A STUDY OF THE IMPACT OF SOCIAL NETWORKS ON ADOLESCENT ANTIRETROVIRAL THERAPY ADHERENCE IN ZIMBABWE

BY

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A study of the impact of social networks on adolescent antiretroviral therapy adherence in Zimbabwe.

I declare that the above dissertation is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I submitted the dissertation to originality checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other higher education institution.

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SIGNATURE DATE

KEY TERMS DESCRIBING THE THESIS

Title of thesis: A study of the impact of social networks on adolescent antiretroviral therapy adherence in Zimbabwe.

KEY TERMS

Treatment adherence; thematic data analysis; social networks; social capital; adolescents; trust and reciprocity; social obligations; social stigma; HIV status disclosure; cyber-based social ties; charismatic churches; AIDS Service Organisations, social media; networking norms and values.

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ABSTRACT

There have been many attempts to explore the significance of social networks in influencing positive health behaviours among different population groups. However, few studies have focused on adolescents and particularly those living with HIV. This study took an in-depth exploration of the role played by social networks in influencing ART adherence among adolescents living with HIV and AIDS in Zimbabwe.

Adolescents living with HIV are involved in different types of social networks that include those entered by members of their households and those that they initiate. The social networking involving adolescents takes place within a complex web of unwritten norms and rules. The norms and rules are deliberately designed to govern behaviours within the networks and to evade societal stigma directed at people living with HIV. Strict adherence to the unwritten norms and rules has created bonding and trust among the adolescents who regard their social networks as a dependable form of support in their day to day lives. The bonding amongst the adolescents has however in some circumstances led to negative coping behaviours such as reluctance towards HIV status disclosure which can undermine ART adherence in the long term.

Social networks are vital means through which resources and vital information that shape adherence to ART behaviours is shared. The results in this study have demonstrated that the different forms of social networks are socially constructed within specific social settings and they play a significant role in shaping ART adherence behaviours among adolescents living with HIV.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMTO	Assisted Medical Treatment Order
ART	Anti- Retroviral Therapy
ASO	AIDS Service Organisations
HIV	Human Immune Deficiency Virus
MoHCC	Ministry of Health and Child Care
MoLSW	Ministry of Labour and Social Welfare
NAC	National AIDS Council
NATF	National AIDS Trust Fund
OIC	Opportunistic Infections Clinic
PLWHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PEPFAR	President's Emergency Plan for AIDS Relief
PHD	Prophetic Healing and Deliverance
POTRAZ	Post and Telecommunications Regulatory Authority of Zimbabwe
UFIC	United Family Inter-Denominational Church
UNAIDS	United Nations AIDS Organisation
UNICEF	United Nations Children's Fund
USAID	United States International Development Agency
WHO	World Health Organisation
ZDHS	Zimbabwe Demographic Health Survey
ZIMPHIA	Zimbabwe Population-Based HIV Impact Assessment
ZIMSTATS	Zimbabwe Statistics Agency

CHAPTER 1: INTRODUCTION

1.1 Introduction

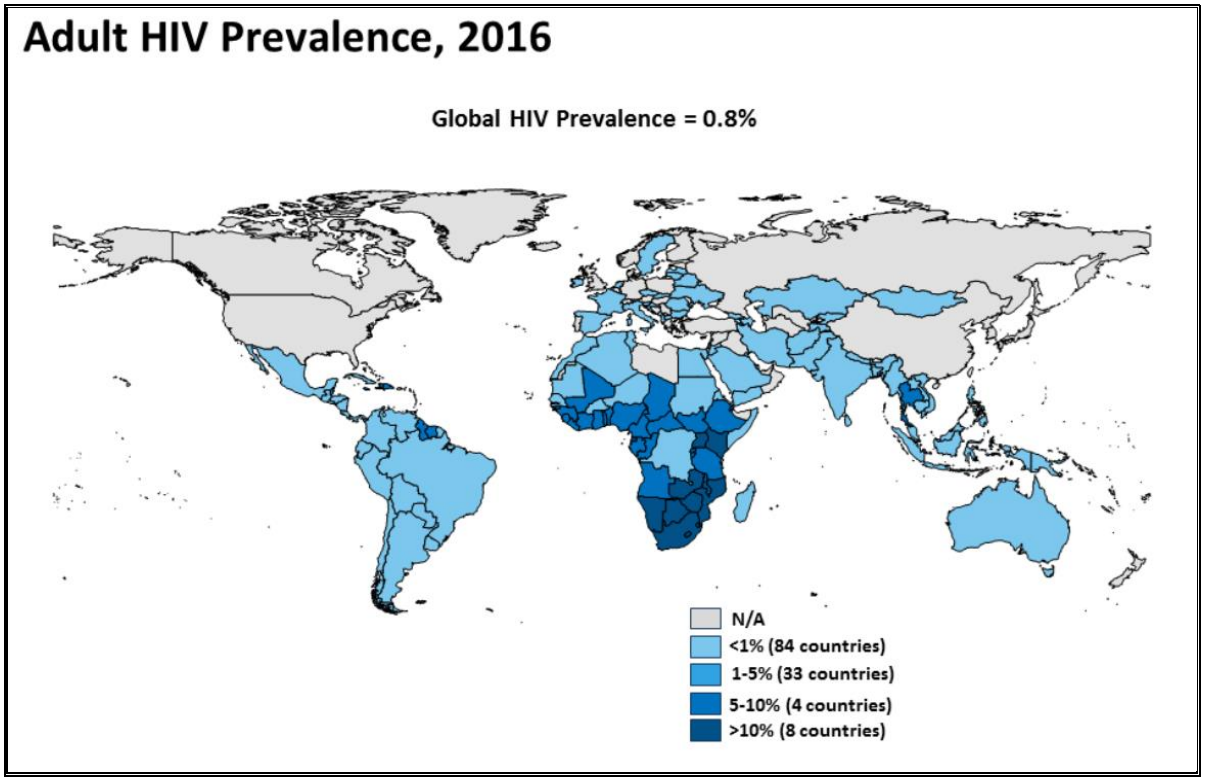
The advent of Human Immune Virus (HIV) and the Acquired Immuno Deficiency Syndrome (AIDS) as a disease in the early 1980s resulted in many socio-economic challenges in both developed and developing countries (UNICEF 2005). Whilst in the early years HIV and AIDS were primarily associated with health, social and economic challenges amongst the general population, in the late 1990s, HIV and AIDS began to have direct devastating effects on children, particularly those children who were born with HIV. The introduction of Antiretroviral therapy (ART to children born with HIV began to increase their survival rates to adolescences. As noted by Schmid and Chiba (2017:1) whilst there has been extensive research into the health-related challenges children born with HIV face, there is a lack of information on the social challenges that the children face and how they navigate the everyday world.

Schmid and Chiba (2017:1) further highlighted that the transition process from childhood to adulthood is complex and challenging for young persons and it is particularly difficult for children born with HIV. Some of the challenges that adolescents living with HIV face are stigma among their peers at school, difficulties discussing their HIV statuses, feeling discriminated against and feeling a lack of belonging, among others (Schmid and Chiba 2017:1). Other notable effects of HIV and AIDS on children include a lack of social and economic as well as parental support, high levels of malnutrition, poor school attendances, high school dropout rates and the phenomenon of child-headed households, particularly in sub-Saharan Africa where 80 % of people living with HIV are located (UNAIDS 2017:1).

Statistics from the United Nations Joint Program on AIDS (UNAIDS 2017:1) indicate that by June 2016, 2.1 million people younger than fifteen years were living with HIV. It is therefore essential that research efforts are devoted towards understanding the key challenges that these young people face in coping with their HIV status. According to the UNAIDS, AIDS continues to be a major contributor to global annual mortality rates with approximately one million people dying due to AIDS-related illnesses in 2016. At the same time, 1.8 million new HIV infections were also recorded globally, an indication that HIV and AIDS continue to pose a serious challenge to humanity across the globe. The HIV adult prevalence rate

which is an indicator of the global HIV burden across different geographical regions in the world indicates that countries in the sub-Saharan region continue to experience high HIV prevalence rates of above 10 % as shown in the map below.

