack training in terms of assuming caregiving roles. This point led me to the historical background of transformative learning theory. Transformative learning theory has had its fair share of critiques, some of which are present in the next sub-heading.

3.2.2 **Critiques of Transformative Learning Theory (TLT)**

Although the contributions of transformative learning were acknowledged and distinguished, various researchers have pointed to the need for additional explanation in certain areas which were viewed to be problematic (Keagan 2000; Merriam and Cafferella 1999; Taylor 2007). It was Taylor (2001) who suggested its extension to include a neurobiological focus to be able to explain the role of emotions in transformative learning, and this eventually led to a closure of the gap that had existed between rationality and emotion in this theory (Baumgartner 2002). In a bid to update Mezirow's original theory, Taylor (2007) argues that the availability of contemporary equipment such as the MRI (magnetic resonance imaging), and PET (positron emission tomography) means that emotions could now be also scrutinised to determine which neurological systems of the brain were working during Mezirow's disorienting dilemmas.

Cranton (2006) claims that; superficially, the two viewpoints of Mezirow's theory are inconsistent. While one view supports rationality, which largely relies on critical reflection, the other is predominantly dependent upon intuition and emotion. Nevertheless, variances in these opinions may perhaps be understood as a matter of emphasis mainly because they both apply rationality in their processes, as well as integrating imagination in the process of creativity.

With extensive debate challenging the ten steps, specifically the critical thinking concept, research was implemented to also include the situational, emotional and spiritual domains (Dirkx 2012; Tisdell 2012). Authorities such as Dirkx, Boyd, Myers, and Ruether connected transformative learning theory (Mezirow 1978) to the concepts of intuition and creativity, resulting in an all-inclusive view of transformative theory (Grabove 1997). Various revisions to the earlier version of transformative learning theory were made over twenty years, with Mezirow acknowledging and renaming his original concept of *critical reflection* (the core of the theory) to *perspective reflection* *or reframing*. He came up with this change so that the new name would include cognition, the situation, emotions and spiritual features, as well as additional means of knowing.

In spite of the debates in the 1980s and 1990s, Mezirow's transformative learning theory has persevered and inspired further research in both qualitative and quantitative approaches. Taylor and Cranton (2013) highlight that Mezirow's theory essentially lays out the process of change in cognition, i.e., at an individual's psychological level, nevertheless it is understood from research that the theory is far more than a rational procedure and tends to be complex, individual and frequently strongly emotional (Baumgartner 2012; Collard and Law 1989).

Transformative learning theory has numerous dimensions which are non-cognitive which as well require further research (Kim and Merriam 2011; Ntseane 2011). It is further suggested that integrating these perspectives would reinforce the philosophy and render it more appropriate to people whose activities nurture transformative learning (O'Sullivan 2002).

The theory is also critiqued for its disregard of people's culture (Ntseane 2011). Even though Mezirow came up with the theory characterised by culturally appropriate principles of adult learning, it continued to be critiqued for being developed in a single cultural environment which is the Western world (Merriam and Ntseane 2008). While the concept of this theory is fundamental in enabling us to make sense of and interpret the phenomena around us, it is also essential that it be culturally appropriate. Hence, it was argued that transformative learning theory could be joined with a paradigm that was Afrocentric as one way of addressing this anomaly. An Afrocentric understanding of transformative learning would focus on black people, being the subjects of the transformative learning experience.

Similarly, if we compare it with Freire's emancipatory learning, the vocabulary often linked to transformation is normally ignored. Africans possess their own transformation educational systems, such as rites of passage, as well as certain ceremonials that have been utilised to raise awareness of all people into a larger association with the self, society, and also the universe (Brookfield 2000).

The experience of transformative learning is usually a process and not a one-time occurrence. It is noted that the experience regularly comprises constant building, rebuilding, and modification of an individual's altered meaning-making structure and functions to come up with a series of caring practices and learning experiences or changes in oneself (Mezirow 2000). Accordingly, to better comprehend the transformation process, more time is required to study the procedures and underlying forces that are involved in the transformative learning experience (Butterwick and Lawrence 2009; Taylor 2007). The second theory, the transactional model of stress and coping, (TMSC) which addressed the coping strategies of my elderly caregivers is explained in the next sub-heading putting it into perspective within my study.

The use of a complementary theory in this study helped minimise the impact of weaknesses on the findings. Employing multiple theories in a framework not only helps to combine strengths of the theories but also alleviates the problems of incomprehensiveness and/or weaknesses of a single theory.

3.3 Transactional model of stress and coping (TMSC) Lazarus and Folkman 1984

The literature on coping aspects evolved during the 1960s as a reaction to outcomes on the unsafe effects of stress on people's health (Folkman 2008). The major objective was to come up with factors that possibly could lessen the harmful effects of stress. Initially these factors were perceived as focused on the individual (Yusoff 2010), until Lazarus presented a proposal of a coping model grounded on interactions between a person and his/her situation.

3.3.1 Coping

Lazarus and Folkman (1984:51) describe coping as "the cognitive and behavioural efforts made to master, tolerate, or reduce external and internal demands and conflicts among them". Barnett et al. (1990:22) define coping as a concept used "in general terms to include defence mechanisms, active ways of solving problems and methods of managing stress". Barnett et al. (1990) observe that crisis events occur from time to time in people's lives and in the lives of whole communities. For example, looking after adolescent AIDS orphans presents a crisis particularly for elderly caregivers who are generally deemed to have retired from active household chores. But confronted with uncertainty in the environment, it is expected that households and communities, as their experience of new situations increases, tend to undertake a range of experiments in an effort to cope. The elderly caregiver-headed household might also be viewed as an experiment in coping with life challenges after the parents of these children have died. But the major challenge of these elderly caregivers may be that they did not go through any training prior to executing the new caregiving responsibility.

According to Lazarus and Folkman (1984), older adults vary in the types of coping that they bring to bear when under stressful situations. Coping involves those things individuals do to prevent, avoid, or control emotional stress in order to maintain psychosocial adaptation during demanding circumstances; it encompasses direct actions to resolve the problems as well as cognitive responses to control emotional distress (Billings et al. 2000; Lazarus and Folkman 2015). Hence it was vital to reveal the caring practices, learning experiences and coping mechanisms of elderly caregivers to the dilemma of adolescent AIDS orphans they look after. As they faced this disorienting dilemma, how did they control their emotions; and did they take their problems head on, or did they try and avoid the dilemma? Answers to such questions would be illuminated by this study through the two lenses of transformative learning theory and the transactional model of stress and coping.

Coping behaviours are used to help alleviate a disorienting dilemma, to reduce perceived threats, and to manage the symptoms of stress (Endler et al. 2000). Presented by Folkman and Lazarus (1980), coping is most effective when the strategy engaged matches the characteristics of the individual, the individual's needs, and the nature of the stressors involved. Some studies have shown that older individuals use fewer active problem-focused strategies and employ more emotion-focused strategies (Beresford 1994; Lazarus and Folkman 1984; Moon 2011). However, such age differences between young and old may be due to functions of different types of stressors (Folkman and Moskowitz 2007; Lazarus and Folkman 2015).

Older persons facing somewhat overwhelming stressors (such as a chronic disease, bereavement, and caregiving responsibilities) may cope effectively by way of acceptance alongside other emotion-focused coping strategies (Lazarus and Folkman 1984). It is important to consider the types of stressors and their natures when trying to identify true age differences in coping (Lazarus and Folkman 2015). Also, older adults have gone through a variety of stressful experiences through life course transitions (Barnett et al. 1990). They may have come to know what strategies are effective in particular situations and to develop their own ways of coping from their experiences. It was the interest of this study to find out how the elderly caregivers of adolescent AIDS orphans normally learned and coped with this fairly contemporary phenomenon of orphan crisis presented by HIV/AIDS. Since they have already accumulated vast treasured experiences from their yesteryears, (which may also be their frame of reference), did they adapt to new learning to be able to accept new frames of reference in order to cope with contemporary crises?

The conception of coping is a multifaceted one which is inseparably interlinked to the idea of stress (Lazarus and Folkman 2015). Stress gained prominence with the work of Robert Hooke who utilised it mechanically in the context of engineering. Hooke's works motivated the approaches to stress in the early 20th century, where it was mechanically viewed as a burden on either psycho-social or biological systems (Lazarus and Folkman 1984). Further interest in the concept of stress emanated from the stress that was related to combat during World War II: it was then that the notion became applicable to people and their settings.

3.3.2 **Stress**

Literature says that the term 'stress' was initially coined by Hans Selye in the 1970s. According to Selye (1975), stress comprised the totality of all general physical changes within a person that are caused by the degree of the body's wear and tear. Other writers such as Pollock (1988) claimed the use of 'stress' as a term was fairly contemporary. Although the term was in use to a certain extent during the nineteenth century, being loosely linked to ill health, it is only in the preceding few decades that it has become a well-recognized term (Folkman 2008).

Lazarus and Folkman (1984:19) posit that psychological stress is "a particular relationship between the person and the environment that is appraised by the person as taking or exceeding his or her resources and endangering his or her wellbeing". If conceptualised in this manner, every challenging stimulus from the environment can be viewed as a stressor or a disorienting dilemma according to Mezirow which people strive to cope with. However, the stressor is centred on the view of one's capability to apportion the necessary resources to sufficiently manage a specific condition. People are required to exploit available resources at their disposal so that some coping with the situation is realised.

Stress is a term borrowed from the engineering field, which was later challenged by the finding that the conditions of stress could not produce predictable results, hence; individual differences became acknowledged as important variables (Lazarus and Folkman 2015). This led to a review of the mechanistic definitions of stress which were explained in terms of the response of an organism to threat, to a more multifaceted one which is interactional. The interactional definition of stress implies that the individual will interact with the environment from where disorienting dilemmas normally originate. Any happening is perceived as a stressor if an individual considers it as such.

This was viewed as a more humanistic approach as opposed to the former approach that started in the engineering field and which relied solely on machines. The humanistic approach gave impetus to scholars who began to define the term stress in different ways in their efforts to fully apply it to human beings (Buck and Parke 1972). It was then that researchers began to use psychological standardised measures to come up with reliable stress impacts on human beings. According to Lazarus (1984), the idea of stress and how it relates to being healthy has been a subject of much enthusiasm in academic circles for more than five decades now. Stress is an individual's physical reaction to environmental demands (Selye 1975) as the individual attempts to regain some equilibrium (or homeostasis) (Endler et al. 2000).

Coping efforts have originally been conceptualised by Lazarus and Folkman (1984) as being two-dimensional: in other words, problem management, which is also referred to as a problem-centred approach; and emotional regulation, which is known in other circles as an emotion-based approach. While the strategies in the former dimension are focused on altering the stressful condition, the latter focuses on varying one's thoughts and feelings about the disorienting dilemma (Lazarus and Folkman 2015). These are further elaborated in the tenets section.

The study would probably reveal how elderly caregivers take necessary actions in solving issues in their caregiving roles. If these actions were problem-centred then they would seek further learning to illuminate ways of caregiving, thereby making their lives more manageable. Emotionally, they would also seek psycho-social support probably by means of counselling, as well as joining support groups. However, seeking information could also be categorised as being problem-focused because one may have realised the information gap existing in one's cognition. Thus, their frames of reference should continuously be challenged and gaps identified (Mezirow 1978) in order to survive in this contemporary world. This takes me to the management of stressors.

The management of stressors is a procedure comprising three separate parts which are **primary appraisal**, **secondary appraisal** and **coping** (Moon 2011). *Primary appraisal* is where an individual notices the threat(s) within his/her environment and acknowledges it (them). The elderly caregivers have the adolescent AIDS orphans as their threat(s) within their environments. Staying with these orphans implied that they have already acknowledged the threat or the disorienting dilemma.

Secondary appraisal is where one is figuring out a means to overcome the threat. Lazarus and Folkman (1984) and Pearlin et al. (1990) view coping mechanisms as the arbitrators between the stressors and the health outcomes of the caregivers. Thus, problems that are not effectively dealt with have a high probability of lowering the caregivers' quality of life (Penley and Tomaka 2002). So, what overcoming means did the elderly caregivers have in their households? This and many other questions would be answered in the study findings.

The third part is *coping* which is when a specific plan has been effectively executed (Lazarus and Folkman 1984). The study would reveal the coping ways elderly caregivers engaged to minimise or overcome the problem. This led me to exploring types of coping as identified in the literature.

3.3.3 **Types of coping**

While Lazarus and Folkman (1984) concentrated on two types of coping, which are problem-centred and emotion-centred, Carver, Scheier and Weintraub (1989) provided an additional model of coping which they named dysfunctional coping. This model focuses on maladaptive ways of coping such as drug and alcohol abuse, venting out anger, behavioural disengagement and denial. I adopted the Lazarus and Folkman (1984) interactive model together with the addition that was made by Carver, Scheier and Weintraub (1989). I was interested to see if the elderly caregivers engaged in maladaptive way of coping, such as resigning to fate. The study revealed their reactions to their caregiving responsibilities in order to cope with the crisis. What caring practices and learning experiences could lead them into being fatalistic? These were some of the experiences which the study was keen to document. Below are the two tables of coping ways as posited by Lazarus and Folkman (1984) with the addition made by Carver, Scheier and Weintraub (1989) and a diagrammatic presentation of the transactional model of stress and coping (TMSC):

Table 3.1: Ways of coping (Lazarus and Folkman 1984)

Problem-focused coping	***Emotion-focused coping***
Confrontative coping	Self-control
Seeking social support	
Plan full problem-solving	Seeking social support
	Distancing
	Positive appraisal
	Accepting responsibility
	Escape/avoidance

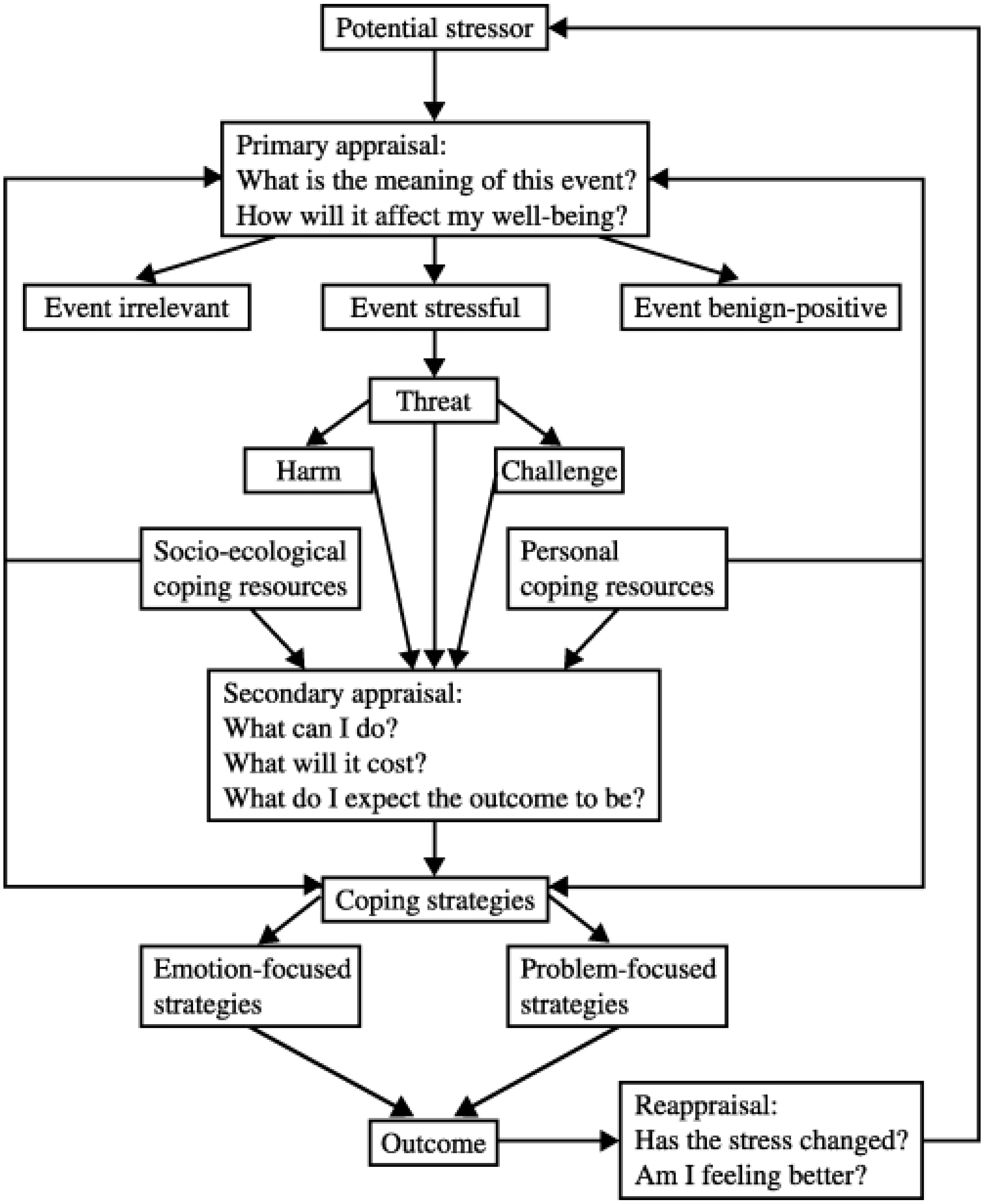
Table 3.2: Ways of coping (Carver, Scheier and Weintraub 1989)

Problem-focused coping	***Emotion-focused coping***	***Dysfunctional coping***
Active coping	Seeking social support for emotional reasons	Focus on and venting out emotions
Planning		
Suppression of competing activities		Behavioural disengagement
Restraint coping	Positive reinforcement and growth	Mental disengagement
Seeking social support for instrumental reasons	Acceptance	Alcohol and drug use
	Turning to religion	Denial
	Humour	

(Source: Bagutayan S.M.S. 2015:482)

The Lazarus and Folkman (1984) transactional model of coping is diagrammatically presented below:

Figure 3.1: Transactional Model of Stress and Coping (TMSC)



Taken from: Lazarus and Folkman (1984:91)

Not all means of coping are positive. Lazarus and Folkman (1984) observe that after increasing experiences of crises, many poor people tend to develop a ‘culture’ and accept their state of hopelessness and helplessness as final and a result of God's wish (Freire 2005). In his concept of critical consciousness, Freire further notes the poor’s perceptions of their conditions as worsening, as they simply accept their circumstances and become fatalistic. Folkman and Moskowitz (2007) postulate that some people turn to religion and/or alcoholism; while others tend to resort to crime and violence. People have a habit to engage in lawful and/or illicit enterprises like prostitution and pilfering when faced with disorienting dilemmas. The study would reveal whether the elderly caregivers utilised these dysfunctional coping strategies. Being fatalistic about these strategies, might stand as a hindrance to the elderly caregivers' efforts to engage in task-oriented and emotion-oriented coping strategies (Carver, Scheier and Weintraub 1989) which are more positive and effective. The tenets of TMSC are explained in the following sub-heading:

Tenets of transactional model of stress and coping (Lazarus and Folkman 1984; Carver, Scheier and Weintraub 1989)

- Primary appraisal: a stage when one evaluates the importance of the encounter and decides on its relevance. It was important to explore the elderly caregivers' caring practices, learning experiences and coping mechanisms in view of the orphan crisis they were facing. What the crisis meant to elderly caregivers would be unpacked in the analysis of findings for this study.
- Secondary appraisal: the individual assesses the manageability of the encounter in terms of resources available to him/her for coping and decides the way forward. I explored the caregiver's assessment of resources available and compared it with Lazarus and Folkman's (1984) concept. For my participants, resources to be looked out for included material ones such as money, foodstuffs, shelter and household goods, while non-material ones implied availability of necessary knowledge, attitudes and skills to effectively deal with the disorienting dilemma, and the desire to deal with the problem.
- Efforts to cope: these are the attempts and mechanisms an individual engages in order to arbitrate primary appraisal and secondary appraisal assessing if any available choices may realise the preferred result in the context of the particular individual and the environmental encounter. The study was keen to explore the coping efforts which the elderly caregivers came up with during the execution of their caregiving roles. Were these task-based, emotion-based or dysfunctional coping ways as posited by Lazarus and Folkman (1984) and Carver, Scheier and Weintraub 1989)? The study findings would provide answers to such questions.
- Task-oriented coping: These are ways and means that are focused on the management or changing of the miserable situation. The task-focused model is envisaged to be most adaptive

particularly if the dilemmas are variable. The elderly caregivers might have been interested to face their problems head-on in an effort to manage and minimise the problems in their new roles, however, they would have required knowledge, skills and attitudes to effectively do that.

- Emotion-oriented coping: ways and means which are engaged in, in the regulation of emotional reaction and how the individual feels or thinks about the demanding situation. Lazarus and Folkman (1984) claim that emotion-based coping ways are greatly adaptive if the dilemmas are unchangeable and consistent, or if the strategies are used jointly with those in the problem-focused model. Lazarus and Folkman (1984) consider coping as a self-motivated process comprising tactics to diminish stressors within one's environment. There was need to link this with transformative learning to determine whether, after dialoguing with others or peers during emotional coping, they would become practically reflective of the ways they used to do things in the past and find out if there were learning gaps in the previous ways.
- Coping: these are mental and practical efforts utilised in managing the inner and/or outer challenges that are considered to be harmful and beyond the person's resources. In professional support cognitive behaviour therapy is engaged in order to help the individual attain a satisfactory outcome (Lazarus and Folkman 1984). Therapy is substantial in the dropping of the levels of stress thereby enabling one to improve coping. The research would establish whether caregivers would seek therapy in times of emotional stress. Emotionally oriented coping is normally engaged in when one is under stress. Some opt for divine intervention while others may look for professional counselling. New responsibilities must come with new learning, which was not the case for the elderly caregivers of adolescent AIDS orphans who were already caregiving without any form of training.

It is important to note that sufficient means of coping tends to weaken the impact of the perceived threat (Lazarus and Folkman 2015; Carver, Scheier and Weintraub 1989). The concept of coping fits in well with the elderly caregivers of adolescent AIDS orphans as this research strove to document their caring practices, learning experiences and coping with the disorienting dilemmas such as looking after the many orphans that were the creation of HIV/AIDS. This framework was also effectively used by Pearlin et al. (1990) when they developed their model which was specific to the situation of caregivers looking after children with disabilities.

According to Zvinavashe et al. (2015), the twin pressures of economic crisis with on-going food and energy insecurity in areas hard hit by HIV/AIDS has forced many susceptible households to resort to limited, frequently detrimental coping mechanisms, such as eating less nourishing diets, selling livestock and other assets, or going into debt by way of borrowing in order to feed their kinfolk. High prices mean that the poor spend their income buying less food or food that is less nutritious (Foster 2002). While such coping mechanisms may alleviate hunger momentarily, they have long term effects as they lead to malnutrition, deplete resources, harm livelihoods and are especially harmful for both the elderly and the youth.

Folkman and Moskowitz (2007) postulate that a more modern approach to coping named meaning-focused coping has been introduced. Meaning-based coping is grounded in the appraisal-based coping concept by which a person appeals to his/her frame of reference such as values, attitudes, and beliefs in order to tolerate the necessary coping. This approach to coping frequently arises if coping becomes ineffective, thus, it is utilised in the revival of coping theory (Folkman 2008; Goh, Sawang and Oei 2010).

In the stress and coping model it should be noted that the emotional reaction to stressful conditions is not essentially the origin of the stress (Folkman and Moskowitz 2007). It is actually a mixture of an individual’s frame of reference understood in the current setting. According to Lazarus and Folkman (1984), it is important to view persons over time within the context of their life experiences in order to appreciate how growth and varying circumstances impact approaches to coping. In view of this, I would call upon the elderly caregivers of adolescent AIDS orphans to describe their caring practices, learning experiences and coping mechanisms, reflecting over a period of time through interviews and focus group discussions. The critiques of TMSC are presented in the next sub-heading.

3.4 Critiques of Lazarus and Folkman’s Theory

Although the transactional model of stress and coping is a dynamic idea in giving therapy (Lazarus and Folkman 1984), for those faced with disorienting dilemmas (Mezirow 1978) it has been critiqued for not being empirically confirmed and for some overlap in its primary and secondary evaluations (Goh, Sawang and Oei 2010). The researcher has settled for Lazarus and Folkman’s theory (1984), together with the additional dysfunctional model (Carver, Scheier and Weintraub 1989). The rationale for this coping theory is that it describes the coping process, as well as the experiences of the problem and its assessment. Since the transaction model of coping looks at coping ways of people in stressful conditions, it becomes appropriate for the research on elderly caregivers of adolescent AIDS orphans, complementing the TLT which addresses their learning and caring practices.

3.5 Chapter Summary

Chapter Three has discussed the two theories used in this study as lenses through which to explain the caring practices, learning experiences and coping mechanisms of the elderly caregivers of adolescent AIDS orphans in Epworth, Zimbabwe. The theories are transformative learning theory presented by Mezirow (1978) and the transactional model of stress and coping conceptualised by Lazarus and Folkman (1984). The historical developments, as well as critiques of these theories, have also been discussed in this chapter. The following chapter discusses the methodology used in this study.

CHAPTER FOUR

RESEARCH DESIGN AND METHODOLOGY

4.0 Introduction

This study aims to explore the caring practices, learning experiences and coping mechanisms of elderly caregivers of adolescent AIDS orphans and draw educational implications from it. The research site was a peri-urban unplanned settlement called Epworth in Harare, Zimbabwe. As the preceding chapter has discussed the theoretical framework, this chapter describes the methodological issues of this research.

4.1 Research Paradigm

After reviewing literature about research methodology in the field of education, I grasped the meaning of the term research paradigm as a researcher's theoretical orientation. Khun (1962) initially used paradigm to refer to a theoretical way of thinking. The term, in educational circles, is generally used in describing an investigator's world view. Creswell (2014) and Guba and Lincoln (2005) concur that a paradigm is a basic set of views that directs action. The worldview can be regarded as the perspective or school of thought that enlightens the understanding or meaning of the generated data in research. The paradigm, hence, is the conceptual lens through which I discussed methodological issues in my study in order to decide the methods that I used to generate and analyse data on the caring practices, learning experiences and coping ways of my participants. It is crucial that my study be located in a certain paradigm because that is where I got the beliefs, as well as the dictates, which impacted on what I was studying, how I intended to study the caring practices, learning experiences of elderly caregivers and how the generated data was interpreted. For every decision that I made, the paradigm had implications.

Three paradigms were identified in literature, namely, positivist, interpretivist and critical, although there is a fourth one called pragmatic suggested by Tashakkori and Teddlie (2003a; 2003b), which tends to derive its components from the other three. Before looking at the individual paradigms that I have identified in literature I first looked at the philosophical components of a paradigm.

Components of a paradigm.

A paradigm is composed of four basic assumptions which are epistemology, ontology, methodology and axiology (Guba and Lincoln 2005).

Epistemology is said to be that branch of philosophy which studies knowledge or knowing the things that are in existence around us (Guba and Lincoln 2005). The major question to ask here is: How do people know what they claim to know? Thus, according to Patton (2002), it is a theory of knowledge that is concerned with principles and rules which enable a researcher to decide whether and how social phenomena can be known, and how the knowledge can be established. These epistemological questions directed me to get what I theoretically considered as social knowledge in my study on exploring caring practices, learning experiences and coping mechanisms of elderly caregivers of adolescent AIDS orphans. Examples of questions I could ask were: What is knowledge? What is the caregivers' understanding of the phenomenon of AIDS orphans? In this instance the caring practices, learning experiences and coping mechanisms were the knowledge that my research was seeking. How do we know what we claim to know? I knew this through confirmability (which is adequately addressed in the trustworthiness section) which was obtained by way of repeatable and verifiable techniques.

There was a need for me to be as close to my research participants as possible, thus, being in their homes, which is a natural setting (Creswell and Creswell 2017). Epistemology is also about the distance between the researcher (knower) and researched (participant) which linked me with generating data with elderly caregivers through interviews, for example, and being in their homes. In other words, there was minimal distance between me as the researcher and my participants in data production, as generation was in interaction.

By so doing, the effectiveness of my data generation and interpretation (understanding what the elderly caregivers may say) could be enhanced. Epistemologically, there is a need to also consider what can be acceptable knowledge in a particular discipline (Martens 2015). In the positivist paradigm, the social world is studied from a distance in terms of principles such as those in the natural sciences which assume that knowledge exists out there and has to be revealed by research in an objective manner (Carpenter 2013), contrary to the interpretivist paradigm in which my study is located, where there is no distance.

Ontology is another branch of philosophy that examines the nature of human beings' existence as individuals, in communities and also in the world (ARC 2015). Likely questions to ask are: Who are we? What are we there for? What is the nature of knowledge? Is it objective or subjective? Ontology as adopted in my study entails a stance towards the nature of truth or reality as subjective. According to Searle (2015), it is the nature and essence of things existing in our social world. Choices about ontological aspects of research should be well-thought-out prior to embarking on the actual research as this helps clarify issues of what really has to be tackled through the process of research (Carpenter 2013). So, to arrive at such a position, I was guided by ontological questions such as: What is the nature of the phenomenon under study? In my study this could be: What is the nature of caregiving that the elderly caregivers provide for adolescent AIDS orphans? My research, thus, primarily dwelt on socially construed subjective meanings and understandings of the phenomena as said by the elderly caregivers from their perspectives, and this justified my adoption of an interpretivist paradigm. I now describe axiology as another philosophical element of a paradigm.

Axiology discusses the ethical issues which require consideration in the process of planning to carry out a piece of research (Searle 2015; Martens 2015). This entails describing, evaluating, as well as understanding, the conception of right and wrong actions concerning the research activity. The major question to ask here is: What was the nature of ethical behaviour (Guba and Lincoln 2005)? As an answer to such a question, it was crucial for me to consider my own regard for the human values of the elderly caregivers (ARC 2015). This led me to additional questions such as: What values were guiding me in conducting this research? The axiological supposition holds that researchers in a qualitative approach tend to bring values which obviously impact the study (Carpenter 2013). I acknowledged the value-laden nature of my study and actively reported values and biases, as well as the value laden nature of the data that I generated from the elderly caregivers (Creswell 2014).

My existence in the study was, therefore, apparent and there was a need to disclose that the research findings signified an interpretation of the elderly caregivers together with me. Contrary to positivists, who are inclined to objectivity and generalisability (Patton 2002), a qualitative approach to research flourishes on data generation from the perceptions of individual participants (ARC 2015). Hence, I concluded and reported from the point of the individual elderly caregiver's caring practices, learning experiences and coping with the dilemma of AIDS orphans as the phenomenon under my study. In my section on ethical considerations I have demonstrated good ethical conduct by showing some understanding of what is the wrong or right manner during the process of carrying out my study. My consideration was, thus, grounded in the belief that every person has dignity, which researchers should respect and researchers should also allow participants the essential human right to choose what they want (ARC 2015). Consequently, if an elderly caregiver had chosen to leave the study, I was obliged to respect that.

Methodology is a philosophical assumption that is used in research to normally refer to design, methods, approaches and procedures that researchers utilise in carrying out a study (Creswell and Creswell 2017). For instance, generation of data, study respondents, tools for data generation, data analysis and interpretation are all components of the wide-ranging field called methodology (Williman 2017). Methodology pronounces the logic and flow of the methodical procedures followed in conducting a study. It answers the question: How do we come to know the world around us (Carpenter 2013)? In deciding a methodology for a piece of research, it is important to ask how one goes about generating the required data in order to be able to provide answers to the research questions and ultimately contribute to the knowledge base (Neuman 2016).

My study used a qualitative methodological assumption which was shown by Creswell (2014) as inductive, emerging, and largely shaped by the researcher's expertise in generating and analysing data. In a qualitative approach the research does not start by testing a theory as in the quantitative domain: it actually generates theories at the end. How I would obtain data from the elderly caregivers has been articulated in some sections of this chapter, and this includes in-depth interviews and focus group discussions. This takes me to the discussion of paradigms, starting with positivism.

4.1.1 **Positivist paradigm**

Suggested by Comte (1798-1857), positivism explains a researcher's world view when conducting some research. He further posits that the foundation for understanding human behaviour is through experiments, observations and reasoning centred on experience. Objectivity and generalisability are of paramount importance in a positivist worldview (Guba and Lincoln 2005). By objectivity the researcher in this paradigm assumes that people's understanding is arrived at by way of reasoning (Creswell 2014), implying that we obtain knowledge which progressively estimates the actual nature of what it is that researchers want to examine.

Generalisability holds that research findings obtained from a study done in the positivist paradigm in one setting can be relevant to new situations by inductive extrapolations (Guba and Lincoln 2005). This means that an investigator observes an event in a specific phenomenon he/she has studied, and is able to generalise on what can be anticipated somewhere else in the world. These assumptions lead to reliance on the use of quantitative methods as the basis for the researcher's precision in describing the data to find some understanding of the relationships that are entrenched in the analysed data (Denzin and Lincoln 2000; Creswell 2014; Guba and Lincoln 2005).

Comte (1856) thought this was the only legitimate way of furthering people's knowledge and understanding, as it normally searches for cause and effect relationships between variables and is selected as the favourite opinion of seeing the world where explanations are construed in terms of numerical facts. This paradigm was not appropriate for my study which sought to explore the meaning making and interpretations of elderly caregivers' situations with AIDS orphans. In the following section I discuss the critical paradigm.

4.1.2 **Critical paradigm**

The critical research paradigm deals with issues of social justice where the major target is in addressing socio-economic and political aspects, such as war, social repression, struggle and any level of power structure (Martens 2015). It is also termed the transformative paradigm because of its intention to alter politics in order to challenge social dominance and make better social integrity (Scotland 2012). In the transformative paradigm the researcher's way of knowing (epistemology) is through interacting with the participants (Martens 2015). Ontologically he/she can look at history particularly as it relates to repression (Searle 2015). The researcher also engages in dialogue as a research methodology, and must respect people's cultural norms as his/her axiology (Martens 2015). This paradigm was not appropriate for my study because I do not intend to question any social dominance. The pragmatic paradigm now follows:

4.1.3 **Pragmatic paradigm**

The pragmatic paradigm came to being after some philosophers (Biesta 2010; Patton 1990; Tashakkori and Teddlie 2003b) disputed that it was not possible to arrive at the truth about social realities around us merely by means of a single scientific method as claimed by positivists, nor that it was possible to conclude social reality as construed by interpretivists. These authors claimed that there was a need for a paradigm that would offer research methods viewed as suitable for investigating any phenomenon. In view of this, philosophers devised approaches that were more practical and varied in order to permit a mixture of methods that in combination would illuminate the real actions of respondents, the beliefs that caused the participants' actions, as well as the results likely to follow from diverse actions (Tashakkori and Teddlie 2003b). This then gave birth to the worldview that utilises mixed methods in a bid to better comprehend people's behaviour. This is what the theorists named the pragmatic paradigm (Biesta 2010; Patton 1990).

The pragmatic worldview holds that relationships in conducting an inquiry are mostly based on what the investigator considers suitable to a particular study (hence the epistemology is relational) (Tashakkori and Teddlie 2003a; Martens 2015). Ontologically, theorists advocate multiple realities as people have unique understandings of the truth (Scotland 2012). Their methodology is a combination of methods in both quantitative and qualitative approaches (Tashakkori and Teddlie 2003b; Martens 2015), which made it not very suitable for my study because of various reasons, such as time required and the great number of participants.

The interpretivist school of thought, in which my study is located, now follows with more explanation.

4.1.4 **Interpretivist paradigm**

Guba and Lincoln (2005) postulate that the interpretivist paradigm's essential endeavour is to find some understanding of the subjective world of the people's experiences. Thus, it makes every effort to come up with some understanding and interpretation of what participants are thinking about a particular phenomenon and the meanings they attach to their situation (Creswell 2017; Searle 2015). In the present study, there was a need, therefore, to attempt to understand the elderly caregivers' caring practices, learning experiences and coping ways from their own standpoint as opposed to my own perspective. In the interpretivist paradigm, prominence is on the participants and how they interpret their own world (Patton 2002).

According to Bogdan and Biklen (1998), the major tenet for this paradigm is the conception that reality is socially created, and that is the reason why this paradigm is sometimes referred to as constructivist. This is the paradigm that my research has adopted as I intended to explore caring practices, learning experiences and coping ways of the elderly caregivers' world, in view of the caregiving responsibility that befell them without any training. The way I revealed their caring practices, learning experiences and coping mechanism demonstrates the subjectivist epistemology (ARC 2015; Punch 2003), which holds that I make meaning of the generated data through my own thinking after having been informed by the interfaces that I make with my participants.

Interpretive research is regularly assumed to be identical with qualitative research although the two are dissimilar (Denzin and Lincoln 2000; Silverman 2016). The former is a research paradigm or model that is founded on the notion that there are multiple social realities which are formed by human experiences and social settings (ontology) (ARC 2015); and the latter is a research approach which is located under the umbrella body of the interpretivist paradigm (Searle 2015). As such, social reality is better studied within its socio-historic background by merging the individual interpretations of its numerous participants (epistemology) (Silverman 2016). Researchers in this paradigm view social realities as being rooted in social settings (Best and Kahn 2016; Creswell and Creswell 2017; Leung 2015), hence they assume that reality or the truth should be interpreted through a sense-making process as opposed to the process of testing a hypothesis which is found in the positivist paradigm, where suppositions are that reality is somewhat autonomous of context (Gutterman, Fetters and Creswell 2015; Searle 2015). Social reality in my study was the truth that elderly caregivers were taking care of adolescent AIDS orphans without prior training to perform such a task. Hence, it was important that I got into the caregivers' homesteads for data generation, for this was their natural environment, in an effort to subjectively understand their caring practices, learning experiences and coping ways with this reality.

The roots of the interpretivist paradigm can be traced in psychology, anthropology, sociology and linguistics (Kant 2003; Patton 2002; Ormston et al. 2014); and the evolution of qualitative research dates back to the 19th century, way before the development of positivist strategies (Howell 2013). Given its subjective nature, positivists viewed qualitative research as flawed and biased (Gutterman, Fetters and Creswell 2015; Creswell and Creswell 2017). On the contrary, the inability of the various techniques in the positivist paradigm to produce thought-provoking insights gave rise to the rebirth of interest in research in the interpretivist domain around the 1970s (Ormston et al. 2014).

Authorities in the quantitative sphere such as Comte (1798-1857) understood that both the social context and the natural world could be studied by way of standardised measures and invariant laws, before this was opposed by authors such as Kant (2003) who claimed there were other means of knowing about the world around us. This eventually led to the birth of interpretivism (Ormston et al. 2014). Dilthey (1977), also one of the proponents of the interpretivist paradigm, posits that researchers must discover lived experiences in order to bring out the associations between social, cultural and historical issues of a people; and to understand the contexts where certain behaviours occur.

According to Max Weber (1864-1920), a bridge should exist between the two paradigms in terms of comprehending of social engagements in the context of the physical settings in which people dwell. In the social sciences the intention is mainly to understand subjectively significant experiences (Creswell and Creswell 2017; Kant 2003), as opposed to manufacturing law-like suggestions as happens in the natural sciences (Patton 2002). Since my study focused on caring practices, learning experiences and coping mechanisms of elderly caregivers of adolescent AIDS orphans, it was deemed more appropriate to adopt an interpretivist paradigm. The paradigms are now complete, taking me to discussing the research approach.

4.2 Research Design

A study design is described by Gall et al. (2014) as the plan for generating and analysing the evidence that makes it possible for me to answer my research questions. The design is the overall umbrella term for the methodology (Patton 2002), which touches on almost every aspect of the research, from the details of data generation to the choice of data analysis techniques. Therefore, in selecting a design for my study, I took into consideration a number of issues and decided to adopt a phenomenology design (Creswell 2014). The issues were:

- the aim and purpose of the study;
- research questions;
- the theoretical underpinnings;
- the type of data that I intend to generate;
- data analysis and interpretation;
- and material resources for conducting the research.

Whatever I did in this research would have to be congruent with the dictates and rules of the interpretivist paradigm which shelters the qualitative approach in which I have positioned my study. According to Creswell (2014), Howell (2014), and Leung (2015), qualitative research has various methods in its approach and these are comprised of ethnography, narrative and phenomenology. The qualitative design is hence briefly explained below, with further elaboration on phenomenology design that is adopted for this study.

Ethnography: It is rooted in cultural anthropology which assumes that the researcher immerses him/herself within a particular culture for periods, going on for years (Leung, 2015). Instead of depending on surveys, observations and/or interviews, the researcher tends to have first-hand experience of the people's setting where he/she can be a participant observer. However, this is not ideal for the present study.

Narrative: The approach knits together a series of events, generally from one or two persons to come up with a consistent story. According to Howell (2014), the researcher can conduct in-depth interviews, analyse documents and then identify emerging themes. The narrative does not demand to be presented in order of chronology and the interviews are conducted over a long time: weeks, months or years (Leung 2015). This again is not appropriate for my study.

Phenomenology is a philosophical worldview or school of thought which has become increasingly popular in psychological research (Gall et al. 2014). Its fundamental purpose is to describe and interpret the perceptions and insights of the respondents, and study how these can be connected to their lived experiences of their situations (Creswell 2014). This design also deals with how some people have experienced a certain phenomenon. In my study, phenomenology was adopted as it was applicable in exploring caring practices, learning experiences and coping ways of the elderly caregivers in looking after the adolescent AIDS orphans.

Further to this Creswell (2014) says phenomenology reduces the individual's experiences of an occurrence to a combined explanation of entire essence. The phenomenological data that my study collected comprised the 'what' and 'how' of the elderly caregivers' caring practices, learning experiences and coping mechanisms. This is consequently the prime truth of my participants, the actual thing itself that is the occurrence, event, or the phenomenon. Phenomenology exploration examines the precise nature of a phenomenon as that which makes an incident what it is, and without which it might be different (Creswell 2014).

Phenomenology is a research tradition that strives to understand "the constructs that people use in everyday life to make sense of their world" (Ormston et al. 2014:12). The philosophical underpinnings of the two theories are also linked with the theoretical footing of phenomenological research which tends to highlight that individual past knowledge impacts on how the lived experience is understood. From Mezirow's lens of transformation, a different interpretation of previous knowledge, skills and attitudes tends to facilitate one's growth and improvement in practice. From a phenomenological standpoint, our experiences and knowledge can only be interpreted when we reflect upon them (Mezirow 1978). This means that reflection on a recent frame of reference can end up changing the implication of a previous experience.

By utilising the phenomenology research design, my study emphasised understanding and interpreting the caring practices, learning experiences and coping mechanisms of elderly caregivers of adolescent AIDS orphans. The analysis of the two theories adopted for this study made me realise the existence of similarities in that they both referred to an individual depending on prior experiences when in a dilemma. However, the justification for using both theories, as discussed in Chapter Three, was entirely to ensure a nuanced understanding, interpretation and description of all variables in the topic, namely, 'caring practices', 'learning experiences' and 'coping mechanisms', as a single theory may not have been adequate. In the next section I cover issues pertaining to methods.

4.3 Research approach

My study has adopted a qualitative research approach, which various authors such as Creswell and Creswell (2017), Guba and Lincoln (1985), Howell (2014) and Patton (2002) agree it comprises the following features, which were also found in my study:

- It is founded under a philosophical umbrella broadly known as 'interpretivist' whose concern is how we view, understand, interpret, and experience the social world. The current study fitted in very well with this paradigm and approach as focus was on the lived experiences and coping ways of elderly caregivers. It also reveals if their learning is reflective in order to transform their frames of references (Mezirow 1978). Can their coping mechanisms be influenced by the works of Lazarus and Folkman (1984) and Carver, Scheier and Weintraub (1989)? This was explored and documented in this study.

- The data generation is sensitive to the social context from which it was produced (Silverman 2016), hence it is subjective in nature as opposed to the rigidity of standardised measures which are utterly abstracted from the real-life issues of the researched (Creswell and Creswell 2017). The fact that I visited the elderly caregivers in their home settings brought in bias, according to positivism. However, the nature of the research under study called for such a method of data generation. It was important that the elderly caregivers be studied in their natural environment (in this case their homes) so that they expressed their own lived experiences without limiting them to measures such as structured questionnaires and experiments. I was interested in knowing and understanding how they made meanings out of their situations, as well as how they coped.

- The researcher herself is the data generation instrument as she conducts the interviews and the focus group discussions with the elderly caregivers. Therefore, I learned about and gained a deeper understanding of the phenomenon from the elderly caregivers who were entrenched in this situation. I came up with a holistic picture of the phenomena under research by way of recording the various viewpoints, identifying the numerous themes emerging in the study setting, and generally outlining the bigger picture that emerged in the caring practices, learning experiences and coping of the elderly caregivers of adolescent AIDS orphans.

- The data would be interpreted through the lens of the theoretical perspectives that are discussed in the theoretical framework chapter; however, the views of my participants who were ingrained in this social context impacted the interpretation. The qualitative approach allowed for a multi-modal quality which enabled me to generate data using in-depth interviews, FGDs and Observations. The importance of the multi-modal approach lies in the complementary nature of data generated through multiple techniques (Mukeredzi 2009). In such cases, apart from enabling the methods to filter one another as shortcomings of one are complemented by strengths of the other, this also minimises method boundedness or exclusive reliance on one method (Mukeredzi 2009). In addition, more methods would give me a nuanced and a multifaceted picture of the phenomenon being explored.

As quantitative and qualitative research stand on opposite ends, it is important to juxtapose them in order to justify my choice of utilising a qualitative approach in my study (Silverman 2015). Quantitative research uses probability techniques of sampling where generalisability and objectivity are highly pronounced (Patton 2002). The investigator is regarded as an outsider to and independent of the context under study so that the generated data and procedures used in its analysis are not treated as biased (Creswell and Creswell 2017; Denzin and Lincoln 2000; Howitt 2016). Hence the methods normally used are surveys and experiments whose data is exposed to statistical manipulation to bring out a figurative outcome. There is no room for participants to explain what they are experiencing in their real world. Quantitative research makes inferences from a phenomenon and attempts to explain associations between events (Gutterman, Fetters and Creswell 2015).

In contrast, interpretivist investigation is holistic and circumstantial (Patton 2002; Neuman 2016). Rigour in the qualitative approach is viewed in terms of the orderly and transparent methods of the generation of data and analysis, rather than the numerical yardsticks for significance testing normally utilised in quantitative methods (Creswell and Creswell 2017; Howell 2013; Neuman 2016). Sense-making and understanding of the caring practices and learning experiences of the elderly caregivers are aspects of great focus in my qualitative research (Patton 2002). Phenomena are studied in their natural contexts in order to try to make sense of and interpret issues in view of the meanings attached to them by the people affected (Silverman 2016; Creswell 2014). In view of this, I sought the elderly caregivers' permission to visit them in their homesteads to conduct interviews as these were their natural settings. It was after being in their natural backgrounds that better understanding of their realities was correctly documented. This takes me to the methods section.

4.4 Population

The population is understood as the entire collection of units under study (Howell 2013; Silverman 2016). These are the units of analysis which can be in the form of individuals, communities, institutions or objects which can be the researcher's major focus. In this study, the population comprised all the elderly caregivers of adolescent AIDS orphans in Epworth. Some researchers claim that the statistics for the population in the community of Epworth are controversial (Chirisa 2013).

As highlighted in Chapter One, the total number of elderly persons in Epworth was revealed by the Zimbabwe 2012 Census as 3,815 within the ages 55 and beyond (Zimbabwe National Statistics Agency 2012). Among these, it is not clear how many were looking after AIDS orphans as the 2012 Census did not state. In terms of age, this is the pool from which the research derived a purposive sample of elderly caregivers that were looking after adolescent AIDS orphans. In other words, the population for my study was made up of all elderly care givers who were looking after adolescent AIDS orphans in Epworth.

4.5 Sampling

This study used snowball sampling to extract participants and used interviews, focus group discussions and observation to generate data. Sampling is an approach by which we deduce information concerning an entire population from a partial number of elements (Creswell and Creswell 2017). The importance of sampling in any research endeavour is underscored by Punch (2002:193) when he says, “We cannot study everyone, everywhere doing everything. Sampling decisions are required not only about which people to interview or which events to observe, but also about settings and processes”. This implies that only appropriate selection of a sampling strategy drives us in the direction of the legitimacy of the results. Howitt (2016) espouses that the activity of sampling must be closely connected to the questions which the research seeks to answer.

In this study a sample was understood to be a sub-set of the population that was of interest to me (Silverman 2016), which I selected from the total population. Snowball sampling, which is a subcategory of the purposive sampling method, is a non-probability type of sampling that was adopted for my study after having correctly positioned it in the qualitative domain under the broad umbrella of the interpretivist paradigm. This was so because of the type of sampling was appropriate to profoundly explore and understand the caring practices, learning experiences and coping ways of the elderly caregivers of adolescent AIDS orphans. The study sampled 20 elderly caregivers of adolescent AIDS orphans, being cognisant that if I reached saturation in the emerging themes I would stop the data generation exercise (Creswell 2014; Leung 2015; Patton 2002). My inclusion criterion was being an elderly caregiver (55 years and beyond) who was caring for adolescent AIDS orphans from ages 10 to 19 years. Caregivers falling outside of this criterion were not recruited into the study. Snowball sampling is where the investigator picks only possible participants for the study. After identifying one participant, they can go further to identify more until the sample has enough units. In this exercise, I had to approach Epworth Local Board for clearance and to find out if a list of elderly caregivers for their area existed. If it existed I would have to pick respondents from that list, however, in the absence of such a list I adopted snowball sampling, where possible participants for the study were picked with assistance from Village Health Workers (VHWs) in Epworth who were able to identify my initial respondent for the study. I met the first respondent through the VHWs, who then led me to another and the process went on till I sampled 20 elderly caregivers. Various authors concur that snowball sampling is a quicker way of finding research samples (Creswell and Creswell 2018; Paton 2002). Participants are normally easy and quick to find as they would have been identified by a dependable source. This way of sampling is also inexpensive because referrals are found from a primary source of the data. This justifies the use of snowball sampling in this study.

The sample size is normally decided on the basis of the type of research to be conducted, be it qualitative or quantitative (Patton 2002; Williman 2017). Although diverse criteria for sample size have been defined in literature for quantitative and qualitative research, it remains common that criteria are determined by characteristics of the population from which the sample is drawn, the kind of data and its truth (Creswell 2014; Leung 2015; Gutterman, Fetters and Creswell 2015). What matters more is the adequacy in terms of in-depth data generation to reach saturation and answer research questions. According to Silverman (2016), relevance is regarded as even more important than representativeness in directing the research towards selection of study participants. Creswell (2014) postulates that even a sample of ten units can be studied representing a sensible size, since in the interpretivist paradigm quality rather than quantity is what matters most (Guba and Lincoln 1985; Leung 2015). This now leads me to accessing of participants.

4.6 Accessing Participants

The plan for data generation as espoused by Howell (2013) comprises the details of how the research is carried out. Any strategy for data generation should be specific to the study that the researcher wants to conduct (Williman 2017). In the present study, I worked in close consultation with the Village Health Workers (VHW), with official clearance from the Epworth Local Board, to link me up with potential respondents in their community. With the permission of the Epworth Local Board (ELB), I visited the elderly caregivers in their home environments (natural environments). I made initial home visits in the company of a VHW to develop rapport with participants and explain the study. It was on this initial visit that I sat down with each one of them to come up with a schedule for interviews and another schedule for Focus Group Discussions (FGDs). The schedule that I jointly agreed with the participants was what I followed in the data generation process. The VHW are influential people who are well versed with issues around their communities, hence it was not anticipated that great difficulties would be experienced in the identification and sampling of respondents.

4.7 Piloting

A pilot research is a small scale initial investigation carried out to assess how feasible the bigger study will be (Creswell and Creswell 2017; Patton 2002). The pilot makes the evaluation in terms of finance and time that is available for the study and strives to make improvements as necessary to the data generation tools (Howell 2014). It is normally done on units of the pertinent population to particularly test the design of the large scale research project and the instruments (Guba and Lincoln 2005). In this study, I pilot tested the study design and methods in one of the sections in Domboramwari, which is one of the six sections of Epworth, to ascertain the feasibility of my study. In the bigger study, this particular section was excluded. The Epworth community is comprised of six sections that are described in the literature review chapter. A smaller study was helpful as it enabled me to polish up my interview and FGD schedules. Some questions which were ambiguous were clarified, and others which were repeating material were merged for the main study. I recruited five participants for the pilot of both the interview and FGDs schedules for the study. I interviewed them first, following which I put them into a group for the FGD. These five participants were not part of the actual study. Below is a section on the data generation.

4.8 Data generation

The study utilised interviews, focus group discussions and observations in the generation of data from the 20 elderly caregivers of adolescent AIDS orphans recruited for the study. Data generation commenced with individual interviews. This decision was made to capture individual ideas before they were influenced by other participants during FGDs. I discuss data generation through interviewing below.

4.8.1 **Interviews**

An interview is described as a conversation that has a purpose (Williman 2017; Gutterman, Fetters and Creswell 2015). It can be the only method or one of various ones in a particular study (Silverman 2016). In this study it was one of the data generation methods.

There are various types of interviews which include telephonic, computer assisted, semi-structured, focus group discussions and face-to-face interviews (Gutterman, Fetters and Creswell 2015; Williman 2017). Given the nature of the Epworth community, which is described in Chapter One, the appropriate type of interview for this study was the face-to-face. Interviews such as telephonic and computer assisted would not suffice due to the unavailability of these electronic gadgets among my participants. It was, therefore, important for my study to adopt face-to-face interviews, complemented by FGDs and observation to gather data. Interviews are critical as they permit the investigator to simplify any matters of ambiguity and emphasise important points, thereby generating rich and intricate data from the researched (Guba and Lincoln 2005). Through the face-to-face interview interactions, I was able to deal with ambiguity and the participants got the opportunity of asking any questions they had.

The setting where the interviews are conducted plays a vital role in the way the researcher prepares to implement the interviews (Patton 2002). Issues to do with choosing the participants, the interview structure, materials for questioning, and how the investigator comprehends and interprets the information are all important (Silverman 2016). In the present study I carried out face-to-face individual interviews with the elderly caregivers in their homes or natural settings after seeking their permission and that of the local authorities. Their natural settings assisted me in studying and observing their context. Since the orphans were not included in the study, I held interviews during their absence (or when they were at school) so that my presence did not trigger suspicion from them. Using the interview guide (Appendix A), interviews were approximately 40 minutes to one hour long. The vernacular Shona language – the participants' mother tongue – was used throughout the data generation exercise as all caregivers were comfortable with it. The generated data were then translated for analysis after all the fieldwork was complete. A Linguist at the University of Zimbabwe did the translation of the data (See Appendix J). Both interviews and FGDs were tape recorded to ensure accuracy of participants' responses and to allow me to take sparse notes while attending fully to the interviewee and upholding the flow of conversation. Permission to tape record was sought from all the 20 participants. Through non-verbal cues such as maintaining eye contact and making verbal sounds (M-mmm), as well as nodding my head, the elderly caregivers became more and more inclined to talk to give the in-depth data that I needed.

The limitation of interviews is that since they involve personal interaction, they call for a high degree of cooperation mainly on the part of the interviewer (Patton 2002). The elderly caregivers might have refused to share the information that I hoped to get, hence, I may have had to continue the recruitment till I reached the sample size I required for this study or till no more new themes were emerging (Creswell 2014). The people being interviewed sometimes give untruthful information (Krueger 1988). To counter the untruthfulness that the data may have, I triangulated the interviews data with that of focus group discussions (Creswell and Creswell 2017). All participants recruited for the study were very cooperative despite the fact that HIV/AIDS matters are sensitive. As highlighted above, data were also generated through FGDs, which is my next sub-heading.

4.8.2 **Focus group discussions**

According to Paton (2002), it is crucial to interact with the groups of participants in order to generate rich information. A focus group can be defined as a group of interacting individuals with some common interest or characteristics, who are normally brought together by a moderator, who uses the group and its interaction as a way to generate data concerning a specific or focused issue (Morgan and Krueger 1998). Lambert and Loiselle (2008) posit that focus group discussion is a qualitative method of gathering participants with related situations to deliberate on a particular phenomenon of interest to the researcher. The elderly caregivers were gathered at their local school to conduct the focus group discussions. I led the group as the facilitator or moderator and initially announced the subject matter for deliberation (Krueger 1988). Care was taken to assist all caregivers to take part in an active and natural manner amongst themselves (Stewart and Shamdasani 1990).

According to Stewart and Shamdasani (1990), this qualitative method of data generation is named focused interviews or group depth interviews. The technique was established subsequent to World

War II to evaluate audience reactions to broadcasting. It was from that time that social scientists have viewed focus group discussions as useful in interpreting people's held beliefs on certain subject matters that are under research. There are various strengths in using focus group discussion as a method of data generation in research, such as gaining a deeper understanding of the phenomenon and having participants narrate their own stories (Nyumba 2018). FGDs gave me deeper understanding of the issues surrounding my elderly caregivers, as well as helping me to discover issues that emerged in the discussion that I had not anticipated to find, for example, the aspect of the legal orientation which seemed to have stood between the caregivers and their orphans, creating some friction along the way. In the discussion, participants may provoke and remind each other of the common problems they may be facing in orphan caring and which may not have emerged in individual interviews (Creswell and Creswell 2018). In my study, this spontaneity had some enrichment effect on my data, thereby justifying my use of this method in the study. However, I acknowledge as a possible limitation that some participants would not freely discuss sensitive information about HIV and AIDS in a focus group discussion. Such weakness was overcome by use of further probing.

A focus group discussion usually comprises six to ten participants who generally do not know each other (Krueger 1988). Respondents are chosen because they possess certain common features related to the topic under discussion (Lambert and Loiselle 2008). I purposively sampled twenty elderly caregivers of adolescent AIDS orphans, who attended focus group discussions in groups of five. Four FGDs were conducted with the same elderly caregivers who participated in the face-to-face interviews in order to follow up and pick up on issues raised in individual interviews and generate more in-depth data enhanced by relationship and trust developed during interviews. The FGDs lasted between one hour and one and a half hours. Each FGD had five caregivers.

I also took advantage of the notion that my participants may naturally interact and influence one another thereby improving on face validity (Lambert and Loiselle 2008). Interaction with respondents was direct and this allowed for clarification of misunderstandings and inconsistencies, as well as obtaining more information through non-verbal cues (Stewart and Shamdasani 1990). The generated data were rich with elderly caregivers' own words from which profounder levels of meanings were derived and also revealed subtle nuances in my data (Krueger 1988).

Morgan and Krueger (1998) claim that the power of FGDs is dependent upon permitting respondents to discuss, agreeing and disagreeing with one another, thereby offering a better understanding of just how the elderly caregivers make new learning about their situation under study, about the variety of views and concepts, and the contradictions that may exist in Epworth community in terms of beliefs, experiences and practices. In the FGD I collected a wide variety of thoughts and ideas on the dilemma of my respondents and also gathered a broad range of indigenous terms (Creswell 2014).

On the weaker side, focus group discussion produces thick data which is difficult to analyse (Krueger 1988). The moderator is required to be knowledgeable about group dynamics to be able to remain in control of the discussion. This was managed by way of directing questions and maintaining eye contact, particularly for the introverts, to show them that I expected answers from them and to allow them chances for opening up and fully participating in the discussions. By so doing I was politely blocking the extroverts from grabbing opportunities from the others and dominating the discussions. The cited introverts/extroverts are in fact some of the characteristics of the methods in the qualitative approach, and as such interpretivists may not treat these as a weakness as they have their own way of ensuring trustworthiness (Guba and Lincoln 2005).

The focus group discussions were judiciously planned beforehand (Guba and Lincoln 2005) to elicit views of the elderly caregivers in a non-intimidating atmosphere. I welcomed all the caregivers to the group meeting by engaging in general small talk before the actual group discussions. We then started the discussion with simple questions which were not thought provoking to motivate all of them to talk. There was heterogeneity in terms of gender in my elderly caregivers and this was an advantage in that it exposed a male perspective which perhaps might have been lacking in previous orphan caring studies where such responsibility normally lies with females (Foster and German 2002). Permission was sought from the elderly caregivers to audio-tape the discussions so that I would not miss any of the information given. An FGD schedule guide (Appendix B) was used to help keep me focussed and so ensure that data generated addressed all aspects of my research questions.

4.8.3 **Observation**

Observation is a way in which data are generated by means of observing (Creswell and Creswell 2017). I adopted the observation method to complement the one-on-one interviews and the FGD data. The data generated by this method included observing the caregivers' surroundings, their shelter, household possessions, as well as their physical appearances. Such data would not be elicited by the one-on-one interviews and the FGDs and yet it was important for my research. My observation was naturalistic as I studied the spontaneous behaviours and surroundings of my participants (Candela 2019). This took place in their natural settings and the observation was non-participatory and informed by an observation checklist (see Appendix C). An observation can be structured or unstructured, with the former having predefined objectives and certain variables to look at (Creswell and Creswell 2017) whereas the latter is held in an open and free manner without any predetermined objectives (Patton 2002). In my study, it was structured observation as I had planned to observe their surroundings, their shelter, household possessions, their physical appearances and any other related aspects that would depict their caring practices, coping mechanisms and learning experiences (Appendix C). Its strength is in the fact that the researcher gets direct contact with the phenomena, thereby producing a lasting record of the phenomena which may be referred to at a later stage (Guba and Lincoln 2005). Observing the elderly caregivers performing more naturally in their homes enhanced reliability of my data (Creswell and Creswell 2018). Some of the aspects observed included their homesteads, backyards, and sources of water. Interactional settings were not observed as the caregivers' orphans were not available at homes and could not be included in the data generation because of ethical reasons described in the methodology chapter.

The weaknesses of this method of data generation are that the researcher is required to observe for a long time and his/her presence may end up manipulating the behaviour of participants (Patton 2002). My study adopted observation as a way of triangulation so that I improved on the credibility of my study findings. The observation was done mainly during the one-on-one interviews because that was when I visited the caregivers' natural settings. The observations were jotted down as notes in my notebook. However, it should be noted that this method of data generation may be linked to specific ethical matters. As such there was a need for me to consider the informed consent of the elderly caregivers, as well as the gatekeeper's letter of permission which was obtained from

Epworth Local Board. The DUT also gave me its ethical clearance to do this study. For ethical reasons the study did not observe the orphans, and during the data generation (face-to-face interviews) exercise the children were in school and not available at home.

The combination of these three methods in my study might have produced an iterative process whereby we go back and forth in an attempt to make meaning and interpret the caring practices, learning experiences and coping ways of the elderly caregivers (Stewart and Shamdasani 1990). There was bound to be convergence of key features of the phenomenon throughout the FGDs, in-depth interviews and the observations, which further boosted the trustworthiness of my study findings (Morgan and Krueger 1998). Combining the three helped me offset weaknesses in each of them.

Member checking

Creswell and Creswell (2017) espouse that credibility can be obtained through member checking so as to assess the results and interpretations with the respondents, as well as the thick descriptions of the research context and research procedures. Member checking was carried out in two stages: preliminarily, when I summarised key points at the end of the interviews and FGDs for participants to check accuracy, and then afterwards when I went back with my transcriptions for members to check the accuracy of the responses. Member checking was done with some of the participants. Farquhar, Michels and Robson (2020) and also recently Candela (2019) view member checking as a process in which the researcher asks one or some of the participants in the study to check the accuracy of the transcription. The accuracy confirmations made by some of the participants enhanced credibility of the generated data, as well as giving me confidence in the research.

4.8.4 **Data analysis**

In the interpretivist paradigm, Creswell (2014) and Leung (2015) advocate that data signifies the non-quantifiable information such as interview transcriptions, pictures, both audio and video recordings, as well as manuscripts. To allow for analysis, the data was translated from Shona to English and this exercise was done by a translator from the University of Zimbabwe Department of Linguistics. The analysis was manual, which is usually critiqued by positivists as laborious and time consuming (Khan 2014). Although there are computer assisted coding methods, which may sound superior to the manual, the data in this research utilised manual coding, which uses filing cabinets and folders to gather the materials which are illustrations of related ideas (Patton 2002). The use of computer assisted coding has not been considered in this study as it required time to gain mastery in the use of the more sophisticated but relevant software, the cost of procuring the software and learning it was also a prohibitive factor. In addition, I engaged in manual data analysis to better immerse myself in my data and gain a deeper understanding of it. In qualitative research, a researcher can engage in manual ways of coding (Patton 2002) or utilise the software in qualitative analysis such as HyperRESEARCH 2.8, Max QDA, NVivo, and Atlas ti 6.0. (Creswell 2017; Creswell 2015; Silverman 2015). However, as highlighted above, I adopted manual data analysis.

The data analysis followed Creswell's (2009) steps as summarised below:

1. Managing and organising data: In this stage_transcription of the raw data from the tape-recorded interviews and focus group discussions and any field notes was done. It required me to be entirely captivated and keenly engaged in the generated data through transcribing the interviews and the focus group discussion recordings, and the observation notes. It was crucial for me to have a comprehensive understanding of the content of my interactions with the elderly caregivers and to familiarise myself with every facet of it. The initial stage was important as it provided a basis for the analysis to follow. Costs of hiring someone to transcribe the data were prohibitive and I had to do it alone, though it was quite cumbersome. The analysis of data was not only limited to the end of fieldwork, but infield analysis which commenced on the initial day of fieldwork and went on throughout the data generation exercise, where I had to make observations and take notes of the emerging patterns.

2. I organised my data according to research questions, familiarising myself with the data and prepared for analysis. When I got fully familiar with the data I then established some preliminary codes, which were the characteristics of my data that seemed to be thought-provoking and also meaningful.

3. I read through the data over and over again and listened to the audio tapes several times to properly acquaint myself with the data.

4. I manually coded the data, thus, dividing the data into components of related meanings. My thought process referred to the link amongst the codes, sub-themes, as well as themes.

5. I described and interconnected the themes at step number five. Thus, there was a need for a thorough review of the established themes where I queried whether to join some of the similar themes, improve, disconnect or remove some of the preliminary themes. The data in the identified themes should, hence, be meaningfully coherent.

6. In this step, I came up with meanings and understandings of the research data. There was continuous refining and defining of the identified themes and sub-themes to further improve the analysis. A cohesive narrative of the data started to develop from the themes. The analysis was then transformed into an understandable script by use of rich and convincing instances that communicated with the themes from the data, the research, as well as the literature reviewed for the study. The report that I produced with data from the elderly caregivers went beyond a simple explanation of themes, and depicted an analysis that was wholly supported with scientific evidence which related to the research questions.

4.9 Trustworthiness

Since qualitative studies have become progressively acknowledged and respected, it has become important that researchers conduct the research in a rigorous and systematic way in order to come up with significant and valuable findings (Leung 2015). The subjective nature of the qualitative approach has regularly come under questioning by positivists who view it as lacking objectivity (Creswell and Creswell 2017). In the qualitative approach to research, trustworthiness is the preferred term, instead of validity and reliability, which allows for generalisations of study findings in the quantitative domain (Guba and Lincoln 2005).

According to Guba and Lincoln (2005), trustworthiness is the manner in which investigators can convince themselves, as well as their readers, that the results from their research are worthy of consideration. The concept of trustworthiness was refined by Guba and Lincoln (2005) by introducing four criteria into it – credibility, transferability, dependability and confirmability – so as to stand side by side with conventional positivist standards of assessment of reliability and validity (Patton 2002). Although others have recently offered extensive and flexible indicators of quality in the interpretive paradigm (Creswell 2014), I have selected to utilise the original, broadly acknowledged and generally familiar benchmarks presented by Guba and Lincoln (2005) to investigate the caring practices, learning experiences and coping ways of the elderly caregivers of adolescent AIDS orphans. Following are the criteria for establishing trustworthiness in the qualitative research approach.

4.9.1 **Measures for trustworthiness**

- *Credibility*

  Credibility encompasses the establishment that the findings of a research study are sound or credible or, put simply, believable (Guba and Lincoln 2005; Patton 2002). In terms of qualitative studies, it is only the respondents who can reasonably judge the soundness or credibility of the study findings (Creswell 2014). In the current study, the elderly caregivers were the only people able to tell that the findings of the study were believable or not.

  To ensure credibility in this study I engaged some of the techniques presented by Guba and Lincoln (2005), some of which are prolonged engagement with the respondents and data generation triangulation. My field work lasted for eight months. During the COVID-19 period data generation was not all that smooth as I could go to look for one respondent many times without finding them. Efforts to find the elderly caregivers were continued until the data were generated with all who were recruited. This prolonged fieldwork also helped to enhance credibility.

- *Transferability*

The term transferability is defined by Guba and Lincoln (2005) as the degree to which the research findings of a qualitative approach can be transferred to similar situations, yielding the same findings with different respondents. It is the investigator’s responsibility to show that the results of the study are also applicable to other situations (Patton 2002). In terms of quantitative studies, transferability will be comparable to generalisability of a study (Creswell 2014). The other situations here can be similar contexts, similar problems, and similar populations that the findings can be transferred to.

Use of thick descriptions in the qualitative approach enables the researcher to transfer applicability of findings to other situations (Guba and Lincoln 2005). The thick descriptions are defined by Guba and Lincoln (2005) as the manner in which researchers attain external validity. In the current research, I described the phenomenon under study in adequate detail to enable my readers to assess the degree to which my conclusions may be transferable to other circumstances.

The thick descriptions were provided in the data presentation and analysis chapters where findings for each question were presented as a separate chapter to enable detailed discussion of findings, contributing to transferability. In addition, in Chapter One I provided a detailed description of the research context from where data were generated and analysed. However, the decision to transfer findings to similar specific groups, communities and /or circumstances will be left to the researcher and reader to confirm based on their understanding and experiences. The next item is dependability.

- *Dependability or Auditability*

Dependability is the stability of data over time and over situations (Guba and Lincoln 2005). Dependability is comparable to reliability in the positivist paradigm. It is vital in that researchers strive to verify the consistence of their findings with the raw data generated to the extent that if a different researcher were to scrutinise the generated data they would get similar results, understandings and conclusions about the same data (Creswell 2014). This is important in ensuring that the researcher was not mistaken in the final report, thus, there is dependability in such research findings. Qualitative researchers use inquiry audit trails to ensure dependability in their studies. The audits need an external individual to evaluate the process of the research and how data were analysed to ascertain consistency of the findings in the same data (Guba and Lincoln 2005).

The audit trails will give the readers confirmation of judgements and choices that the researcher made in terms of theoretical and methodological bases (Paton 2002). Creswell (2014) states that a research study will be auditable if a different investigator can unmistakably track the trail of decisions and choices that the investigator was making. In order that the current study be dependable, I strove to keep all my records of the raw data (field notes that I came up with, as well as all the transcriptions from interviews and FGDs) available for any audit exercise that would be necessary. This included detailed records of all the moves and decisions made during data generation and analysis exercises, as well as peer de-briefing with my supervisors. The principle of confirmability of study results is next.

- *Confirmability*

Confirmability deals with determining that the investigator's results and interpretations obviously result from the generated data (Guba and Lincoln 2005). It is the extent of neutrality in the study outcomes (Patton 2002), which means that the results are actually grounded on the responses given by the researched without any likely prejudice or bias of the investigator (Creswell 2014). This further requires that the investigator shows how he/she reached conclusions and interpretations. Guba and Lincoln (2005) posit that confirmability is proven when the other three criteria of trustworthiness (credibility, transferability, dependability) are realised.

This same notion also applies in this study. In this study, I endeavoured to achieve these three yardsticks in exploring the caring practices, learning experiences and coping ways of the elderly caregivers of adolescent AIDS orphans in Epworth so that confirmability of the findings and their interpretation would be apparent. I bracketed my own biases so that they would not tilt the interpretations of what the participants might have said in order to fit my liking or expectations (Guba and Lincoln 2005), maintaining an open mind throughout data generation and not interrupting them when they were speaking to minimise biases. Audit trails, where I recorded and justified every step that I made in the data generation and analysis, were also helpful in confirming that the study results correctly represented the replies of the elderly caregivers under study (Patton 2002). From the criteria for trustworthiness I move on to ethical issues.

4.10 Ethical considerations

Ethics are generally a set of guidelines which govern our behaviour when conducting research with human beings (Thorne 2016). These can be written as well as unwritten. According to Ryen (2016), in research institutions these rules precisely set out the way the systematic studies must be done and how the information generated can be disseminated. Ethics in research is long-standing and crucial to any researcher (Creswell 2014), however, it is imperative in qualitative studies where the investigator frequently encroaches into the respondents' personal space (Townsend 2016). In this study, I visited the elderly caregivers in their homes, therefore, it was important to be on the look-out not to violate ethics that govern the data generation exercise. Hence, ethics assist in the protection of individuals and their environments. It is the researcher who really is aware of the probable profits and harms that are involved in a particular study (Best and Khan 2016).

Consequently, as an investigator, I had to behave in a righteous and virtuous manner (Thorne 2016) for the sake of the elderly caregivers who invested their faith in me and my research, my academic institution, my research funders, as well as the profession at large (Creswell 2014). It became an honourable responsibility for me to be ethically principled even if the elderly caregivers might have been ignorant of or undisturbed about violation of ethics (Khan 2014). I also sought permission from the Epworth Local Board to refer any participant to the clinic counsellor in the event that such services became necessary. Being a qualified counsellor, I ensured that my questioning might not trigger any anxiety in my participants.

It was important that I, while generating any type of data from the elderly caregivers, must expose all likely benefits and losses that the research exercise may incur (Leung 2015). It was also my concern to assure the elderly caregivers of confidentiality in terms of the information that was generated from interviews (Best and Khan 2016), so that they felt relaxed and willing to share with me the much-needed rich data to provide answers to the research questions. The current study's integrity was enriched through the observation of ethical practices discussed in the subsequent paragraphs.

Beneficence and non-maleficence

The research participants must not be exposed to any harm during the study's data generation exercise (Best and Khan 2016; Thorne 2016; Ryen 2016; Townsend 2016). In the present study, the elderly caregivers were not forced to proffer any information in areas where they might feel emotionally offended. Issues about AIDS are generally surrounded with stigma and discrimination and some people may choose not to answer certain questions as they may provoke past painful experiences. I had to point out such issues in advance within the informed consent. The present study aimed to benefit the learners, who were the elderly caregivers. In the course of data generation, I also had to be protected from possible harm (Creswell 2016). This was achieved by way of using a reliable means of transport that I provided in going to Epworth, keeping to scheduled appointments so that the elderly caregivers did not wait for me, as well as interviewing in a professional manner that did not trigger anger from the elderly caregivers. The interview questions were pilot tested to see how they might be accepted by elderly caregivers in a different but similar setting (Patton 2002). The principle of fidelity and responsibility is next.