Figure 1: Global HIV adult Prevalence Rates

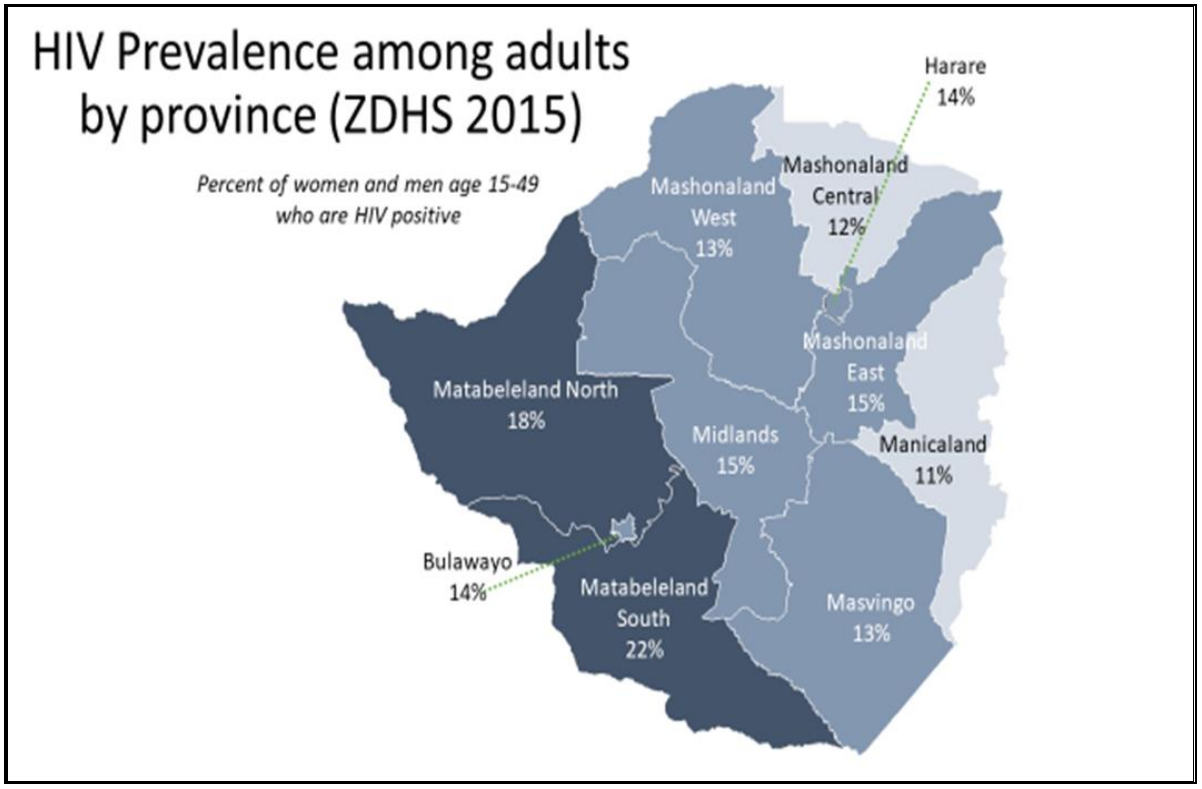


Source: UNAIDS Factsheet Report 2017

According to the UNAIDS (2017:2) by 2016, 19.4 million people were living with HIV in Eastern and Southern African regions. At the global level, and specifically in the sub-Saharan African region, the effects of HIV and AIDS have also taken a notably gendered nature with women and girls being the most affected. Women and girls accounted for 59 % of the total number of people living with HIV in 2016 (UNAIDS 2017: 2). Sub-Saharan African region also accounted for 43 % of the global new HIV infections in 2016 with an estimated 790,000 new infections. In line with the declining global trends in the rates of new infections, the region has also experienced a 29 % reduction in rates of new infections between 2010 and 2016. However, at the same time, the region contributed approximately 42 % of the annual AIDS deaths with 420,000 people dying in 2016. The UNAIDS 2017 Report showed that an estimated 77,000 new infections were recorded among children aged 15-17 within the sub-Saharan region in 2016

Zimbabwe is one of the sub-Saharan African countries whose population is suffering from both the social and economic burden of the HIV and AIDS pandemic. According to the Zimbabwe National AIDS Council (NAC) 2017 Annual Report, the country's adult HIV prevalence rate has been stagnant at 14 % since 2010 which is an indication that the HIV burden has not changed for the past nine years. The country's HIV prevalence rate of 14 % has been validated so far by the results of the 2015 Zimbabwe Demographic Health Survey (ZDHS) report and the results of the 2016 Zimbabwe Population-Based HIV Impact Assessment (ZIMPHIA) survey. The distribution of prevalence differs as shown in figure 2 below among provinces with Zimbabwe attributed to a wide array of reasons which include social, economic and cultural factors.

Figure 2: HIV Prevalence rates in Zimbabwe for 2017 by Province



Source: National AIDS Council 2017 Annual Report

As with the global trends in terms of the gendered nature of HIV infections, statistics show that by 2016 sixty % of the infected population in Zimbabwe were women (Ministry of Health and Child Care National HIV and AIDS Estimates Report 2017: 8).

In the late 1990s in response to the HIV and AIDS pandemic, most governments across the globe rolled out extensive HIV and AIDS treatment, care and support programmes. Since

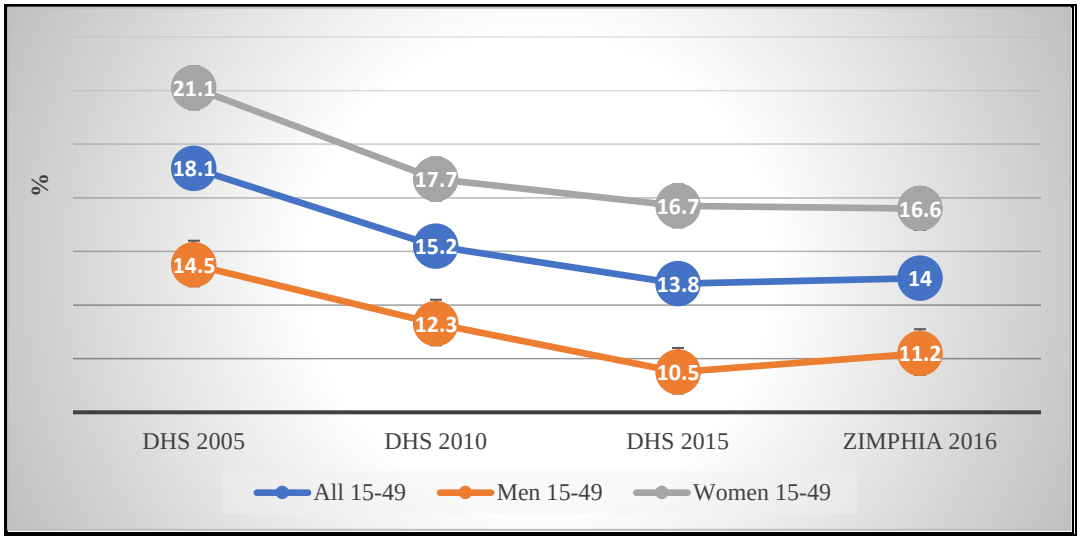
then, the trend has continued and numerous successes have been witnessed in the fight against HIV and AIDS. As of June 2017, UNAIDS reports that 20.9 million people constituting 53 % of those infected with HIV were accessing ART across the globe. This is an increase from the 17.1 million that were accessing ART in 2015. These statistics indicate that there is still a large gap in terms of access to treatment services for people living with HIV (PLWHIV). The UNAIDS report of 2017 further highlights that treatment coverage among children aged between 0-14 years was only 43 % of the total global population of children diagnosed with HIV at birth.

Zimbabwe has not been left behind in the rolling out an extensive HIV and AIDS treatment programme targeting all age categories (adults, adolescents and children). In 1999 the government enacted the National AIDS Trust Fund (NATF) Act that introduced a mandatory HIV and AIDS levy for both individuals and companies. Using the NATF funds and other resources obtained from multilateral development partners, the government rolled out a well-funded HIV and AIDS prevention and treatment programme. As a result of this Zimbabwe has experienced a reduction in HIV prevalence rates from 27 per cent in 1997 to 14 % in 2018 (National AIDS Council Report, 2017: 8). Despite this decline, the National AIDS Council Report (2017: 8) notes that Zimbabwe has the sixth highest HIV prevalence rate in Africa. Thus, despite the tremendous achievements in the fight against HIV and AIDS, there is still a lot that the government and other development partners should do to further reduce the burden of HIV on the population (Gregson, Gonese, Hallett and Taruberekera (2011: 296–318).

1.2 Adolescents and HIV in Zimbabwe

The Zimbabwe Demographic Health Survey (ZDHS) Report (2015:39) showed that the HIV prevalence rate for people aged 15-17 years in 2015 was 16 %. The ZDHS report of 2015 further showed a trend of increase in prevalence by age for both female and males and a significant prevalence difference by gender. For example, female between 15-17 years had a prevalence rate of 2.7% and their male counterpart was at 2.5% (see Figure 3 below). On the contrary females between 23-24 had a prevalence of 13.9% and males of the same age group were at 8.5%.

Figure 3: HIV Prevalence rates for people aged 15 – 49 years, disaggregated by sex, 2016



Source: Zimbabwe National AIDS Council 2017

These statistics are on the conservative side as only 64% of young women (15-24) and 47.5 % of young men among this age group have undertaken voluntary HIV testing meaning that the HIV prevalence among this group could be significantly higher than what the available official statistics show.

According to the ZDHS (2015:40), 17% of young women aged 15-19 in Zimbabwe reported having had sex with a man 10 years older than them in the past 12 months. This increases the risk of HIV infection among young women as they are exposed to older men who are likely to be infected. The ZDHS further argues that the adolescent girls are also at risk in their relationships with older men as they do not have the power to determine safer sex including condom use. Also, the adolescents are more vulnerable to HIV as only 46 % of young women and 47 % of young men have comprehensive knowledge about HIV, thereby limiting their ability to take control of their sexual health (ZDHS 2015:40). The observed patterns for HIV infection rates among adolescent girls in Zimbabwe are a replica of the general patterns of HIV infections in Africa whereby girls are disproportionally affected by HIV compared to boys. For example, according to the UNICEF Annual Results Report (2015:14) in 2016 two thirds of the new HIV infections among adolescents aged 15-19 were among girls. The same report notes that within the population group aged 15-19 years girls were five times more likely to be infected with HIV than boys.

1.3 ART Interventions in Zimbabwe

There is a growing number of adolescents who are living with HIV. According to the UNAIDS, in 2015, there were approximately 2 million adolescents aged 10-19 living with HIV worldwide. The increase in the number of adolescents living with HIV has been attributed to many reasons including the remarkable increases in the global roll-out of anti-retroviral therapy which increased survival rates of children born with HIV (UNAIDS 2017:8). UNAIDS projects that the number of HIV infected adolescents is likely to continue increasing for at least another decade till 2027.