Fidelity and responsibility

Another principle of ethics is that researchers must take charge of their actions and observe professional benchmarks in terms of their behaviour (Best and Khan 2016; Robson and McCartan 2016). The ethical expectations and their implementation should always be monitored if the research is to be reliable (Leung 2015). The current study strove to achieve these aspects as the researcher is experienced in qualitative data generation activities when she used to be engaged by academics to conduct interviews and focus group discussions for their research. The next principle under discussion is the rights and dignity of participants.

Respondents' rights and dignity

The researcher should make it a priority to respect the rights and the dignity of the research participants in the study (Townsend 2016). As people, these elderly caregivers had their own rights that I had to observe in the research process. These rights included the right to withdraw from the study at any given time, anonymity and confidentiality as presented in the subsequent paragraphs.

- Withdrawal right: It must not be taken as a crime if respondents withdraw their entry into the study (Creswell and Creswell 2017; Ryen 2016). In fact, it is important to assure them of no impact if they choose to withdraw at any point during the research. I strove to keep all the recruited elderly caregivers by revealing the truth about the study so that they made informed decisions about being in the study (Patton 2002).

- Anonymity and confidentiality: This aspect entails that the information pertaining to the respondents should not be known beyond the research team (Williman 2017) and, in the event that the information generated is published, any comments in the data should not be attributed to a specific respondent (Townsend 2016). The elderly caregivers in this study were not asked for their real names. In fact, the researcher allocated a number for each caregiver so that real names were not taken and used (Robson and McCartan 2016). The data would be kept by the supervisors under lock and key for five years after graduation and would be eventually destroyed by shredding. The electronic data would be kept under a password known to me and my supervisors only.

- Informed consent: Before embarking on the fieldwork I had to obtain ethical clearance from the Durban University of Technology Institutional Research and Ethics Committee (IREC) (Appendix D). The researcher sought the elderly caregivers' agreement to be enrolled in the study prior to the generation of data (Patton 2002). Approval to engage in the research was sought from the Epworth Local Board (Appendix I), which is the local government for Epworth. When seeking informed consent, I gave the respondents the information through an information letter (Appendix E) which gave details of the purpose and nature of study so that they made informed decisions about whether to take part or not (Howell 2013). Vital information to be included when seeking consent includes how the respondents will take part in the research, the duration of interviews and/or focus group discussions, the sponsors of the research activity and the structure of the study team (Khan 2014).

  The elderly caregivers in this study were adequately informed about the study so that they made informed choices (Robson and McCartan 2016). A letter was written to the Epworth Local Board (Appendix G) to the effect of being allowed to carry out the study. I was granted Ethical Clearance from my academic institute, the Durban University of Technology (Appendix D), as well as obtaining gatekeeper's letters (Appendix H).

I gave consideration to the outlined research ethics, as overlooking them might leave the Epworth community at the mercy of unconfirmed claims grounded on scanty evidence (Creswell and Creswell 2017). I, therefore, guaranteed the professional handling of the elderly caregivers of adolescent AIDS orphans by sticking to the research ethics documented in literature.

4.11 Limitations of the study

The main limitation of my study was its methodological positioning. Having located it in the interpretive paradigm whose dictates derive from the qualitative approach where non-probability types of sampling (purposive) are pronounced, could have involuntarily denied the opportunity to take part to other potential participants with rich data. Because of this, the subjective nature of the interpretivist paradigm adopted for this study barred objectivity and generalisation of findings. While it may be so, my use of various methods of data generation which are face-to-face interviews, FGDs and observation improved triangulation of my data thereby keeping bias to a minimum. My study findings are limited to the Epworth community only and may not be transferred to other communities around Zimbabwe. However, it is documented in literature that it is appropriate for research findings to be limited to particular groups of people, to certain communities or specific people (Creswell 2018). Thick descriptions of my research situation were provided in the presentation and analysis of data and this may enable readers to make choices of transferring the findings to similar situations or not. Continuous reference to the two theories (TLT and TMSC) adopted for the study was also helpful in keeping me focused on my research questions thereby minimising bias.

As the principal investigator of this study, I carried out the research on my own instead of engaging research assistants. This was the case in order that I maintain issues of confidentiality and anonymity of my elderly caregivers. The caregivers were, thus, allocated codes P-1 up to P-20 as their names. I dealt with issues of bias through remaining open-minded and bracketing my own notions and ideas throughout data generation and analysis to ensure that findings truly reflected participants' responses and perspectives. Researchers have the temptation of interpreting their research finding to suit their hypotheses, or including only the data which they view to be of relevance or value to them. According to Candela (2019), all the data should be analysed to reveal everything that has been said by participants in order to minimise bias. Open-ended questions which I used helped in allowing a free flow of information without having to impose a limit on the caregivers' responses. My supervisors also checked my data during the course of the study to minimise the issue of bias and enhance credibility.

4.12 Chapter Summary

Chapter Four deliberated on the methodological aspects which the study embraced. Features making headlines in the chapter were the research paradigm, design, population and sample. Data generation instruments and analysis are also discussed. The chapter wound up with issues to do with trustworthiness and ethics in research. Limitations of the study were also discussed and these will allow for further improvement on this piece of work and other research.

CHAPTER FIVE

CARING PRACTICES OF ELDERLY CAREGIVERS OF ADOLESCENT AIDS ORPHANS IN EPWORTH

5.0 Introduction

The purpose of the study was to establish the caregivers' caring practices, learning experiences and coping mechanisms in order to draw up inferences for Adult Education. The aim of the current chapter was to explore the nature of caring practices engaged in by elderly caregivers of adolescent AIDS orphans under their care in the Epworth area of Zimbabwe. The chapter presents, interprets and discusses findings on the caring practices and coping mechanisms that elderly caregivers engaged in. Data generated through interviews, focus group discussions (FGD) and observations are interpreted, discussed and related to literature reviewed in Chapter Two. I draw on previous studies in order to see how my findings relate to existing research.

Data were analysed and described using transformative learning theory (TLT) and the transactional model of stress and coping (TMSC), the theoretical framework which was adopted as a lens to explore the caring practices, learning experiences and coping mechanisms of the elderly caregivers of the adolescent AIDS orphans. The chapter discusses the demographic data first, followed by caring practices, with challenges and coping mechanisms coming last.

The study was guided by two research questions. Each research question is presented in its independent chapter in order that each question is exhaustively discussed. The present chapter provides answers to Research Question One which deals with the nature of caring practices and coping mechanisms that the elderly caregivers of adolescent AIDS orphans engaged in. The demographic data are presented, together with Research Question One in this chapter. The themes that emerged in response to the caring practices of the elderly caregivers of adolescent AIDS orphans, together with those derived from demographics are reflected in Table 5.1 below.

Table 5.1: Themes that emerged from demography and nature of caring practices

THEMES FOR QUESTION ONE

Demography	**Nature of caring practices**		
	Caring practices	**Challenges**	**Coping ways**
Ages and gender	Character formation	Social challenges	Supplementing inadequate income
Educational levels	Provision of material needs	Financial challenges	External help
Length of time they have looked after orphans		Psychological challenges	Counselling
Time when parents of child(ren) died			Correction, sanction and discipline
Number of orphans			Talking out issues
Ages of orphans			Cutting meals
Orphans' school status			

The structure of this chapter starts with presentation of the demographic data. The reader is reminded of the dual theoretical lens which was utilised in the study; hence a summary for TLT and TMSC is given after the demographic data. Caring practices are next, followed by the challenges and lastly the coping ways.

5.1 Demography of the elderly caregivers of adolescent orphans

In the demographic data, pseudonyms were utilised to protect the participants' identity, hence codes such as P-1 up to P-20 were used, where P represented participants. Below is a tabular presentation of the demographic data of the 20 participants.

Table 5.2: Demographic data

			THEMES				
Participants	**Age & gender**	**Edu. level**	**Length of time looking after orphans**	**Length of time after orphans' parent died**	**# of orphans in the household**	**Ages of Orphans**	**Orphans' school status**
P-1	76 (M)	Form 2	11 years	11 and 7 years	4	17, 13, 13, 10	In school
P-2	69 (F)	No school	10 years	10 years	3	Don't know	In school
P-3	57 (F)	Form 2	12 years	13 years	1	16 years	In school
P-4	65 (F)	Form 4	5 years	9 years	3	14, 16, 17	In school
P-5	63 (M)	Form 1	10 years	10 years	3	18, 13, 16	In school
P-6	58 (F)	Form 4	8 years	15 years	2	16, 18	In school
P-7	68 (F)	Form 3	10 years	11 years	2	12, 15	In school
P-8	59 (F)	Form 4	7 years	7 years	3	11, 16, 18	In school
P-9	69 (M)	Form 6 2 Diplomas	9 years	10 years	3	13, 15, 18	In school
P-10	71 (F)	Std. 1	10 years	11 years	4	Don't know	In school
P-11	65 (F)	Form 2	11 years	11 years	3	Not sure	In school
P-12	65 (F)	Form 4 Diploma in Edu.	5 years	6 years	3	11, 14, 15	In school
P-13	68 (M)	Univ. degree	10 years	10 years	2	15, 17	In school
P-14	69 (F)	Form 1	13 years	13 years	6	13, 15, 18 and 3 under 13 years	In school
P-15	60 (F)	Grade 7	6 years	6 years	2	16 years (twins)	In school
P-16	61 (F)	Univ. degree	8 years	8 years	3	10, 12, 15	In school
P17	67 (M)	Form 4	6 years	6 years	3	13, 15, 17	In school
P-18	60 (F)	Form 4	7 years	7 years	5	8, 9, 12, 14, 16	In school
P-19	59 (F)	Form 4	9 years	9 years	5	17, 15, 13, 9, 10	In school
P-20	60 (F)	No school	4 years	4 years	3	14, 17, 17	In school

In the subsequent section I discuss the demographic information of participants, drawing on themes presented in Table 5.2.

5.1.1 Age and gender of the participants

The participants included one male and one female both above the age of 70, with the rest ranging from age 57 to 69 years. Among the participants, a quarter of them (5) were elderly males while the rest were females. All the participants were beyond 55 years which was the youngest age that constitutes an elderly person as defined by HelpAge International (2017). While caregiving duties were normally ascribed to womenfolk in previous times (Foster and German 2002), I found that men were now participating in these roles probably due to the AIDS ravages that produced many orphans in the developing world. Though they were in smaller numbers when compared to their female counterparts, the males' appearance in the study confirmed that caregiving activities had ceased to be an exclusively female domain.

5.1.2 **Educational Levels**

Given the age groups of these participants, one would think that they were not educated, but this was not the case. The majority of the elderly caregivers investigated had gone up to ordinary level, which is the equivalence of Grade 11 in other countries such as South Africa. The O level which the caregivers claimed to have reached was, unfortunately, not completed to obtain the necessary credentials which would have enabled their formal employment. Ordinary level in the Zimbabwean educational system runs for the first four years of secondary education, thus, from Form One to Form Four. There were two participants with university degrees and two with diplomas. Only two caregivers had not been to school at all. However, most of the elderly caregivers did not have any employment history probably because they did not complete O level studies. The common reason given by participants for failure to complete school was cited as having come from large families which could not educate one person to higher level at the expense of other siblings. For example, P17 said:

> *Our family was big and parents could not afford to send one sibling to school for many years because of lack of financial resources. As long as one could be able to write a letter, that was deemed enough.*

The two participants who never went to school were both females, giving credence to the gender imbalances that were experienced in most households in the past. Without educational certificates at a certain level it would be difficult for one to get formally and gainfully employed. This corroborated the literature (Zvinavashe et al. 2015; Maronganye 2017) where some of the caregivers have also not been to school and this was more pronounced on the female gender.

5.1.3 **Length of time looking after orphans/When did the orphans' parents die?**

The range of years looking after orphans was 4 to 15, which in most cases also corresponded with the number of years after their adult children had died. In some households the caregivers experienced deaths of more than one adult child, as evidenced by P-12 and P-1who said:

> *They passed on round about the same time, the 2 passed on 6 years ago and then the other one 4 years ago*. P-12

> *The elder one died first in 2009, and the other followed in 2013.* P-1

Looking after orphans seemed to have immediately commenced after the passing on of their adult children. This was because the length of time looking after the orphans and the time at which the adult children died corresponded. The elderly caregivers gained experience looking after their own children, as well as caring for their grandchildren although this was done in different situations. Adults identify themselves by the experiences they have accumulated throughout life and this could be the reason why they tapped into their cultural canons (Mezirow 2012) to see how best they could proceed with the task of caregiving in the contemporary context of HIV/AIDS.

5.1.4 **Ages of orphans in the caregivers households**

The ages of orphans in the caregivers' households ranged from 8 to 18 years, with three participants expressing ignorance of the ages of the children. This age range covered all three stages of adolescence, namely, early adolescence, middle adolescence and late adolescence. It is the stage when adolescents become ill-tempered and demand more concealment from their guardians (Quas 2014; Zaky 2016). The age ranges for early adolescence is between 10 and 13 for girls, and 12 and 15 for boys (Zaky 2016; Omotoso 2007; Quas 2014). In Zimbabwe's educational system, these are the children transitioning to secondary school. It is a characteristic of this stage that conflict occurs between the teenagers and their caregivers as the adolescents were said to misbehave and not listen to the caregivers (Zaky 2016; Wagner et al. 2017). Although the study had wanted to look at elderly caregivers with adolescent children aged 10 to 19 years, it emerged that some households had orphans younger than 10 years, and having these younger children in households impacted on the caregivers' abilities to care. The presence of these younger children must have increased the burden on caregivers in that they were not yet able to perform most of the household chores. Contrarily, teenagers were at a stage of having capacities to perform household chores without difficulty. Three participants, P-2, P-10 and P-11, did not know the ages of their orphans as evidenced by the following extracts:

> *I don't know the ages of these orphans. I am just glad that the school has accepted them to learn with the others. They keep their birth certificates which I am not able to read and make sense. P-2*
>
> *I did not check to find out how old the children are but they are still in the school-going age group. They came into my custody at infancy up to now. P-10*
>
> *I am not really sure how old they are now. May be if the children were here you could have seen them. P-11*

P-2 and P-10 are the participants who never went to school, giving rise to illiteracy in calculating the ages of their orphans. In view of the definition of teenager (or adolescent), which WHO says begins at age 10 years and extends to 19 years, it is evident that the elderly caregivers in this research had been looking after orphans for periods exceeding 10 years at the time of the study.

5.1.5 **Number of orphans per household**

The number of orphans in each caregiver's family ranged from one to six, with an average of three orphans per household. The least number of orphans was found in P-3's family which had one adolescent, while the highest figure was recorded in P-14's household with six orphans. P-10, a female elder, expressed ignorance of the ages of the four orphans she was looking after. As observed during interviews, the adolescents were not around and the one orphan who was available could be around the age six to eight years. The same situation of having children who had not reached adolescence was also found in P-18's family where two orphans were aged eight and nine years. The data also indicated P-3 caring for a single orphan in her household.

5.1.6 **Orphans school status**

All the orphans in the elderly caregivers' households were going to school. It is important to mention that even those caregivers who had never been to school were serious about sending their orphans to school. All the children seemed to be going to school despite their gender differences and the financial hardships of their caregivers. It appeared that the elderly caregivers realised the benefits of sending all the children to school and were all striving to do so. Two participants had not been to school, citing reasons that in the olden days parents preferred educating boys at the expense of girl children because girls were expected to marry and enrich their husbands who in this case were regarded as foreigners for family relationship purposes (Bourdillon 1991; Chitempa 2018). After facing the dilemma of adult children's deaths and remaining with orphans, the caregivers seemed to have realised the significance of sending children to school despite some having not been to school themselves. This is the critical assessment stage of the TLT which empowered all of the participants to reflect back on the previous disposition of belittling education. The following quotes evidenced this point, with P-2 saying:

> *Most of those of my generation were not learned. Our fathers used to side-line the education of girls and favoured that of boys.*

P-20 said:

> *During the times we were growing up, we were made to belittle educational issues pertaining to women as we were made to believe that when a girl gets married she would be looked after by her husband.*

In the above illustrations, cultural issues related to gender preferences in educating children were distinct. Society had used this gender inequality to determine who possessed power, who made decisions, and also who did what in certain environments. In many households, boy children got preference in terms of being sent to school (Kariwo and Shizha 2012). According to UNICEF (2016), equality on gender requires that both males and females enjoy similar rights and opportunities. However, in various societies throughout the world, it is pervasive that boys are more favoured thereby compromising girls' or women's situations (World Bank 2012). For those elderly caregivers who had been to school, it was worth noting that they did not complete the much needed O level which could have come as the driver to further education and employment. The gender disparity, as well as the relatively low levels of education, that some of the elders suffered in their childhood probably gave rise to their failure to critically think about and effectively solve their problems. With such educational deficiencies one would lack rational critical thinking capabilities which are essential in the processing and filtering information (Tuzlukova and Usha-Prabhukanth 2018). Hence, the caregivers' problem-solving skills were probably ineffective as most of them went to school but did not complete their O levels citing various reasons which were mentioned in above. The contemporary society in which we live today requires educationally developed individuals who recognise their full potential to become fully functional in solving modern-day problems (Karakoc 2016). Education would have been the means of providing the elderly caregivers with critical thinking and problem-solving skills essential in life.

Gender parity is said to be a vital state which permits both males and females to completely enjoy human rights (Zindi 1996). Human rights are documented as a context which enables growth and development of people. Inequality on gender issues still remains widespread in many cultures (World Bank 2012). Overcoming this problem would require thoughtful cultural transformation mostly on how women and men relate (Mezirow 2012). If a selection is to be done between a boy and a girl's education the boy normally gets the opportunity. The customary division of labour has more often hindered the growth and development of girls, confining them to domestic work, farming, taking care of siblings and household chores (Zindi 1996), and this was quite pronounced in the situation of my women participants' educational statuses which were also compromised. Patriarchal society habitually emphasised the insignificance of girls' education, with the curriculum in schools also reinforcing the status quo (Kariwo and Shizha 2012). Thus, women lived in a society where they suffered discrimination along gender lines.

However, as discussed in the literature review chapter, the learning of adults comes in various ways, not just formal (Kaziboni 2018; Schugurensky 2015). For the participants to be where they were at the time of my study without significant levels of education they could have been engaging in things like non-formal and incidental learning to face the ever-changing demands of life and the disorienting dilemma of losing their adult children through AIDS and having to care for the orphans left by their deceased children. Hence formal education may not be the only domain of learning that is required in life (Kolb 2005).

Some of those who went to school could not perform well enough to get the much-needed credentials to prepare for formal employment. P-6 said:

> *I went up to form 4 with my education but I did not pass even a single subject. I believe I did not obtain good grades due to challenges we were facing.*

P-15, who did not perform well in school, also said:

> *I went to school for more than seven years doing the primary level. I failed my grade seven for several times so I was just repeating until age 15 when I had to quit and started to work as a domestic worker in our neighbourhood.*

Experience is the best teacher. The caregivers realised transformative learning through their lived experience of their poor performance in school, and that of not having been sent to school by their own parents (Mezirow 2012). Thus, the caregivers had adopted new perspectives of sending both boy and girl children to school to prepare better foundations for their future. However, due to poverty, they found many hurdles in sending these children through to high school.

In the next sub-section, I give an overview of the twin theories which were adopted for this study in order to keep the reader in perspective.

5.2 Summary of Theoretical Framework

The research utilised two theories in its theoretical framework in order to cover the variables which were in the research topic. The variables could not be fully addressed by a single theory. The transformative learning theory (TLT) propounded by Jack Mezirow (1978) addressed the caring practices and learning experiences of the elderly caregivers. In Mezirow's assessment, learning is an expedition which the learner embarks on in order to transform their earlier held suppositions by understanding the experience. It is this interpretation which guides one's actions and allows one to provide a basis for these actions. Learning of adults thus transforms from prescriptive assimilation to more integrated understandings in relation to real life situations. The TLT comprises of ten stages which are:

Disorienting dilemma: A stage in which one encounters situations, ideologies, values, and beliefs which vary from the formerly held ones (Mezirow 2012; Kolb 1984). All the study participants experienced disorienting dilemmas through loss of adult children and having to care for the orphans left behind.

Self-examination: The disorienting dilemma motivates one to interrogate previously held beliefs, understandings and values (Mezirow 2012; McLeod 2013). The elderly caregivers relooked at their previous frames of reference with a view to learning about caring for adolescent AIDS orphans.

Sense of alienation: These are feelings of isolation and segregation. AIDS has been a greatly stigmatised condition which the elderly caregivers had difficulty in handling. Losing their adult children to AIDS could lead to isolation and segregation by their communities and families.

Relating discontent to others: By experiencing the disorienting dilemma, the caregivers knew their condition was common to others but, as was discussed in this chapter, the caregivers did not engage means of collectively managing the dilemmas.

Explaining options of new behaviour: Alternatives for new ways of behaviour are discovered. The caregivers asked themselves ‘what now?’ so as to think of the next necessary move (Kolb and Kolb 2005; Mezirow 2000; McLeod 2013). Thus, the caregivers had insights into their problems and this triggered the examination of their frames of reference with a view to learning certain aspects of their new roles.

Building confidence in new ways: The implication of this stage is the construction of abilities and self-assurance in the contemporary roles and responsibilities of the caregivers. The elderly caregivers realised the need to acquire skills, knowledge and attitudes in order to manage the dilemmas.

Planning a course of action. Building capabilities and self-confidence led to planning approaches which enabled the needed adjustments to the caregivers’ lives. The blueprint of the subsequent course of action became necessary as it pointed participants to caring practices, learning experiences and positive ways of coping with the crises.

Knowledge to implement plans: There was a need for the participants to acquire new knowledge, skills and attitudes in order to implement the new behaviour. The development of a plan to adopt new perspectives frequently leads to the requirement for additional information, knowledge, skills and attitudes.

Experimenting with new roles: After the achievement of new learning, the elderly caregivers tried it out through new roles and responsibilities, while evaluating its utility in solving life problems (Mezirow 2012; Kolb 2005).

Reintegration: The new learning and the transformed frames of reference were then brought back into their real lives in society.

The transactional model of stress and coping (TMSC) propounded by Lazarus and Folkman (1984) concentrates on how people cope with their situations after experiencing a disorienting dilemma. TMSC suggests that people get stressed only if their coping mechanisms are insufficient to overcome the present demand. Thus, the elderly caregivers and the disorienting dilemmas were viewed to be in an active, mutual, multi-directional relationship. Hence, the dominant fact of TMSC is the correlation between my elderly caregivers' burdens and their capacities to manage these strains in their life situations (Lazarus and Folkman 2015).

These two theories were appropriate for this study in that the elderly caregivers of adolescent AIDS orphans had all experienced disorienting dilemmas through the loss of adult children, who had left many orphans to be cared for. Both theories provided lenses to better understand the caring practices, learning experiences and coping strategies of the caregivers.

Having discussed the demography of the participants and summarised the theoretical framework I move on to the nature of the caring practices.

5.3 The nature of the caring practices engaged by participants

Data analysis showed caring practices manifesting in two ways: what was done to care and how it was done (Babalola-Jacobs and Babalola-Jacobs 2020). It manifested at the levels of assistance with character formation, as well as provision of material needs. These are shown in Table 5.3 below:

Table 5.3: Caring practices elderly caregivers engaged in

THE NATURE OF CARING STRATEGIES

Character formation	**Provision of material needs**
Modelling behaviour	Food
Talking to adolescents	
Working with adolescents	Clothes
Task delegation	Fees
Supervision	Learning materials (Phone, laptop, data etc.)
Encouraging church attendance	
Sending to school	Shelter
Sending for guidance and counselling	
Story telling	
Playing games	

As reflected in Table 5.3, caring practices were targeted at achieving two main purposes, namely, character formation and the provision of material needs. Babalola-Jacobs and Babalola-Jacobs (2020) define character formation as the process by which a person (adolescent) acquires those behavioural, ethical and moral principles or traits and values that mark his/her personality. It is also a process of moulding adolescents to learn suitable behaviour and make good choices. It includes skills building or development which involves moulding behaviour with the intention of inculcating and nurturing the development of competences that deal with concerns of how well one is able to do something (Huitt, 2004). Material needs were found to be what could sustain the adolescents in their day to day lives. Data presented on the table are explained below.

5.3.1 **Caring practices targeting adolescent orphans' character formation**

Data showed that caring involved socialising adolescents into roles and responsibilities expected of them by society. P-1, a male caregiver said he should portray behaviour which, when copied by his orphans, society would accept. He had this to say:

> *The good behaviour of an adolescent should start from the caregiver because these children learn through imitating. If I am a thief the children will also become thieves. So, it all starts from me as a parent.*

P-16 concurred, saying:

> *I have to develop the skills of performing many of these household chores, such as cooking and washing clothes. I actually do some demonstration so that tomorrow the children will not fail to do as expected.*

It also included nurturing the development of skills necessary for their survival in their day to day lives. In other words, character formation and skill building were regarded as constituting a person's personality. While participants had built characters of their own offspring previously, this time around the setting was altered due to contemporary diseases. Therefore, there was possibly an understanding of transformative learning which was prompted by the numerous disorienting dilemmas of losing their adult children through AIDS and having to care for the orphans left behind by the departed adult children. They seemed to have comprehended their difficulties and questioned themselves 'what now?' so as to generate changes in facing the problems. The subsequent change they thought of was to admit that the problems had struck and had to consider caring for the orphans notwithstanding the trials that were connected with the mission. These disorienting dilemmas finally forced the caregivers to view their own world in an altered manner (Taylor and Cranton 2012; Mezirow 2012) and re-engage their child-rearing in a diverse background. The previous literature reviewed on AIDS orphan caring does not cover character formation, making this finding from my study exclusive.

5.3.2 **Modelling behaviour as an adolescent orphan caring practice**

One way of caring which emerged from the data in this study was modelling behaviour. Modelling refers to using one's own behaviour as a teaching device. The following responses illustrate this. For example, *P-2 says:*

> *I wake up early with them going to the pieces of land that we have down there to farm. I expect them to learn from what I do. This is how we also were taught by our parents.*

P-3 added:

> *I myself do not sit with next doors to talk and gossip. So, she should learn from me.*

P-8 explained:

> *I mould her through my own behaviour. I do not sit and put my hands on my lap. I do household chores, do part-time jobs where I clean houses for a small fee and then come to cook after that.*

These responses illustrated how participants explained their caring for orphans in terms of nurturing good behaviour and ensuring appropriate upbringing. The first response by P-2, an elderly woman of 69 years of age and without education herself, displayed modelling behaviour. The elderly lady woke up early and engaged in work. The expectation was that the adolescent would see what the caregiver was doing and emulate her. Skills in working were, therefore, nurtured through demonstration of what ought to be done. This attitude of work also corroborated the observation which I made during data generation. On arrival at P-2's homestead I found her working in the agricultural field. She left her hoe to welcome me in her house. Despite having been working in her small field, I observed that the yard and the household surroundings were neatly swept to reinforce the point of hard work.

The behaviour being modelled by P-3 was not sitting with neighbours to "talk and gossip". P-3, a 57-year-old, demonstrated self-control, being in one place and not constantly moving around. This was important given the problem of loitering among adolescents in urban and peri-urban areas. P-3 was similar to P-2 and the behaviour targeted through the caring practice was working. After doing all the jobs at home the caregiver went to work outside despite her old age. Focus group discussions also revealed that modelling behaviour was often the strategy employed to impart skills for doing menial tasks such as household chores. In the case under study, household chores manifested as agricultural activities, cleaning the household, food preparation and vending.

This was a way of building confidence in new ways of behaviour being taught to the adolescents. It relates to stage six of the TLT (Mezirow 2009). This stage deals with the building of abilities and self-assurance in the contemporary roles and responsibilities which the caregivers were performing. P-3 constructed her own abilities and self-assurance in imparting the desired skills, knowledge and attitudes to orphans. The caregiver was cognisant that life was not stagnant: it was always riddled with problems requiring one to make critical reflections and change as was necessary. The adolescent, therefore, was taught the attitude of not wasting time through gossip:

rather, one should work for one's own good. Although abilities and self-assurance could have been built, P-3 also seems to be confining herself in a solitary lane, giving rise to the presence of stage three of TLT which focuses on isolation and segregation. The sense of alienation stage appeared to be pronounced here as well, probably due to the fact that AIDS itself has always been an issue of segregation around the globe (Gonese et al. 2020). Having been affected by this disease by way of losing adult children to AIDS and taking care of the remaining orphans, the elderly caregivers might have been driven into isolation, unlike in previous studies (Chazan 2014; Zvinavashe et al. 2017) where carers joined support groups and benefited.

In all cases, lessons were imparted to the adolescents but without specifically explaining to the adolescent what was happening. The adolescent was expected to watch and imitate the required behaviour (Bandura 1977). By so doing, the adolescents were trained to have right-thinking through controlling interpretations of what they saw and directing them in productive ways. Implied in the behaviour were also lessons on prohibitives, which were laziness, loitering and gossip. Instead of talking to the adolescents the caregivers chose to model behaviour. Care, thus, took the form of inculcating appropriate moral values. According to Ungar (2004), young people want guidance and support from caring adults and need a balance between autonomy and setting limits (Jorg et al. 2016). Modelling behaviour as shown enabled the adolescents to independently observe and make decisions to follow suit and also note the limits without being told.

While it is generally understood that elderly people are no longer taking a physically active role in families due to their advanced ages (Bourdillon 1991) the participants under study lacked such a luxury because the experiences of disorienting dilemmas during the course of their lives enforced an adjustment in their predispositions (Preece 2003). As was observed during the face-to-face interviews and FGDs, some of the caregivers even looked frail most probably due to age, and the burdens of AIDS orphan care which P-10 labelled as the 'programme of no rest'. Coming face to face with the disorienting dilemma of losing their own adult children and having to take care of orphans prompted some discourse with their individual minds and with other people around them in order to incite the much-needed self-reflection as a way of helping them come to terms with issues being faced (Kitchenham 2008; Taylor and Cranton 2012;). Although culturally we do not normally expose our beliefs to questioning, the elderly caregivers adopted new attitudes from self-examination and critical assessment subsequent to their multiple dilemmas and ignored their much-needed retirement. The issue of lack of questioning one's beliefs is documented in Hawkins's (2013) study where the caregivers actually relied on their cultural canons and used this as a way of responding to their dilemmas. They used their past experience to face their present situation, and this is a similarity to my study's finding.

Daluba (2013) contends that demonstration helps to make learning easy to understand and permanent. It also motivates active participation making coercion inapplicable and showing that the targeted behaviour can be achieved. The assumption was that adolescents could think autonomously and make decisions based on the modelled behaviour. They could construct knowledge from observation of the elders doing the chores. On this issue it would have been important to observe how the elderly caregivers interacted with their orphans in demonstrating the care, but due to ethical issues discussed in Chapter 4, I could not observe children. Instead, observations were done in other aspects such as the home environment, their shelter, the physical appearance of the caregivers and the backyard where they grew maize and vegetables. In their caring practices the elderly caregivers also talked issues out with their adolescents as a way of socialisation. In the next section I discuss this aspect of caring.

5.3.3 **Talking to orphans as a socialising practice for adolescent orphans**

Focus groups discussions revealed that caring also manifested as talking to the orphans as a way of socialising them into expected and desired norms and values. Talking about issues emerged from seven participants in the data. P-4 said talking was done after performing their household chores during the time when they would be resting. Following is an extract from P-4:

> *Well, after doing all the house chores, we sit down and talk about anything that could have been brought up by either myself or the orphans.*

P-7 said:

> *I have encouraged the orphans to ask me to discuss about issues of interest if there are any.*

P-17 weighed in to say:

> *… and by midday most of the chores will have been accomplished so that we have time to relax and talk about other things.*

All this talking was done as the socialisation process unfolded. According to Ostrowski (2021), socialisation is a process in which the individual's norms, skills, motivations, attitudes and behaviours are formed so that the individual recognises his/her current or future role in the desired society. Participants concurred that having a heart-to-heart talk assured orphans that they were valued and trusted (Shangwa and Mathende 2019) and that the caregivers believed in them and their capabilities. Concurring with this point, Jaworska and MacQueen (2015) assert that it is imperative to generate a stage to frequently talk to the teenagers. This also gave the caregivers the opportunity to listen to and appreciate the adolescents without essentially arbitrating and criticising. Judgement and criticising could instil bad behaviour and ruin relations between the guardian and the adolescents (Jaworska and MacQueen, 2015).

Some male caregivers in the study, however, expressed difficulty in dealing with adolescent girls' issues. Two of the caregivers made the following points:

> *We sometimes sit around the table to talk about anything the orphans want. Normally girls bring in issues to do with their adolescence but uuummm I am not really sure what to say to them. I also feel it is inappropriate for me as a grandfather. P-17*
>
> *But I face problem in talking about those physical changes that take place on girls. P-5*

Culturally, it was inappropriate for males to talk about adolescent issues or bodily changes which affect girl children. This was one of those tasks society ascribed to aunts to handle and considered unsuitable for males to do (Jarus 2017). In these modern times people are faced with contemporary problems which warrant changes in skills, knowledge, attitudes and values so that their child care becomes effective. The male caregivers had moved in to close the parental gap that was created by AIDS but they were stuck with issues of prior disposition, as they failed to open up new spaces to talk about the issues facing them. This could drive the girls out to seek information from outside sources which could be wrong information.

In their caring practices the elderly caregivers identified the behaviour which they wanted the orphans to exhibit and engaged these children in those behaviours. This result is consistent with Oosthuizen's (2014) study where care was described as occurring in particular reciprocal interactions. While the elderly demonstrated care through teaching and disciplining the adolescents, the adolescents would be expected to accept and obey the caregivers' teachings. In the ensuing section the engagement of adolescents with the desired manners is discussed.

5.3.4 **Engaging adolescents in targeted behavior and task delegation as a caring practice for adolescent orphans**

The data revealed that caregivers engaged in targeted behaviour as a caring strategy. This manifested as task delegation. The following examples illustrated:

> *The eldest does part-time jobs in the neighbourhood while the others stay here working with me. I do not just let them eat and drink. They have to learn to make a living. Being affected by the disease does not mean being incapacitated. If one wants to live one should work.* P-20
>
> *They do household chores like cleaning the house, washing and cooking before and after school. I do not have a maid as you can see. So, as they work, they are getting trained for them to be able to manage in future.* P-12
>
> *She is the one who mans (looks after) our stall. Actually, she has good blood. If she is there, customers flock to buy. Even if she does not go far with education but she can earn a living.* P-9

The examples above showed caring as engaging adolescents in work so that they could learn through practice. For P-20 working was seen as both a survival strategy and a learning curve. For the adolescents to eat they had to work and by so doing learnt to make a living. Caring in this case was giving guidance in order for the adolescents to support themselves. *"If one wants to live, one should work"* has implications for now and always. Engagement with work was portrayed as a lifestyle adolescents should get used to. Commitment with work became socio-psychological training in order to create a mindset required in society. This is in line with Zietz, Hoop and Handa's (2018) observations that behaviours adopted during this life course period have critical implications for adolescents' future health and well-being. In terms of coping, the caregivers embraced the problem-centred approach and at the same time critically reflected on their past and learned the need to share with others in similar circumstances. In a way Stage Four of the TLT, which concentrates on sharing discontent with others in similar circumstances, was evident here. The process of transformative learning was evident in that they shared their displeasures with their adolescents who were also in the same AIDS situation. In view of the reviewed literature, this had similarities with Oosthuizen (2014) who explained that care happens in precise mutual relations where the carers shows care for adolescents in their teachings and the adolescents receive and conform to the instructions.

For P-12, caring was in the form of gap filling. Instead of employing a maid, the orphans performed the duties of maid. That was regarded as training in those duties. The engagements reflected the productive life targeted for adolescents to live. Focus group data concurred with findings from interviews. All participants agreed that task delegation was a means to have tasks done as part of caring for the orphans.

P-9 illustrated caring practices where adolescents were exposed to problem solving through managing projects and engaging in part-time employment. The reference to 'good blood' made the practice of delegating tasks to adolescents an act of nurturing the talents for orphans. 'Good blood' in this case referred to the fact that the adolescent possessed some luck with customers flocking her stall to buy wares if she was the one staffing it. Caregivers, thus, considered engaging adolescents with work as a caring strategy. This is consistent with scholars like Theron (2007), for example, who regard heavy household tasks and chores at home as one reason for orphans to drop out of school. FGD data revealed that there was a degree to which delegation of duty could serve well as a caring strategy. Passing through P-9's flea market I observed her grandchild staffing the stall and this triangulated the FGD and interviews which revealed delegation of tasks to these adolescents.

Delegation of chores to the orphans was revealed as an undertaking of significance as it trained them to become independent adults in future. Delegation emerged as crucial in that adolescents felt that their elderly guardians trusted them (Shangwa and Mathende 2019). It became a platform for talking and discussing with teenagers, a way elderly caregivers could show that the orphans were valuable and trustworthy and also that the caregivers believed in them and their capabilities (Shangwa and Mathende 2019). Whenever one had delegated tasks to other people it meant that the load was being shared thereby alleviating the pressure on these elderly caregivers. Most of them were observed to be physically weak and frail during the interviews and the FGDs.