According to the Zimbabwe Ministry of Health and Child Care 2017 HIV Estimates report approximately 1.3 million people are living with HIV (PLHIV) in Zimbabwe of which 87 % were on ART. This is still below the national set target of achieving 90% placement of all people diagnosed with HIV on ART. The Government of Zimbabwe (GoZ) Global AIDS Response Progress Report (2016:19) show that ART coverage in children and adolescents is disproportionately low with children aged 0-14 years the lowest at 55%, which is significantly below the universal access target of 90 % by 2020.

There is a general lack of information that pertains to the HIV and AIDS situation for adolescents in Zimbabwe. The lack of reliable statistical data on adolescents is also compounded by the fact that research studies and programmes often exclude adolescents or group them with children and adults (see for example the ZDHS Report). In addition, adolescents are often grouped as a homogenous group and the heterogeneity emanating from the adolescents different socio-cultural, psycho-social and economic backgrounds is not given sufficient attention.

The statistical information challenges presented above also affects other data emanating from ART interventions among adolescents. Whilst the %age of children benefiting from the national ART programme is generally agreed to be low, there are also current problems in establishing the adherence levels to ART treatment for those already initiated on ART. According to the National HIV Estimates Report (2017:13) whilst Zimbabwe has registered successes in reducing new incidences of HIV among new-born babies from 21% in 2011 to 6.7 % in 2017, these statistics show that there are still some infants that get infected at birth. Problems associated with stereotypes, stigmatisation, household poverty and poor access to

health care services including PMTCT have resulted in some children not benefitting from preventive interventions and having continued exposure to HIV infections. The phenomenon of HIV infected children needing ART and their adherence to the treatment regimen once placed on ART is thus a concern for health and development specialists, civil society and social scientists alike.

According to the UNAIDS and PEPFAR (2011: 35), evidence from various African countries, such as Uganda, Botswana and Kenya indicate that whilst three-quarters of adult antiretroviral (ARV) users in Africa are adhering successfully to ART, one-quarter of ARV users, mostly children and adolescents, still struggle to adhere. High levels of ART adherence are critical for viral suppression and reduced morbidity and mortality among HIV infected adolescents. Furthermore, several studies, such as a study by Donnell et al (2010: 2092–2098), suggest that provision of ART to HIV infected patients could be an effective strategy to achieve reductions in HIV transmission.

Throughout the evolution of the epidemic, strategies and efforts have been devised by actors that include government, research, civic society organisations and international development partners such as United Nations agencies to mitigate the impact of HIV and AIDS on the population. According to the World Health Organisation (2010: 78), these efforts have tended to be heavily influenced by the medical approach with its emphasis on HIV and AIDS treatment. However, according to the same source, evidence on HIV intervention programmes from several developing countries has shown that in most cases treatment programmes have failed as a result of the negative influence of certain social factors that impact on the success of treatment programmes. This study explores the extent to which social networks play a critical role in influencing health outcomes among adolescences born with HIV. Through an analysis of the impact of social networks on ART, adherence among adolescents will be analysed as it is key to the success of treatment and prevention programmes among adolescences.

1.4 Theoretical Framework

The study of the impact of social networks in influencing human behaviour is prominent in sociological studies, for example, Pierre Bourdieu's work on social networks and social capital. This study adopted the definition of social networks coined by Bourdieu (1983:244)

who refers to social networks as “sets of linkages or relations between people”. Examples of social networks highlighted by Bourdieu include those that are based on kinship ties, friendship, sexual contact, or the exchange of information or services.

As noted by Bourdieu (1983:245), social networks initiated by individuals or individuals representing groups such as families result in relationships of mutual obligations that extend to members of the social network. In other words, individuals such as adolescents may thus become members of social networks into which they have entered as individuals or of networks that have been initiated by members of their family, households or other social institutions which they belong to, thereby creating extended obligations.

In this study, the theoretical framework that was propounded by Pierre Bourdieu in his study of social capital is the basis for analysing the impact of social networks in influencing adherence to ART among adolescents living with HIV in Zimbabwe. The importance of Bourdieu's theoretical framework to this study is his assertion that social network relations in most cases become transformed into durable long-term social ties with mutual and ritual obligations which become a form of capital which he refers to as "social capital". Bourdieu defines social capital as; "the sum of resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition" (Bourdieu and Wacquant 1992:119).

The development of new communication technologies has also resulted in the phenomenon of "social networks in cyber-space" as conceptualised by Lin (1999:43). Lin tended to deviate from the analysis of social capital done by Bourdieu and argued that whilst social networks have for a long time been associated with the concept of social capital, the extensive involvement of youths in cyber-based social networks is in most cases not accompanied by the development of robust forms of social capital. With Zimbabwe having an internet penetration rate of 50.1% according to the Post and Regulatory Authority of Zimbabwe (2017:3) the implication is that most of the adolescents, particularly those in urban areas, are exposed to such forms of cyber-social networks. The phenomenon of social networks in cyber-space is explored in this thesis given that Chitungwiza which is one of the study sites is a highly urbanised area. Whilst the aspect of cyber-based social networks is mostly biased towards the urban settings as opposed to the rural areas, this study will provide a balanced

analysis of the cyber-based social networks on influencing adherence behaviour among adolescents in both the rural and urban areas in Zimbabwe.

Sociologists have rightly contended that the HIV and AIDS epidemic occurs in a socio-cultural context that defines the epidemic and its effects on people as social actors (Mararike 2009:39). Interventions to tackle the epidemic therefore must be cognisant of this context, which in turn consists of social networks in their different identities and forms, among others. As stated by Bourdieu (1983), once the social networks become durable with clear social obligations, the networks become a form of social capital which members of the social network can depend on in their times of need. This implies that individuals in social networks become obliged to fulfil certain social responsibilities as defined by the social networks to which the individual belongs.

This study contends that social networks in their different forms can either be enablers for ART adherence or barriers to ART adherence for adolescents on ART. This will involve analysis of the role played by social networks in influencing adherence behaviours among adolescents. According to Myroniuk (2011: 32), there are many reasons why people do not adhere to their treatment regimens and particularly for adolescents, there are additional barriers and complexities. Myroniuk argues that this is because for the young adults it is a time of rapid development and the constant flux of peer pressure and the search for social identity. Evidence from a study done in Malawi by Myroniuk (2011:47) indicates that while children on ART have various support mechanisms, including social support groups, to enhance adherence to the treatment regime, the children are also impacted on differently by the social dynamics they encounter from their various social networking relationships with institutions such as their families, households, communities, and religious and other social entities they interact with. Citing the example of religious groups in the study, Myroniuk argues that not all religious groupings supported adherence to ART therapy and that PLWHIV are often condemned and ostracised.

1.5 Problem Statement

This study seeks to undertake an in-depth assessment of the impact of social networks on ART adherence among adolescents using Zimbabwe as a case study. Adolescents for the purpose of this study are those aged 15-19 years. The study focuses on children who were

born with HIV and have survived to become adolescents and are currently enrolled on ART programmes. There is now accumulating evidence that children born with HIV do survive to become adolescents. In Zimbabwe, there are currently no statistics on the number of children born with HIV and their survival rates. However, the fact that the selection of this target group in this study was possible already shows how ART challenges the strongly held assumption that survival from birth to adolescence with HIV was highly unlikely and HIV in late childhood was very unusual. Traditionally, the accepted view was that the majority of children would die before the age of five (Ferrand et al 2010:428). According to information in the UNAIDS (2006) despite the emergence of this new social group of HIV infected adolescents, globally, there is a general lack of awareness of the health and social challenges that face adolescents living with HIV and AIDS. The challenges include the long-term effects of the therapy, drug resistance, severe side effects, mental health issues, and a plethora of challenges related to HIV and AIDS stereotyping and stigmatisation.

The adolescence stage is a time for both physical and social development and thus the adolescent is faced with a multiplicity of social networks which in some cases call for the individual to make certain choices. For example, in certain instances, individual adolescents make choices on the type of social grouping they may want to belong to, but in certain cases, the social networks are imposed on them due to commitments made by their families, households or institutions to which they are voluntarily or involuntarily affiliated. Like their peers who may not be infected with the virus, adolescents living with HIV are faced with a complex social environment with extensive and sometimes complex social networks.

Besides, the adolescents are faced with an already complex social world in which they have to define their sexuality, social identity, and also engage in social rituals like marriages which present and construct new social networks. According to Dzimiri, Chikunda and Ingwani (2017:73), the increase in the phenomenon of child marriages is a social challenge that is affecting girl adolescents. In 2017 Africa had an alarming child marriage prevalence rate of 30% which was equal to that of Zimbabwe. The phenomenon of child marriages often attributed to high and increasing levels of poverty have also been blamed for the increasing HIV prevalence rates among adolescents (Dzimiri et al. 2017:73).

The growth of technologically-driven communication systems is also a phenomenon that complicates the socio-cultural and economic environment in which adolescents develop. Of

particular importance is the development of cyber-based social networks which are enabling youths to connect across countries, regionally and inter-continentally on such social platforms like *Facebook, Twitter, Instagram* and *Whatsapp*. As noted by Lin (1999:45) the development of cyber-space and cyber-based social networks presents a new era of globalised social networks where information and resources flow, and new practices develop which influence individual behaviour.

1.6 Study Objectives

In the context of the background discussed above, the overall objective of the study is to explore the role played by social networks in influencing ART adherence among HIV positive adolescents in Zimbabwe. To gain an in-depth understanding of the study objective, the study will seek to answer the following research questions

1. What is the significance of different types of social networks in determining ART adherence among HIV positive adolescents?
2. What is the nature of social networks involving adolescents living with HIV and personnel or staff working for formal health institutions and state welfare institutions? What are the implications of such social networking relationships on ART adherence?
3. What is the role played by religious institutions, particularly emerging charismatic churches in influencing ART adherence among adolescents?
4. How are adolescents networking on social media platforms such as *Twitter, WhatsApp, Facebook?* How does social networking on these social media platforms inform their adherence to ART?