Their delegation of duties was evidence of engaging the task-oriented form of coping in their caring. Task-oriented coping is a means focused on the management of miserable circumstances. This model is envisaged to be most adaptive particularly if the dilemmas are variable (Lazarus and Folkman 1984). Thus, the caregivers faced the burden head-on, as it became lessened by the delegation of household chores to the adolescent orphans. Linking this to TLT Stage Six, the caregivers seemed to have planned courses of action that enabled the development of the orphans' capabilities and self-assurance in order to make necessary modifications as they both navigated through multiple disorienting dilemmas. Use of this stage of TLT was noteworthy as it pointed them to caring practices and learning experiences, as well as positive means of coping with caring. This finding has not been experienced in previous literature reviewed on adolescent AIDS orphan care as there was no mention of task delegation as a strategy of caring. Hence, it is unique to the present study.

In their day to day caring the caregivers shared tasks amongst themselves and their orphans thereby creating some team spirit. Task sharing as a caring practice of the elderly caregivers is my next point of discussion.

5.3.5 **Task sharing as a caring practice for adolescent orphans**

Caring practices in the data was demonstrated as sharing activities with the orphans. The following excerpts from P-6 and P-7 illustrate this:

> *When we wake up in the morning, we share our house chores in a rotation, such as fetching water, cleaning the house, washing utensils, washing clothes, cooking, and gardening. P-6*
>
> *Most of the heavy chores such as fetching water are performed by the Form 2 adolescent because he still has the strength. I wash utensils and clothes and do the cooking while I am seated because my back always aches. P-7*

Both P-6 and P-7 revealed that cleaning and related tasks were shared. The caregivers shared menial tasks with the orphans. Further probing of reasons why this was done revealed the caregivers' desire to demonstrate how to do some of the tasks and to show the orphans that such tasks could be done. It also emerged in FGD that sharing tasks helped inculcate team working skills and allowed for good relationships as participants interacted, facilitating the formation of a formidable team of orphans and their caregivers. I observed evidence of sharing tasks at the water wells of these two caregivers where empty buckets where placed waiting for the orphans to fetch water when they returned from school. Fetching water was one of those tasks which was difficult for these grandparents due to their observable physical frailty. The data suggested that all elderly caregivers in the study shared duties with the orphans that they looked after. According to Wong et al. (2018) team work has important benefits in many human endeavours, including in the family setup. It encourages team members to come up with bright ideas and ingenuity. There is improvement in productivity thereby provoking more enthusiasm, as well as swift learning. As teams working for the common good, the caregivers and the orphans worked in harmony. This finding has congruence with one local study which revealed that, over time, the orphans developed into being active members of their families whose input in their subsistence way of life was central (Maronganye 2017). However, literature on the global arena did not show similar strategies in caring. Another approach to caring that emerged in the data was sending children to school. This is discussed in the following section.

5.3.6 Sending adolescent orphans to school as a caring practice

According to Huitt (2004), character education is seen as a primary function of educational institutions in addition to skills development. Data showed caregivers shouldering the responsibility of sending adolescents to school as another caring practice. The below texts are illustrative of this point. P-10 explained:

> *I take care of her through sending her to school. I myself am not educated and do not know much about this sophisticated life. This is why I sacrifice to send her to school. I want her to learn so that she can sustain herself in future.*

P-15 further remarked:

> *I don't rest. From the moment I wake up I will be running around until sleep time again to make sure that I get school fees so that they can go to school. Even if they do not go far but they should be able to read and write and also have their brains opened.*

P-3 added:

> *If she stays at home she ends up roaming the streets. She better be in school so that she is occupied and can be watched over by teachers.*

All the orphans in the elderly caregivers' households were in school demonstrating this aspect as another caring activity. I observed that there were no adolescent children around the caregivers' homes when I visited for the interviews, suggesting that they were all in school. School was seen as a means to ensure future self-sustenance by P-10. P-15 regarded school as a source of enlightenment where 'brains are opened', while P-3 took the school as a place where the adolescent could have wayward behaviours controlled. School was regarded as helping in inculcating discipline in adolescents. Sending adolescents to school was, thus, caregiving. Paying school fees was also a way of caregiving for the benefits that school offered. Although the majority of participants did not attain high standards of education during their teenage times, they treated education as an important tool to be possessed by their grandchildren.

Thus, they scrounged for school fees, indicating a transformation from the previous thought that used to demean education. In sending children to school, caregivers had positively planned a course of action which would develop the orphans' capabilities and self-confidence later in life (Mezirow 2012). If these children became educated they probably would be able to help their grandparents to overcome the challenges of their situations. Consequently, learning would have some ripple effects which would benefit the grandparents. The finding of sending children to school was consistent with previous local studies where caregivers lamented lack of school fees for the children, indicating that they also cared through sending them to school (Maronganye 2017; Zvinavashe et al. 2015). Supervision and monitoring of adolescent orphans' work was established as another practice of caring by the elderly caregivers and this is presented below.

5.3.7 **Supervision/ monitoring of adolescent orphans as a caring practice**

Care was also given in the form of supervising the orphans in various tasks assigned to them. The following responses demonstrate this:

> *If an adolescent is left unattended she can be lured into unwanted behaviour easily. So I monitor her behaviour and monitor her whenever possible.* P-18
>
> *I check on their behaviour in order to correct. Adolescents cannot be considered as being taken care of if they are not monitored and supervised.* P-8
>
> *She is grown up now but I still get into the room where she stays to check on how she manages the room. Even her books I ask her to give me so I can see progress.* P-13

As shown in the examples, caring was exhibited as supervising or monitoring with a view to approve or disapprove of what the adolescent was doing. P-18 showed that without supervision and monitoring, the adolescent's behaviour might not be acceptable. Caring in this case emerged as checking on behaviour to ensure the development of expected behaviours. All caregivers emphasised the need for supervision. This worked as a substantial device for the elderly caregivers to make assessments of the performance of their adolescent orphans with household chores, school work and any other delegated task. Supervision emerged as a pre-activity to remedial action when necessary. Supervision inspired vital ingredients in their relationship with adolescents, such as open communication, self-confidence, as well as trust among the caregivers and their orphans (Das 2021). If the orphans knew that their grandparents were going to check on their work this would give them stimulus to work even harder in order to please them. This finding, however, did not emerge in any of the literature reviewed.

The elderly caregivers also monitored the medication adherence of their adolescent orphans who were living with HIV. If no monitoring mechanisms were put in place, some adolescents were likely to develop tendencies of not regularly adhering to their clinical treatments such as ARVs. Yet, according to Bukenya (2019), adherence is a prerequisite to realising Anti-Retroviral Therapy benefits. So, their monitoring was fundamental in the treatment regimens of the orphans. Constant communication with the clinic proved to be working well because when the orphans received counselling they continued with their medication as prescribed. The monitoring of ARVs intake by the elderly caregivers came as a new phenomenon for the caregivers which they had to adapt to.

Since HIV/AIDS issues normally were stigmatised, the caregivers appeared to have altered their mindsets from this stigma in order to fully encourage their orphans to adhere to these clinical treatments. The finding of monitoring drug adherence was consistent with various studies which deal with HIV/AIDS (Mhaka-Mutepfa, Mpofu, and Cumming 2015; Hawkins 2013). However, although the disease was common with people in other communities and even globally, my participants appeared to have failed to utilise Stage Four of transformative learning which is about relating the discontent to others (Mezirow 2009). The disorienting dilemmas could have been managed collectively, probably in structures such as support groups but this did not emerge in the data generation. The elderly caregivers normally referred their adolescents to other role models in the community or within their kinship so that they could emulate good behaviour and shun undesired behaviour. The reference to such role models by the elderly caregivers, therefore, becomes the next point of discussion.

5.3.8 **Referring adolescent orphans to role models as a caring practice**

Modelling has long been identified as an important socialisation practice as it visually conveys the worth of values and behaviour in ways that affect youths' attitudes, behaviour and emotional dispositions toward others (Sanderse 2013). Participants mentioned how they relied on referring adolescents to people with both preferred and undesired characters within their kinship and the wider community. Care, thus, emerged in the form of the caregiver identifying a role model and providing for the adolescent to learn from the role model. The following extracts that emerged from focus group discussion recordings illustrate.

P-6 said:

> *I cannot teach them everything. Sometimes they visit my sister in waterfalls. They have to know both sides of life. We are struggling but who knows about the future. They may end up living such lives quite different from ours.*

P-4 weighed in to say:

> *I often urge girls to emulate people with good character like our neighbour's daughter. You hardly see her loitering about. That is good behaviour. There are also certain people whom I refer them to, whose behaviour is bad.*

The above examples show the value of models in inculcating socio-cultural values and discouraging unwanted behaviour. The practice could be explained through Huitt's (2004) argument that character, good or bad, is considered to be observable in one's conduct. This possibly explained why caregivers felt they should engage adolescents in observing both good and bad characters around their communities with a view to critically evaluating and making judgments in their personality development. It emerged from this that the caregiver could actually engage resources outside themselves to nurture behaviour they targeted and eliminate those that were undesired. The elderly caregivers engaged Stage Five of transformative learning through which they explored and discovered alternatives for new ways of behaviour (Mezirow 2009). After experiencing disorienting dilemmas they could have sat back and critically reflected on their own frames of reference to enable them to contemplate the next necessary moves, which are TLT Stages Two and Three. They identified role modelling as a caring strategy which seemed to work in terms of behaviour modification for the adolescents (Sanderse 2013). The AIDS caring studies that I reviewed did not identify such a caring practice and, therefore, this stood as a unique result of my study. Another practice of caring that the participants revealed was to encourage adolescents to go to church. This is the next point of discussion in the ensuing sub-section.

5.3.9 **Encouraging adolescent orphans to attend church**

Caring was also demonstrated through identification of places where the adolescent could have certain needs addressed and making sure that they accessed the source of help. The church emerged as a foundation that could cater for adolescents' needs and so caring manifested as encouraging church attendance. The following data exemplifies what emerged from the interviews.

> *Every Sunday, they should be in church and they should take part in church activities. This engages them and allows them to learn moral values. They are also likely to meet good characters to play with.* P-18

> *My desire is that they find a church of their choice to join. It helps to ward off evil spirits. Some spirits may repel church. There are certain spiritual issues which need super powers for them to be cast out. P-1*

> *I made them to join youths guilds at church so they mix and mingle with others. There they are moulded spiritually.* P12

The church in the examples offered several benefits which included being a place for character moulding (P-18 and P-12), a source of counselling and entertainment (P-12 and P-18) as well as for inculcation of moral values (P-18). It was also seen as offering protection against spiritual attacks (P1). The participant (P-1) expressed his belief that human beings were capable of being attacked by evil spirits and that these could be cast out through church attendance. P-1 was a manager over 70. The age of the caregiver qualified him to consider health care in the form of warding off evil spirits. This was in line with traditional perceptions (Bourdillon 1991) where an individual is prone to attack by forces beyond his/her own capacity to control, hence the need for superior powers which in this case were expected to be found in the church. The adolescents had to attend church services for spiritual nourishment.

Focus group discussions revealed how the church served to boost adolescents' spiritual nurture, peace building and restoring hope to the hopeless, as well as equipping adolescents with life skills to enable them to overcome life challenges like early marriages and drug abuse among others (Babalola-Jacobs and Babalola-Jacobs 2020). The belief in church in the life of the elderly caregivers seemed to be in conflict with their previous perception of generally trusting in traditional healers when one got attacked by evil spirits or when one was facing a disorienting dilemma (Babalola-Jacobs and Babalola-Jacobs 2020). With the passage of time and exposure to contemporary issues such as disease and death, it appeared the confidence with past traditions was subjected to critical assessment (Stage Two) through which self-examination (Stage Two) was made (Mezirow 2012). This enabled exploration of options (Stage Six) and the planning and adoption of new consideration of new courses of action (Stage Six) (Mezirow 2012) in the form of divine intervention. Thus, children were urged to go to church with a view to warding off evil spirits. This finding resembled Hawkins's (2013) study which revealed some divine intervention, where participants got comfort from Buddhism and this gave relief in the caregiving. Story-telling also emerged as an alternative caring practice, and this is discussed in the succeeding subsection.

5.3.10 **Story-telling as a strategy for adolescent orphan caring by elderly caregivers**

Telling stories to adolescents was mentioned by three caregivers in the study, as exemplified in the quotes below:

> *Well we do all the house chores, we even play games at times, we play checkers/draft. We talk a lot, at times she brings stories from school so we chat a lot about them.* P-4

> *When we are tired with house chores we normally sit together to tell stories. These stories can be from the school where the orphans go; and sometimes I tell stories from my own childhood.* P-10

> *Sometimes I tell them stories to cheer them up from the many household chores which we normally have to carry out for our survival. All our work is manual and one gets really tired quickly. P-7*

Such socialisation was uncommon in other research reviewed. Although this appeared as an outlier in this study, story-telling has key benefits such as instilling some understanding and trustworthiness in adolescents (Mapara 2009). Story telling used to be the domain of grandparents in yesteryears (Bourdillon 1991), probably because during those times the elderly would take a less active role in family matters.

However, the reason it came out as an outlier was perhaps because most caregivers would already be too tired from the many chores to engage in story-telling. Those who told stories said they normally talked about their roots, as well as their culture, thereby enabling the adolescents to learn more about their ancestry in a simpler way. Through stories portraying characters facing hard circumstances, both caregivers and adolescents were made to better comprehend the idea of hardship in a simple way (Mapara 2009). Their situation of living with HIV and/or being affected by HIV/AIDS would not continue to threaten them but rather to face them head-on. Such stories may teach them that agony and sorrow are part of living as much as pleasure and cheerful moments. This was essential in equipping adolescent orphans with emotional abilities to face and handle different situations in life. Story-telling emerged in this study as a new phenomenon, as it was not revealed in the prior literature despite its significance in child rearing. Some of the elderly caregivers played games with their adolescents. Playing games is elaborated on in the subsequent section.

5.3.11 **Playing games as a caregiving strategy**

Some caregivers reported playing games with the adolescents. The games they played included *nhodo, chihwandehwande* (hide and seek), *tsoro*, and *sarurawako* in the vernacular Shona and this was done as recreation.

Nhodo (Round stones)

The caregivers said when they were tired of household chores they normally engaged in games such as *nhodo*. Corroborating the interviews and FGDs data, at P-3's homestead the small holes filled with small stones where this game used to be played were observed under a tree where there was a shade to protect them from sun burn.

> *I play the game called nhodo particularly with the girls to kind of entertain them when they are tired from house work.* P-3

P-4 indicated that she engaged the same game for purposes of fun and interest:

> *We also require time to make fun and get amused when we are relaxing at home so we can even play games such as nhodo and sarurawako and any other traditional games we may think of.*

According to Mapara (2009), this game comprises of three or more players so that it becomes fun. A small hole is dug on the ground and filled with small stones, about 20 to 30 of them. The players then sit around the small hole in order to play. The first one takes one of these small pebbles and tosses it in the air. While it is in the air the player picks as many other stones from the hole as he/she can. When all players have had the opportunity to play, the pebbles are tallied, with the one gathering the maximum number being declared the winner. If a player loses several times he/she would have to pave the way for others to play. The significance of this game is that it teaches and sharpens the players' numerical competency, as they pick stones singly, in twos, threes and so on (Mutema 2013; Koskinen and Merilainen 2021).

***Chihwandehwande* (hide and seek)**

Data revealed that caregivers played hide and seek with their orphans. This is a game involving more than one person whereby one goes into hiding and the others look for him/her. The following comment illustrates:

> *Sometimes we play hide and seek, that is if we are not very tired to run around as is required in the game.* P-20

In this game the prominent values to highlight were endurance and perseverance, as well as improvement of players' auditory senses and sight, and making following up on cues easy and possible (Koskinen and Merilainen 2021). The adolescents were being taught to be tolerant and persistent until they found what they wanted, and the same should apply in real life situations where one should not simply resign to fate for failure to solve a problem.

Tsoro

The caregivers also engaged in *tsoro* as a recreational game. P-4 said she liked to play *tsoro* when they were relaxing at home because the game was not a strenuous activity. A torn cardboard box where the *Tsoro* was drawn was noted lying around the yard when I got to the homestead of P-4, giving credence to the fact that he played *tsoro* with the children. The comment below is testimony of playing *tsoro*:

> *With the many household chores around home the game I can play with children is tsoro. This can be played even when I feel tired because it does not require any running around.* P-4

Tsoro is normally played on a timber board or even on levelled ground. Holes measuring about fifteen to twenty centimetres in circumference are prepared, whose depth is about one centimetre. The overall number of such holes is twenty-four and they are organized in the order of four by six holes. A few stones, two, three, or even five, are positioned in each of the holes. When the players play each set of these pebbles is relocated from one hole to another which is opposite that of a challenger. The participant gathers the stones in the adjacent holes of his/her rival and augments his/hers. If any stone falls in an empty hole, the player stops to give his/her opponent a turn or chance to also play. As they take turns like that, the player who is first to clear an opponent's stones is the winner of the game.

Tsoro requires that one becomes calculative in every move one makes. Its additional importance, however, is that it instils the values of tolerance and careful planning in individuals (Mapara 2009), ingredients which are important for the caregivers' adolescent orphans. Because of its recreational significance, tsoro has also been introduced in towns by the migrant labour system (Mutema 2013).

Today we witness the game being played in beer halls and other platforms as a leisure activity and in homes to while away time.

Sarurawako (Choose your lover)

It emerged in the data that the elderly caregivers also played courtship games with their orphans. This was evidenced in P-20's comment:

> *I like to play Sarurawako with these adolescents as I feel they are at a more suitable time of moving towards adulthood.*

The game was mainly to introduce and transition their adolescents to adulthood. In the game players learnt how to select a partner and this is done on the basis of cleanliness and hard work (Mapara 2009). This game was appropriate for adolescents as there was a need for them to think of identifying partners with characteristics congruent with their caregivers' teachings.

All these games were not a new phenomenon for the elderly caregivers under study as even in the past these were there (Mutema 2013; Mapara 2009). However, playing games as a caring practice appeared as a new insight in the current research as it had not emerged in prior studies.

5.4 Brief summary on the nature of caring practices meant for character formation

As shown above, caring practices included skills development and nurturing, need provision, behaviour moulding or character formation and spiritual moulding. Strategies for skill development and nurturing included modelling targeted behaviour, engaging orphans in targeted behaviour, working with them, delegating duties, etc. Skills targeted were in performing household chores and those needed for lifelong survival. Data showed that caregivers were sometimes directly involved and at other times indirectly involved. As the process of caring unfolded, various stages of the TLT were evident in their practices, as well as the approaches to coping derived from the TMSC.

Character formation nurturing also involved promoting the development of acceptable social and moral values. This is normally the responsibility of parents but it was taken up by the elderly caregivers (Mezirow 2012). These elderly caregivers were all of advanced age which should have warranted their retirement from issues of child rearing (Bourdillon 1991). But because of the disorienting dilemmas which they all experienced, they no longer enjoyed this ‘luxury’ as they had become parents of the orphans left by their adult children in an HIV/AIDS circumstance (Foster and German 2002). The elderly caregivers utilised Stage Five of the TLT which deals with explaining options of new behaviour (Mezirow 2012). Having discovered alternative new ways of behaviour, they forewent their usual retirement and considered the necessary next move which was looking after the orphans and instilling in them socially acceptable behaviour (Preece 2003). This TLT phase links with Lazarus and Folkman’s 1984 problem-centred approach to coping with disorienting dilemmas because the problem was being faced head-on. In the next sub-section, data on the elderly caregivers’ caring practices focusing on provision of basic needs are presented and discussed.

5.5 Caring practices focusing on provision of basic needs

Caregivers indicated that caring practices involved providing orphans with basic material needs which are discussed below.

5.5.1 Basic needs

Participants revealed that they cared for orphans through provision of food, clothes, shelter, learning materials and school fees. As I observed some were working in their fields, it became evident that they produced their own food to provide for their families. During my observations, I noted that shelter was sometimes in bad condition, as rain was leaking through the roof and the walls, suggesting that some houses were poorly built. The following responses are illustrations of what participants said.

> *We give them everything they need. I treat them just like my own children as I am the one to provide food, shelter, as well as sending them to school.* P-11

> *I provide them with all that street kids do not have. This means food, accommodation, clothes, among other things.* P-20

All caregivers said they catered for the orphans' basic needs. This situation was similar to findings from local studies (Zvinavashe et al. and Maronganye 2017) which were reviewed, but dissimilar to those done elsewhere where the caregivers were actually remunerated for orphan caring responsibility and the government took charge of the orphans' welfare (Hong 2015). The results of my study confirmed that in the local scenario elderly caregiving of orphans entailed provision of basic needs which were mentioned in the above paragraph.

5.5.2 **Health matters**

Caring was also expressed as promoting good health among the orphans. The following excerpt illustrates care in terms of health issues:

> *If they continue to take their medication regularly the clinic told us that they maintain a good health and they do not become sickly children.* P-18

P-17 echoed this saying:

> *I have to ensure their drug adherence since these are just children it is my responsibility to see to it that they adhere. I can show you their medication if it is so required.*

Health matters according to my participants would include encouraging visits to the clinic as necessary; supervision and monitoring clinic check-ups; and monitoring medication adherence of orphans living with HIV. Findings revealed that the elderly caregivers would accompany their orphans to the clinic when the scheduled visits became due. There was a notable shift of standpoints (Duveskog et al. 2011) where people used to believe in traditional healers whose concoctions generally lacked scientific approval. After realising the importance of medication in AIDS situations the elderly caregivers made it a habit to adhere to every piece of advice that the clinic gave them. The health seeking behaviour was evidence of Stage Nine of the TLT which is about building confidence (Mezirow 2009), which manifested in the caring practices.

Reflecting back to their predispositions (TLT Stage Three), it was highly likely that caregivers dialogued with others, as well as amongst themselves, and ended up learning to accompany adolescents to the clinic and hear from the clinic staff what should be done for the adolescent when they got home. The medication adherence issue which they learned from the clinic was then applied in their homes to further enlighten their caring (TLT Stage Ten). By so doing the elderly caregiver had brought their new learning, combined with reformed perspectives, back into their daily lives in order to make caring bearable. This was confirmation of the presence of the last stage of TLT – reintegration – where the caregivers had to acclimate to the new self and return to their lives with fresh perspectives (Duveskog et al. 2011) in the nature of their caring practice.

Such transformative thinking motivated the elderly caregivers to adopt health seeking behaviour by way of following the scheduled clinic visits. Although the caregivers would visit the clinics with their own adolescents in the past, the frequency of clinical visits for people living with HIV was higher. The caregivers embraced an attitude of looking forward to going to the clinic to ensure that they and their orphans continued to stay healthy. The finding on health matters where medication adherence is paramount is common across literature on HIV/AIDS caring (Makurumidze et al. 2020; Gonese et al. 2020). While the elderly caregivers in the current study did all that they could to care for the orphans, their caring efforts were often hampered by numerous challenges – financial, social and psychological – as is discussed in the subsequent sub-section.

In conclusion of the nature of caring segment, it became clear that the positive caring practices were not necessarily accomplished because the challenges often contradicted what the elderly caregivers were doing. For instance, getting the adolescents to do household chores did not always happen successfully, food was always in short supply, etc. Hence their caring efforts were frequently stalled by the numerous challenges which were financial, social and psychological in nature and these are discussed in the next sub-section.

5.6 Challenges with caring for adolescent AIDS orphans

The data suggested that caregivers met social, financial, and psychosocial challenges in their caregiving responsibilities. The challenges were said to emanate from adolescents, relatives and society in general. Data which were generated from focus group discussions are presented in Table 5.4 below.

Table 5.4: Challenges faced by caregivers in adolescent AIDS orphan care

	CHALLENGES	
Social challenges	**Financial challenges**	**Psychosocial challenges**
Orphans not listening They do as they please as disciplining them is difficult Harsh words from orphans Gossip from relatives Lack of appreciation of my efforts by orphans	Balanced diet (Lack of food) Inadequate clothing Inadequate income to sustain the households	Peer pressure (Use of glue, illicit brew, and other substance) Denial of status

The data on challenges were grouped in the three categories as illustrated in Table 5.4 above. The following sections elaborate on these findings. Results from focus group discussions were corroborated by interviews and observations.

5.6.1 **Social challenges faced in caring for adolescent orphans**

This sub-theme generated various codes suggesting issues which adversely affected the caregivers' households. Topping the list was interference from extended families and the community at large, followed by others as indicated in the table. The data suggested that outsiders were curious about how things were done in the caregivers' families, although they did not offer any help to the caregivers' situation. Three of the participants remarked as follows:

> *People in our wider kinship sometimes gossip about the way I am raising these adolescents, especially if they see them performing household chores. If this 16 year old girl is not sick I treat her just like any other adolescent without necessarily looking at her HIV status. But the community around us thinks she would stay and do nothing as if she is a disabled adolescent. People don't like to see the orphans performing chores here. P-6.*

> B*ut the challenge arose when the 18 year old boy told my sister that "handina kugara zvakanaka" (***I am not comfortably settled***) after so many years of staying*

> *together. I do not know what wrong I did to him. There is disharmony between us. P-9*

> *The challenges cut across social challenges, what the family is expecting, what you can do, what you cannot do, and what the community is also expecting. They are looking at you expecting you to do certain things, expecting you to make mistakes because you are in context. Socially you still have to connect with context, connect with extended family and the community; and that connection will be linking with these adolescents. P-13*

As shown above, caregivers experienced criticism concerning the way they cared for the orphans from the orphans themselves, relatives and neighbours. In view of this, Mpofu (2021) asserts that elderly caregivers often suffer feelings of guilt and view themselves as bad parents. Focus group discussions revealed that this happened when no one among neighbours and relatives was willing to take up the orphans. P-9 narrated an upsetting instance where the orphan reported that he was not being well looked after. Focus group discussions revealed that many such cases occurred when orphans themselves complained to the relatives. In the past, the relatives would stand by one another in the event of hardship (Bourdillon 1991), unlike nowadays when there is generally reluctance to help each other in this AIDS context (Foster and German 2002; Makurumidze et al. 2020). This could be due to the stigma that is generally associated with HIV/AIDS issues. The caregivers must have altered their perspectives on the stigma in order to have provided effective care. As they faced reproach from the close community and kinsfolk who could have been their support in times of hardships (Bourdillon 1991; Makurumidze et al. 2020), it appeared that they were gripped by a sense of alienation (Mezirow 2012). These social challenges seemed to be connected with stigma and discrimination that are commonly experienced with such situations, and these issues are similar to findings in other studies reviewed (Chazan 2014; Maronganye 2017; Zvinavashe et al. 2015). It was necessary for the caregivers to adopt positive attitudes to fight this stigma.

5.6.2 **Financial challenges in caring for adolescent orphans**

Data also revealed challenges of a financial nature which affected food provision, general sustenance, clothing and day-to-day upkeep. These are presented and discussed below.

5.6.2.1 **Challenges of inadequate food and balanced diet**

Almost all caregivers bemoaned lack of food in their families due to lack of money. The data from interviews, FGDs and observation confirmed that food production was done on a very low scale after cultivating the little open spaces in their backyards. With the adolescents in their households the scarcity of food has become more pronounced as consumption by adolescents is high (Zaky 2016; Quas 2014). P-3 indicated that she normally went around with a begging bowel when she did not have anything to give the adolescents, however, she did not always receive anything from the community as people seemed to have become tired of her begging. She had this to say:

> *With food, one day you can run around with a begging bowl, although not very many people in the community still want to entertain us because of borrowing something which we are not able to return. I can say we lack everything which a normal home should have.* P-3

I observed that the maize fields had poor quality maize plants, with no variety of the food they produced, suggesting they lacked agricultural input such as fertiliser and seed maize. The data also indicated that their diets were not balanced even if they were aware of this requirement in their food production. They grew a few vegetables in their yards but as observed during interviews the vegetables had no nutritious balance. In their gardens were rape and sweet cabbages, with some having a few tomato and onion plants. P-3 revealed that the food they ate was of no nutritious balance, although people living with HIV required balanced diets. This was confirmed in the following excerpts:

> *Our food is not all that balanced as would be required for people on ART. We usually skip some meals if the food is insufficient as is normally the case, but I always reserve even a small portion for this adolescent who is on treatment in order*

> *that he doesn't default treatment. Sometimes I prepare porridge without sugar for him to enable him to take treatment*. P-3

> *The main problem is that of unbalanced diet bearing in mind that the boy is on ARVs should have been on these nutritious diets. These are hard to come by.* P-5

Insufficient food and an unbalanced diet was supplemented by vending activities which most caregivers said they practised, but it was also noted that vending was not yielding meaningful income. The little income they got was reserved for the school requirements of the orphans, leaving the home struggling with inadequacies and imbalanced diets. Participants mentioned having no constant source of food as they depended on subsistence agriculture. The finding was common in the reviewed literature (Kidman and Thurman 2014; Maronganye 2017; Zvinavashe et al. 2015). In the past they could rely on their adult children but now must endure shortages in their households. Adolescence is reported as a period of greater food consumption because of hyperactivity which is pronounced in teenagers (Omotoso 2007; Quas 2014). Even if maize was grown in abundance, it would still require other types of foods to give the much-needed nutritious balance in their diets. The obtainability of balanced diets in the caregivers' homes was crucial in view of their vulnerability due to the AIDS context. Although all the elderly caregivers were cognisant of the importance of balanced diets, lack of money to buy these requirements continued to be a stumbling block to their caring efforts.

The issue of financial challenges included deficiency in almost all basic needs. The observations which I made at their homesteads during interviews was testimony to their being poor because their shelters were poorly constructed, with some dilapidated. Most of their houses were not constructed following local government by-laws and the likelihood of such structures being demolished is high. Their household possessions were few and old, and broken furniture was lying around the yard implying the furniture had been dumped. Lack of money suggested poverty in various aspects of the lives of the elderly caregivers (HelpAge Zimbabwe 2017). This was congruent with national studies (Maronganye 2017; Mpofu 2021; Zvinavashe et al. 2015), but inconsistent with Hong's (2015) where the caregivers were taking care of AIDS orphans in institutionalised care and were, thus, remunerated thereby relieving them from the severe impact of poverty.

The other challenges which emerged from the data were related to inadequate clothing as discussed in the following subsection.

5.6.2.2 **Challenges of inadequate clothing for both caregivers and orphans**

Limited finances emerged from the data as also triggering the challenge of inadequate clothing for both orphans and caregivers. P-17 herself put on torn clothes which was suggestive of lack of money to dress in a better way. Clothing as a requirement in the families was mentioned by only two caregivers although my observation suggested they all lacked better clothing, probably due to lack of money as discussed above and like in the pilot data where all caregivers bemoaned the lack of clothes for their orphans. The situation is narrated in the following quotations:

> *If you see these adolescents you will notice that they lack even presentable clothes, I am not able to buy clothes.* P-17

> *Just like any other adolescents, they also make demands of age appropriate goodies such as new clothes and phones though I am not able to put these in place.* P-12

The issue of clothing appeared as an outlier in the main data, suggesting that it was not a priority for caregivers to worry about as they struggled to put food on the table for their families. Most of the caregivers were vendors in second hand clothes and this could have meant that clothing for the family was readily available and did not present a challenge. However, taking from the vending wares would result in reduced profits. In view of the related reviewed literature, this finding was uncommon although it is well documented that adolescents in general make demands for nice clothes (Omotoso 2007; Zaky 2016; Quas 2014). Having discussed the challenges of clothing above, the discussion now focuses on insufficient income for the sustenance of the caregivers' households.

5.6.2.3 **Challenges of inadequate income to sustain families of caregivers**

The economic means of survival for the elderly caregivers were limited to agricultural activities and vending as revealed in the quotations below:

> *In rainy season we cultivate in our backyard although we do not harvest enough maize for our consumption, let alone surplus. The land is too little for producing food enough for us, and most of the times we lack the agricultural inputs such as seed and fertilizers.* P-3

> *Being an elderly person staying at home without any income I find it difficult to take care of children on a day to day basis. Most of the time children are returned home by school authorities due to non-payment of school fees.* P-19

Out of the 20 participants, only three were previously employed and were currently coping by way of their pensions which they accumulated during the years they were working. The rest were growing maize in their backyards and in other small pieces of land which they could lay their hands on. The data from the interviews and FGDs, as well as from observation, revealed that the crop they grew was maize and this could be attributed to the fact that the staple food for Zimbabwe is sadza which is made from maize mealie meal. The caregivers strove to put sadza on the table for their households, however, the quantities they produced were far from sufficient due to lack of land and agricultural input. This finding was consistent with the Zvinavashe et al. (2015) and Maronganye (2017) studies which were conducted on elderly caregivers in two different Zimbabwe rural areas where one would assume that there was plenty of space for agricultural activities. Their agricultural output was perennially lacking for their households, which was similar to the current finding. The psychosocial challenges which were experienced by the elderly caregivers are discussed in the ensuing section.

5.6.3 **Psychological challenges experienced in caring for adolescent AIDS orphans**

Data also showed some psychological challenges faced in caregiving. These are presented and discussed below.

5.6.3.1 Orphans succumbing to peer pressure

Participants cited peer pressure as a challenge that complicated caring for the orphans. The following data illustrates what was found:

> *Orphans do not seem to appreciate my care as they most of the times do not do what I would have requested them to do. They expect me to carry out most of the chores while they loiter with friends smoking mbanje (marijuana).* P-2.
>
> *The drugs which I was advised by the clinic to keep monitoring their intake because with peer pressure some adolescents abandon their treatment.* P-9
>
> *The orphans sometimes sniffed glue in order to be intoxicated.* P-1

The data revealed that orphans gave in to peer pressure and started taking drugs, drinking alcohol and some abandoning medication. It also emerged that due to the influence of peers, the orphans ended up not listening to their guardians. Peer pressure also led to drug abuse as indicated in the above excerpt from P-2. Such challenges are well documented by scholars such as Omotoso (2007), Quas (2014) and Zaky (2016). The adolescents were interested in the assumption of adult roles and tended to experiment with their bodies that were rapidly growing (Quas 2014; Wagner et al. 2017). At this age they would often be emotional as an effect of hormonal fluctuations. The transitions gave challenges to elderly caregivers who struggled to whip the adolescents into line (Jorg et al. 2016).

Despite the problems presented by adolescence, the caregivers did not give up the responsibility. Rather, they made some critical assessments of their disorienting dilemmas (TLT Stage Two) (Taylor 2008) and chose to go to the clinic with the orphans for expert advice. By so doing, the caregivers found possible changes to their previously held standpoint of generally stigmatising HIV infected and affected people. The clinical counselling triggered self-examination which allowed them to look at HIV/AIDS critically, facilitating some alteration in their perceptions to improve caring. Involvement with their AIDS orphaned grandchildren gave them new meaning (Mpofu 2021) for their elderly life, as is discussed in the new insights section of this study.

Substance abuse leading to intoxication resulted in adolescents not listening to caregivers and withdrawing from performing duties assigned to them. The orphans, despite having these poor backgrounds, seemed to be way ahead of the elderly caregivers in terms of possessing information, probably due to the modern communication technologies which they were exposed to. Most of these problems were quite contemporary and required the caregivers to gather more information about dealing with them (Kidman and Thurman 2014).

5.6.3.2 **Denial of status leading to worry**

Denial of HIV status emerged as another challenge. Data illustrated that the elderly caregivers worried about the adolescents' realisation that they were different from others.

> *Sometimes I think their misbehaviours are due to denial of the loss of their parents due to AIDS, and that she is also living with this condition. This worries me a lot.* P-1

Having to deal with such issues looked like a formidable challenge for the elderly caregivers as they were supposed to embrace such contemporary challenges and deal with them in an effective manner. These challenges were modern and would have required gathering of further information on the part of the grandparents to be able to effectively care. In other studies, the caregivers worked as teams in support groups to be able to counter such challenges (Maronganye 2017), but in the current study support groups did not exist. On this point I conclude the challenges which the elderly caregivers faced in the execution of their responsibilities. The following sub-section focuses on how caregivers coped with these challenges as revealed in the data.

5.7 Coping strategies meant to counteract challenges faced in caring for adolescents

Lazarus and Folkman (1984:51) describe coping as "the cognitive and behavioural efforts made to master, tolerate, or reduce external and internal demands and conflicts among them". The following table presents findings which emerged concerning coping strategies used by the elderly caregivers in order to deal with the challenges discussed above.

Table 5.5: Coping strategies used by elderly caregivers

Coping mechanisms	- Agriculture - Vending - Supplementing with pension earnings - Counselling - Correction, sanctions and discipline - Donations - Talking out issues - Rewarding good behaviour

The data in Table 5.5 are discussed in the sub-section below:

5.7.1 **Coping with inadequate income**

Financial difficulties emerged in the data as prevalent among caregivers. In this section some of the ways of coping with this challenge are addressed.

5.7.1.1 **Agricultural activities**

Out of the 20 participants, only three had been previously employed and were currently surviving on their retirement pensions as alluded to above. The data from interviews, FGDs, and observation revealed that the rest survived by growing maize in their backyards and other small pieces of land which was available to them. P-3 is quoted below:

> *In rainy season we cultivate in our backyard although we do not harvest enough maize for our consumption. The land is too little for producing food enough for us.*
>
> *The small piece of land behind our house is normally used as a vegetable garden, but in rain season this becomes my maize field despite being as small as it is.* p-8.
>
> *Due to scarcity of land, you find that the backyards here in Epwortth are used to grow maize in the rainy season, however, this has a risk of thieves hiding in the maize fields.* P-16.