1.7 The rationale for the Study

Whilst there have been studies on the linkages between HIV and AIDS and social networks in Zimbabwe and the sub-Saharan African region, most of these have focused on the influence of social networks on HIV prevention programmes at the general population level (Gregson et al 2011). The studies by Gregson et al for example used the households as the social unit of analysis when analysing the interface between HIV programmes and the impact of social networks. This has resulted in the individual voices of adolescents in households being lost. This study will fill this gap by giving a voice to the adolescents to evidence the

role played by social networks in influencing adolescents' ART adherence which is a vital component of HIV and AIDS treatment programmes worldwide.

In addition to the above, by offering an in-depth exploration of the influence of social networks on ART adherence this study highlights the importance of analysing social networks among adolescents as part of the response of their general health challenges among this social group. The main argument in this thesis is that social networks play play a significant role either positively or negatively in influencing adherence to ART behaviours among adolescents in Zimbabwe. I also argue that social relations involving adolescents influence their social behaviours and when the social networks extend to involve other external people from community institutions this even goes further to influence the adolescents ART adherence patterns. In this thesis I also contest that the advent of various social media paltforms has resulted in the increased sharing of information within the social networks in which adolescents interact. The information flowing through the social networks influences to a great extent the adolescents ART adherence behaviours.

This thesis aims to provide a much broader understanding of the intricate relationship between adolescents' social networks and HIV treatment outcomes. There is a need for the development of systematic accounts of the role played by social capital in shaping community responses to health threats and particularly among HIV positive adolescents who are struggling with adherence challenges. HIV and AIDS have evolved within different social contexts which play a significant role in determining ART adherence patterns among HIV positive adolescents. Different social environments give rise to different forms of social networks and this factor is further compounded by the fact that adolescents are not a homogenous group. Therefore, adolescents are not impacted on similarly by the different forms of social networks that they interface with.

The study aims to provide critical recommendations for the design, implementation and improvement of HIV treatment intervention policies and programmes targeting adolescents, showing how social networks can be positively manipulated to bring out positive health outcomes for adolescents. The outcomes of strengthened social network systems can be evidenced by a robust social capital base that enhances ART adherence among adolescents as well as their general wellbeing.

1.8 Methodological Approach

The study focuses on adolescents attending the community-based HIV and AIDS support groups and includes adolescents facing challenges adhering to their ART treatment regimens. This study employs mixed qualitative methodologies to facilitate the collection of in-depth narratives from adolescents, their heads of household, staff members from community institutions (health facilities, social welfare, churches and community-based organisations) on how social networks are significant for adherence to ART among HIV positive adolescents.

The application of the in-depth interview technique can be described as a case study of someone's life or some aspect of their life and is used in this study to gain access to the lifeworlds of adolescents and the impact of social networks in influencing ART adherence (Wainright 2007:1).

This research was conducted within the confines of the research ethics and guidelines of the University of South Africa as enshrined in its research policy. Ethical clearance for the study was provided by the UNISA Ethics Committee before the commencement of the study (see Appendix 1). In addition, the study also adhered to other International Research Ethics Guidelines that guide researching children and young adults, particularly on issues of privacy and confidentiality.

1.9 Definitional Issues

In this section, I define key terms that will be used throughout this study. While these definitions are largely derived from their application in the field of sociology and public health, they are also contextualised to the study context in Zimbabwe.

Adherence: Kagee, Emien, Berkman, Hoffman, Campos and Swartz (2011: 83) defines ART adherence as constituting the following treatment elements: *Dose adherence* which refers to number and proportion of doses taken; *schedule adherence* to doses taken on time; *dietary adherence* to doses taken correctly with food and *adherence to care* to the attendance of clinic appointments. Kagee et al (2011) have argued that the aspect of adherence emanates from the medical discourse on HIV and AIDS treatment and therefore does not provide thresholds for adherence. For example, nowhere in the WHO Guidelines do they mention partial adherence.

Non-Adherence: For this study non-ART adherence will be considered as not taking the medication at all for a prolonged period extending over one month, taking the medication at the wrong time, taking the wrong doses, prematurely terminating treatment and self-adjusting doses to modulate side effects as well as not filling prescriptions and not attending clinical appointments. The other element related to adherence to specific dietary requirements is not considered as a parameter for non-adherence as it is difficult to trace at the household level and obtain reliable statistics in Zimbabwe due to the high levels of poverty and unemployment which naturally affect most of the people's choices for balanced diets including those not on ART.

Antiretroviral therapy (ART): The term has become synonymous with most HIV and AIDS treatment interventions. As noted by the World Health Organisation (2016:34) ART consists of several elements of the treatment interventions that are linked to a person's behaviours that promote positive treatment outcomes. These behaviours include but are not limited to religiously taking prescribed medication at the right time, following a specific diet and changing lifestyle in line with recommendations from a health worker.

1.10 Outline of the Thesis

Eight chapters make up this thesis. Chapter one is an introduction to the study and provides a background to the HIV and AIDS problem in sub-Saharan Africa, progress made in the implementation of HIV and AIDS interventions and the sociological interface between HIV and AIDS programming and the role of social networks. The chapter describes the problem statement, the objectives and research questions of the study, the significance of the research as well as the outline of the thesis. Chapter two provides a literature review and chapter three presents the theoretical framework and a detailed analysis of the study's conceptual framework. Chapter three also presents the key concepts of social networks and social capital and how these concepts are interpreted and applied throughout the study. Chapter four is the methodology and study design section which spells out the methods used for sampling of study participants, data collection, management and analysis, the justification for the methodological approach, and challenges and limitations in the application of the methods during the research process. This chapter also provides a detailed description of study sites and the selection process of the study. Chapters five to eight presents the research findings in detail while chapter nine is the conclusion with insights on contribution to knowledge and areas for further research.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature linked to the study. Globally, many academics, researchers and practitioners have focused on how social factors such as gender, educational background, religious affiliation among other factors influence the treatment adherence of people infected with HIV. A lot of the research and literature on HIV and AIDS has also tended to focus on the significance of social factors in the prevention of HIV (see for example Béchu, 1997; Mushati, et al, 2003; Booysen, 2000, Campbell et al 2013). At the time most intervention efforts were directed towards prevention programmes. Researches on the subject were also biased towards quantitative methodologies and where this was not the case, researchers adopted a balance of both the quantitative and qualitative methodologies (see for example Nostlinger et al. 2015 and Bandason et al 2013).

The inclusion of social network analysis within the sociological and HIV and AIDS discourses is not a new phenomenon, but the focus was not on adherence and adolescents as the focus of the study. For example, Campbell, Scott, Nhamo, Nyamukapa, Madanhire, Skovdal, Sherr, and Gregson (2013:1), in their study of the role of community groups in HIV and AIDS prevention, focused on adult women in Zimbabwe. In this chapter, I will focus broadly on the literature on HIV and AIDS treatment with an emphasis on adherence and social networks among adolescents. I acknowledge that there is a lot of work that has focused on other population groups such as adult men and women and HIV and AIDS prevention.

2.2 HIV and AIDS within Sociological Discourse

Mykhalovskiy and Rosengarten (2009) in a critical analysis of the social theory around HIV and AIDS have argued that the emergence of ART in the late 1990s resulted in the HIV and AIDS discourse being subjected to new forms of social inquiry. Researchers now started enquiring how the therapy can be effective within different socio-cultural environments and among different social groups such as adolescents (see for example Carpiano, 2006).

While the work of Mykhalovskiy and Rosengarten (2009) broadly focuses on the need for an inclusive social science enquiry in the HIV and AIDS discourse, it raises issues pertinent to this study. The two writers' analysis provides insights into the shortcomings of previous HIV

and AIDS studies that tended to focus more on providing medical responses to the pandemic without raising questions on the significance of social factors that determine the effectiveness of such interventions. This position has also been supported by other writers like Piot et al (2008:853) who have argued that social science research on HIV and AIDS tended to focus on where to direct impact mitigation interventions with little attention given to how interventions work in different social environments across different social groups.

While Mykhalovskiy and Rosengarten (2009) do not mention anything about adolescents, they highlight the need to explore relevant sociological factors such as social networks in influencing the success of HIV and AIDS interventions. In his latest study Mykhalovskiy and Namaste (2019) pointed out the importance of AIDS Service Organisations (ASOs) in providing a social environment that supports the empowerment of people living with HIV to make positive decisions related to their health. Mykhalovskiy and Namaste (2019:12) argued that a condicuve social environment is necessary for for empowering people living with HIV to meaningfully enegage in what they refer to as the "treatment decision making discourse. The two authors define the treatment decision making discouse as consisting of a variety of ideas and thinking and the social arrangements related to how people living with HIV come to engage with HIV treatment regimes.

Other contemporary theorists involved in the field of medical sociology, particularly those engaged in the HIV and AIDS discourse, there is a considerable recognition of the significance of the social context as a viable resource and mediator of health and well-being (see Minkler and Wallerstein 1997; McKnight and Kretzman 1997). This thinking is also shared among development agencies fighting the HIV and AIDS pandemic such as the World Health Organisation who recognised that, "…social capital creates health, and enhances the benefits of investments for health" (WHO Health Promotion Glossary1998:19).