This finding was consistent with the study by Zvinavashe et al. (2015) which was conducted in one Zimbabwe rural area where the elderly caregivers experienced food deficiencies. In studies done elsewhere, NGOs would remunerate such caregivers to ease their responsibility of orphan caring (Hong 2015; Chazan 2014). The output for my elderly caregivers from their gardens was perennially scarce for their households. The government of Zimbabwe did not financially recognise the elderly caregivers such as my study participants, as opposed to a South African study conducted by Mpofu (2021) which reveals the involvement of the government and NGOs in giving grants to all elderly people regardless of the HIV/AIDS context. During data generation there was no mention of assistance or social grants from the government. This left the elderly caregivers at the mercy of their communities and relatives who in some instances were sources of the caregivers' problems with adolescents. In Zimbabwe social grants were given to those who had retired from formal employment and who had made contributions to the fund during their time of active employment.

5.7.1.2 **Vending**

In order to supplement inadequate finances, vending was cited as a widespread source of income among caregivers in Epworth as illustrated in the following quotes:

> *But now I am not able to run battles with police as I have grown old to continue with such job. In town vending is a bit lucrative but there is a problem with our police and the city council who would normally arrest us and impound our wares.* P-7

> *I can sell any surplus vegetables here at my gate because I am too old and cannot be seen engage in town vending which is laced with a lot of risks.* P-18

> *I have a small vegetable stall that I run, so by 8am we start packing the vegetables which we would have picked in our garden so that I can sell them at the market.* P-20

Vending was an activity of choice for the caregivers as almost everyone was into it. This type of income generation was in line with previous research where the majority of people who were not employed were observed embarking on vending projects and subsistence farming to earn a living (Zvinavashe et al. 2015; Gandidzanwa 2003). In the current study the caregivers sold items like vegetables, second hand shoes and clothes, as well as anything else they could lay their hands on. Their vending wares were observed displayed at the gates of their homesteads with the participants citing various reasons such as old age for not moving around the community to sell.

Vending was also said to be lucrative when done in the central business district in Harare, however, this was prohibited by city authorities. The caregivers narrated their ordeals with law enforcement agents who ran battles with them to arrest and impound their wares. For example, P-19 narrated:

> *One time I had to run leaving my wares on the pavement because I could not lift them. I could not wait to be beaten and made to also pay a fine, after having my wares confiscated.*

Vending was described as a risky business, as the elderly caregivers would normally run away leaving behind their wares to be confiscated. Having wares confiscated meant that someone was no longer able to continue in business, thus they would always be looking for capital to re-start their ventures. Vending was a task-oriented way of coping despite the many hassles the elderly caregivers would come across during that activity.

From Mezirow's perspective, the caregivers developed confidence in coming up with new ways of surviving. They could not continue moving around with their wares so they sold wares from their homestead gates to passers-by. This is Stage Six of the TLT which is concerned with planning a course of action (Mezirow 2012), whose significance in my participants manifested in building capabilities and self-assurance in their caregiving responsibilities. Due to old age which prohibited them from carrying heavy wares and going around in communities selling, they realised they needed to alter their ways of vending. Thus, in life the caregivers constantly critically reflected back to earlier experiences and learned as was necessary (Mezirow 2009). The elderly caregivers adopted new attitudes in order to build their confidence in the execution of orphan care. Due to old age, elderly people tend to slow down in productivity (Mpofu 2021), although in my study they did not have the luxury of slowing down to explore life as retired elders who may be consulted for certain issues in their communities, mainly because of the disorienting dilemmas they experienced.

5.7.1.3 **Supplementing with pension earnings**

Three caregivers indicated that their way of coping was from the retirement pensions from their previous employment. However, they lamented insufficiency in the retirement pensions.

> *As a retiree, the money which I get from my pension is far from being sufficient, the retirement package has since been exhausted.* P-16

> *My pension is very little to cover the needs of these children. As you know the food consumption of teenagers tends to increase.* P-13

Because of the pensions, their households were observed during the data generation exercise to be better than those of their counterparts who had no pensions as they were never formally employed. Their adolescent orphans were in better schools outside Epworth and they could also afford the e-learning which many schools were calling for in this era of COVID-19. In the Epworth community adolescents could be observed wandering in the streets to while away the long holiday that was brought about by this pandemic, which is again another new communicable disease likely to create further challenges for families. Despite receiving pensions, the caregivers bemoaned the scantiness of their pensions. As a coping strategy, the receipt of a pension could be categorised as a problem-centred approach to coping because the pension money would enable the caregivers to face their challenges head-on (Lazarus and Folkman 1984). Problem-centred strategies to coping focus on altering the stressful condition (Lazarus and Folkman 2015). However, instead of a pension being helpful to the former employee the money was now being used for re-parenting of the AIDS orphans, depriving the elderly caregiver of the much-needed resource during their terminal years. This finding appeared to be unique to the current study as the literature reviewed did not identify a similar result.

5.7.2 **External help provided to elderly care givers as coping strategy**

The external assistance which was mentioned by the caregivers was quite varied, coming from the wider family linkages, the church and the surrounding community. In the ensuing paragraphs, I discuss the assistance which the elderly caregivers occasionally received.

5.7.2.1 **Donations from relatives**

Help from relatives stood out as an outlier, as only one caregiver, P-13, mentioned that he got help from this wider network. Although the help was given, he indicated that this was done in a clandestine manner because he just saw the adolescents using gadgets such as cell-phones or laptops which he was never informed about. The caregiver commented that he was not against such assistance but such giving needed to be transparent to guard against instilling bad behaviour in the adolescents. The caregiver was worried that such donations were likely to have some ulterior motives which inculcated gossiping. P-13 stated that:

> *My extended family secretly gives the adolescents support without having to declare it. I just see the adolescents using whatever they would have given them without knowing where the gadget came from. It is very difficult, or a weakness in us as caregivers. Sometimes we do not confront problems as they come. We see them but do not question. We just submit and no questions, and then we put up with the consequences. That is one of our weaknesses.*

The help that P-13 received from his extended family would help all other people in the family if this was done in a transparent way. It emerged from the data that adolescents were being roped into gossiping by the wider kinship network. At this transitional stage from adolescence to adulthood it was not ideal for these adolescents to be involved in family infighting. P-13 seemed to be stuck in previous perspectives in which there was no questioning as to why something had been done. Problems tended to pile up without any effort to solve them because people appeared to be afraid of destabilising their relations. Hence there was a sense of alienation from P-13 who was reluctant to iron out differences between him and his relatives.

The aspect of donations from relatives revealed the caregiver's coping strategy which was described by Carver, Scheier and Weintraub (1989) as dysfunctional. The model of coping which included not questioning or challenging the concealed donations, as in P-13's case, emphasised maladaptive means of coping. The dysfunctional model focuses on maladaptive ways of coping such as drug and alcohol abuse, resigning to fate, emitting rage, behavioural disconnection, and denial. P-13 was venting out anger at the behaviour of his relatives. By not commenting on issues as they happened, the caregiver also appeared to be in denial of the donations given to the orphans by relatives. It also seemed P-13 had disengaged from his relative(s) because of their clandestinely donating these gadgets to the orphan. This way, he embraced the Third Stage of TLT which highlights isolation of oneself as a way of learning as well as coping (Mezirow 2012). This finding was in contradiction with what was found in prior studies where donations from relatives were actually something that one could look forward to receiving (Zvinavashe et al. 2015). Caregivers in Zvinavashe et al.'s (2015) study relied heavily on their extended kin though issues of stigma and discrimination in relation to poor support could not be ruled out.

5.7.2.2. **Assistance from other adult children to elderly care givers as coping strategy**

Most of the caregivers had biological adult children who were still living. These sometimes helped their parents with a few grocery items but not on a regular basis. P-15 has adult children who try to help here and there. She said:

> *My other adult children occasionally help with a few groceries like soap and sugar. They are people who are also struggling in their homes. The girl is a full-time housewife who does not have any influence about her household resources. The boys are also struggling to keep up with their families.*

P-11 also weighed in:

> *My son is a poor man who is also struggling to make ends meet with his family. His wife being a vegetable vendor as myself cannot be able to give me any meaningful help.*

The caregivers lamented that these adult children were as poor as their parents, so regularly helping them with material things was a constant challenge. The adult children nowadays, due to poverty, were no longer able to support their elderly parents perhaps because the parents had larger families, due to AIDS orphans, than would have been expected. Previously, it was more manageable for adult children to look after their parents as opposed to now. From the observations made, there were many school dropouts as evidenced by school-aged adolescents wandering the streets and milling about at shops during times they could be in school. Many of the people in Epworth were uneducated (Mujere, 2016), making it difficult for them to get formal employment.

As such, people were confined to working as vendors, farm labourers, domestic workers and security guards in affluent surrounding suburbs where their earnings were only for the subsistence of their nuclear families. They lacked capacity to look after their parents, and this was worrisome to the elderly caregivers who expected these adult children to also reciprocate the care. In Shona, there is a saying which says *chirere chigokurerawo*, meaning children had to be raised in the proper manner so that they would be able to also look after parents in future. In old age, parents used to be taken care of by their offspring (Bourdillon, 1991), as opposed to now when many households are torn apart by HIV/AIDS (Foster and German 2002; Mpofu 2021), requiring the elderly to continue with child rearing issues.

5.7.2.3 **Help from the Church as coping strategy**

Almost all the caregivers alluded to receiving help from their diverse church denominations. P-14 was observed going to church in her church uniform soon after I had finished interviewing her. Help in the form of spiritual support, food hampers or grocery items was mentioned. P-14 illustrates below:

> *The church normally prays for me, gives me a food hamper around Christmas, comprising a bottle of cooking oil, 10kg mealie meal, 5kg beans, 2kg salt, 1 bar soap, 5kg sugar. This goes a long way in caring for the family, I really appreciate their efforts. But with this COVID-19 problem, people do not congregate most of the times.*

> *From the church I used to get small donations of a bottle of cooking oil, five kilograms of meali-meal; washing soap and salt at infrequent intervals. But right now with this new disease called COVID its now a crime to be seen gathering at church. This means that my source of livelihood has been exhausted.* P-2

> *Things seem to have come to a standstill because the church is no longer operational. If people are not gathering it would be difficult for the church to find something to give to the needy due to lack of financial resources. I just hope and pray that COVID-19 will soon disappear so that people restore their normal ways of living, which include going to church.* P-19

With the presence of COVID-19, churches were required to observe the lockdown measures of not gathering at their church premises, and this compromised my elderly caregivers' coping with AIDS orphan care. The much needed help to the elderly caregivers was not regularly forthcoming as congregants were not congregating on a consistent basis. Help from the church was also mentioned in previous literature (Hawkins 2013; Zvinavashe et al. 2015) where the elderly caregivers would look to the Church for assistance. Nevertheless, in view of prayers or spiritual support which the elderly caregivers received from the church, Dirkx (2012) indicates that it involves the entire person, thus the body, mind, as well as the spirit. As such, exposure to church formed and moulded both my caregivers and their adolescents to be well behaved and respectful citizens. According to Macharaga (2020), going to church is a necessary ingredient for transformative learning, which I found to be important for my elderly caregivers in the present study. Religion helped my caregivers to be tolerant of their circumstances and contributed to their general wellbeing in this difficult situation, characteristics essential for transformative learning (Gatley 2021).

5.7.3 **Counselling as a coping strategy to psychosocial challenges**

The psychosocial aspect of help came in the form of counselling of both caregivers as well as adolescents. The church, the community and the clinic rendered such assistance to the caregivers and their orphans in Epworth. The data suggested that the church offered spiritual counselling to the elderly caregivers and the adolescents, as well as material goods.

> *My church pastor and elders have always embraced us and tried to mould him into a person pleasant to stay with.* P-4

> *Counselling from even the elders in our neighbourhood is good because it is in our community where they walk around and play, and should exhibit acceptable behaviours to the community.* P-18

> *The clinic came to my rescue by counselling me. Before I came to clinic I used to discriminate these children on the basis that their mother had succumbed to AIDS. It took me some time before I accepted them wholeheartedly for fear of what I was not really sure of.* P-7

Counselling by the church was often given where there was a need for instilling a sense of hope in people. As people who experienced numerous disorienting dilemmas, such as the deaths of adult children through HIV/AIDS, as well as caring for the orphans, they lost all hope to live a normal life again, but the church gave them assurance in line with what was also found in the studies by Hong (2015), Macharaga (2020) and Zvinavashe et al. (2015). Thus, the caregivers greatly relied upon the emotional coping strategy espoused by Lazarus and Folkman (1984). Emotion-oriented coping entails the regulation of the elderly caregivers' emotional responses and how they felt or thought about their demanding circumstance. Lazarus and Folkman (1984) assert that emotion-based coping ways are significantly adaptive if the dilemmas are fixed and consistent, or if the strategies are used jointly with those in the problem-focused model. It is the emotional strategies of coping, such as counselling, that triggered some introspection in caregivers in order that the problem-centred approaches could be engaged as well. All the caregivers who participated in the study mentioned going to church, or taking time to pray in the process of caregiving. The church was thus impactful as it offered psychosocial support, as well as material and spiritual assistance, to both elderly caregivers and the orphans (Macharaga 2020). The psychosocial support generated motivation to deal with caregiving challenges head-on (Mezirow 2012; Lazarus and Folkman 2015).

Linking counselling to TLT, the elderly caregivers were capacitated to self-examine and question their previously held viewpoints, which relates to Stage Two of the learning process. For example, P-7 used to discriminate against the orphans because their parents had died of AIDS. However, with counselling, she made some self-assessment and adopted new attitudes to positively influence her caring (Mezirow 2012). HIV/AIDS was generally stigmatised as illustrated in the quote and changes were necessary so that positive impacts were realised in the care.

The community around the elderly caregivers were said to help in reprimanding some of the orphans when they saw them misbehaving. Data showed that community intervention involved counselling the adolescent(s). It emerged from the findings that the orphans generally accepted the counselling given by their community. P-18 was grateful for the counselling given to her orphans because it was within the same community where children walked around and played with peers. As such, appropriate behaviours were expected from them by the community. Some community elders rendered counselling to the elderly caregivers because of the difficult role of caregiving they had engaged in. Chats by the roadside were believed to go far in providing relief and strength to continue caring even in difficult times. The finding of counselling by the community was unique to the current study as the reviewed literature was silent about it.

Counselling by the clinic staff was mainly realised when individuals visited the clinic for diagnosis of HIV. The positive diagnosis of this disease is normally associated with denial (Chingombe et al. 2022) and so the clinic would first prepare, through pre-counselling, individuals to accept whatever would be the outcome of the test. This was an important aspect as it would capacitate the elderly caregivers to embrace the necessary treatments and to adhere to them as required if one was found to be living with the disease. Most of the elderly caregivers exposed their orphans to HIV testing; hence, they went through the clinical counselling which was now helping them to face this formidable task head on. Counselling is an important instrument in issues to do with the diagnosis and treatment of HIV (Chingombe 2020), and its engagement by my caregivers validates this literature. Kanekar (2011) espouses that counselling is important in high-risk people such as teenagers as it reduces further transmission of the disease.

All the counselling that the elderly caregivers engaged in seemed to have worked in triggering self-examination, the second stage of TLT. Reflections were then made into the caregivers' frames of reference enabling them to critically question the denial and discrimination that were previously generally related to HIV/AIDS. Consistent with self-reflection, HIV/AIDS counselling became an essential component in the entire health care (Chingombe 2022), in which emotional matters are acknowledged as fundamental (Chippindale and French 2001) to orphan care. It is these emotions which were provoked by counselling, giving rise to the elderly caregivers' critical reflections which prompted some transformative learning.

However, the caregivers were not able to relate their discontent to others, which is a Stage Four in TLT. Despite HIV/AIDS being a common condition with other people around communities, the participants did not think of collectively managing the crisis with others in similar circumstances. Establishment of platforms such as support groups did not emerge in the current research although these were a common phenomenon in other local studies (Zvinavashe et al. 2015; Maronganye 2017).

5.7.4 Correction, sanctions and discipline as strategies for coping

Data showed that coping ways varied according to situations. The following table contains notes which were collected from focus groups discussions which illustrate the coping strategies in the context of indiscipline.

Table 5.6: Coping ways in the context of indiscipline

Caregiving in the context of indiscipline	Corporal punishment
	Indicating areas of errors in conversations/correction
	Withdrawing benefits/sanctions
	Administering small punishments/disciplining
	Positive reinforcements
	Guidance and counselling

The notes in Table 5.6 are discussed in the following paragraphs.

5.7.4.1 **Corporal punishment as a coping strategy**

Though there were few such responses, discussions revealed that coping with misbehaving orphans sometimes involved corporal punishment where the adolescent was physically beaten in order to force behaviour change and mould them into the desired behaviour. Participants cited things such as thieving, being rude, and repelling the caregivers' control as serious issues that warranted inflicting physical pain on the adolescent.

> *Adolescents tend to develop erratic behaviours, such as stealing, being disrespectful, and resisting to be disciplined. So it becomes a serious challenge for me.* P-16

> *In prior years problematic children would be disciplined by way of beating, even neighbours could take up the responsibility to discipline another household's child but nowadays if you do that it can be a crime so people will just look on like spectators.* P-12

Corporal punishment was rife in yesteryears but with some government policy shifts, the elderly caregivers were not very keen on it as they too had shifted from previously held ideas of inflicting pain on children if they misbehaved (Dhal 2016). With policy pronouncements such as Children's Rights, it is a crime in Zimbabwe to inflict corporal punishment on children (Matope 2011). In the same instrument, children are required to respect their elders and assist them as required, be virtuous citizens through national service and be morally upright. In the frames of reference of the caregivers, beating children was one of the disciplinary measures inflicted on misbehaving children. However, critics of Children's Rights instruments have voiced concern that the tools have given the youngsters dangerous freedoms which tend to destabilise respect for their elders (Alderson 2020), an issue which became consistent with my caregivers and their orphans. The acceptance of these tools was universal, though queries continue to emerge with Faulkner and Nyamutata (2020) postulating that the instruments preserve Western ideas about child rearing, arguing that local cultures are often omitted in the background of children's rights. In his writings, Harris-Short (2003) says such instruments are restrictions to family lives, while Ngozwana (2014) believes that these have brought in numerous tensions which have swept away cultural principles within local communities. In all this literature concern focuses on bringing up uncultured children, a feeling similar to that of my caregivers.

The caregivers' critical reflection (TLT Stage Two) through dialogue with others (TLT Stage Four) and with the self, enabled the use of Freire's (1970) model of critical consciousness leading to the abandonment of beating children as a corrective measure. Given their advanced age, such punishments could be physically problematic due to their frailty, which might tempt some teenagers to attempt to fight back.

5.7.4.2 **Withdrawing benefits/sanctions**

Data revealed withdrawal of opportunities and benefits as not only punitive but also as training and, therefore, a coping strategy. P-19 had to withdraw the benefit of the orphan meeting with his peers. The following is illustrative of this:

> *One time my elder grandson stole money here after friends had advised him to do so in order that they could buy alcohol and drugs. Since he was youngest in this group of friends he stole the money so that he could not be harassed and abused by them. I responded by prohibiting him to associate with these friends.*

Discussions revealed the need for removing benefits from adolescents for them to have a feel of life without. Withdrawals manifested as restricted movement, allowances, freedom etc. However, in view of the fact that adolescents are too attached to their peers (Omotoso 2007; Zaky 2016), such sanctions as in P-19's case might perhaps further cause friction between the teenagers and their caregivers. The consequence of such sanctions might cause rebellion from the adolescents as it is widely confirmed that at adolescence children value their peers and tend to pay attention to what friends say (Lazarus and Folkman 1984; Omotoso 2007; Zaky 2016; Quas 2014).

5.7.4.3 **Correction/guidance and counselling**

Coping also manifested as correcting misbehaviour through engaging in talk with the orphans. The following extract from the data revealed:

> *One day they came asking if they could stop their ARVs at the friends' advice. When I advised them not to stop medication they become angry with me until I had to go*

> *back to the clinic with them where they were counselled and continued well with their medication.* P-19

> *Sometimes peer pressure at school tends to be overwhelming for my grandchildren. One day the boy reported having been forced to take alcohol at a party at school, which is not very well compatible with his condition. I am not so sure why he is powerless to refuse such influences from peers. I had to approach the school authorities who later provided counselling to the boy.* P-15

Data suggested that talk may be done between the orphan and the caregiver, relative or neighbour considered as worthy of doing that. Worthiness was according to trust that the person invited had the welfare of the adolescent at heart (Lazarus and Folkman 1984). Talk in this regard entailed good communication with the adolescents. The elderly caregivers were cognisant of the importance of communication between themselves and their orphans. Communication skills literature confirms that communication in families ensures that solutions are successfully carried out and that all family members stay on the same page regarding their family issues (Theiss 2018). Appropriate communication skills essential to the resolution of problems comprise active listening, getting and giving feedback, and respect for one another (Theiss 2018). As my caregivers embraced talking out issues with their orphans they may have been looking for more operational answers to their orphan caring in an AIDS context. Their engagement with their adolescent orphans was indicative of good communication skills which was a vital ingredient in meeting the challenges in their families.

Another source of guidance and counselling was the clinic, and in some instances the school, where some orphans were taught the significance of adhering to their medication despite their friends trying to influence the abandonment of the same, as shown in section 5.4.3. By seeking guidance and counselling from the clinic, community and relatives the elderly caregivers were engaging in an emotion-based way of coping, as well as self-examination as discussed above. On this finding, there is not much similarity between the current study and prior research on elderly caregivers.

5.7.4.4 **Positive reinforcement as a coping strategy**

Coping with the challenge of indiscipline also manifested as promoting the development of good that was observed in the adolescent. This was done through complimenting good behaviour and rewarding it.

> *If he sells a lot of wares, I give him some money for airtime and actually appreciate him directly.* P-9

> *I normally compliment him by giving him more opportunities to do what he will have done well. I also ask him to offer his views and I adopt them in order to encourage him.* P-11

This factor of motivation had the potential to sustain the good behaviour in the adolescents as they transitioned into adulthood. In terms of coping theory, positive reinforcement derives from both action-based and emotional approaches to coping (Lazarus and Folkman 1984). The adolescent would feel satisfied by the caregivers' reinforcement while the caregivers would have managed to avert any misconduct that could have manifested in the adolescent.

As the caregivers used positive reinforcement as a way of coping, they embraced Stage Nine of TLT which focuses on experimenting with new learning and new roles (Mezirow 2012). The new learning of positive reinforcement was tried out on the orphans and from the quote above it proved to be working. This point validates literature on motivation where Gaffar, Atmowardoyo and Dollah (2022) and Nickerson (2022) concur that positive reinforcement strengthens the good behaviour that the child is exhibiting instead of focusing on the bad behaviour. The elderly caregivers utilised this type of motivation so that the likelihood of the orphans repeating any bad behaviour would be minimal. As Nickerson (2022) sums up, if an action is followed by a positive result (reinforcement), it then means that the action is more likely to transpire again tomorrow; equally, it would not happen again in future if a negative response (punishment) was applied. This means that caregivers assessed the utility of this reinforcement and continued to positively reinforce desired behaviour.

Caregivers continued to learn, as in the concept that adult learning is a life-long process (Kaziboni 2018). Although it is generally believed that elderly persons have no need to learn new things since they are too old for that, it was necessary for my participants to learn as was demanded by the disorienting dilemmas that came their way during their elderly years (Findsen and Formosa 2011). This finding was also exceptional to the current study as it did not emerge in any of the reviewed literature.

5.7.5 **Talking out issues as a coping strategy**

The elderly caregivers also mentioned that they created time to talk out issues with their adolescent orphans. For example, P-20 said:

> *After we have dinner the children wash up the dishes and clean up the surfaces then we sit down and talk for a while as a family until we retire to bed around 8:30pm.*

P-10 concurred:

> *I gradually talked to them about the death of their parents because some of the behaviours that I see on them probably point to denial.*

It was fundamental that the elderly caregivers, after becoming the parents of these teenagers, generated time to talk over these changes as the adolescents tried to figure out their identity and what they really liked and wanted for their own lives. Communicating with adolescents would reveal their dreams and aspirations and this must have helped the caregivers to nurture the adolescents into achieving these (Quas 2014; Zaky 2016).

Talking out issues is also important in moulding the adolescent into an autonomous adult (Omotoso 2007; Zaky 2016; Quas 2014). The elderly caregivers ensured the provision of information on the matters under discussion, although in some instances they revealed that they were not sure of solving certain behavioural misconducts due to peer pressure. The following excerpt shows challenges faced even after talking to the teenagers. "*In some cases, you talk to them but they do not listen at all*" (P-13). Parents normally face problems with teenagers failing to comply: this is a regular transitory period which every adult has experienced (Zaky 2016). With some self-examination after talking to orphans, the caregiver learned to listen and understand them without necessarily refereeing and condemning them. If such platforms were not put in place the probability of certain situations degenerating into even worse conduct and ruined associations between the elderly caregivers and the adolescents would be high (Jaworska and MacQueen 2015).

In previous years, the task of talking to teenagers was mainly reserved for aunts and uncles but in this day and age, it seems everyone who has such adolescents in their household should strive to talk out issues with the teenagers (Bourdillon 1991). This directly points to the issue that the elderly have now moved from certain viewpoints of yesteryear where discussion of issues was assigned to particular individuals (Preece 2003). The participants took it upon themselves to talk to the children as it appeared there were no longer people like aunts and uncles to do the task as previously ascribed by society. Due to various reasons, such as death as well as migration to far away areas, aunts and uncles are scarce nowadays (Foster and German 2002).

5.7.6 **Cutting meals to cater for food shortages**

In order to cope with food shortages, households reacted by reducing food intake, for instance, by cutting the number of meals per day, which in the long term may lead to chronic malnutrition. This was demonstrated in these two excerpts from P-3 and P-8 below:

> *I normally don't eat early morning as I wake up around 5am to go to the market to buy the wares for vending; or on some days to go into my agricultural field to work there.* P-3

> *We do not have the luxury of three meals per day. Instead I make sure that supper is available but during the day we can eat around 11 am only till supper time when we can have sadza.* P-8

The data indicated that the caregivers' households were not able to provide the usual three meals per day. The meal frequency was sometimes reduced from the normal three to two and in some households from two meals to one, which in the long term may cause other problems such as severe malnutrition. In some families meals (in particular lunch) would be skipped although this compromised the caregivers' and orphans' nutrition. Hence such coping fell into the maladaptive domain of coping because it allowed the caregiver families sufficient food just for survival. It did not guarantee the necessary nutrition for ordinary growth for these families.

There was a sharp contrast with the Vietnamese study in which caregivers understood that their coping ways should be problem-centred (Maradik and Kim 2014) when they considered engaging in caregiving-related undertakings such as generating money, borrowing money, cooking, and doing other household chores.

Problem-centred coping adopts ways and means which focus on management of or changing the miserable situation (Lazarus and Folkman 2015). The elderly caregivers made efforts to face their problems head-on with a view to managing and minimising the challenges in their new roles. However, when they skipped meals it never crossed their minds that they were engaging in dysfunctional ways of coping (Carver, Scheier and Weintraub 1989) This was mainly necessitated by poverty which was said to be rife in the elderly (HelpAge Zimbabwe 2017). Unfortunately, they might have thought they could spread the food by skipping some meals without taking much consideration about consequences in view of the AIDS context in which they dwelt. As a strategy to cope with food shortages, the elderly caregivers' families responded by reducing their food consumption. This saw them reducing the number of meals per day and the meal sizes too. Several scholars (Wakhweya et al. 2008; Topouzis 1994) have noted how cutting meals threatens their health and capacity to provide care to their orphans. In fact, Carver, Scheier and Weintraub (1989) regard it as a dysfunctional way of coping, as it may cause malnutrition.

5.8 Chapter Summary

The chapter presented and discussed data and analysis for research question one which read as follows:
What is the nature of caring practices and coping mechanisms that the elderly caregivers of adolescent AIDS orphans engage in?

Caring practices manifested as nurturing character development and provision of basic needs for survival. Character formation included socialisation of adolescents into roles and responsibilities, as well as skills building. Character building strategies found included modelling the adolescents' behaviour, talking to adolescents, working with adolescents, task delegation, and encouraging church attendance, among others. Material needs care included the provision of food, clothes, school fees, learning materials (phone, laptop, data etc.) and shelter.

Challenges which emerged from the data were social, financial and psychosocial in nature, with coping strategies encompassing the provision of counselling, donations, cutting meals and finding help from neighbours and the church. Some of the emerging practices which were different from the related literature were modelling the behaviour of adolescents, talking out issues with them, delegating and supervising tasks, sending adolescents for counselling, story-telling and games. During their caring, it emerged that the elderly caregivers utilised all the stages of Mezirow's transformative learning theory (TLT) as discussed, although these stages were not followed in a linear way. The study also revealed the use of the transactional model of stress and coping (TMSC) (Lazarus and Folkman 1984; Carver, Scheier and Weintraub 1989) in their coping strategies. All the three coping strategies, namely, problem-oriented, emotion-oriented and harmful coping have evidence of use by the elderly caregivers in this study. The subsequent chapter presents findings in response to Research Question Two which addresses the new meanings or insights coming out of the research.

CHAPTER SIX

INSIGHTS FROM THE CAREGIVING RESPONSIBILITIES

6.0 Introduction

In the previous chapter I discussed the nature of the caring practices of elderly caregivers of adolescent AIDS orphans under their care in Epworth, with a view to establishing their caring practices and coping ways in order to draw up implications for Adult Education. The current chapter presents, interprets and discusses the findings which were generated in response to Research Question Two which sought to establish whether there were new meanings/insights which the elderly caregivers derived from their caregiving roles and how they derived these new learnings or insights. Data are presented as direct quotations and in tables, while the interpretations and discussions are guided by references to the literature reviewed and the theoretical framework, namely, transformative learning theory (TLT) and the transactional model of stress and coping (TMSC) which were outlined in previous chapters.

6.1 New insights derived from the role of caring for adolescent orphans

Regardless of the fact that the caregivers who participated in the study were adults who had previously had their own families, the actual activity of caring for orphans revealed that the caregivers had developed new meanings and insights which presented as new knowledge that they did not have or had not anticipated prior to taking up the caregiving responsibility. These are the focus of this chapter. The data exploration showed caregivers coming up with the new insights in relation to themselves as caregivers, the adolescents they cared for and the system of caring for orphans. The following table presents what caregivers realised concerning their roles and the orphans they cared for, as well as how they came to realise that.

Table 6.1: The new meanings emanating from the caregivers' roles and responsibilities

The caregiving responsibility
❖ Responsibility is age sensitive
❖ It is a collaborative activity
❖ Caregiver efforts are not always appreciated / reciprocated
❖ Caregiving and the legal orientation
❖ Biased support
❖ Different from looking after own children

The data presented in Table 6.1 is discussed below.

6.1.1 **The age-sensitive nature of the caregiving responsibility**

Participants noted how taking care of adolescent orphans was an age sensitive activity. The following excerpts illustrate this:

> *I used to think anyone can take care of orphans provided they have resources. However I discovered that someone who is young cannot cope with the responsibility. It requires maturity to contain the challenges involved otherwise one will break down or give up. Otherwise, one would actually need counselling to handle the pressure.* P-2

> *The problem is I am too old to be taking care of these adolescents. They need someone who is still agile and capable of working hard to provide them with the luxuries they want. Besides I don't have time to entertain their whims.* P-1

The above responses demonstrate how age emerged as a major aspect in issues of taking care of adolescent orphans. P-2 was a female caregiver aged 69 years who was taking care of three adolescent orphans. The reason for her conclusion was the discovery of how difficult it was to look after the children, which could result in failure to continue or breaking down. The implications were that caring for adolescent orphans was an emotion-laden activity which could impact negatively on the relationship between the caregiver and the orphan. The reference to breaking down and giving up suggests burden, challenge or difficulty. Observation data also revealed that these elderly caregivers' physical appearances were very frail and weak, giving credence to the suggestion that the caregiving role was burdensome for their age. The sentiments raised by P-2 were confirmed in focus groups discussions where the caregiving role was described as an infinite and traumatic burden which required endurance, especially when carried out by the elderly who had already suffered multiple disorienting dilemmas of losing adult children through AIDS and now had to care for the remaining orphans. This point is suggestive of the elderly caregivers stressing and worrying over their situations, corroborating Mpofu's (2021) study which asserts that elderly caregivers had fear of the unknown when exposed to the orphan dilemma. Various authors reveal that the adolescent stage is fraught with trouble, as children are navigating their way through to adulthood (Zaky 2016; Omotoso 2007; Quas 2014; Wagner et al. 2017). One would have thought that since the carers were looking after adolescents for the second time in their life course, they were now aware of problems that arise from the exercise and how to resolve them. Alas, it would appear as if the issues in adolescence were always new. This is probably because of the contemporary nature of the problems and maybe the poverty among the elderly people (HelpAge Zimbabwe 2017).

In terms of the transactional model of stress and coping (TMSC) (Lazarus and Folkman 1984), the elderly caregivers used an emotion-based approach which focuses on altering one's thoughts and feelings about the stressful circumstance or the disorienting dilemmas one has experienced (Lazarus and Folkman 2015). They utilised problem-oriented coping. Both emotion-based and problem-based coping were achieved through their proactive actions to find ways of surviving the stressful situations they found themselves in. Linking this point to transformative learning theory (TLT) the elderly caregivers utilised Stage Two of this theory whose emphasis is on introspection into prior held norms and values. The acceptance of taking care of these adolescents was testimony enough that they had shifted their attitudes towards this disease which generally is still stigmatised in many circles (UNAIDS 2018). In the reviewed literature on caregivers of AIDS orphans, the finding of age sensitivity did not emerge.

For P-1 the adolescents' requirements were 'luxuries' which he could not provide, due to lack of finance. He had no time for their whims. There were implications of variances in values and interests which affected effective performance of the responsibility. This response dispelled the common assumption that anyone could look after orphans or that the elderly were better at enduring transitional instabilities of adolescent children. Because the task of caring for adolescent AIDS orphans was difficult for the elderly caregivers, they did not attach any significance to these ‘luxurious’ interests as they could not afford them. On the one hand, ignoring the interests of orphans might have been utilised as a problem-centred coping strategy, because with or without these ‘luxuries’ one transitions to the next stage in life, which is adulthood. On the other hand, the finding could fall under the maladaptive way of coping because if the ‘luxuries’ continued to be lacking, the adolescents might indulge in certain undesired behaviours in order to get the goodies (Lazarus and Folkman 2015; Zaky 2016).

Overall, the common knowledge which was derived from the data was that caregiving was age-sensitive. However, there was no common agreement concerning which age was the most suitable to do it, although Mpofu (2021) espouses that at 65 years of age people tend to slow down on their productivity due to old age incapacitation.

6.1.2 **The caregiving role as a collaborative activity**

Findings from the data revealed that caregiving was seen as a collaborative activity. The following were illustrations of what participants said concerning this point:

> *When I resolved to look after my grandchild, I thought she will be my responsibility. However, I am now realising that so many people are involved in looking after her. The teachers, nurses, neighbours, her friends, church people and others are all taking part in caring for my orphan.* P-9

> *The experience I have had with looking after these children is that the role is not an individual activity. I discovered that there is need for various people who come in at different times according to the needs of the child to provide care for the child.* P-12

> *I discovered that the role of caregiving is complicated by the involvement of various people some of which will influence the child in the negative. This complicates controlling or moulding the child as one may want.* P-13

> *I realised later that what I regarded as my responsibility ended up a community activity with or without my consent. Sometimes I suggest who to help me with the child's upbringing yet at other times I have no control. As long as the child is exposed to the community and she allows people to influence her, I cannot control her.* P-16

As shown in examples from P-9 and P-12, collaboration was seen as a positive activity which contributed to holistic care being given to the child. P-9 demonstrated how different people played different roles with the result that the children benefited. The two examples showed how the roles were complementary, with each party filling in a gap which the other could not. A teacher, for example, could not do what a nurse or a friend could do, and above all the caregiver could not do both roles in the way these two could. This implied that where there was no such support, the caregiving responsibility became a burden. Thus, this suggests that the role of the elderly caregivers would have been strengthened had they belonged to support groups which would enable them to provide various types of support to each other. P-16, however, brought another insight of collaboration as sometimes being both intentional, desired and indispensable but sometimes being unintended and undesired. Collaboration of caregiver, nurse and teacher appeared intentional and desired. The reason this kind of collaboration was considered as a new discovery was because of the composition of collaborators.

The predominant form of collaborators in Zimbabwe is often the extended families with kinship ties comprising the frontline relatives, such as paternal and maternal uncles and aunts and grandparents (Foster and German 2002; Mpofu 2020). These frontline relatives were traditionally responsible for assuming the care and support of orphans upon the death of one or both parents and vulnerable children in cases of abandonment or otherwise (Zvinavashe et al. 2015). Ordinarily, one member of the extended family network assumed the primary caregiver role while others might periodically contribute resources as secondary caregivers (Foster and German 2002). Now with change of life as discussed above and the disruption of traditional life, it became essential that these other collaborators in the current study participated in the children's lives.