The above supposition is also evidenced in the work of Campbell et al. (2013:2) among adult women living with HIV and AIDS in Zimbabwe where community group membership resulted in the reduction of social stigma and improved access to HIV and AIDS services. The study also concluded that participation by women in formal community groups such as church or women's groups and other informal local networks such as those with neighbours and families provided opportunities for critical dialogue about HIV and AIDS. Campbell et al

(2013) also noted that such social networks involving formal and informal community groups were important in providing a platform that facilitated the renegotiation of harmful social norms and sharing of previously hidden personal experiences on HIV and AIDS (Campbell et al 2013:1).

Perry and Pescosolido (2015: 117) in a longitudinal study in Indianapolis provided evidence that social networks are conduits of health-related cultural capital, including the ability to identify symptoms of illness, recognise a need for formal and informal support, and help secure access to health and social services. The two authors argued that networks that possess health capital are probably more likely to be activated for medical advice and discussions on health issues as they are perceived to be knowledgeable and helpful to those involved in such social networks. In their bid to demonstrate the important linkage between social networks and health, Perry and Pescosolido (2015) studied the instances whereby individuals activated their social networks ties in response to being affected by mental illness. Using this approach, the authors discovered that individuals in the longitudinal study that had a history of mental illnesses had a better quality of life as a result of their social networks ties. The study noted that those patients with activated social network ties felt closer to people within their social networks and this tended to have positive health outcomes among the patients that suffered from episodes of mental illness.

The two authors, Perry and Pescosolido (2015) also noted that when examining the health outcomes of social networks, it is not enough to just focus on how the social network functions, but also the characterization of the social network in terms of its size and complexity. Among their participants in the longitudinal study, they discovered that individuals with larger health discussion networks characterized by close ties and a culture of support for medical care at the point of entry into treatment enjoy better outcomes ten months later. Having a strong social safety net that includes engagement in health discussions with specific people translates into improved quality of life, social satisfaction, ability to perform social roles, and mental health (Perry and Pescosolido, 2015:123).

Whilst the discussion above focuses on the positive health outcomes from the influence of social networks, there is also a growing interest from other researchers that have examined the negative influence of social networks on health outcomes. For example, Fujimoto and

Valente (2015: 173), in their study of alcoholism among adolescents in Los Angeles, discovered that social networks based on friendships among adolescents created a risk among adolescents to abuse alcohol and drugs. Other authors like Browning, Soller and Jackson (2015:162) have also argued that social networking among youths may lead to worse health outcomes. Browning et al (2015) noted that social networks among adolescents in the United State of America (USA) were a contributory factor to several forms of delinquent behaviours that included early sexual debut among youths, unwanted pregnancies, and high incidences of sexually transmitted infections.

Other authors like Kelly, Patel, Narayan, Prabhakaran and Cunningham (2014:2) have argued that the analysis of social networks is fraught with complexities arising from the need to understand how social and economic conditions such as poverty and inequality affect the structure of one's social networks, access to networks, or even how one mobilizes one's social capital within and across networks. There has also been a dearth of information specifically targeted at adolescents as many studies have tended to focus on the general population level, thereby omitting adolescents. As argued by Idele, Gillespie, Porth, Suzuki, Mahy, Kasedde, and Luo (2014:144) whilst commitments to engage and involve adolescents in HIV prevention and treatment programmes have been made specifically at United Nations forums, these global commitments have largely remained unfulfilled. Idele et (2014: 144) also note that whilst the United Nations reporting processes recommend disaggregation of data on adolescents, many countries still have challenges in collecting disaggregated information. Idele et al (2014) have therefore concluded that in the absence of such data the social circumstance of adolescents and the challenges they face remain obscure.

The tendency amongst many scholars has been to assume that adolescents are readily captured within the category of children. For example, Campbell et al (2012:123) in their investigation of the factors that affect children's adherence to ARV treatment in rural Zimbabwe, focused on those aged from zero to nineteen years. This also creates another problem as this age categorisation of research respondents introduces parents and guardians as the respondents speaking on behalf of the children and adolescents. For example, Campbell et al (2012:124) mention in their methodology that: "We draw on perspectives of 25 nurses and 40 guardians of children on an ART programme".

Linked to the above discussion, while the growth in studies of adolescents as social agents is an interesting development, evidence shows that very little of this discourse is informed by what adolescents say about their health, sexuality and their experiences (see also Bhatasara, Chevo and Changadeya, 2013). Another study by Gregson et al (2005) on HIV and AIDS treatment adherence among youth in Manicaland province in Zimbabwe that used the household as its study focus is a classic example of this theoretical shortcoming. In the study, the voices of the youth are submerged and those of heads of households prevailed, thereby relegating the individual agency of the adolescents with adults presenting the perceived experiences of the adolescents. Morrow (2002:746) further explains that the main problem with the current literature on youth social networks and social capital is its failure to consider children and youth's independent perspectives.

Campbell, Andersen, Mutsikiwa, Madanhire, Skovdal, Nyamukapa and Gregson (2015: 56) added their voice to these criticisms and noted that the accounts discussed above failed to consider in detail children's (thus including adolescents') own experiences. From a developmental perspective, this could result in unwittingly masking the degree of children's suffering at a time when welfare and development aid for children are being reduced in many settings. Campbell et al (2015:59) concluded that such shortcomings also "mask" constraints on the outcomes of choices available to children in conditions of poverty, violence and abuse, and may play a role in 'normalising' the extent of their suffering.

Studies that have included adolescents have also tended to treat this group as a homogeneous entity. These studies have failed to explore the intricate differences among adolescents and how they are impacted by social factors differently. As noted by Bhatasara, Chevo, and Changadeya (2013) in their study of male adolescent sexuality in Zimbabwe, most social science enquiries tend to regard youths as a homogenous group and often define them strictly in terms of their relationship to adults and as beings in need of adult protection. This thesis contends that this is a major shortfall in the studies focusing on the health of adolescents as this group is heterogeneous and is impacted on differently by HIV and AIDS. As noted by Morrison et al (2005) in studies conducted among girls in a rural community in the Caribbean residing in economically disadvantaged households, girls from female-headed households and those living primarily in rural areas were more vulnerable to HIV and AIDS infections.

To emphasise the importance of paying attention to adolescents, authors like Idele et al (2014: 144) have also added that adolescence is the period when young people begin to explore their sexuality. The authors note that as a result, access to sexual and reproductive health information and services becomes increasingly vital for this group. Idele et al () highlighted that adolescence is typically a period of experimentation, new experiences, and vulnerability as some adolescents may experiment with injecting drugs, sexuality, and sexual orientation (men may engage in unprotected sex with other men), and some are exploited sexually. Millions of adolescents who are becoming sexually active live in countries with a high burden of HIV. The authors conclude by highlighting that adolescence, therefore, provides an excellent window of opportunity in which interventions can be initiated (Idele et al, 2014: 144).

Given the foregoing facts, the sociological enquiry must widen its focus to documenting adolescents' life experiences. This, placed within the HIV and AIDS discourse, will consequently lead to the development of appropriate adolescent-centred research and interventions that help adolescents cope with their experiences. Willis, Frewin, Miller, Dziwa, Mavhu and Cowan (2013: 129) have pointed out that despite survival improvements, the childhoods of children and adolescents living with HIV are typically dominated by numerous complex physical, psychological and social stressors which impact on their well-being and affect their ability to enjoy happy, healthy, fulfilled lives.

Various studies and national surveys focusing on HIV and AIDS treatment have highlighted the enormous adherence challenges faced by the general population in adhering to their treatment (see for example Zimbabwe Stigma Index Report, 2014; Zimbabwe Demographic Health Survey Report 2013). Willis et al (2013: 131) noted that the effectiveness of ART depends on high levels of adherence, yet adherence is challenging particularly for adolescents. Willis et al (2013:131) have rightly concluded that even for adults on ART, few adherence interventions have been rigorously evaluated, especially more innovative adherence interventions for adolescents.

2. 3 ART Adherence Issues in Zimbabwe

Campbell et al (2013:21) have argued that compared to other sub-Saharan countries, Zimbabwe’s ART adherence rates are significantly higher given the constraints in the social,

economic and political environment, particularly the high levels of poverty, high unemployment rates and perennial household food insecurity. The social, economic and political impediments to ART adherence have also been the focus of some scholars writing on ART adherence in Zimbabwe. For example, Hodgson, Plummer, Konopka, Colvin, Jonas, Albertini and Fogg (2014:38) assessed the social barriers to ART adherence among pregnant women living with HIV and AIDS in Zimbabwe and highlighted that religion played an important role in determining adherence rates among them. Hodgson et. al discovered that women belonging to certain religious groups that also promoted the use of alternative forms of medicine, such as traditional healing, had high rates of non-adherence to ART. Apart from their focus on social barriers to adherence, Hodgson et. al (2014:52) also highlighted other factors such as educational level, alcohol and substance abuse and drug shortages at health facilities that affected adherence.

Skovdal, Campbell, Madanhire, Mupambireyi, Nyamukapa and Gregson (2011: 25) studied the gender dimensions of ART adherence in Zimbabwe and found that adherence rates in Zimbabwe were highly gendered. They argued that the attitudes and beliefs of male Zimbabweans determined their health-seeking behaviours. The authors cited that such attitudes and beliefs acted as a barrier to ART adherence among men living with HIV. In the study by Skovdal et al, they mentioned that traits such as being tough, unemotional, aggressive, denying weaknesses, sexually un-stoppable, appearing physically strong and in competition with other men were identified as the stereotypes that characterised manhood among the men in Zimbabwe. These stereotypes have affected their health-seeking behaviours.