This finding is of significance noting the embracing of Stages Nine and Ten of the TLT in the collaboration activity. The former stage is about experimentation with new roles while the latter reintegrates the learned information into the daily lives of society (Mezirow 2012). The caregivers learned that their responsibility should be a joint operation with the other players mentioned above, and they tried out and evaluated its usefulness in managing their disorienting dilemmas. Collaboration as a new insight and reformed perspectives were brought back or reintegrated in their daily caring activities (Mezirow 2009). As evidenced by their responses, partnering with clinic staff, the community, as well as school teachers, created an opportunity for better collective management of the disorienting dilemma. Otherwise, the elderly caregivers would not be able to provide all that the children needed. In terms of reviewed literature, there has not been such a finding recorded, making it exclusive for the current research.

6.1.3 **Caregiving and the need for reciprocity of actions**

Data showed the realisation by caregivers that the responsibility required reciprocation as displayed by the responses quoted below:

> *I had conceptualised taking care of these orphans as an act of charity but I now realise that it should be a partnership with the child also taking their part.* P-17

> *I realised that it is a two-way activity where I am supposed to take care of the child's needs as he also cares for mine. This makes it easier for me to cope. If the child does not play her part then I am also compromised in what I can do.* P-3

The above examples showed the insight obtained by the caregivers that successful rearing of an orphan was greatly reliant on the child's reaction. The adolescent was supposed to take care of the caregiver so that they helped each other (Bourdillon 1991). Failure to do that would result in challenges. To this extent caregiving ceased to be a mere act of charity although it had initially appeared to be. This observation had implications for the need to conscientise the orphans of this two-way nature of the relationship. The caregivers knew the implication of the Shona adage which says *chirere chigokurerawo* literally meaning that the children should reciprocate the care given to them when their caregivers became incapacitated mostly with old age (Bourdillon 1991). The adult children nowadays, because many had died and due to poverty, were no longer able to support their elderly parents because the caregivers had larger families due to AIDS orphans than would have been expected (Foster and German 2002; Mujere 2016).

Reciprocity of care could be viewed as a problem-oriented strategy of coping if both parties could play their parts. However, it seemed it was more manageable for children to look after their parents prior to the advent of such disorienting dilemmas as deaths from AIDS and the creation of orphans. Epworth community has experienced many children having to drop out of school as verified by school-going aged children observed loitering around the streets and shopping centres during school time. As a result, most of the people were uneducated (Mujere 2016). This restricts such people to getting menial jobs, such as vending, house maids and gardeners, in affluent surrounding suburbs where their earnings would be for the subsistence of their nuclear families. Hence the probability of these orphans being able to reciprocate the care of their elderly caregivers seemed to be minimal. Commonly, adult children observe the need to reciprocate past support which they would have been given by their elderly parents. Literature points to adult children voicing that they were offering less care than what they got from their parents and articulating feelings of gratefulness to their parents (Akinrolie, Okoh and Kalu 2020). The awareness of reciprocity continues to be quite strong even in my elderly caregivers who kept on bringing up the concept of *chirere chigokurerawo* during data generation. Embracing the thought of no reciprocity between the caregivers and the orphans must have been painful for the caregivers, who might have shifted from the previous perspective of expecting returns for their care.

6.1.4 **Caregiving and the legal orientation**

One other insight which emerged from the study data concerned the legal orientation of caregiving. Contrary to the assumption which the caregivers had that they would raise the children according to how they had raised their adult children and in the manner they preferred, they discovered there was an aspect of the law which affected the conduct of their caregiving responsibility.

> *I have come to recognize that sometimes you end up on the wrong side of the law in a desire to help the child.* P-16

> *I learnt that there is now need to find out about the law concerning looking after these children or else you end up in trouble. I have just heard some people saying it's now a crime to beat your own child.* P-20

> *I discovered the unfortunate situation that whilst you have taken the largest risk of caring for the children you can actually be arrested for disciplining them.* P-13

Participants who gave these responses showed disappointment at what they felt as ungratefulness where all that they had done for the adolescents tended to be overlooked because they had breached these rights. Participants in focus group discussions (FGD) expressed anger, as well as disappointment, with such an ironic scenario where the caregiver became prone to condemnation regardless of efforts to protect the child. The elderly caregivers cited the legal aspect as making it difficult for children to be disciplined, hence, complicating their relationship. The interference of the law had also been noted in Save the Children (2006) which observed that in the Southern Africa region, the need to discipline children had been regarded traditionally as a right of parents and caregivers, even if that discipline involved physical violence in terms of the UN Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child. The legal interference brought into viewpoint Harris-Short's (2003) disapproval of the legal framework in which the opinions of the citizens were successfully quieted. The misperception between duty and child rights limitations appeared to upset caregivers as they struggled to view themselves as 'virtuous parents' and, hence, tended to perceive and treat the children as their own. Customarily, within the Zimbabwean tradition orphans used to be enthralled with their extended families that would shoulder the obligation to care for and support them (Zagheni 2011; Dhal 2016). Similarly, vulnerable children would be absorbed by the extended families. To this extent, the legal aspect of bringing in restrictions was actually disrupting family life (Harris-Short 2003).

As a new finding, caregivers were reluctant to shift their prior perspectives on violent ways of disciplining children. They continued to stay in the past despite the legal frameworks and policy pronouncements which would bind anyone when violated. In reference to the TLT, the caregivers' transformation was hindered as they still remained in their earlier life experiences, views and attitudes. The legal frameworks induced negative emotions in the caregivers as they responded to the orphan crisis. This implies that more conscientisation programmes on these legalities are necessary to keep the elderly caregivers abreast of legal trends.

6.1.5 **Biased support**

Data also revealed how the law protected the children, leaving the caregivers vulnerable as shown by the following response:

> *I got to discover that in as much as the law seems to be protecting the child; it is leaving me with nothing to help me control the child in the form of discipline. This is because if I scold her it's regarded as emotional abuse, if I deny her certain things as punishment, its considered abuse, if I beat her it is also unacceptable. The protection of the child is, therefore, without an accompanying guideline as to how we should control them.* P-16

Data from the focus group discussion also corroborated with the one-on-one interviews when participants expressed concern with the removal of harsh punishments even in schools. P-5 had this to say:

> *Children of nowadays have become very naughty and hardly listen even their teachers in school. This must be attributed to the same laws which seem to protect children at the expense of us. No wonder why we seem to face a lot of vices such as drug abuse when it comes to raising children.*
>
> *My grandchild one time threatened to committee suicide when I tried to harshly reprimand her for coming home late from school. She has a tendency of lying to me and since her suicidal threats, I do not know how to handle the matter because I am now afraid of the law.* P-9

The concern raised by the participant was that there was a realisation that the government seemed to continue to empower the children in the name of providing social security and child protection rights while overlooking the caregivers and thereby undermining the roles they performed. Participants observed how the government had hardly put any alternatives in place for caregivers to use so they were forced to leave traditional methods. To this extent, both the caregivers and their children were unlikely to be able to address their challenges (Harris-Short 2003). FGDs revealed that the caregivers accepted the responsibility of caring for the adolescents hoping to use their past experiences and knowledge of childcare but they were now in a quandary as their ways were deemed unfit and yet there were no alternative options provided (Harris-Short 2003).

The literature which was reviewed in this study did not reveal such findings or complaints from study participants. The disciplining of a child in the SADC region is known to belong to the parents who would normally inflict some physical beating on children (Save the Children 2006). Hence the advent of the legal framework in child rearing has initiated some criticism from writers such as Harris-Short (2003) and Ngozwana (2014) whose own research participants viewed it as an instrument to silence parents on issues about their children's discipline. The elderly caregivers seemed reluctant to completely shift their perspective on this one, but this rigidity is not a healthy situation as it may land them in confinement which is a maladaptive way of coping with challenges. Although there is literature about complaints logged on the legal issues in disciplining children (Ngozwana 2014), HIV/AIDS literature on caring has apparently not revealed this despite the fact that it is a longstanding issue in African literature. These observations raised implications for training or guidelines being required on how to react in the context of child indiscipline and other situations. The observations by the participants implied that caregivers should be provided with training on understanding children's needs and rights. Creating an environment that enables the empowerment of caregivers would help in improving their role and responsibilities as caregivers.

6.1.5.1 The difference between raising one's own child and an orphan

The data also suggested that caregiving for AIDS orphans was different from looking after one's own children. The difference could have been drawn from the fact that when caregivers looked after their own children they were still youthful parents, unlike looking after grandchildren when already in advanced years. Looking after the orphans, thus, was a disorienting dilemma which made parenting seem like an infinite exercise because they were repeating the responsibility and getting deprived of their retirement from such activities. The excerpt below was testimony to the perceived differences:

> *If it were my own children they would always understand our resource shortages. Not having something is a fact, and it is who we are. These ones we have now (orphans) however will always nurse the 'If only … at the back of their heads'.* P-7

Some caregivers expressed the perspective that it required younger parents who would possibly be able to work for the orphans and satisfy their desires.

The other reason which was cited for the difference was the disposition of the orphans. Participants concurred on the perception that the adolescent children continued to nurse feelings that the situation would have been different if they had been raised by their own parents (Foster and German 2002). The thought of their deceased parents continued to linger in their minds, especially when they faced challenges or when they conflicted with the caregivers.

Caregivers were in agreement during focus groups discussions that there was a difference between raising one's own children and the orphans, citing the issue of getting satisfied even in the absence of adequate resources. Society and its judgements emerged as the other reason why raising one's own children was perceived as different from raising orphans:

> *I raised my children the way I wanted with no one thinking about the law. But now because I am looking after these ones out of my good heart, the law is brought in and people are watching to see what I am doing so that they could report me.* P11

Society was presented as always expecting injustice if one is raising a child that is not one's own. This had the effect on caregivers of not giving their best for fear of criticism. Indeed, some caregivers perceived the children as spoilt and different from their own biological ones but laid the blame not on the children but on the community, as well as the child rights principles which they tried to satisfy (Harris-Short 2003). Out of fear of being judged by society, the caregivers ended up neglecting firmness in raising the children. This had implications for society needing to be conscientised on the effects of 'careless' interference in these issues. Theoretically, TLT Stage Five, which explains options of new ways of behaviour, was evident here. The caregivers discovered that it was a crime to beat children as a disciplinary measure and the new way of behaving was to stop this out-dated behaviour, failure of which would be regarded as a crime. Literature on complaints about the legal framework in child rearing does exist (Ngozwana 2014), although without being directly linked to the HIV/AIDS situation.

6.2 Ways of learning

The data were suggestive of caregivers of AIDS orphans discovering new knowledge about themselves, the orphans and the caregiving role. Insights presented and discussed above in Section 6.1 were derived through several ways which are presented and discussed in this section. The following table presents ways by which the caregivers obtained the new meanings or insights.

Table 6.2: Ways through which new meanings were derived by caregivers in Epworth

Ways of knowing	
-	Past experience
-	Counselling/informed by clinic
-	Reading around the issue
-	Knowing caring from caring
-	Through radio and TV
-	Observation

The data presented in Table 6.2 is thematically analysed below.

6.2.1 **Experiential learning**

The domains of learning are here briefly explained to aid the analysis of the caregivers' ways of knowing.

Non-formal is a deliberately scheduled learning activity conducted outside the formal system for specific groups of people (Colardyn and Bjornavoid 2004). Such learning is more pronounced in formal workplaces where workshops and seminars are normally held to improve worker performance (Schugurensky 2015). However, this type of learning is also applicable in activities such as health education and agricultural extension programmes. This domain is applicable to my caregivers as well who also attend workshops or seminars on AIDS orphan care activities.

Informal learning which is also called incidental learning includes all learning that takes place without following any established curriculum (Colardyn and Bjornavoid 2004; Kaziboni 2018). The learning happens everywhere including within formal and non-formal learning situations, but does not contribute to intended outcomes of the former domains (Schugurensky 2015). This is viewed as a process of sense-making where people try to understand the vast experiences they have accumulated in their life course (Knowland and Thomas 2014; Knowles, Holton III and Swanson 2014). It is appropriate for the elderly caregivers to embrace this learning domain as it allows them to critically reflect upon their former experiences to make necessary shifts in their frames of reference.

Experiential learning is learning from experience. After exposure to disorienting dilemmas the elderly caregivers learned from their past experiences as they had no knowledge of how to deal with the new problem at hand (Christie et al. 2015), so they learned as the process of caring happened (Bassett and Jackson 1994). Their past experiences, therefore, stood as the foundation on which the new learning about orphan care was built. The following is illustrative of caregivers using their past experience to tackle the orphan care crisis:

> *Aaa-ah, we are parents already. We got in a path which we had previously walked. We know that we have re-started along the same path. So, what we did for their fathers is what we are also doing for them.* P-1

> *I got to realise these things from the experience of rearing my own children. Otherwise if I had not cared for these children I would never have known what I know now.* P-2

For P-1 and P-2 one way of knowing how to care was tapping into the previous experiences of looking after their own children. The elderly caregivers reflected on the approaches they had adopted in looking after their own children in the past in order to deal with the contemporary challenges of these disorienting dilemmas in their context. These approaches hence stood as a foundation on which to build additional learning which gave the participants courage to take new steps in finding ways and means of survival (Christie et al. 2015). Although the AIDS situation was not present when they reared their own children, the prior experiences of caring for children must have been enlightening for the task at hand, though they might not suffice for the contemporary context of caring for the AIDS orphans. The caregivers tapped into their experiences in order to face the disorienting dilemmas head-on. This, according to Lazarus and Folkman (2015), is a problem-oriented way of coping, whose emphasis is chiefly on the management of the problem. Given the nature of how adults learn, the elderly caregivers included the numerous domains of learning which were outlined above in dealing with orphan care (Colardyn and Bjornavoid 2004; Kolb 1994; Schugurensky 2015). Formal learning which takes place in classrooms, structured hierarchically and teacher-centred, was not appropriate for my elderly caregivers as its utility tends to be dedicated to future knowledge use rather than to solve the immediate problems they have.

6.2.2 **Counselling as a way of knowing**

Counselling manifested as another way of knowing how to care for adolescent AIDS orphans. The counselling for the caregivers would come as formal and informal. Formalised counselling was obtained when they visited the clinic and informal could be given in the community where even by the roadside people would stop by and chat with each other. The following were illustrations of the counselling the caregivers obtained from the clinic:

> *On my first visit with the child to the clinic they explained to me that I would not get infected even through touching the child. I understood it when I took the grandchild for the first time to clinic.* P-15

> *Clinic staff enabled me to deal with the stigma I used to have for the orphans.* P-1

It was through the clinic counselling that they were made aware of the various means of HIV transmission and how they could prevent it.

Caring for adolescent AIDS orphans was a contemporary phenomenon which required the acquisition of new skills, knowledge and attitudes for the elderly caregivers to implement new behaviours in caring (Schugurensky 2015). The various forms in which adults learn, such as formal, non-formal, and incidental learning, appeared to have been engaged by the elderly caregivers to adopt new perspectives in view of HIV/AIDS (Findsen 2011). Counselling by the clinic staff was engaged in when the caregivers were trying to handle the situation at hand. Counselling became noteworthy in that it enabled them to critically reflect on and deal with their circumstances in a more effective manner (Burnett 1999; Duveskog et al. 2011). Whatever was learned from counselling had the potential of being transferred to future encounters (Kolb 1984). Learning through counselling was transferrable to other health issues.

Through counselling, introspection tapped into their previously held suppositions, which is Stage Two in the TLT. The self-examination appeared to have helped them to grasp new attitudes about the HIV/AIDS context as this was generally viewed with stigma and discrimination in the past. Hence, counselling led to the attainment of positive attitudes and knowledge during the course of caregiving as indicated in the illustrations above.

6.2.3 **Reading around the issue**

Reading around the issues of HIV/AIDS was mentioned as another way of knowing how to care for adolescent orphans. Three respondents whose educational levels were beyond O Level said they read whatever material they could lay their hands on. They were the same participants who listened to the radio or watched TV to learn more about their caring. The following are examples of how they learned how to care:

> *I began by reading the pamphlets which I got from the clinic. From there I found it helpful to listen to AIDS issues from the radio and watching the Mai Chisamba shows whenever there was a subject of interest to me.* P-9

> *Listening to radio was a helpful aspect as information was just being broadcasted for free for everyone. The TV programmes were also equally good but the challenge*

> *was that they would require one to sit down and watch, which I could not always afford to do due to my busy schedule.* P12
>
> *When I started to look after these orphans I was not sure of the correct thing to do. But I had to learn in the process, with nobody giving me the correct or wrong answer. I sometimes read newspapers if I happen to get them*. P-16

The media, both print and electronic, appear to be excellent ways of reaching a wider audience with information. P-9 referred to the Mai Chisamba Show which is a popular Zimbabwean television show that discusses many different issues which are topical at any given time. The show runs once per week during the evenings, and this is a prime time to capture the audience of many as people would have returned home from their various work activities. However, in the Epworth community many of the households lacked electricity and even the necessary electronic gadgets in order to reach such information. As was observed during data generation, the possession of such gadgets was found in the households of those who mentioned them. The majority of the households lacked the gadgets, as well as electricity; hence they were deprived of the free information being broadcasted. The previous literature on caring for adolescent AIDS orphans did not raise this aspect as an issue, though it is a common feature in the more general literature on African households (Sarkodie and Adams 2020).

For P-16 the way of knowing was a trial and error issue where one learned in the process. Although newspapers could sometimes be read, it was not every newspaper that carried issues of interest to the caregivers, hence they ended up giving up on looking out for issues in the newspapers. With the dilemmas experienced by these caregivers, it was not possible to put caring on hold while looking for appropriate ways to care. The dilemmas just struck the caregivers without preparing them for the next move to make. Hence learning was done in the process of caring without anyone confirming the correctness of their practice or lack of it.

This type of learning engaged in by the elderly caregivers is experiential, which means that the caregivers had the responsibility to learn vested in them. Such learning according to Kolb (1984) does not essentially occur in a schoolroom, neither does it follow any curriculum of study (Kolb

1984). It was the caregivers who identified the information that was suitable for them and obtained it (Lewis and Williams 1994). It appeared that throughout the learning by doing, the caregivers kept on reflecting on their learning thereby becoming effective experiential learners with a readiness to reshuffle their knowledge of the AIDS context facing them (Knowles, Holton III and Swanson 2014). Thus, the elderly caregivers' disorienting dilemmas triggered some willingness to learn in order to successfully execute the caregiving tasks. Reflections were made on the prior experiences of looking after children so that they could come up with new insights from the contemporary context (Duveskog et al. 2011). By so doing they embraced Stage Two of TLT which highlights the significance of self-reflection on one's previously held traditions.

6.2.4 **Observation**

The findings revealed that observation made about similar circumstances was one way by which caregivers derived new meanings:

> *I learnt some of what I now know from copying what other caregivers are doing and what is said about them.* P-14
>
> *AIDS has been a common phenomenon in our community. As we visited each other in our neighbourhood one would see how others were going about similar problems. If the observations were applicable to our situations then we would pick one or two things to also lessen burdens for my household. This is how I also learned to come to terms with my orphan situation, although some would shy away from being observed probably due to AIDS stigma.* P-11

The caregivers, thus, were not exempt from judging the way others cared for children who were not theirs. Their reason was to learn and to improve their own caregiving.

A sense of alienation, which is TLT's Third Stage, which deals with feelings of isolation and segregation, can also be sensed in P-4's illustration. For P11, visits to people in similar circumstances around the community has also instilled some learning in her. If observational learning was paired with getting into support group, where caregivers could relate their discontent to others (Stage Four), this might have yielded even better outcomes in their caring activities. The example was also suggestive of the issue that AIDS stigma and discrimination was still rife amidst families and communities (UNAIDS 2018) as some of the elderly caregivers appeared to be shy to expose their situation. Had they been able to form support groups this would have enabled them to manage the disorienting dilemmas in a collective manner. Such structures were more pronounced in prior literature (Kidman and Thurman 2014; Maronganye 2017; Zvinavashe et al. 2015) than in the current study.

6.3 Chapter Summary

The chapter presented and discussed data and analysis for research question two which read, How do the elderly caregivers learn to make new meaning out of their caregiving roles? This chapter was concerned with presenting and discussing findings on two themes: new meanings or insights which caregivers derived from their caring responsibility, as well as the ways they learned these new insights. Emerging meanings included the idea that the responsibility of caring was age-sensitive although there was no agreement as to what age should constitute a caregiver of an adolescent AIDS orphan. It also arose that caring was a collaborative exercise involving the caregiver and external players, and that there was reciprocity between the orphans and their caregivers. Legal orientation was mentioned as affecting the way caregivers wanted to raise their orphans using traditional disciplinary measures. This legal support was viewed as benefitting the children (Harris-Short 2003) without mentioning the elderly caregivers' rights. The ways of learning of these elderly caregivers was mainly experiential. However, other means of learning such as counselling, use of print and electronic media and observation also emerged.

The applicability of the theoretical framework to the current study was proven by the caregivers through use of eight out of ten stages in TLT (Mezirow 2009), as well as the use of all three models of TMSC (Lazarus and Folkman 1984). The following Chapter Seven discussed the summary of findings, conclusions and recommendations.

CHAPTER SEVEN

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

7.0 Introduction

This study explored the caring practices, coping mechanisms and learning experiences of elderly caregivers of adolescent AIDS orphans in one residential area with a view to drawing up implications for Adult Education in Zimbabwe. As alluded to earlier, the middle-aged generation is missing after having been eliminated by AIDS (UNESCO 2015) creating a gap of care and, as alluded to earlier, requiring the elderly and orphans to support and care for each other (Nyasani, Sterberg and Smith 2009; WHO 2016; Zvinavashe et al. 2015).

These parental bereavements triggered some alterations in caring for the orphans within family homes (Chazan 2014). Commonly, orphans used to be cared for by extended kin such as elder brothers, sisters, uncles, aunts, grandparents and other relatives within the kinship (Fauk et al. 2017). As the epidemic has hit right at the core of the family institution, this has led to transformations in their arrangements (Malinga-Musamba 2015). These variations mean that the elderly are currently assuming responsibility for adolescent AIDS orphan care and lack prior knowledge, skills and attitudes to simplify their role, notwithstanding the general anticipation that they would be looking forward to being cared for because of frailty prompted by aging (Zvinavashe et al. 2015; Tanyi 2018; Kidman and Thurman 2014). This new burden of care has fallen on the grandparent generation (HelpAge International, 2017; Maronganye 2017, Mudavanhu, Segalo and Fourie 2008), because those most under threat of dying are the working age populace which is pronounced by WHO (2016) to be between 15 and 49 years, also termed the productive years.

While in the past the elderly efficiently cared for orphans (Bourdillon 1991), those in the present day are experiencing challenges because of contemporary times, with HIV/AIDS continuing to create orphans and burdening the elderly caregivers who seem to lack knowledge of caring (Schatz and Gilbert 2014).

It was against this backdrop that, as more and more older people nowadays embrace the duty of caring for AIDS orphans without prior knowledge (Nyasani, Sterberg and Smith 2009; HelpAge International 2017), it became crucial to explore their caring practices, coping mechanisms and learning experiences in caring for AIDS orphans. The study addressed the following research questions and drew up educational implications:

1. What is the nature of caring practices and coping mechanisms that the elderly caregivers of adolescent AIDS orphans engage in?
2. How do the elderly caregivers learn to make new meaning out of their caregiving roles?

Addressing these research questions enabled an understanding of how the elderly caregivers cared for the AIDS orphans and experienced learning, the challenges they met and how they coped with the whole burden of AIDS orphan care. Informed by the findings presented in the previous two chapters, this chapter explains their caring practices, coping mechanisms and learning experiences in that light.

Following this introduction, which highlighted the rationale for carrying out the study, are theoretical and methodological reflections. The review of the study abridges the key messages in each chapter. There follows a discussion of the findings of the study where I take each question separately and summarise and theorise it. Contributions of the study to existing literature make up another section, followed by implications based on the study. Lastly are the conclusions drawn from the study findings. Below I outline my reflections on the theoretical framework.

7.1 Reflections on the theoretical framework

As highlighted in the previous chapters, the study used two theories to adequately address all the variables in the topic, which could not have been addressed by one theory. Firstly, the transformative learning theory (TLT) propounded by Jack Mezirow (1978) addressed the caring practices and learning experiences of the elderly caregivers. In the writings of Apte (2009) learning entails alteration, adjustment of perspectives and seeing oneself in relation to the world around one in an altered manner.

This idea essentially reviews the critical concept of TLT, where Mezirow understands learning as a journey on which learners embark so as to modify their formerly held tendencies by comprehending the experience. TLT comprises ten stages which are disorienting dilemma, self-examination, sense of alienation, relating discontent to others, explaining options of new behaviour, building confidence in new ways, planning a course of action, knowledge to implement plans, experimenting with new role and reintegration.

TLT theory was helpful because it illuminated the caring activities of the elderly caregivers and thus enabled me to understand, compare and describe their caring practices and learning experiences through its various stages (Kitchenham 2008). I became acquainted with this theory as the research process unfolded and it was effective in mirroring the caring practices and learning experiences of the caregivers in this study. Using the theory was a learning curve for me as I was able to explain these experiences through it. In the sub-section below, I reflect on the second part of the theoretical framework, the TMSC:

Transactional Model of Stress and Coping (TMSC)

The TMSC theory in this study was meant to help unpack, understand and explain the elderly caregivers' coping mechanisms in adolescent AIDS orphans care. The theory was effective in this regard as it illuminated the caregivers' coping strategies and helped to identify the problem-centred, emotion-centred and maladaptive approaches that caregivers adopted. I was able to determine some harmful coping ways, such as skipping meals in order to spread scarce food, by some elderly caregivers. Such strategies may have implications for adult education programmes.

As I review the process, the use of positive coping behaviours assisted caregivers to alleviate the disorienting dilemma of orphan caring, to diminish seeming threats such as the challenges they faced in caregiving, and to manage the symptoms of stress (Endler et al. 2000). According to Folkman and Lazarus (1980), coping is effective if the approach involved matches the characteristics of the individual, his/her needs and the type of the stressors present. Nonetheless, as the caregivers cut the sizes and frequencies of meals and became dependent on their kin's donations, such actions fall in the category of maladaptive coping because of the negative repercussions in terms of nutrition and developing dependency (Carver, Scheier and Weintraub

1989). Looking back, maladaptive coping was also pronounced in the elderly caregivers resisting the legal framework. I established that my elderly caregivers sometimes were on the wrong side of the law: they were embracing a negative maladaptive approach to coping.

Use of the theoretical framework in this study enhanced my evaluation, matching and description of the elderly caregivers' responses using the applicable stages of the TLT (Kitchenham 2008) and the three models of coping in the TMSC. In this research the theories enabled my understanding and appreciation of the caring practices, ways of coping and learning experiences of the adults in the numerous situations where they find themselves (McEwen, Strachan and Lynch 2010). The ten-stage TLT and the TMSC's three types of coping enhanced an unbiased and methodical exploration of my participants' caring practices, learning experiences and coping ways (Rahman and Hoque 2017). For my study, both theories appeared to be complete and universal as they addressed higher order questions, responses being understood in a more comprehensive manner. In view of this, embracing both theories was effective in my study. Following is a discussion of the methodological reflections.

7.2 Methodological Reflections

An interpretivist paradigm whose prime emphasis is to interpret the subjective world of the participants' experiences was adopted for this exploration (Creswell and Creswell 2018). A qualitative approach which called for the generation of data through interviews, focus group discussions, and observation (Williman 2017; Cohen, Manion and Morrison 2018) was adopted. This combination enhanced my understanding of what the twenty purposively sampled elderly caregivers thought about the adolescent AIDS orphan phenomenon, and the meanings they attached to their contexts (Searle 2015). The data that were generated through the instruments highlighted above enabled me to understand the caring practices, coping mechanisms and learning experiences of the elderly caregivers (Patton 2002; Creswell and Creswell 2018).

In the surveyed literature (Cohen, Manion and Morrison 2018; Creswell and Creswell 2018), it is known that as the generation of data in my research was done from a primary source it enhanced the credibility of findings. The data which I generated through the face-to-face interviews, observations and focus group discussions supported my understanding of this phenomenon of orphan care by elderly caregivers.

Social reality in my study was the certainty that elderly caregivers were taking care of adolescent AIDS orphans without previous training. The selection of this approach was based on issues such as study purpose, theoretical frameworks, approach, and analysis and interpretation of the data (Creswell 2014; Creswell and Creswell 2018). There was harmony of all these aspects with the principles of the chosen interpretivist paradigm (Patton 2002; Cohen, Manion and Morrison 2018). The actions I took were consistent with the principles and guidelines of the interpretivist paradigm which covered the methodological aspects that I had taken. The participants had the chance to narrate their caring practices, coping mechanisms and learning experiences in their own words and views thereby giving trustworthiness and reliability to my study (Cohen, Manion and Morrison 2018). This also enhanced the generation of adequate data to answer all my research questions.

As the study involved going into the caregivers' households for interviews and focus group discussions and observation, member-checking was done when transcriptions were completed to verify whether I had captured the correct data according to the elderly caregivers under study (Creswell and Creswell 2018; Mertens 2015). I gave the participants the opportunity to verify the data generated so that as the researcher I would not generate incorrect data which would not represent the caregivers. Member-checking is a necessary activity as it minimises bias on the part of the researcher, as well as improving the credibility of the study (Candela 2019). The member-checking yielded positive results, as all my participants agreed with the data that I had generated. Such harmony with the elderly caregivers increased my confidence with the data I generated and, thus, I felt that the research was credible.

During focus groups discussions, I noted two of the participants not being as active as the other group members, and when they gave responses these were too brief. I tried to extract longer responses through further probes but would end up straying from the focus of the question. By continuing with the probes, I felt that my role as researcher was influencing the way my participants were responding to the questions. This confirms that some participants were really difficult to engage with, which may have caused the generation of a bit of unbalanced data

(DeJonckheere and Vaughn 2019). This was probably because Epworth, the research site, was a community where NGOs were running various programmes and whenever these were implemented participants were rewarded. This was contrary to the current study as it had no remuneration for taking part, hence there was no extrinsic reward attached. The discomfort could also have been due to the stigma and discrimination that has over the years been generally associated with HIV/AIDS issues (WHO 2016). What I could have done differently was to engage a professional counsellor for counselling sessions with the elderly caregivers in preparation for my data generation which may have triggered some painful memories about the losses they had suffered and prompted them to open up and talk during my data generation sessions. If the study were to be repeated in future I also feel there would be a need to source funds for remunerating these poor elderlies.

Qualitative data analysis is said to be cumbersome (Patton 2002; Creswell and Creswell 2018). I would have utilised computer software packages for this exercise but there were prohibitive reasons for me to adopt them, such as the need to learn and understand the software, as well as the costs involved in buying it. However, the manual data analysis using the six stages of Creswell (2014) immersed me in the data from where I obtained a deep understanding of my participants' nature of caring practices, coping mechanisms and learning experiences. Having gone through the data several times, codes, categories, and themes were generated and my supervisors helped me to polish them in order to curb any deviations and/or omissions.

Despite the noted glitches, my methodological choices were effective because the methods allowed the generation of data that sufficiently addressed the research questions set out in Chapter One on the nature of caring, coping mechanisms and learning experiences of the elderly caregivers of adolescent AIDS orphans. Nonetheless, I want to learn to use computer software packages for data analysis in future research. Conducting the face-to-face interviews and focus group discussions, as well as observing, proved to be time and labour intensive (Patton 2002) for me as I spent more time than I had expected. Some of my participants were not readily available during the times I visited their homesteads despite the fact that I had made appointments beforehand. I went back to their places sometimes twice or thrice to find them. Going back several times enriched the nature and quality of my data because all the participants managed to proffer responses to all the questions that I had. The data analysis also presented its challenges as I felt that too much data was generated and it became cumbersome to manage (Creswell 2014). However, with the help of my two supervisors who took me through the process of generating codes, themes, and categories from the data, it became manageable, although it took me more time to complete the analysis than I had projected. In the next section I review the study.

7.3 Review of the Study

In this review, I make a summary of the seven chapters that comprise this study.

Chapter One was the preamble to this investigation containing strategic features such as the background, central questions which the research intended to answer, statement of the problem, rationale for the study and other relevant components. Key points in these structures were that the elderly caregivers were undertaking the caring responsibilities without any kind of prior learning with regards to the AIDS context. It seems no educational programmes had targeted their learning and caring for AIDS orphans despite their having to resume parenting due to AIDS (Chepngeno-Langat 2014). I unpacked the issues in these features in order to simplify what I was investigating. The purpose of the study, which was to explore the elderly caregivers' nature of caring practices and the new insights emerging from their adolescent AIDS orphan care, enabled me to draw up boundaries of the research to discover the nature of caring practices, strategies of coping and the new insights which emerged from the research. Numerous studies around the globe (Tanyi 2018; Fauk et al. 2017; Maronganye 2017; Maradik and Kim 2014; Hawkins 2013; Hong 2015) have focused on caring for orphans by various groups but not the elderly. Subsequently I made overviews of the theoretical framework and the methodology.

Chapter Two looked at the global, regional, and national literature reviewed for the study. In the global arena and in relation to Research Question One the nature of caring practices for caregivers was established through monitory assistance from NGOs, the central and local governments (Hong 2015). There was provision of the basic needs of these children and a low child-carer ratio was safeguarded. Caregivers had regular incomes with periodical assessment and parenting consultation from the associate NGOs.

Regionally, a quantitative study investigated the caregiver burden among adults who cared for orphans (Kidman and Thurman 2014). In relation to my Research Question Two, the new learning which emerged from past research is that caregiving was a heavy burden and that caregivers were incompetent in executing their caring responsibilities.

Nationally, a qualitative study investigated coping ways of caregivers of HIV/AIDS orphans in a rural setting (Zvinavashe et al. 2015). The elderly caregivers lacked information on caring for the young in view of AIDS, as well as money. Their chief strategy in responding to the orphan crisis was engagement in subsistence farming of vegetables and maize. The previous research looked at coping ways of caregivers and not specifically their caring practices and learning experiences, and without a theory to illuminate their coping.

Chapter Three presented the theoretical framework which consisted of two theories, namely, Transformative Learning Theory (Mezirow 1978) and the Transactional Model of Stress and Coping (Lazarus and Folkman 1984) as discussed above. Use of two theories was necessitated by the different variables in my topic. While TLT addressed the caring practices and learning experiences of the elderly caregivers, the TMSC addressed their coping strategies.

Chapter Four presented the methodological issues which were embraced for this research. The interpretivist research paradigm enhanced the discovery of the caregivers' nature of caring practices and new learning. The approach that I used was qualitative, which various writers agreed enables better understanding of the researcher's realities about a particular phenomenon (Leung 2015; Guba and Lincoln 2005; Williman 2017). Accordingly, the qualitative approach with meanings entrenched in my elderly caregivers' nature of caring practices and new insights were found appropriate for this study (Silverman 2016).

The study adopted the phenomenology research design which endeavours to understand "the constructs that people use in everyday life to make sense of their world" (Ormston et al. 2014:12). The methods of data generation were face-to face interviews, focus group discussions and observation. Manual data analysis using the six stages of Cresswell (2014) was adopted. Other issues discussed in this chapter included ways of enhancing the trustworthiness of the findings, and how ethical issues were considered and adhered to throughout the research.

Chapter Five presented and analysed Research Question One data on the caring practices, challenges and coping mechanisms of the elderly caregivers of adolescent AIDS orphans. Two major themes that emerged on the nature of caring practices were nurturing character development of adolescents and provision of basic needs for survival. Character development appeared to be a new finding for this study, while provision of basic needs is common in local and regional literature surveyed (Maronganye 2017; Zvinavashe et al. 2015; Kidman and Thurman 2014) but not in the global arena. Challenges experienced were of a social, financial and psychological nature. Social challenges that emerged appeared to be a new phenomenon, while monetary and psychological challenges were common across national and regional literature reviewed (Zvinavashe et al. 2015; Maronganye 2017; Kidman and Thurman 2014). The coping skills revealed were related to counselling, receiving small donations from relatives, reducing meal sizes and the frequency of taking meals.

Chapter Six presented and discussed findings on the two themes which emerged in answer to Research Question Two focusing on the new learning that the elderly caregivers gained in their caring practices. The themes were new meanings or insights which caregivers derived from their caring responsibility, as well as ways of knowing the new insights. Emerging meanings were that the responsibility of caring was age-sensitive, caring was a collaborative exercise and caring was now bound by legal orientation. Ways of knowing included experiential learning, observation, listening to the radio, watching television and reading.

Chapter Seven commented first on the theoretical framework, the methodology and the study itself. The discussion of findings, and lessons and contribution of the study followed. In the next sub-section, I discuss the findings drawing on the theoretical framework and literature.

7.4 Discussion of findings

The study was illuminated by a theoretical framework that included two theories: Transformative Learning Theory (TLT) (Mezirow 2012), and the Transactional Model of Stress and Coping (TMSC) to mirror the nature of caring practices and learning experiences of the elderly caregivers (Mezirow 2012), with the latter being a complementary lens through which the elderly caregivers' coping mechanisms were understood and explained (Lazarus and Folkman 2015). Under this sub-section I discuss, synthesise and conclude the research findings which were presented in Chapters Five and Six and also draw up implications for adult education programming from the findings.