Skovdal et. al (2011: 35) found that men's health beliefs and behaviours were defined by their social construction of what constituted a "real man" as reflected in the traits noted above. The authors discovered that the social construction of masculinity was an important determinant of men's health-seeking behaviour. For example, seeking health assistance was considered a sign of weakness and vulnerability among men. Within the social construction of masculinity, the authors discovered that health facilities such as clinics and hospitals were regarded as "women spaces" (Skovdal, 2011: 32). The authors noted that men perceived being infected with HIV, queuing up for drugs, patiently waiting amongst women in the hospital and taking instructions from female nurses as signs of a compromised man. The study concluded that the social construction of masculinity among Zimbabwean men, particularly the presentation of

men as strong and resilient to illness, led to the majority of men not seeking medical services and highly unlikely to adhere to health professional advice (Skovdal 2011:38).

Statistical data on adolescents ART adherence in Zimbabwe obtained from surveys highlight low adherence rates. For example, a cross-sectional study by Cataldo et al (2014) on factors affecting adolescents ART adherence in Malawi, Mozambique, Zambia and Zimbabwe found that as many as 12% of the adolescents who took part in the study had defaulted on their ART therapy at least once in the previous month for a variety of reasons. Cataldo et al noted that there is an urgent need to understand factors linked to poor adherence as more adolescents living with HIV begin to access ART.

ART adherence challenges have been noted to be more prominent among adolescents compared to adults. Bygrave et al (2012: 10) noted that in resource-limited settings and specifically within the 10-15 years age group ART adherence challenges among adolescents were mostly linked to factors such as medication side effects, appointment schedules at health facilities that interfered with daily chores, depression and stigmatization. Apart from listing the factors above, most of the studies on adolescent adherence do not offer concrete social theoretical explanations of the underlying social factors at the individual and community level that influence the observed patterns of adherence.

2.4 Social Networks and ART Adherence

The tendency by many writers on social networks has been to draw a straight relationship between social networks and social capital. As noted by Lin (2008: 185) there is consensus among researchers of social networks that social capital is derived directly from people's social networking behaviours. While there is a general agreement amongst scholars that social networking leads to the development of social capital, authors like Lin (2008) have argued that there is no consensus with regards to the exact characteristics of social networks that result in the construction of social capital. The advent of cyber-based social networks due to advances in information technology has also given rise to new forms of social networks that are based in virtual spaces across the globe. Lin (2001) has therefore argued that there is need for further robust academic enquiries to establish whether virtual networks also contribute to the generation of social capital. Whilst the aspect of social capital is

important, this study will restrict itself to the relationship between social networks and its impact on influencing ART adherence among adolescents living with HIV.

The significance of social networks in influencing health outcomes among people living with HIV and AIDS has been well documented. According to Campbell et al (2012:127), the focus on social networks within the HIV and AIDS discourse was because of the shift from an analysis of the barriers to adherence to the facilitators of adherence. Campbell et al. (2012:129) argue that this shift to the facilitators of adherence was informed by the need to understand why adherence rates within the sub-Saharan African region were higher in the context of such constraints as high poverty levels, poor health facilities and unreliable drug supplies. To bring out the relationship between social networking and ART adherence among adolescents, this thesis will 'privilege' the voices of the research participants. Whilst this methodology is largely borrowed from ethnography it is relevant for this study as it attempts to explore the "truths of the study participants" (see Snyder 2005).

An analysis of the role played by social networks in influencing ART adherence at the general population level was done by Ware, Idoko, Kaaya, Biraro and Wyatt (2009:118) who conducted cross-sectional studies in Nigeria, Tanzania and Uganda. The study outcomes indicated there were intricate relationships between poor quality social networks and ART adherence. Ware et al, however, argued that poor social networking was often characterised by other challenges that included poverty and household food insecurity which therefore directly affected adherence to ART among their study participants. In this study, I will focus on how social networks among adolescents enhance access to material resources that reduce poverty and therefore support ART adherence behaviours among adolescents.

Recently authors like Kelly et al (2014:2) have buttressed this perspective by arguing that an analysis of social networks should also take into cognizance the effects of high poverty levels. Authors like Kovdal et al (2011) have also reinforced this by highlighting that a poor social capital base can consequently result in negative adherence outcomes for HIV positive adolescents on ART treatment.

Authors like Lyons and Santos (2002:87) have envisaged a linear causal relationship between investment in social networks and health outcomes. Lyons and Santos noted that investments

in social relations are seen to affect health positively in a variety of ways, such as promoting health-related behaviours (that is encouraging healthy behaviours and discouraging unhealthy behaviours) and promoting access to services and support. Lyons and Santo (2002) have also attempted to balance their discussion on the significance of social networking in determining health outcomes by arguing that there are other contesting theoretical views that view social networking as an obstacle in the management of HIV and AIDS. Lyons and Santo have therefore argued that the negative aspects of social capital have been grossly overlooked in literature.

Citing the example of religious-based social networks, Lyons and Santo claimed that frequent church attendance could result in social networking that supports positive health behaviours, yet in other circumstances certain religious sects perceive people living with HIV as immoral and deserving of the infection. This argument has been made robust by evidence from studies done by Myroniuk (2011) in Malawi on HIV positive people attending certain religious groups. The evidence from this study indicates that people living with HIV who are members of certain religious sects were often ostracised. In this case investment in such social institutional networks is likely to result in negative adherence outcomes for those people placed on ART treatment.

Campbell, Skovdal and Gibbs (2011: 1205) reinforced the above supposition in their study of the role of religious-based social networks. Campbell, Skovdal and Gibbs (2011) noted that church groups in Africa are key in creating social spaces that nurture social interaction and exposure to social issues. The authors further noted that the church plays a complex and contradictory role in responding to HIV and AIDS, due to its traditionally conservative and judgemental views of 'sexual transgressors' whilst at the same time it is undeniable that the church is a solid bedrock of social networking. Within the scope of this thesis, this could imply that adolescents living with HIV and AIDS who have developed religious-based social networks could suffer potential stigmatisation and social exclusion which could negatively affect their adherence to ART.

Other studies have argued that people affected by HIV tend to have weak social network relations. Webel et al (2009:2) conducted a cross-sectional study of persons living with HIV and AIDS in Canada, China, Namibia, Thailand, and the United States and revealed that

people infected by HIV are likely to have a depleted social capital base and this is often shown through high levels of social exclusion, marginalization and decreased access to health care resources. According to the findings of the study, the relationship between social networks and health may be different among people infected by HIV and AIDS in comparison to the general population. The study concluded that the social environment of people living with HIV and AIDS provides the context that shapes the configuration of their social networks and their decisions about health behaviours.

This thesis acknowledges that the social environment is important in shaping the types of social networks. This fact is demonstrated in the studies by Campbell and Cornish (2009:125) in cross-sectional studies they conducted in Zambia, Kenya and Malawi. This study by Campbell and Cornish is relevant for this study as it specifically focuses on social networking in HIV and AIDS-affected communities. According to Campbell and Cornish (2010:132), social networking among people living in HIV affected communities acted as a form of the resource base that enhances access to opportunities for paid employment, access to food, microcredit schemes and opportunities for welfare grants for people living with HIV. Campbell and Cornish (2009:134) went further to discuss the existence of social networks between people living within HIV affected communities and people working for institutions that provide services to the HIV affected communities. The authors did not only acknowledge the existence such social networks but also argued that the quality of such social relationships and partnerships between individual, family, community, health service users, health providers and funders provided an opportunity for positive health behaviours.

The importance of this analysis by Campbell and Cornish in the context of this study is its reference to the concept of "institutionalized" relations that extend beyond individual networking but involves people from community-based institutions that provide various services and support to people living with HIV. Besides, this analysis also brings to the fore the need to understand and focus not only on individuals social networking but social networking within the wider social context.

This acknowledgement by Campbell and Cornish above is worth noting in this study as adolescents voluntarily or involuntarily belong to various community-based institutions and sometimes form social networks with people from different community-based institutions

that include health institutions, religious institutions and in some cases voluntary associations. Lin and Erickson (2018: 186) have also argued that it is important to gain a deeper understanding into the social network characteristics that result in individuals willingly participating in the activities of a community based voluntary association or institution.

Martinez et al (2012) commenting on the same aspect above noted that trusting, positive social relationships with primary care providers and satisfaction with the health care delivery system may be a powerful tool for HIV positive youths to adhere to their treatment and to combat HIV stigma. The authors also noted that this is a complex process as the needs of youth living with HIV and their satisfaction with health care is often overlooked and in some cases the youths are taken care of in health care facilities that are designed for adults. This study, therefore, contends that the quality of institutionally related social networks plays a significant role in determining adherence among adolescents on ART.

While this study focuses on how social networks among adolescents' influence ART adherence patterns, studies by Ware et al. (2009:25) have provided evidence to the effect that in some Sub-Saharan African countries, adherence to ART treatment is a means of fulfilling social responsibilities and thus preserving social capital in essential relationships. In an ethnographic study conducted in Nigeria, Tanzania and Uganda, Ware et al (2009) concluded that people living with HIV and AIDS struggled to overcome the barriers to adherence so that their health could improve, thus enhancing their ability to support themselves and their families' social networks. In this case, the need to maintain a favourable social capital base worked as a motivation for people to adhere to their treatment regimens.

Ware et al (2009) have however argued that individuals that adhere to fulfil their obligations related to the maintenance of their social networks have now become "trapped in coercive webs of social responsibility". This means that the individual in a social network is obliged to behave, participate and perform certain roles and responsibilities in conformity with the expectations of that social network. The concept of "coercive web of social responsibility" is also an important social factor to understand social networking among adolescents, the majority of whom do not have outlined responsibilities and are not under pressure to establish and maintain a robust social capital base.