Mezirow's TLT has broadly been utilised in the comparison and explanation of how adults learn in the various contexts in which they find themselves (Kitchenham 2008). The disorienting dilemmas which elderly caregivers in this study faced in their life journeys were numerous and these required to be placed under a microscopic lens, such as the TLT and TMSC, to be able to make appropriate comparisons, discussions, and conclusions about their caring practices, coping mechanisms, learning experiences and any challenges which they may face.

Whereas the TLT has its stages structured in a sequential way, the real procedure of learning did not happen in the same way (Mezirow 2012). This is established in the works of McEwen, Strachan and Lynch (2010) when they support that transformative learning is not fundamentally well-ordered or linear, notwithstanding that it may have a remarkable basis for potential alteration. As I reflect on it now, the majority of the caregivers experienced eight stages of the TLT: disorienting dilemma, self-examination, explaining options of new behaviour, building confidence in new ways, planning a course of action, knowledge to implement plans, experimenting with new roles, and reintegration, but not in a linear fashion. The two stages that the caregivers did not experience – Stages Three and Four – deal with 'sense of alienation'; and 'relating discontent to others' respectively. This may have been because of the stigma and discrimination that almost always surrounded the HIV/AIDS situation and, also, fear of the unknown (Mpofu 2021). In addition, within this context in which my caregivers lived I expected that they would open up and join support groups in their community in order not to be alienated from others in a similar situation.

But as I look at it now, alas, this was not the case for all of them. The sense of alienation, and relating discontent to others were not evident in the data analysis.

The following sub-section discusses the findings which emerged in response to Research Question One.

7.4.1 **The nature of caring practices and coping mechanisms**

Research Question One had two main segments, namely, the nature of caring practices and coping mechanisms. However, within the caring practices, the elderly caregivers experienced challenges. Discussion of these challenges formed another section. Data analysis of the nature of caring practices section revealed two major caring issues: character formation and provision of material needs. The challenges were social, financial and psychological in nature, while the coping strategies encompassed the provision of counselling, donations from relatives, and cutting down on the size and frequency of meals in their households, as highlighted above. These issues are discussed below:

Character formation as a nature of caring practice

Based on the practical nature of the activities that they performed in caring, the elderly caregivers formed the characters or personalities of the adolescent orphans through modelling appropriate behaviour, delegating tasks, encouraging church attendance, sending for guidance and counselling, story-telling and playing games, among many others as indicated above. Character formation involved various aspects which warranted that caregivers sought further knowledge in the execution of their responsibilities. Their situation called for self-introspection, where a reassessment of previously held assumptions and prejudices was made, to be able to trigger the much-needed learning into caring for these orphans (Taylor and Cranton 2012). It was critical that the adolescent orphans had their personalities formed through modelling appropriate behaviour and delegating tasks to them in preparation for adult life and as would be expected by the society in which they lived. Compatibility with society would have been problematic for such children had the elderly caregivers not assisted with building their personalities (Ntseane 2011).

In relation to coping theory, character formation can also be viewed as a coping strategy fitting in the problem-centred approach. Such a strategy focuses on shifting the stressful condition caused by the disorienting dilemmas (Lazarus and Folkman 2015). In the same vein, their caring also had traces of the emotion-centred approach to caring which focuses on changing thoughts and feelings about disorienting dilemmas. For instance, encouraging the adolescents to go to Church was a way of building their emotions where there was a realisation of divine intervention as a coping way (Gatley 2021). The going to church aspect of character building is similar to Hawkins' (2013) finding revealing caregivers relying on their Buddhist religion to cope with the orphan care crisis in Thailand. Under the same theme of character formation, the elderly caregivers viewed counselling as another significant coping strategy in their orphan care. Counselling and guidance was reinforced with story-telling and playing games, all of which was performed to form personalities which were compatible with society.

Satisfied with the characters of the orphans that they formed, the elderly caregivers were relieved that the adolescents would become good adults who fit in well with the society around them. This thought shifted the focus from the deaths of their adult children, thereby enabling healing from the bereavement (Mezirow 2012). The caregivers wanted the adolescents to be responsible future adults who would also reciprocate the care to their elderly caregivers, in fulfilment of our Shona adage which says *chirere chigokurerawo.* This adage means that children had to be raised in the proper manner so that they would be responsible people who would also look after their elderly parents in future. In old age, parents normally get care from their adult offspring (Bourdillon, 1991). In a South African study, Oosthuizen (2014) revealed the elderly showing care for their orphans through teaching and disciplining them, whereas the adolescents were supposed to submit to the teachings. This study got pointers from the South African study in terms of intergenerational interactions which in both studies were problematic. These problems are well documented in Omotoso (2007) and Zaky's (2016) writings although for the elderly caregivers this may appear as a new phenomenon. Character formation as a finding is unique to the current research as the reviewed studies were silent on it.

Character formation nurturing also involved promoting the development of acceptable social and moral values (Bourdillon 1991). This is normally the responsibility of parents but it was taken up by the elderly caregivers who made a paradigm shift from previous tradition (Foster and German 2002). These elderly caregivers were all of advanced ages which should have warranted their retirement from child rearing. But because of the disorienting dilemmas which they all experienced, they no longer enjoyed this 'luxury' as they had become parents of the orphans left by their adult children in HIV/AIDS circumstances. The elderly caregivers utilised Stage Five of the TLT which deals with explaining options of new behaviour (Mezirow 2012). They had to forego their usual retirement and consider the necessary next move which was looking after the orphans and instilling in them some socially acceptable behaviour (Taylor and Cranton 2012) through modelling appropriate behaviour, assigning them tasks in preparation for adult life, encouraging them to go to church, sending them for counselling, story-telling and playing games. This TLT phase also links with Lazarus and Folkman's 1984 problem-centred approach and emotion-centred approach to coping with the disorienting dilemmas through engagement with character formation to assist in managing the dilemmas.

Even though the elderly caregivers had in the past built their adult children's characters, this time around the same task had a varied context in view of HIV/AIDS. Thus, they realised some transformative learning which was driven by multiple disorienting dilemmas (Mezirow 2012). The majority of the participants grasped insights of their dilemmas and asked themselves 'what now?' in order to construct alternatives in facing the dilemmas (Taylor and Cranton 2012). The first port of call was the clinic, where their fears (which were another dilemma) were allayed through receiving accurate information to foster a shift in their attitudes about HIV/AIDS. With the clinic visits, the elderly caregivers gradually reassessed their worldviews (Taylor and Cranton 2012) and re-engaged caring in the changed circumstance. In all the itemised aspects under the theme of character formation, it would appear the adolescents were being trained to have right thinking through controlling interpretations of what they saw and directing them in productive ways. Implicit in the conduct were also teachings on prohibitives such as idleness, wandering and gossip. Instead of talking to the adolescents the caregivers chose to model behaviour. Care involved the instilling of correct moral values. From the findings discussed above one can, therefore, conclude that caring for adolescents HIV/AIDS orphans by elderly caregivers encompasses mainly character nurturing and building.

Provision of material needs as a caring practice

The provision of basic needs such as money, food, shelter and school requirements to the adolescent orphans was a common finding in the related national and regional literature (Fauk et al. 2017; Maronganye 2017; Zvinavashe 2015), but inconsistent with studies from the international arena where such provisions would be the responsibility of governments (Hong 2015). Basically, provision of such materials is what constitutes caring for an orphan in our Zimbabwean sense (Foster and German 2002). Any parent or caregiver would not feel good if they could not provide these basic needs for their family (orphans). It would mean that they had failed in their caring responsibility. Failure to provide the basic requirements was illuminated by coping theory, enabling me to place it under the maladaptive coping approach. It is harmful if the adolescents do not have food, shelter and school requirements.

Provision of material needs in the caring practice is a common practice (Fauk et al. 2017; Foster and German 2002; Maronganye 2017; Zvinavashe et al. 2015). Money appeared to be the most important need in my elderly caregivers' orphan caring, affecting the availability of all other needs such as food, shelter, school requirements, clothing, and many more. The absence of money resulted in deficiencies in these other requisites thereby amplifying the vulnerability of the caregivers and their families. The situation of food deficit is likely to increase the frequency of going to the clinic as opportunistic illnesses become inevitable in such situations. It is also important that caregivers have decent shelter if their caring practices are to be effective. Without proper shelter there is a likelihood of these families being exposed to harsh weather conditions such as cold, heat, rain and wind.

Lack of money to buy school requirements for the orphans was a source of worry for the caregivers as they all had to scrounge for school fees and other school accessories. Although the orphans' school attendance was intermittent due to financial problems, the caregivers were cognisant of the importance of sending children to school, which included orphans getting disciplined. As the caregivers had difficulty in disciplining the adolescents it was significant that these children attended school to further benefit from the discipline under the umbrella of the school. The school would unleash the adolescents' potential through imparting knowledge, skills and attitudes to capacitate them to reciprocate the care in future to traditionally achieve the Shona adage of *chirere* *chigokurerawo*. By providing for the orphans the caregivers expected some return in future. From the findings it can, therefore, be theorised that apart from character building, HIV/AIDS adolescent orphan care includes material provisions.

This finding, although it may not be new (Fauk et al. 2017; Maronganye 2017; Zvinavashe et al. 2015), enabled this research to realise the many challenges that came with this aspect, as will be discussed below. For instance, getting the adolescents to do household chores clearly did not always happen successfully as the teenagers had a tendency of disappearing with peers without performing assigned tasks. Food was always in short supply, as illustrated in previous literature (Fauk et al. 2017; Maronganye 2017; Zvinavashe et al. 2015). For such reasons caregivers caring efforts were often hindered by financial, social and psychological problems, as discussed in the following sub-section.

Challenges faced by caregivers in their caring practices

The challenges faced by the elderly caregivers were divided into social, financial and psychological problems. Social challenges were linked to the bad manners demonstrated by the orphans, financial challenges were pronounced in their lack of foodstuffs in the home, while psychological challenges had to do with denial. Below is the discussion of these challenges:

Social challenges

The data analysis revealed social challenges associated with the adolescents' behaviour. Issues such as *orphans do not listen,* or *they do as they please, orphans lack appreciation of caregivers' efforts* all pointed to lack of discipline on the part of the teenagers. Such disciplinary issues are widely documented by writers such as Jorg et al. (2016) and Jaworska and MacQueen (2015) and are applicable to any adolescent, not necessarily only those in the AIDS context. However, for the elderly caregivers it was a new phenomenon. Previously, families would stand by each other in the times of suffering (Bourdillon 1991), but in this study the orphans would actually gossip with relatives about their caregivers. There is generally some reluctance to help each other in this AIDS context probably due to fear of the unknown, as well as denial (Foster and German 2002). This could also be due to the stigma that has generally been allied to HIV/AIDS issues (Foster and

German 2002). The implication for my caregivers is that they have no one to lean on in terms of disciplinary issues. The relatives whom they could have relied on gossiped with the adolescents thereby influencing the children not to listen to their caregivers. It seemed the school was the only place where the orphans could receive further discipline as discussed above.

The caregivers must have altered their perspectives on the stigma matter in order to have provided the care (Mezirow 2012). As they faced criticism from the surrounding community and relatives who could have been their pillars of strength in times of need, they were obsessed with a sense of alienation (TLT Stage Three). The sense of alienation was caused by denial, which then linked the caregivers to taking up a maladaptive coping mechanism (Carver, Scheier and Weintraub 1989) because they did not open up to structures like support groups (Maronganye 2017). Rather, they chose to stay in isolation. It was, however, essential for the elderly caregivers to embrace positive attitudes in a bid to combat this stigma. In some households, the caregivers faced some hostility from relatives and this manifested through giving the orphans gadgets without consultation with the caregiver. The orphans then became stubborn and lacked respect for the usual caregiver who faced trials and tribulations in looking after them.

As the data analysis demonstrated, orphans normally submitted to peer pressure, leading them to abuse drugs, drink alcohol or abandoning their clinically recommended ARV medicines. These encounters developed into a fertile ground for the adolescents to disobey their caregivers when they were at home. They no longer wanted to take orders from their caregivers whom they regarded as old-fashioned. The youths' behaviour is consistent with literature in the field of psychology (Quas 2014; Wagner et al. 2017), compounded by the AIDS context. The elderly caregivers often struggled to whip the teenagers into line (Jorg et al. 2016). This finding was already well documented (Fauk et al. 2017; Maronganye 2017; Kidman and Thurman 2014).

Financial challenges

The elderly caregivers lived with financial inadequacies as was revealed in the results of this study. Such insufficiencies would mean deficiency in almost every household requirement such as clothing, food and income to generally sustain their households. This result is consistent with locally reviewed literature (Fauk et al. 2017; Maronganye 2017; Zvinavashe et al. 2015) whose research was conducted on elderly caregivers in different rural areas of Tanzania, and Zimbabwe. Similarly, their agricultural output was perennially insufficient for their households. The findings further confirmed the point that the elderly make up a considerable section of people living in poverty (HelpAge International 2017), despite the fact that society expects them to take care of AIDS orphans (Foster and German 2002). The international literature reviewed indicated that the caregivers were remunerated by their respective governments (Hong 2015) for looking after AIDS orphans, a point not similar to my findings. This was probably due to variations in contexts where the remunerated caregivers were looking after orphans in institutionalised situations.

Psychological challenges

Denial of HIV status by the orphans was a psychological challenge the caregivers had to deal with. The elderly caregivers were concerned about the teenagers being acquainted with the fact that they were different from others. The challenges were modern and required caregivers to look for further information to resourcefully care. In some studies, the caregivers efficiently functioned in teams of support groups to counter such challenges (Maronganye 2017), however, in the present research such structures did not emerge. Denial of HIV status is, nevertheless, not a new phenomenon as literature abounds with people denying their statuses (WHO 2016; Maronganye 2017; Zvinavashe 2015). In view of the findings on challenges synthesised above it can be said that the elderly caregivers of adolescent AIDS orphans face social challenges related to orphan indiscipline and strained relations with extended family. They are also confronted with financial challenges for household sustenance, provision of clothing, food and learning materials. Further, denial of HIV status due to stigma is a significant psychological challenge they have to deal with. The next sub-section discusses the coping mechanisms of the elderly caregivers.

Coping mechanisms of the elderly caregivers

The findings of the study revealed various coping strategies which were engaged by the elderly caregivers during their caring activities. The coping encompassed counselling by the clinic, getting donations from relatives and cutting sizes and frequency of meals. These findings are similar to prior research (Maronganye 2017; Zvinavashe 2015), however, in the current study I used the theoretical lens of TMSC to establish the caregivers' coping strategies. The elderly caregivers utilised all three principles of coping: *problem-centred*, *emotion-centred* and *maladaptive* coping (Lazarus and Folkman 2015; Carver, Scheier and Weintraub 1989).

As a coping strategy, counselling emerged as an excellent way of coping with the challenges because in terms of transformative learning, it caused self-introspection in the caregivers (Cranton and Taylor 2012). This is Stage Two of TLT which was experienced by all caregivers. This allowed them to examine their previously held viewpoints in looking after AIDS orphans (Mezirow 2000). Counselling could also be the reason they managed to utilise the other stages of this theory, though in a non-linear way. While my participants coped through counselling, caregivers in Hawkins's (2013) study relied on divine intervention through their Buddhist religion, which falls under the emotion-centred coping approach. Although there may be dissimilarities in the two studies, the current study has methodologically benefitted from Hawkins's (2013) effective application of Creswell's six-step procedure of analysing data in the qualitative approach to research, as well as the phenomenology design. The same frameworks were adopted for the current study, as it falls within a similar paradigm.

Receiving donations from relatives can be viewed as a good gesture in helping these poor elderly caregivers, but from the TMSC lens this may create dependency which falls into harmful or maladaptive coping (Carver, Scheier and Weintraub 1989). Similarly, cutting meals was not an appropriate coping strategy as it would create malnutrition for both elderly caregivers and the adolescents. What became evident is that the elderly caregivers in adolescent AIDs care adopted problem-centred, emotion-centred and maladaptive coping strategies which involved counselling, receipt of donations and reduction of meal sizes and frequency. The demonstration of maladaptive coping by the elderly caregivers has implications for interventions by adult education programmes where issues to do with nutrition in view of the HIV/AIDS situation may be unpacked. This could be done in the form of workshops and through the various media channels so as to capture a wider audience of elderly caregivers. Apart from psychosocial support by the government of Zimbabwe and its numerous stakeholders in AIDS orphan care during recent years, challenges facing the elderly caregivers in dealing with disorienting dilemmas remain unrelieved (Ringson 2022). In the following sub-section, I discuss the findings in response to Research Question Two which focused on the new insights the elderly caregivers gained out of their caregiving responsibilities.

7.4.2 **Learning to make new meaning out of caregiving roles**

The new meanings that were revealed by the data analysis encompassed the age-sensitive nature of caregiving, collaboration as a caring practice and caregiving and the legal orientation. The discussion of these three aspects is made under the ensuing sub-headings.

New Meanings in caregiving

<u>Age sensitivity of the caregiving practice as a new meaning</u>

The data analysis indicated AIDS orphan caring was an activity laden with emotions perhaps because from inception HIV/AIDS has been discriminated against in many if not all circles (WHO 2016). This impacted negatively on the relationship between the caregivers and the orphans, their extended family and even the community at large (Foster and German 2002). One new meaning that was generated from their insights was that the caring responsibility should be age sensitive. In old age one could easily break down and give up: the burden of care was more pronounced in the elderly (HelpAge 2017). The caregivers felt that the work required younger people who would be able to run with the task. However, there was no consensus on the appropriate age of a caregiver of AIDS orphans in my data. This insight reinforced the abundant literature which indicates that the adolescent stage is fraught with trouble as teenagers transition to adulthood (Omotoso 2007; Quas 2014; Wagner et al. 2017; Zaky 2016), the most likely reason why caregivers thought younger carers were required.

The burden of care is further exacerbated by its traumatic nature given that the caregivers lost adult children and bore the brunt of taking over deserted orphans. Linking their tolerance with TLT it appeared that the elderly caregivers endured and suffered in silence as they embraced Stage Three, focusing on self-alienation (Mezirow 2012). Yet from another angle, the mere acceptance of taking the orphans into their households bears testimony to shifted attitudes (Cranton and Taylor 2012) towards this disease which is generally still stigmatised in many circles (UNAIDS 2018). Drawing from the transactional model of stress and coping (TMSC), endurance can be classified as a maladaptive way of coping because their suffering sounded more like resigning to fate rather than solving a problem. The implication of the caring being age-sensitive may be that the caregivers were failing due to advanced age. This could be a cry for help as the burden of care seemed to be beyond their physical strength due to their frailty. Contrary to the findings, Maradik and Kim

(2014) in Vietnam reveal that participants in their study understood that coping was problem-centred, as they considered caregiving to be related to undertakings such as childcare, generating money, borrowing money, cooking. In this study such findings were analysed in relation to various forms of coping which were problem-centred and emotion-centred, all under the TMSC theory of coping (Lazarus and Folkman 2015), and maladaptive coping (Carver, Scheier and Weintraub 1989). Use of the TMSC as a coping lens was not raised in the former studies, which makes the finding exclusive to the current research.

Collaboration in caregiving

Another new learning revealed by the data analysis was that AIDS orphan caregiving was performed in collaboration with other stakeholders such as the clinic, the school, the community, and the elderly caregivers themselves. It is probably due to the HIV/AIDS context that all these players were brought to work together. When the disorienting dilemmas struck, the caregivers were quick to engage the clinic where the routine counselling catalysed their dormant self-introspection (TLT Stage Two) in their previously held traditions (Mezirow 2012; Taylor and Cranton 2012). The learning did not end with the clinic as the elderly caregivers also connected with the schools where their orphans were learners. The school was also realised as a significant player in this matrix of care because the adolescents spent a considerable amount of time at school with teachers who could easily identify problems and alert the parent. The community and the extended families were also viewed as important constituencies because their presence sometimes lessened the burdens of the caregivers. For example, the roadside dialogues that normally started when two or more people met on the way were regarded as helpful (Mezirow 2012). Extended families were mentioned as helpful but in a very minimal way. Instead of giving assistance some would destabilise the well-knit families by luring the adolescents into gossip about how they were being cared for by the elderly caregivers.

The collaboration of caregiver, nurse and teacher in this case emerged as intentional. This type of partnership was considered as a new discovery due to the composition of collaborators. The leading form of teamwork in Zimbabwe is often composed of the extended families with kinship ties comprising the frontline relatives such as paternal and maternal uncles and aunts and grandparents (Foster and German 2002). These frontline relatives were traditionally responsible for assuming the care and support of orphans in the event of the death of parents and for taking care of vulnerable children in cases of abandonment or otherwise (Bourdillon 1991). Ordinarily, one member of the extended family network assumed the primary caregiver role while others periodically contributed resources as secondary caregivers (Foster and German 2002). Now with alterations of life as discussed above, and the disruption of traditional life where extended family used to take an active role in orphan caring, it became essential that these collaborators participated in the caregiving activity.

The finding on collaboration carries the principles of TLT, particularly Stages Nine and Ten. The former stage is about experimentation with new roles while the latter reintegrates the learned information into the daily lives of society (Mezirow 2012). The caregivers learned that their responsibility should be a joint operation with the other players mentioned above and they evaluated its effectiveness in managing their disorienting dilemmas. Collaboration as a new insight was brought or reintegrated into their daily caring activities (Mezirow 2009). As evidenced by their illustrations, partnering with the clinic staff, the community, as well as school teachers, brought about better and shared management of the disorienting dilemmas (Taylor and Cranton 2012). Otherwise the elderly caregivers would not be able to provide all that the children needed. The coming together of such teams implied there were gaps which could not be filled by caregivers alone. The implication of such collaboration for my caregivers was that they drew benefits such as accurate information about their context since they collaborated with professionals.

I expected their collaboration with other people in the same AIDS context, such as support groups as espoused in literature reviewed (Maronganye 2017; Zvinavashe et al. 2015), in order to clearly assess if they managed to reach TLT Stage Four where discontent was related to others. In analysis it looked like this collaboration with stakeholders discussed above, although useful, was not done on an equal echelon compared with what would have happened had they joined HIV/AIDS support groups where they could have bounced ideas off each other as a way of learning and sharing (Zvinavashe et al. 2015; Foster and German 2002). Their collaboration is also contrary to that found in Chazan’s (2014) study in KZN where older women would organise themselves in response to the various influences of HIV/AIDS. Links were formed to generate income, combat stigma and connect with a broader support network. In the former study the participants were successful in combating stigma, unlike in the present research where caregivers could not open up to other community groupings due to stigma.

The composition of the current collaborators carried power dynamics because a nurse and a teacher could be viewed as authorities in the communities due to the nature of their work while the elderly caregivers occupied a position of lower authority in this collaboration (Freire 2000). This may have threatened them not to fully open up to participation on AIDS issues.

The elderly caregivers did not join support groups where there was room for critical appraisal of their presuppositions and matching them with those of others in the group. Despite the importance of joining support groups (Maronganye 2017), my caregivers instead collaborated with people in unrelated contexts and the learning may have been hindered by the power dynamics of the collaborators. The caregivers could have utilised the stage of relating discontent to others and that of the sense of alienation to be in a collaboration with members of the same status. However, transformative learning may not always occur, as some learners draw comfort from the status quo (Taylor 1997; Cranton 2002) through their norms, values, attitudes and so on. Hence interrogating the frames of reference may have been traumatising for my elderly caregivers as they were stuck in their ‘comfort zones’. The implication may be that if they modified their viewpoints they would feel anxious, uncertain and insecure (Taylor 1997). On this account, transformative learning was stalled though the caregivers did experience transformative learning in their collaboration with the clinic, school and the community.

The related reviewed literature had no record of collaboration as new learning from caregiving activities, and as such, the finding is solely for the present study. In the next sub-heading I discuss the legal orientation in child care as it also emerged under the making new meaning research question.

Caregiving and the legal orientation as new learning

The study findings revealed the legal orientation to child care also as new learning for the elderly caregivers. The legal orientation on caring for children, particularly the UN Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child, brought disappointment to the elderly caregivers (Harris-Short 2003). Feelings of ingratitude were voiced across the participants: what they had done for the children was ignored because they had broken the children's rights. Data analysis revealed the elderly caregivers' disappointment as they felt exposed to condemnation notwithstanding their own struggles in adolescent orphan care. The traditional habits of disciplining the children which the elderly caregivers were content with were viewed as violation of this instrument. The children would disobey, hiding behind the guard of these legal instruments.

Save the Children (2006) notes that in the Southern Africa region, the need to discipline children had customarily been considered as a right of parents, even if that discipline involved physically beating the children. The legal interference brought into perspective Harris-Short's (2003) criticism of the legal system in which the voices of the locals were effectively silenced. The uncertainty between caregiving and child rights restrictions discouraged caregivers as they struggled to see themselves as 'good parents' and, therefore, tended to treat the children as their own. Within the Zimbabwean traditional background orphans used to be immersed in the extended families that carried the responsibility to care for and support them (Zagheni 2011; Dhal 2016). Likewise, other vulnerable children would also be taken in by the extended family setup. In this view, the legal characteristic placing limitations on caregivers was essentially disturbing family life (Harris-Short 2003).

Looking at the aspects of upholding the independence of the child's rights and respecting African values and experiences in childcare, conflict of interest between an African caregiver and a modern human rights protagonist was obvious (Harris-Short 2003). It was expected then that the caregivers in Zimbabwe might experience challenges to balance respect for the independence of the child's rights and their cultural dictates. In line with TLT the elderly caregivers partially altered their disciplinary ways for fear of the legalities they would have to face. Rigidity to their old ways was reported to continue in the form of scolding the children (Mezirow 2000; Taylor 1997). On this aspect, the caregivers had no interest in completely shifting their prior perspectives about disciplining children. They seemed to continue to stay in the past despite the legal frameworks and policy pronouncements binding them.

Relating this point to the TMSC, the now prohibited traditional forms of disciplining children fit in with harmful ways of coping because contravention of the statutory instruments constitute a crime warranting confinement (Harris-Short 2003). Having to face a jail term would mean leaving the orphans again without a parental figure, further aggravating an already poor situation in view of AIDS (Foster and German 2002). Hence this becomes a maladaptive strategy to coping which does not work to lessen the problem but rather to escalate it (Carver, Scheier and Weintraub 1989).

The prior literature reviewed for this study did not have such a finding. These observations raised implications for training perhaps in the form of workshops or guidelines on how elderly caregivers should react in the context of child indiscipline and other situations. It implies that conscientisation programmes on these aspects are necessary to keep the elderly caregivers abreast with such global legal trends. Based on the findings, answering Research Question Two about how elderly caregivers make new meanings from their caregiving roles, it can be concluded that the meanings that elderly caregivers make relate to age sensitive caring responsibility and to caring as a collaborative activity which brings the clinic, school, community and the caregiver into the collaborative act. In addition, the legal orientation of child care is another new learning that elderly caregivers become aware of. Research Question Two which focused on new meanings has a segment on how the caregivers came to know about these insights. Their ways of knowing included their past experience, counselling and reading, as discussed in the following sub-section.

Ways of knowing their new meanings

In discussing the ways of knowing which were embraced by the caregivers in this study, it is important to remind the reader about the domains of learning in order to compare them with what emerged in the data analysis. Various scholars have written about the numerous domains in which adults learn and some of them are *formal, non-formal, informal* and *experiential* learning (Colardyn and Bjornavoid 2004; Kolb 1994; Schugurensky 2015). Formal learning is learning which occurs in classroom situations, characterised by hierarchical organisation with the teacher in control of learning, a pre-set syllabus, and being bankable and credit-bearing leading to the awarding of credentials at the end of the programme. This domain of learning was not appropriate for the caregivers in this study. Adults want to learn in order to immediately and practically apply the new learning in solving their daily problems (Freire 1970).

Non-formal is an intentionally planned learning activity carried out outside of the formal system. It is specific learning which is prepared for certain subcategories of people (Colardyn and Bjornavoid 2004), both adults and children. However, non-formal learning does not reward recognisable credentials besides a certificate of attendance that some organisations may give. The illustration of non-formal learning is commonly more prominent in formalised work stations where activities in the form of workshops and seminars are administered as a strategy to progress the performance of employees (Schugurensky 2015). It can also be done in community-based programmes such as agricultural extension, health education and youth clubs to improve performance in their various activities. Non-formal learning may be appropriate for the elderly caregivers especially when talking about the legal issues of child rearing that were discussed in the section above. This can take place in group discussions although it would still have set topics to discuss, such as 'modern ways of child rearing' (Coombs and Ahmed 1974; Kaziboni 2018). Such learning may generate solutions for the elderly caregivers' immediate and practical application in managing the AIDS orphan crisis which is already in their homes.

Informal learning embraces all learning which happens without following any set syllabus (Colardyn and Bjornavoid 2004; Kaziboni 2018). The learning occurs anywhere including within formal and non-formal learning situations, although it may not contribute to the set outcomes of these other domains (Schugurensky 2015). Informal learning, which can also be called incidental learning, is perceived as a meaning-making process in which people endeavour to comprehend and understand the plentiful life experiences they have (Knowland and Thomas 2014; Knowles, Holton III and Swanson 2014). As the caregivers continued to informally learn in their daily activities, they tended to critically mirror their prior experiences or frames of reference making necessary revisions, thereby generating new meanings in view of new experiences (Mezirow 2000). Most of the learning that occurs throughout life is acquired by way of informal learning (Kaziboni 2018; Schugurensky 2015). This means that the elderly caregivers unintentionally utilised this domain of learning as happens to everyone everywhere. The counselling sessions they received from the clinics fall in this domain of learning. As they visited the clinic or the school or met with community members they incidentally observed how certain issues were dealt with and thereafter improved practice in their homes (Kolb 1994). In the sub-heading below, I discuss the experiences of the caregivers as a way of knowing the new learning that they generated from caregiving.

Experiential learning is defined by Bassett and Jackson (1994) as the process of learning through lived experiences. Kolb (1984:4) says it is the process by which "knowledge is created through the transformation of experience". The learning comes through reflection on the experience and doing (Lewis and Williams 1994). The elderly caregivers, when exposed to the disorienting dilemmas, had to learn from their previous experiences because they did not possess knowledge of how to care in the context of AIDS (Christie et al. 2015): they learned as the process of caring unfolded. In other words, they learned caring from caring. In the writings of Kolb (1984) the creation of knowledge is through the transformation of these past experiences which does not require a teacher. As such, the elderly caregivers tapped into their previous experiences as a foundation on which to build the new knowledge that caregiving should be collaborative, should be age-sensitive and was now bound with legal connotations as discussed in the above section. Thus, this new knowledge came by way of transformation of their experiences (Lewis and Williams 1994; Mezirow 2012).

For them to learn, the caregivers first experienced the disorienting dilemmas of losing adult children through AIDS and having to take care of the remaining orphans. Because their situation was contextualised by AIDS they approached the clinic to have orphans assessed and have appropriate measures taken. The counselling they got there enabled them to reflect on their previous beliefs, values, attitudes, knowledge, skills, etcetera, and all this constituted their prior experiences upon which the new learning was constructed (Mezirow 2012). The way orphans were looked after in yesteryears cannot be compared with the present because of the changed circumstances surrounding them. Previously, the extended family members would converge, giving various types of support to the family that would be looking after the orphan (Foster and German 2002). Uncles and aunts were ascribed certain assignments relating to puberty and issues in the changeover to adulthood of adolescents (Bourdillon 1991). This was done to supplement the child rearing that parents would have implemented from childbirth. Nowadays families have deviated from traditional structures, with many concentrating on their own families and some transferring to faraway places and not coming back to assist the vulnerable.

Collaboration has emerged as the new experiential learning because of the different collaborators such as nurses, teachers and the caregivers. It is the new HIV/AIDS context which has brought these stakeholders together. Having tapped from the previous experience of collaborating based on familial ties, the caregivers found the current collaborative activity viable because they had engaged teamwork in the past, although on kinship linkages (Bourdillon 1991). Previous experience was significant in the elderly caregivers' learning because they managed to create connections between the past and present in order to generate these new insights about adolescent AIDS orphan care (Mezirow 2012).

The central idea in experiential learning is that it involves practical ways of learning as opposed to rote learning mainly encountered in the formal learning domain (Bassett and Jackson 1994). Experiential learning appropriate for the elderly caregivers because they were eager to immediately apply the transformed knowledge, skills, attitudes, values, etc, in the management of the dilemmas presented to them (Mezirow 2012; Knowles, Holton III and Swanson 2014).

Counselling

The study findings also showed use of counselling as another significant way of acquiring new understanding about caring for AIDS orphans. The clinic assesses clients in terms of diagnosis and treatment, however, the process calls for pre and post counselling where the client is conscientised about the 'dos' and 'don'ts' of this disease. Counselling was also obtained from community members and sometimes from the schools where their children learned. As they went about their daily activities the caregivers would meet community people along the way and stop by the roadside to chat about issues of interest while they embraced an incidental domain of learning.

Counselling was critical for these elderly caregivers in facilitating the engagement of some transformative learning after being struck by disorienting dilemmas (Karim and Kharsany 2016; Mezirow 2012). With the advent of HIV/AIDS almost everyone would shun those who were known to be infected and affected by it, and so they were discriminated against (WHO 2016), some even by their family members. It took a considerable amount of time before people across the globe came to terms with the pandemic (UNAIDS 2018). It was important that the elderly caregivers received counselling from the clinic as it was probable that some or all of them were stigmatising their orphans as their parents had died of AIDS.

The assessment of their prior beliefs about this disease started when clinic counsellors commenced work with them. People generally had misconceptions about AIDS. Through counselling they got their fears allayed thereby enabling transformation in their attitudes, knowledge and skills, i.e., their worldviews (Karim and Kharsany 2016). The caregivers embraced self-reflection in a critical way: they reconsidered certain of their previous standpoints. If they had initially discriminated against AIDS orphans, through counselling they changed and managed to stay and care for these adolescents in harmony due to transformation of experience. Faced with an unusual circumstance the caregivers, through counselling services, reviewed their past experiences and found gaps in which the transformed perspectives would stand.

The reflective phase of TLT was pronounced in the caregivers' activities. Associating this phase with coping strategies, use of emotion-centred, as well as problem-centred approaches, became prominent. The former are ways which one engages in when regulating emotional responses and how one thinks or feels about disorienting dilemmas (Lazarus and Folkman 2015). This strategy was used together with those that are in the latter model, which are ways and means targeting the management of disorienting dilemmas. Coping is viewed as a self-motivated process encompassing tactics utilised by the elderly caregivers to weaken or manage the disorienting dilemmas in their environment (Lazarus and Folkman 2015). After dialoguing with others in the environment, such as nurses, school teachers and members within the community, the elderly caregivers become practically insightful of the ways they used to do things in the past and became transformed in view of the new learning discussed above.

Reading

The findings revealed reading around the issues of HIV/AIDS as a way of knowing. The elderly caregivers would read materials such as pamphlets which were normally given for free in places such as clinics. Nevertheless, the reading was disjointed and created gaps in their bid to know more about their context. They only managed to read that material which they could lay their hands on, and only when they visited the clinic. Visits to the clinic where not all that frequent if there was no illness in their households. Otherwise their going there would be after months, mostly to replenish medicine supplies. This way of knowing was probably complementary to other ways of knowing because on its own it left gaps in the caregivers' knowledge. Some got information from both electronic and print media. However, this type of knowing was compromised by issues such as electricity and lack of electric gadgets prevalent in their households. In an observation made during data generation, the three caregivers who had a history of having been formally employed were the only ones whose houses had electricity and radios and TV sets. This type of learning engaged by the elderly caregivers was experiential as well as incidental, which entailed that the caregivers had the responsibility to learn vested in them. Such learning according to Kolb (1984) does not essentially occur in schoolroom; neither does it follow any curriculum for study (Kolb 1984).

The use of print and electronic media as a way of knowing is indicative of the use of TLT Stages Five and Six which focus on explaining options of new behaviour and building confidence in new ways. In the former stage the elderly caregivers discovered their own alternatives for new ways they could behave in view of the disorienting dilemmas (Mezirow 2012). This discovery armed them with contemplation of the next necessary move, which in this case was insight into their dilemmas and a relook into their frames of reference with a view to transforming their worldviews about being caregivers of adolescent AIDS orphans (Malkki 2010). A relook into their suppositions has unleashed some readiness to learn in order to effectively execute the caregiving task (Mezirow 2000). The caregivers enhanced their confidence in the new responsibilities because having realised that they faced dilemmas they sought further learning through reading and listening to the radio and watching TV. As such, there seems to be an implication for adult education to provide learning materials simplified for the understanding of the elderly caregivers. These may be in the form of printed material or broadcasts on TV and radio although the latter two may not be accessible to some of the caregivers due to lack of electrical gadgets and electricity in their poor homesteads.

Observation

Observation was engaged by caregivers as another way of knowing. However, although this is a way of learning that could have enhanced their practice of caring in terms of skills, knowledge and attitudes, it was disconnected and haphazard, occurring as and when the caregivers bumped into a situation to observe. The caregivers in this study did not really want to expose themselves to the outside world by joining existing structures such as support groups. Support groups are useful and critical in that they are organised to focus on a particular context, such as that of HIV/AIDS, with a view to allaying any fears which members may have and to impart knowledge, skills and attitudes to make caregiving at home more manageable (Fauk et al. 2017; Maronganye 2017).

Stage Three of TLT, which addresses a sense of alienation, stood out in the elderly caregivers' execution of their roles and responsibilities. If they had belonged to support group structures they might have been able to make better observations because these are structured to cater for the needs of people living within the same context (Kidman and Thurman 2014; Maronganye 2017). As such their needs and fears could have been directly dealt with.