As stated by Horne (1998: 67), the relationship between ART adherence and investments in social networks is also influenced by a variety of other dynamic social issues and differs across socio-cultural settings. Horne (1998) cites examples of other social factors such as social demographic characteristics, gender, race, age and educational levels as intervening predictors of adherence. Martinez et al (2012) also noted the existence of such intervening variables in a study on medication adherence in youth in the presence of HIV stigma and list these as "moderating" factors for adherence. Added on to this are the rapidity of social change, exposure to various secular and new forms of religious value systems, and modern technology, particularly the advent of the internet and other computer technologies that have made the world appear to the adolescent as too complex, too relativistic, too unpredictable, and too ambiguous to present a stable frame of reference.

2.5 Conclusion

The linkages involving social networks and adolescents' health is a complex one with different scholars providing different roles played by social networks in influencing adherence to ART. The tendency among researchers and academics has been to examine social networks in terms of their direct contribution to the formation of social capital. Proponents from the medical field perspective have concerned themselves with the assumed positive aspects of social networks on positive health outcomes. Given this, other studies have also highlighted the negative aspects of social networking and social capital among youths and adolescents that may lead to the emergence of social ills such as substance and alcohol abuse, delinquency, gangsterism and sexual offences.

Whilst there is a general agreement among academics that social networks provide the basis for the generation of social capital, the emergence of cyber-based social networks and social media platforms such as *WhatsApp, Facebook, Twitter* and *Instagram* have also complicated the analyses of social networks and the development of social capital. The other complexity arises from the extensive availability of scholarly works that are characterised as adolescent focused, yet the adolescent' voices and life experiences are not fully accounted for in the studies and consultations. In some cases, the adolescents are being grouped with children and adults interchangeably. This is mostly a result of the methodological approaches used by various scholars that focus on parents and guardians as the sources of information on how

adolescents network amongst themselves. In most of the literature, the voices of the adolescents themselves are not audible.

Whilst there is extensive coverage of the linkages between social networks and positive health outcomes, this literature is weakened by a lack of devoted focus on adolescents. In some instances, the focus is on children and youths whilst in other instances, the focus is on young adults. This has created a dearth of information regarding the circumstances of adolescents with regards to social networking, social capital and adherence to HIV and AIDS treatment programmes. In addition, studies on social networks and positive health outcomes within the HIV and AIDS discourse have by and large focused on aspects of health promotion such as HIV prevention and behavioural change among adolescents. There has been very little attention on the effects of adolescents' social networks, social capital and adherence to ART treatment. Thus, the missing link in the academic works has been the lack of a narrative on adolescents, social networking and ART adherence.

The literature presented above however does bring to the fore the significance of social networks and social capital in understanding health-related outcomes among adolescents, particularly within the context of HIV and AIDS. The utilisation of a theoretical framework that provides an in-depth analysis of social networks and social capital is therefore important for gaining a deeper understanding of ART adherence issues among adolescents. The Social Capital theoretical framework propounded by Pierre Bourdieu is discussed in the following chapter as the basis for analysis.

CHAPTER 3: THEORETICAL PERSPECTIVE

3.1 Introduction

This study employs the social capital theoretical framework developed by Pierre Bourdieu as the basis for the research. The adoption of the social capital framework for this study has been necessitated by two main reasons which are central to this social enquiry. Firstly, this thesis recognises that all societies revolve around robust and enduring social networks and these impact on the treatment adherence for adolescents living with HIV. Secondly, the social capital perspective has also been applied extensively in the field of medical sociology but remains untested for studies focusing on adolescents. In this study, I start by focusing on the works of Bourdieu on social capital and then also consider the important work of other scholars like Coleman, Putnam and Lin. Whilst the above forms the central points of my argument, I also acknowledge that an anthropological perspective on gift giving provides important insghts into the understanding of exchanges and reciporocity in the context of social networking.

3.2 Definition and Characterisation of Social Capital

As discussed in chapter two, many scholars on social networks are generally agreed that social networks provide the basis for the development of social capital. However, there is currently no agreed definition of the concept of social capital among the various sociologists who have utilised the theoretical framework in their studies. Woolcock (2010:470) has referred to the concept of social capital as belonging to the category of "essentially contested concepts". Woolcock argues that it is not practical, and neither is it desirable to coin a 'clear consensus regarding the definition and measurement' of social capital. Baum (1999:195) argues that the lack of an agreed definition of social capital is mainly because various writers have approached the subject of social capital from different theoretical perspectives. Baum (1999) further notes that in such cases the different authors make different assumptions about the utility of social capital which then affect how they define social capital and attempt to measure it. Both Woolcock and Baum agree that despite the lack of an agreed definition of social capital, the usefulness of the concept lies in its capacity to draw attention to the study of how individuals can come together to act collectively.

Despite the lack of an agreed theoretical position on the definition of social capital as discussed above, various theorists including Coleman, Putnam, Lin and Lyons and Santo are all agreed on "a set of fundamentals" that characterise and constitute social capital. These fundamental characteristics of social capital include trust, reciprocity, social sanctions, norms and social obligations. In this study, these elements form the basis for the analysis of social networks among adolescents living with HIV. Lyons and Santo (2004) refer to these as the critical "elements" of social capital. These elements are used consistently by these sociologists in their application of the social capital framework in their various studies. Anthropologists such as Sykes (2005:15) have highlighted that the aspect of reciprocity and gift exchange goes beyond the material value of the item of exchange to demonstrate the establishment and confirmation of a social relationship. This anthropological perspective is important as it links closely with the fundamental characteristics of social capital such as trust building and social obligations in social relationships.

It is worth mentioning that the social capital perspective has been widely used in political, economic and medical sociology (Baum, 1999; Hawe and Shiell, 2000; Coleman 1988 and Putnam, 1993). This thesis acknowledges that the concept of social capital is also under continuous reconstruction within the social science discourse and several definitions continue to evolve (for example see the work of Fukuyama (2002), Edmondson (2003) and Tzanakis (2013).

African scholarship on on social capital (see for example Gatogo 2008; and Shuttle 2001) has tended to link the characteristaion of social capital to the concept of *Ubuntu*. As noted by Mbaya (2010: 368) the concept of *Ubuntu* implies a web of social relationships in which Africans are engaged. Mbaya further argues that the social relationships entail a sprit of inter-dependence and mutual trust as people as people rely on each other in everyday life. Shuttle (2001: 12) even makes it more explicit by highlighting that the core values of the African *Ubuntu* is anchored on an interpersonal network of relationships that make an individual fulfil his or her own capacities that make him or her a person. This perspective from the African scholarship on social capital is fundamental for this study as it helps to situate the study in the Zimbabwean community which is by and large a part of social setting where the concept of *Ubuntu* is dominant.

3.3 Bourdieu and Social Capital

This thesis utilises Pierre Bourdieu's social capital analytical framework. Bourdieu arrived at the social capital analytical framework after arguing that the social world is constructed around four forms of capital, which are economic, cultural, social and symbolic capital. Bourdieu starts by stating that the social world is "accumulated history and that one must introduce the concept of capital to understand accumulation and its social effects. In this study, my focus is on social networking amongst adolescents and how this generates the social capital that is important for determining ART adherence behaviours. As mentioned in the definition of social capital above, Bourdieu's social capital analytical framework is constructed around investments in social relations. An important characteristic of Bourdieu's social capital framework is that accumulated investments by individuals or groups in social networks are considered as sources of actual or potential resources that are at the disposal of the individual or group as a result of their social relations or membership of a group.

Bourdieu further argues that membership in a group provides each of its members with the backing of the collectively owned social capital which guarantees certain material privileges. Bourdieu (1986:252) states that “the collectively owned capital provides a credential which entitles group members to credit, in the various senses of the word”. Bourdieu further argues that the profits which accumulate from membership in groups form the basis of institutionalised relationships of material exchanges.

The idea of exchanges is extensively used in the social capital framework to explain the institutionalisation and social construction of the exchange relationships. According to Bourdieu's analysis, the existence of social capital does not occur naturally but is a product of two important processes. Firstly, Bourdieu argues that the existence of a network of connections is constituted by an initial act of institution which is guided by institution rites commonly referred to as "rites of passage". Secondly, the social construction of social capital and exchange relationships is also a result of endless efforts by individuals, family and institutions to forge ties that produce and reproduce lasting and useful relationships that can secure material and symbolic profits (Bourdieu 1983:256).

Two other important aspects of the social capital framework as presented by Bourdieu are his reference to the aspects of durability and size of social networks as giving rise to differences

in the quality of social capital that accrues to individuals or groups involved in the social relations. Bourdieu argues that the amount of social capital possessed by an individual depends on the size of the network connections he or she can effectively mobilise. The implication of this assertion by Bourdieu is therefore that within the social capital framework of analysis, individuals enjoy different quantities and qualities of social capital depending on the size of their social networks. Linked to this is Bourdieu's idea of a durable network of institutionalised relations of mutual acquittance and recognition. Bourdieu argues that the durability of social networks happens as a result of a whole set of instituting acts that are reinforced through the exchange of material goods (Richardson 1986:251). The process of institutionalisation as argued by Bourdieu become the basis for the formation of solidarity among individuals involved in a social network.

Lastly, this thesis recognises that Bourdieu's social capital framework also highlights the dynamism that is associated with most social processes. For example, Bourdieu notes that the introduction of new members into a family, clan or club results in the reconfiguration of the social network boundaries and the identity of the network (Richardson 1986:252). Bourdieu further notes that the introduction of new members to a social network can expose the network to alteration and adulteration of its identity which all have a bearing on the established exchange processes. This argument is very pertinent for this study that focuses on adolescents living with HIV and AIDS as it presents a basis for acknowledging the fluidity of social networks and social capital among adolescents experiencing a transformation process from childhood to adulthood.