The discussion above is illustrative of the caring practices and learning experiences of the elderly caregivers and coping mechanisms. Data analysis revealed character formation and provision of material needs as the two emerging caring practices characterised as social, financial and psychological challenges. The new meanings gained were that the responsibility of looking after adolescent AIDS orphans was age sensitive, that adolescent AIDS orphan caring was a collaborative exercise and that caring was bound with legal connotations. In their ways of knowing the caregivers utilised past experience, counselling, reading and observation. This assisted them in enhancing their knowledge, skills, and attitudes, thus, transforming their worldviews.

TLT has its stages organised in a chronological fashion although the actual process of learning does not unfold in a similar order (Mezirow 2012). This is confirmed in the writings of McEwen, Strachan and Lynch (2010) when they espouse that transformative learning is not essentially ordered or linear. Most of the stages (eight stages) were prominent in the elderly caregivers' orphan care except the sense of alienation (Stage Three) and relating discontent to others (Stage Four) probably because of the stigma and discrimination which are generally connected to HIV/AIDS issues.

7.5 Lessons and contributions of the research

The study purpose was to explore the caring practices, coping mechanisms, and learning experiences of the elderly caregivers of adolescent AIDS orphans in Epworth, a peri-urban residential settlement in Zimbabwe. The study adopted Transformative Learning Theory (TLT) Mezirow (2012) and the Transactional Model of Stress and Coping (TMSC) (Lazarus and Folkman 1984) as lenses. The study makes five contributions and these are:

- Theoretical contribution;
- Character formation as a nature of caring practice;
- Age-sensitivity of caring as a new meaning for caregivers;
- Collaboration as a new learning;
- Legal orientation as new insight.

i. Theoretical contribution

The study found that a combination of TLT and TMSC as the lenses to explore the caring practices and learning experiences of the elderly caregivers of adolescent AIDS orphans was effective. TLT is an exclusively adult learning theory which Mezirow (1990) used to describe how people mature and use their self-reflection in critical ways so that they re-look at their frames of reference. With critical thinking, participants in this study altered their ways of viewing their world. Transformative learning hence took place when the elderly caregivers came across perspectives that were not harmonious with their present viewpoint. Mezirow's major interest was in the worldviews of people and what motivates them to change their specific ways of viewing the world around them (Cranton 2006). TLT has generally been used in adult learning as a single theory, however, its combination with the TMSC was effective in this study.

The TMSC has been utilised in clinical psychology settings where critically ill patients had been exposed to numerous environmental and physiological stressors which could have harmful effects on them (Biggs, Brough and Drummond 2017). This model was used on its own as a foundation for explaining the patients' reactions in critical care. Its major focus is on making assessments so that evaluation of possible threats and challenges, as well as damages, could be made (Janse 2021). Some of the ways in which stress can be experienced are through feelings and behaviour and these are normally triggered by exterior stress issues (Lazarus 2013), which in this study and according to Mezirow (2012) are called disorienting dilemmas. All my elderly caregivers had experienced them. Although clinically the theory has been applied in isolation to patients with critical illnesses, in the current study it was prudent to combine it with TLT to allow the assessment of caring practices, learning experiences and coping strategies of the elderly caregivers' in dealing with adolescent AIDS orphan care as a stressor. The combination of the two theories in the exploration of the caring practices, coping mechanisms and learning experiences of the elderly caregivers is, therefore, a major contribution of the present research because the combined theoretical framework was effective as a lens to analyse the phenomenon that was under study.

Contribution to practice

ii. **Character formation:** Another contribution of this study relates to character formation. It emerged from this study that the elderly caregivers assisted in forming the personalities of the adolescent orphans by way of modelling behaviour, delegating them tasks, encouraging church attendance, sending for guidance and counselling, story-telling and playing games. Character formation embraced numerous issues warranting carers to be more knowledgeable in orphan care. Consequently, the multiple disorienting dilemmas of having adult children die of AIDS, sacrificing their retirement into elderly years and providing care for the adolescent AIDS orphans were a solid base for them to initiate readiness to learn (Mezirow 2012). Such a nature of caring practice was exclusive to this study as related reviewed literature was silent on it.

Contributions related to new learning

iii. **Responsibility of caregivers should be age-sensitive**: Age-sensitivity was new meaning that emerged in the data analysis which derived from the idea that in old age the caregiver could easily break down and give up the caring task. The elderly had foregone the time to retire from parental activity and to look forward to being reciprocally cared for by their adult children. This was no longer an issue with these elderly caregivers. The '*chirere chigokurerawo'* Shona saying did not come to fruition as they would have to toil for the rest of their lives. HIV/AIDS made the task of caregiving infinite. This was another contribution of this study.

iv. **Caregiving is a collaborative activity**: While collaboration may have been present in family matters in yesteryears, this time around caregiving has new players such as nurses, teachers, caregivers and members of community. This resonates well with both TLT and the TMSC. When exposed to disorienting dilemmas people tend to re-assess their frames of reference in order to create new perspectives which transform their lives (Mezirow 2012). The caregivers learned that collaboration with the clinic would enable them to get accurate information particularly in terms of HIV transmission, medication adherence, as well as counselling. Links were also created with the schools in which their orphans learned. The schools could identify any problems that the children may have been encountering while in the school environment and would then engage the caregivers about them to collectively manage them. The community was also a stakeholder as the caregiver and his/her household lived within the community. Meeting and chatting with other people even by the roadside brought relief to elderly caregivers. Collaboration was also viewed in this research as a coping strategy embracing both problem-centred and emotion-centred approaches. The data analysis understood this as a new meaning to caring.

v. **Caregiving and the legal orientation:** Another contribution of this study around new learning was caregiving and the legal orientation. The study findings revealed that the legal orientation to child care was a new learning for the elderly caregivers. The caregivers realised that they were now legally bound by the UN Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child, unlike in the previous years when disciplining children mainly included corporal punishment. However, this angered the caregivers who drew comfort from the old ways of child rearing and were reluctant to budge, as they continued the practice reflecting a resistance to new meaning perspective (Mezirow 2012) on this issue. The general feelings of the caregivers were that the charter was skewed towards the children and not concerned about the caregivers. Their lack of shifting from this perspective has corroborated Mezirow's (2012) assertion that when socialised in sub-cultures which attach no importance to issues of critical reflection, any challenges to the status quo is normally denied because there is a tendency to upset one's sense of self. The elderly caregivers were socialised into perspectives that children should receive corporal punishments as a disciplinary measure. The prohibition of such corrective measures touched the very core of what they felt was child rearing. Their rigidity connects well with TMSC's harmful way of coping. Violation of these policies may carry a detention term for the elderly caregivers which would leave the orphans with no other parental character again. Hence it is a harmful or maladaptive mechanism of coping with disorienting dilemmas (Lazarus and Folkman 2015).

7.6 Implications based on the study

The data analysis showed that caregivers' responses had implications for adult education in connection with themselves as carers, the adolescents they cared for as they transition to adulthood; and the system of caring for orphans in Zimbabwe at large. The implications are further explained below.

Training for caregivers

It emerged in the data analysis that some ways of child rearing were no longer accepted by law. Corporal punishment as a way of disciplining the orphans when they misbehaved was prohibited according to policy pronouncements such as United Nations Convention of the Rights of the Child (UNCRC), International Protocol for Alternative Care and the African Charter on the Rights and Welfare of the Child (ACRWC) (Dahl 2016). The policies have been combined into a plethora of legitimate tools and guidelines with the principal purpose of maintaining children's rights (Dahl 2016). The Zimbabwe government, given that it ratified these treaties, is, therefore, compelled to organise mechanisms and resources to ensure the protection of all children by upholding these principles. Non-formal workshops would be appropriate in raising the caregivers' awareness and embracing of the legal instruments so that they are not found on the wrong side of the law. The data analysis shows that the elderly caregivers criticised the existence of such tools as they felt they were biased towards the children. It could be that they had no understanding of these legalities.

Traditionally, children used to 'tow' the line when they were beaten for issues such as stealing and any other vices (Bourdillon 1991). Exposing the adolescent to work in order to nurture hard work, for example, has been shown in some cases to be interpreted as abuse. The implication for adult education is that caregivers should be trained in modern ways of child rearing, where some of the issues in these instruments would be unpacked for their understanding and appreciation. Non-formal learning groups where participants could bounce ideas off each other, with professionals in their midst to guide and steer the elderly caregivers to new ways of disciplining adolescents, might be appropriate. Their criticism of these instruments seemed to corroborate the condemnation of the same by writers such as Harris-Short (2003) who says the voices of communities are being silenced by the children's rights instruments.

The elderly caregivers mentioned that these legalities were creating problems with their adolescents who were now reluctant to submit to rules and regulations in their households, thus straining their relations. Ironically, on losing parents the NOCP encourages the extended family to take over the protection and caring of the child but regrettably (Dahl 2016), the training mentioned above does not target the extended families, particularly the elderly caregivers of adolescents.

Data analysis also indicated that the majority of the elderly caregivers had no regular income or pension from previous employment as many of them where never formally employed. Most of them survived through mini projects such as market gardening, vending and providing domestic labour as revealed in previous literature. However, this suggests lack of capacity to embark on meaningful income generating ventures, implying a need for the intervention of adult education programmes in issues to do with entrepreneurial skills and securing aid. This would help caregivers to identify opportunities around them and establish how to utilise and sustain money generating activities. The issue of income generating activities may also embrace the adolescents as they were now approaching adulthood.

The findings further suggested the implication that making the traditional parenting system a subject to be taught in schools would allow for the discovery of merits and demerits, which would allow for rationalisation and standardisation of methods that would enrich the current practice. Data analysis also implied the consideration of culture when searching for new ways of child rearing (Ntseane 2011). This emanated from the issue that caregiving be done in a culturally sensitive manner because people are bound together by their culture (Pavlyshyn et al. 2019). This is in line with the current University of Zimbabwe dispensation where the urge is to go back to the past and resuscitate what can be useful in handling issues today. The elderly caregivers would benefit immensely if some training could be given along the lines of caregiving in a traditionally thoughtful way.

The implication of adult educational programming was evident when adult carers revealed interest in knowing modern ways of child rearing. They realised that their confidence in new ways of child rearing would be greatly improved (Stage Three of TLT). Hence their need to acquire skills, knowledge and attitudes to be able to come to terms with modern ways of child care became pronounced.

The importance of continuous education whether formal or informal was one other topic that was suggested in the data analysis. Findings pointed to the fact that caregivers and all who interacted with children in special circumstances, such as AIDS orphans, needed to constantly update their worldviews and engage in international best practices. The world has become a global village and as such there are practices, protocols, regulations and ordinances which are constantly changing, hence the need for continuous education (Findsen 2011; Schugurensky 2015; Karakoc, 2016). Research and continuous learning emerged as necessary for synergy and connections with other contexts, lest one remain steeped in out-dated practices. In other words, caregivers like everybody else in contact with children should strive to connect to both local and international best practices through continued educational advancement. The digital era demands continuous learning so as to update and enhance global practices (Karakoc 2016). Non-formal learning groups, as mentioned above, with professionals giving direction to discussions about the digital era would also be relevant to the elderly caregivers. Therefore, the importance of continued learning cannot be over emphasised.

Some caregivers sometimes engaged in maladaptive ways of coping, particularly when they skipped meals in order to save for the next time they would eat. However, this may be hazardous to their already vulnerable health in view of the AIDS context. As this is a harmful way of coping, there is an implication for adult education along health and nutrition lines.

7.7 Implications for policy

The data analysis implied that the caregivers were not aware of some policy pronouncements which are discussed in this study. They came to know about the legal orientation to caring when their orphans began to refuse their disciplinary measures encompassing corporal punishment.

Orphans may have known about this through their friendship networks, social media and the school. If these instruments are to be applied meaningfully and objectively, there is a need for developing mechanisms for caregivers, adolescents and all other stakeholders involved to be conscientised about them. The adolescents themselves need to know the significance of these policy pronouncements: when they become applicable and what is expected of them as children being cared for. Without caregiver awareness of such issues those who care for such children would continue on the wrong side of these legal frameworks.

7.8 Implications for further research

The current research explored a small-sized sample of twenty elderly caregivers of adolescent AIDS orphans in one residential area of Harare in Zimbabwe. Using an interpretivist paradigm, whose dictates call for the generation of data in a qualitative manner, the study utilised focus group discussions, face-to-face interviews and observations. The findings may not demonstrate what takes place in other elderly caregiver households around the country. The generalisability and objectivity of the results may only be realised after comprehensive study(ies) using a positivist paradigm, a quantitative or pragmatic approach and investigating a larger sample. This study is, therefore, calling for other researchers to carry out further and comprehensive investigations into the caring experiences, challenges and coping mechanisms and learning of elderly caregivers of adolescent AIDS orphans in Zimbabwe. As the adolescent orphans were part of the challenges experienced by the elderly caregivers, it would be prudent, therefore, that further studies be conducted to include both caregivers and teenagers on a wider scale.

7.9 Chapter Summary

In wrapping up the study, whose purpose was to explore the nature of caring practices, the coping mechanisms that were adopted in the care processes and the new meanings of the elderly caregivers of adolescent AIDS orphans, I submit that Research Question One which targeted the nature of caring practices and coping mechanisms of the elderly caregivers was adequately answered. It is concluded that the nature of caring practices the participants engaged in involved the formation of the adolescent orphans' personalities in order that they not become misfits in their society. The caregivers also provided for the material needs of the orphans. The process of caring was characterised by social, and financial challenges which required them to address and find ways of coping. They coped through counselling, donations from some of their relatives and cutting the quantity and frequency of meals.

In Research Question Two about how the caregivers learned to make new meaning in the AIDS orphan caring activity, findings revealed that the caring activity had to be age-sensitive, though they did not reach a consensus in terms of the age that should care. Their concern was that they were too old for the task of caring. They also learnt that caregiving was a collaborative activity with other stakeholders such as the clinic, the school where their orphans were learning, and the community surrounding them. The legal orientation emerged as another new meaning that was gained, though they viewed it as an impediment to their caring. The caregivers came to know about these new meanings through tapping into their vast experiences as a foundation for the new roles they executed. Counselling triggered much-required self-introspection in the elderly caregivers. These ways of knowing were complemented by reading, listening to the radio, watching television and observation, although these were performed in an incoherent manner as was discussed in other sections of this chapter.

Implications for adult education programmes were drawn on a number of issues, such as the need to conscientise caregivers on legal requirements in child rearing; modern ways of child rearing, imparting entrepreneurial skills and caregiving in a traditionally thoughtful manner.

In terms of coping, the prominent approaches were problem-centred and emotion-centred with maladaptive coping minimally utilised. Counselling is pronounced in their activities, with donations from relatives and cutting meals receiving minimal pronouncement. The elderly caregivers’ positive caring practices were not necessarily accomplished because the challenges often contradicted what the elderly caregivers believed they were doing. The research has, however, sharpened my perception and appreciation of the nature of caring practices, coping mechanisms, and learning experiences of the elderly caregivers of adolescent AIDS orphans.

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APPENDIX A: FACE-TO-FACE INTERVIEW SCHEDULE

Interview guide (face-to-face)

Introductory questions

1. Please tell me about yourself, from your school learning up to this time.
2. How did you become the caregiver of these children?
3. For how long have you been looking after these orphans?
4. Who was your child between the mother and father of the orphan?
5. When did the parent(s) of the child(ren) die?
6. Are you the main person looking after the children?
7. How many children do you care for?
8. What are their ages?
9. Are they in school? If not, why?

Nature of caring practices and coping mechanisms that the elderly caregivers engage in (Research Qs 1)

10. Please take me through a typical caring day, all the activities that you do from the time you wake up in the morning to the time you retire at night.
11. Please identify any objects in the house which best describe your caring practices.
12. What are the main challenges that you face in looking after these children?
13. Please give examples of these challenges.

Learning to make new meaning/insights out of the caregiving roles (Research Qs 2)

1. Tell me about how you see your work on caring for the orphans.
2. Please tell me about any things that you learnt or realized when you started caring for these orphans.
3. How have you come to know the way to care for the AIDS orphans.
4. What is the most important thing you have learned about your caring role?

Responding to new roles (Research Qs 3)

5. Do you have any past experience in looking after teenagers?
6. How do you feel about taking on this responsibility this time around?
7. What do you feel you most need help with, (e.g. managing the teenagers' behavior, helping them to cope with their loss, getting them to go to school)
8. Do you have anyone who can help you with any challenges in caring for the children? Who are they?
9. How do they help you?

APPENDIX B: SCHEDULE FOR FOCUS GROUP DISCUSSIONS

Focus group discussions guide

1. Please tell me your life stories of who you really are, your children, any close relatives/ siblings etc.
2. Do these help you in caring?
3. What were the major challenges you faced when you had to look after these children?
4. How have you dealt with these challenges?
5. What have you learned about caring for these children?
6. Tell me the activities that you do in the day to day caring.
7. Tell me about any help that is available for your caregiving responsibility.
8. Do you think you get on well with the orphans?
9. Give examples of when you think things have gone well.
10. Give examples of when you think things have gone badly.
11. Is there anyone who has provided any training in how to care for teenage orphans?
12. Would you like some guidance from the authorities or other people in helping you look after these orphans?
13. Where/in what way do you think you most need help?

APPENDIX C: OBSERVATION CHECK LIST

a) Surrounding of the caregivers' homes
b) Household possessions
c) Shelter
d) Physical appearance of the elderly caregivers
e) Backyard fields where agricultural activities took place

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26 August 2020

Ms A Paradzai
University of Zimbabwe
Department of Linguistics
MP 167
Harare

Dear Ms Paradzai

The learning experiences and coping mechanisms of elderly caregivers of adolescent AIDS orphans in one residential area in Harare: Implications for Adult Education and training
Ethical Clearance number IREC 022/20

The Institutional Research Ethics Committee acknowledges receipt of your final data collection tool for review.

We are pleased to inform you that the data collection tool has been approved. Kindly ensure that participants used for the pilot study are not part of the main study.

In addition, the IREC acknowledges receipt of your gatekeeper permission letter.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC Standard Operating Procedures (SOP's).

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely,

[redacted]

Dr M A Sathar
Deputy Chairperson: IREC

APPENDIX E: LETTER OF INFORMATION

DUT
DURBAN
UNIVERSITY OF
TECHNOLOGY
INSTITUTIONAL
RESEARCH
ETHICS
COMMITTEE

LETTER OF INFORMATION

Title of the Research Study: The caring practices, learning experiences and coping mechanisms of elderly caregivers of adolescent AIDS orphans in one residential area I Harare: Implications for Adult Education in Zimbabwe.
Principal Investigator/s/researcher: Angeline Paradzai

Co-Investigator/s/supervisor/s: Associate Prof Tabitha Mukeredzi and Prof Julia Preece

Brief Introduction and Purpose of the Study: This study seeks to find out the elderly caregivers' caring practices, learning experiences and coping mechanisms in looking after the adolescent AIDS orphans in Epworth, Zimbabwe. I hope to recruit 15 – 20 elderly caregivers from Epworth for individual in-depth interviews and focus group discussions. The elderly caregivers who agree to take part in the study will sign a consent form which confirms their willingness to participate, at the onset of the interviewing process. (Copy of consent form is enclosed).

You will be interviewed in your homes, and focus group discussions conducted at a local school during school holidays. It is anticipated that each interview will take forty-five minutes to one hour, while the focus group discussions may last for about one and a half to two hours each. With your permission, I record our discussions to ensure that all your views are captured accurately, and may also take notes of characteristics of your homes. Your name will not be used in the report, instead pseudonyms will be used to ensure anonymity and confidentiality.

You are being asked to proffer information in terms of caring practices, learning experiences and coping mechanisms with looking after AIDS orphans in their households. This is achieved through in-depth interviews and focus group discussions which are expected to last for forty five minutes to one hour; and one and a half hours to two hours respectively. Permission is being sought from you to allow me to audio-tape the discussions to avoid missing some of the information that you will give. I intend to hold interviews in your natural setting (homes), and focus group discussions at a local school. The inclusion criteria is being an elderly (55 years and beyond) caregiver of adolescent AIDS orphan(s) living in Epworth.

In the unlikely event that questions may trigger distress or discomfort to you I make available a psychologist or counselor free of charge to you.

The findings of this study may inform any discussions and decisions on Adult Education training programmes on caregiving of orphans. I, the researcher, get insights into caring practices, learning experiences and coping strategies of the elderly caregivers of adolescent AIDS orphans.

You may choose to withdraw from the study at any point during the data generation without any impact.

You will receive transport money to come for FGDs, and snacks for refreshment during the discussions.

You will not be expected to meet any costs towards the study.

All materials obtained during the data generation exercise will be stored and ultimately disposed of in a manner that ensures confidentiality of you. You will not be asked for your real names. I will allocate a number for each caregiver so that real names are not taken and used. The data will be kept by the supervisor under lock and key for five years after graduation, and will be eventually destroyed by shredding. The electronic data will be also kept under a password known to me and my supervisors only.

It is not anticipated that you will be injured during the data generation.

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

-(Supervisor and details) Please contact the researcher Angeline Paradzai (Masters in Adult Education) on +263772694715, My supervisor Assoc. Prof Tabitha Mukeredzi (PhD) on +27076 2995974 or the Institutional Research Ethics Administrator on 031 373 2375. Complaints can be reported to the DVC: Research, Innovation and Engagement Prof S Moyo on 031 373 2577 or moyos@dut.ac.za.

APPENDIX F: CONSENT FORM

CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Angeline Paradzai, about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: IREC 022/20
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_______________________ ________ _________ ________________

Full Name of Participant **Date** **Time** **Signature/Right Thumbprint**

I, Angeline Paradzai herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Angeline Paradzai

_______________________ ____________ __________________

Full Name of Researcher **Date** **Signature**

________________________ ____________ ___________________

Full Name of Witness (If applicable) **Date** **Signature**

________________________ ____________ ___________________

Full Name of Legal Guardian (If applicable) **Date** **Signature**

Please note the following:

Research details must be provided in a clear, simple and culturally appropriate manner and prospective participants should be helped to arrive at an informed decision by use of appropriate language (grade 10 level - use Flesch Reading Ease Scores on Microsoft Word), selecting of a non-threatening environment for interaction and the availability of peer counselling (Department of Health, 2004)

If the potential participant is unable to read/illiterate, then a right thumb print is required and an impartial witness, who is literate and knows the participant e.g. parent, sibling, friend, pastor, etc. should verify in writing, duly signed that informed verbal consent was obtained (Department of Health, 2004).

If anyone makes a mistake completing this document e.g. a wrong date or spelling mistake, a new document has to be completed. The incomplete original document has to be kept in the participant's file and not thrown away, and copies thereof must be issued to the participant.

References:

Department of Health: 2004. *Ethics in Health Research: Principles, Structures and Processes* http://www.doh.gov.za/docs/factsheets/guidelines/ethnics/

Department of Health. 2006. *South African Good Clinical Practice Guidelines*. 2nd Ed. Available at:
http://www.nhrec.org.za/?page_id=14

APPENDIX G: APPLICATION FOR PERMISSION TO CARRY OUT STUDY

26 July 2019

Epworth Local Board
P.O. Box Hatfield
Harare

Dear Sir/Madam

RE: **Authorisation to carry out a research in the Epworth Community**

I write to humbly request permission to carry out a research study in Epworth. I am a doctoral candidate with the Durban University of Technology and in the process of writing my thesis whose title is ‘The caring practices, learning experiences and coping mechanisms of elderly caregivers of adolescent AIDS orphans in one residential area in Harare: Implications for Adult Education in Zimbabwe’.

I hope to recruit 15 – 20 elderly caregivers of adolescent AIDS orphans from Epworth for individual in-depth interviews and focus group discussions. Those who will be willing to take part in the study will sign a consent form with which to confirm their willingness to participate, at the onset of the interviewing process. (Copy of consent form is enclosed).

Interviewed will be held in their homes, and focus group discussions conducted at a local school during school holidays. It is anticipated that each interview will take forty-five minutes to one hour, while the focus group discussions may last for about one and a half to two hours each. With their permission I will record our discussions to ensure that all their views are captured accurately. Participants will not be asked for their real names in order to maintain confidentiality and anonymity. Instead, pseudonyms will be used. The study will not incur any costs for your office and for the participants, but participants will be reimbursed for the travelling costs to the focus group discussion venue.

Your endorsement to carry out this research will be really appreciated. Please allow me to make a telephone follow up in seven days. I will be happy to provide answers to any queries or concerns that you may have about the study. I am contactable on my mobile phone number +263772694715 and email address: aparadzai2013@gmail.com

I have attached the research proposal to this letter in case there are questions which it can answer.

I look forward to hearing from you in due course.

Yours sincerely

Ms. A. Paradzai
Doctoral candidate, DUT

Enclosure: Consent form

cc. Associate Prof T Mukeredzi (PhD), Research Supervisor, DUT
Prof J. Preece (PhD), Research Supervisor, DUT

APPENDIX H: APPLICATION TO CONDUCT FOCUS GOUP DISCUSSIONS AT EPWORTH PRIMARY SCHOOL

DUT
DURBAN
UNIVERSITY OF
TECHNOLOGY
INSTITUTIONAL
RESEARCH
ETHICS
COMMITTEE

26 July 2019

The Headmaster
Epworth Primary School
Epworth
P.O. Box Hatfield
Harare

RE: **<u>Authorisation to conduct Focus Group Discussions at your school</u>**

Dear Sir/Madam

I write to humbly request permission to conduct some focus group discussions at your school with the elderly caregiver of adolescent AIDS orphans who will be drawn from Epworth. I am a doctoral candidate with the Durban University of Technology and in the process of writing my thesis whose title is ‘The caring practices, learning experiences and coping mechanisms of elderly caregivers of adolescent AIDS orphans in one residential area Harare: Implications for Adult Education in Zimbabwe’.

I hope to recruit 25 – 30 elderly caregivers of adolescent AIDS orphans from Epworth for five focus group discussions with six participants each, with an approximate duration of one and half hours to two, for six weeks. I also ask for access to an office or classroom that will not be occupied to confidentially conduct the discussions. The study will not incur any costs for your school.

Your endorsement to carry out this research in the school premises will be greatly appreciated. Please allow me to make a telephone follow up in seven days. I will be happy to provide answers to any queries or concerns that you may have about the study. I am contactable on my mobile phone number +263772694715 and email address: aparadzai2013@gmail.com

<u>I have attached the research proposal to this letter in case there are questions which it can answer.</u>

I look forward to hearing from you in due course.

Yours sincerely

Ms. A. Paradzai
Doctoral candidate, DUT

Enclosure: Consent form

cc. Associate Professor T Mukeredzi (PhD), Research Supervisor, DUT
Professor J. Preece (PhD), Research Supervisor, DUT

APPENDIX I: PERMISSION FROM ELB TO CARRY OUT THE STUDY

EPWORTH LOCAL BOARD

1038 Chiremba Road
P. O. BOX EP180
EPWORTH

Telephone :263 4 2936393-6
:263 4 577445/9
Email :elb@africaonline.co.zw

ALL CORRESPONDENCES SHOULD BE ADDRESSED TO THE SECRETARY

ELB REF: YOUR REF:

14/08/20

Ms. A. Paradzai
4667 Ushewekunze
Harare

REQUEST TO CARRY OUT RESEARCH IN EPWORTH

This serves to confirm that authority has been/~~not been~~ granted to carry out a research in Epworth in terms of your area of study.

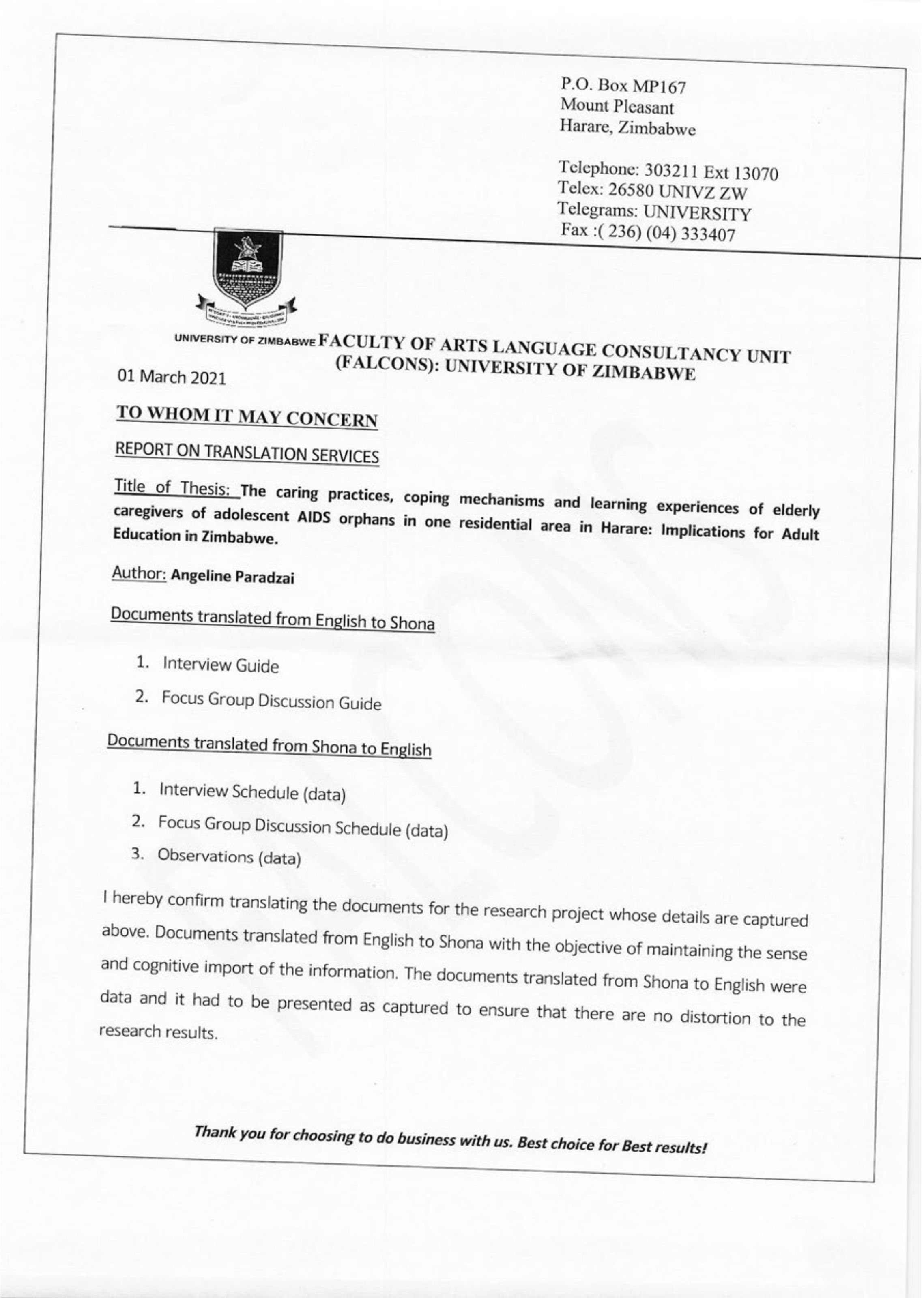
Thank you

Yours faithfully

EPWORTH LOCAL BOARD
REGISTRY
14 AUG 2020
P.O. BOX EP 180
EPWORTH
TEL: +263 4 2936393-6/577 445/9

Dr. W. Mhanda
SECRETARY
EPWORTH LOCAL BOARD

APPENDIX J: REPORT ON TRANSLATION SERVICES



P.O. Box MP167
Mount Pleasant
Harare, Zimbabwe

Telephone: 303211 Ext 13070
Telex: 26580 UNIVZ ZW
Telegrams: UNIVERSITY
Fax :(236) (04) 333407

UNIVERSITY OF ZIMBABWE **FACULTY OF ARTS LANGUAGE CONSULTANCY UNIT (FALCONS): UNIVERSITY OF ZIMBABWE**

01 March 2021

TO WHOM IT MAY CONCERN

REPORT ON TRANSLATION SERVICES

Title of Thesis: **The caring practices, coping mechanisms and learning experiences of elderly caregivers of adolescent AIDS orphans in one residential area in Harare: Implications for Adult Education in Zimbabwe.**

Author: **Angeline Paradzai**

Documents translated from English to Shona

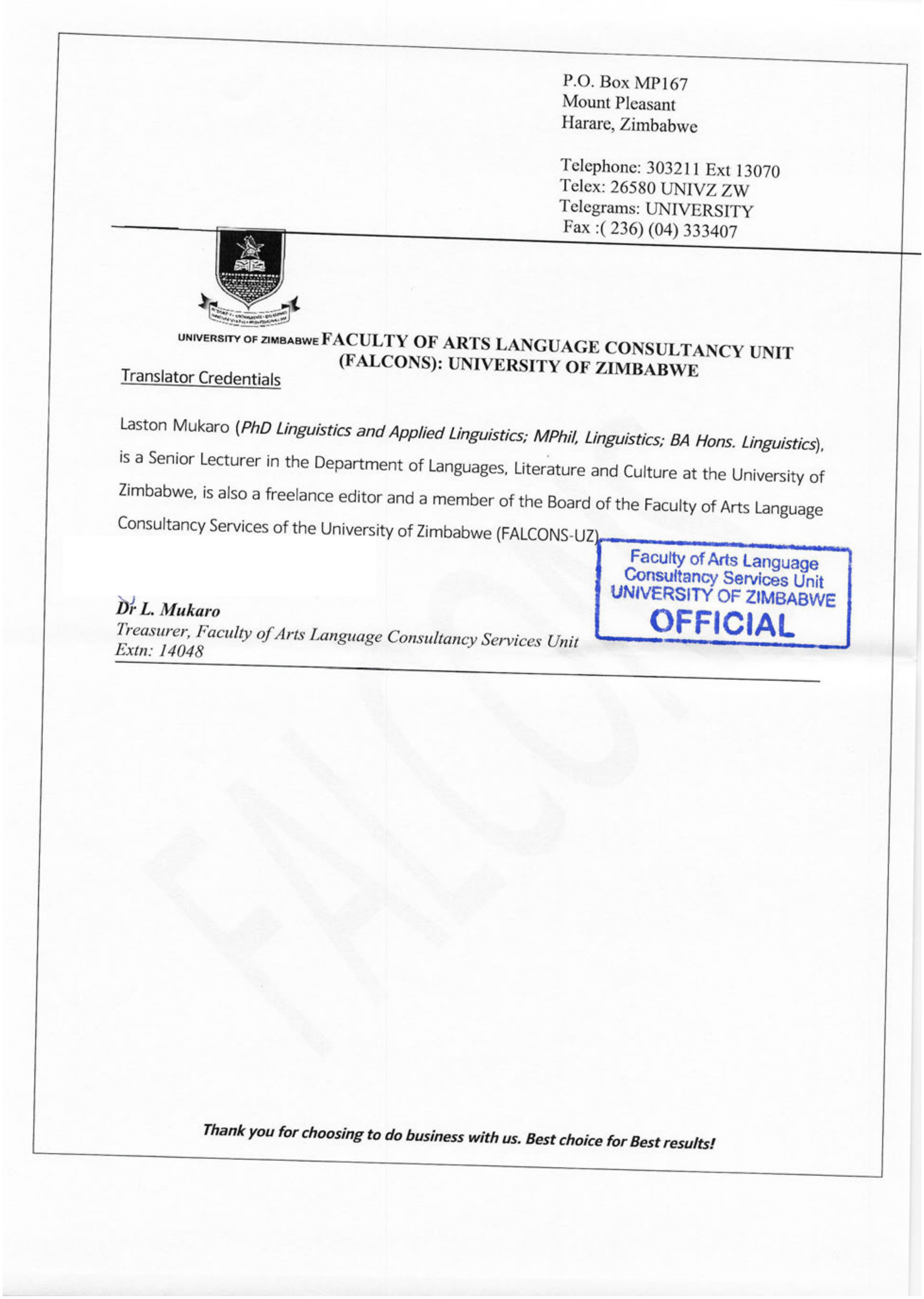
1. Interview Guide
2. Focus Group Discussion Guide

Documents translated from Shona to English

1. Interview Schedule (data)
2. Focus Group Discussion Schedule (data)
3. Observations (data)

I hereby confirm translating the documents for the research project whose details are captured above. Documents translated from English to Shona with the objective of maintaining the sense and cognitive import of the information. The documents translated from Shona to English were data and it had to be presented as captured to ensure that there are no distortion to the research results.

Thank you for choosing to do business with us. Best choice for Best results!



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UNIVERSITY OF ZIMBABWE **FACULTY OF ARTS LANGUAGE CONSULTANCY UNIT (FALCONS): UNIVERSITY OF ZIMBABWE**

Translator Credentials

Laston Mukaro (*PhD Linguistics and Applied Linguistics; MPhil, Linguistics; BA Hons. Linguistics*), is a Senior Lecturer in the Department of Languages, Literature and Culture at the University of Zimbabwe, is also a freelance editor and a member of the Board of the Faculty of Arts Language Consultancy Services of the University of Zimbabwe (FALCONS-UZ).

Faculty of Arts Language
Consultancy Services Unit
UNIVERSITY OF ZIMBABWE
OFFICIAL

Dr L. Mukaro
Treasurer, Faculty of Arts Language Consultancy Services Unit
Extn: 14048

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