Bourdieu's work on social networks laid the platform for the further development of the theoretical perspective by other scholars. Whilst other scholars have explored the social network and social capital conceptual frameworks (see for example Baum (2000); Hawe and Shiell (2000); Coleman (1988) and Putnam (1993); this thesis will pay attention to the works by Putnam, Coleman, Lin and Lyons and Santo as these authors' further explored Bourdieu's theoretical conceptualisation of social capital and used this as important points of departure for their scholarly works. Lyons and Santo's work provides the added advantage to this study in that it is rooted in their work on HIV and AIDS.

3.4 Putnam's Social Capital Conceptualisation

The work by Putnam is very relevant for this thesis as he has developed his arguments with a strong inclination towards the significance of social networks among individuals and also individuals and social institutions. Putnam's social capital framework is derived from his work in the USA and his popular book *"Bowling Alone"* where he studied the impact of declining social capital. Putnam's work in the context of this thesis is considered as adding value to the work on social capital started by Pierre Bourdieu. It is important to note that there are three central themes to Putnam's social capital framework which are: moral obligations and norms, social values, and social networks in voluntary associations. In a review and comparison of Bourdieu and Putnam's work, Siisiäinen (2003: 183) concluded that Putnam emphasises not only the value of networks but also the trust emanating from the socialisation of individuals in social networks and institutions such as the family, voluntary organisations, religious denominations and civic associations among others.

Putnam's analysis of social capital fundamentally differs from that of Bourdieu as he focuses more on society as a whole and the institutions existing in communities. Due to Putnam's inclination towards the application of the social capital framework to the wider society and institutions such as voluntary associations and civic organisations; his framework has tended to be used in the discipline of political sciences to explain the influence of social capital in political participation by different social groups such as women and youths, see for example Fukuyama (2016) and Newton (2001). Putnam's social capital framing will be useful for the analysis of social capital resulting from social networking processes involving community-based institutions working on HIV in the study areas.

In his social capital framework, Putnam (1993: 163-185) conceptualises a social network that can be expressed in a cyclical way whereby trust creates reciprocity for individuals in voluntary associations, in turn, the reciprocity creates social conditions that reinforce and produce trust. In a comparison of Bourdieu and Putnam, Siisiäinen (2000: 1) noted that while Bourdieu emphasises the "tangible and potential" benefits to be accrued from social networking, Putnam's conceptualisation of social capital focuses on the trust and reciprocity characterising relationships of people and groups involved in social networks. Putnam's application of the social capital framework in the USA led him to conclude that the decline in

levels of social capital was disruptive to the normal functioning of society as it resulted in a plethora of social problems such as an increase in the number of murder cases.

An important aspect of Putnam's conceptualisation on social capital which is also punctuated by the components of trust and reciprocity is his theoretical analysis of individuals and their social networks and participation in voluntary associations. Putnam (1993:173-174) asserted that "voluntary associations influence social interaction and co-operation between actors in several ways". A simple breakdown of Putnam's articulation of the aspects surrounding social networking and voluntary associations has been put forward by Siisiäinen (2006:15) who has argued that participation in "a voluntary association fosters robust social norms that promote reciprocity (social exchanges) and the flow of information among the of individuals involved".

The aspect of voluntary associations is critical to the study of adolescents on ART as in most cases adolescents belong to different voluntary associations which play a significant role in influencing their adherence behaviours. The involvement of adolescents in voluntary associations is a complex issue given that in some instances parental control plays a major role in determining which associations the adolescents may belong to. The model by Putnam in this regard is used to explore the aspects of trust and reciprocity by adolescents involved in such voluntary associations. Given the pervasive nature of religious associations in Zimbabwean society today, Putnam's model is used to explore the significance of these on health-related outcomes among adolescents.

Putnam's work has been applied to the health sector in the USA by other theorists like Kawachi, Ichiro, Kennedy, Lochner, Kimberly and Prothrow-Stith (1997) mainly because of the attention that Putnam puts on emphasising the importance of social capital in influencing the functions of the political, social and economic institutions in society. Kawachi et al. (1997) note that Putnam's model of social capital can be applied to the analysis of how social capital influences positive health-related behaviours and promoting access and use of health services in communities. to services and support.

The relevance of Putnam's ideas and their association with health outcomes have also been welcomed by other writers like Campbell (2000: 184). Campbell has argued that in addition to viewing social capital as "an asset for health", linking social capital and health allows for a focus on the individual and community responsibility for individuals' health behaviours. This thesis notes that whilst there is differential access to health services among different social groups due to differences in vulnerability level, there is a need to explore the significance of individual and collective social capital in enhancing ART adherence among adolescents. The issue to be explored is the extent to which individuals and communities become responsible for positive health outcomes based on the available social capital at their disposal.

This thesis notes that adolescents are not a homogeneous group and are likely to be affected differently by aspects of social capital as they strive for ART adherence. Social capital has been proven to either attract people to medical services or draw them away from such services. The works of Kadushin (1966) in the Upper West Side of Manhattan and Puerto Rico and that of Pescosolido et al (1992) in the USA bring out evidence that large networks would assist individuals to seek medical assistance. On the other hand, other forms of social networks tended to influence people to move away from doctors to alternative religious or traditional healers. These aspects of social networks will be explored in this thesis to bring out evidence of these aspects of social capital among the adolescent living with HIV and AIDS.

3.5 Coleman: Social Capital as a Resource for Action by Individuals

This thesis also uses the social capital framework promoted by Coleman (1988). Coleman's framework of social capital, like the work of Bourdieu and Putnam, discussed above, focuses on the positive effects of social networks as resources or capital that can be depended on by individuals or groups in the short, medium and long term. Rooted in his sociological work within the education sector, particularly his analysis of dropouts from high school, Coleman focuses his attention on the effects of social capital within the family and within the society.

Coleman (1988: 98) has argued that social capital is defined by its function and that social capital in its various forms consists of two elements: some aspect of social structure and secondly that this element of social structure facilitates individual actors' actions. In line with his functionalist perspective, Coleman argues that social capital should be looked at in terms

of the influence that it exerts on individual volitions, self-interest and behaviour within a defined social structure consisting of social values, norms and beliefs. Just like Bourdieu and Putnam, Coleman attempts a characterisation of social capital but ends up arguing that social capital itself consists of three forms which are obligations and expectations, information channels and social norms. According to Coleman (1988:98), these typologies of social capital mentioned above are productive and make possible the achievement of certain ends that in the absence of social capital would otherwise not be possible.

In addition to expanding on the concepts of social obligations and exchanges, Coleman also introduces an interesting idea of differentiating the different types of actors that are involved in social network relations. For Coleman, there are two types of actors which are individual actors acting in their personal capacities and there are also "corporate" actors. Coleman (1988:98) justifies the concept of corporate actors by arguing that "purposive organisations can be actors just like persons and relations among corporate actors can constitute social capital..." Drawing on examples from the corporate industrial sector, Coleman further argues that corporate actors also enjoy social capital that can be expressed through information exchanges on price-fixing within a particular industry.

The aspect of corporate actors emanating from the analysis by Coleman in his analysis is very relevant for this thesis as a starting point to identify the corporate actors involved in the health of adolescents and particularly those living with HIV. This component of Coleman's model is used to analyse the relations that HIV infected adolescents have with the corporate actors which are the suppliers of the health services that they depend on for their well-being. Besides, this component is also used in this thesis to interrogate the existence of forms of social capital amongst the various corporate actors with which HIV positive adolescents interact with. This thesis uses Coleman's social capital model to bring out the intricacies between ART adherence and the social capital emanating from the networking of corporate actors. In the Zimbabwean context, these corporate actors include Civic Society Organisations working in the HIV and AIDS sector, religious organisations and government departments, among others.

Coleman also includes the aspects of norms and sanctions as components of his social capital model that play an important role in influencing individual actors' behaviours. Coleman

(1988:104) asserts that “a norm within a collectivity that constitutes an especially important form of social capital is the norm that one should forgo self-interest and act in the interests of the collectivity”. Following this perspective, it would naturally mean that forgoing personal interests in pursuit of collective interests is rewarded while allowing individual interests to prevail is likely to attract sanctions against the individual. As stated by Coleman “norms arise as attempts to limit negative external effects or encourage positive ones”. As stated earlier, Coleman’s model of social capital attempts to strike a balance between the individual volitions of a person as an actor and the influence of the social structure in determining behaviour outcomes. In his analysis of the significance of norms and sanctions as modelling behaviour in social networks, Coleman adds the element of network closure which he argues determines whether rewards or sanctions are applied to people involved in a social network.

Given the above, this study takes the perspective that the social network conceptual framework provides a comprehensive platform from which an in-depth analysis of adolescents’ social networking and its significance on ART treatment adherence can be undertaken. Of importance to this study is the fact that individuals are primarily responsible for their health outcomes; including adhering to their treatment regimens. However, society is seen to be playing a critical policing role which becomes an important aspect not only to the individual but to the other groupings to which the individual belongs. The question of whether the individual becomes entrapped in the social networks to which they are affiliated becomes relevant here.

For Coleman, social networks are characterised by close and intricate social relationships that make the application of rewards and sanctions among actors involved effective, as deviant behaviour among the actors is frowned upon by all the members of the network. The important factor raised by Coleman relating to the aspect of closure is his assertion that closure of networks (1988:107) is not only important for the effectiveness of norms and sanctions but that it also creates a platform for the nurturing of “trustworthiness” as another form of social capital. The aspect of network closure is applied in this thesis to provide an opportunity to analyse the types of social networks that adolescents living with HIV are involved in.

Coleman's model of social capital is also applied to this study to sustain a social analysis of the social capital available for adolescents from within their immediate families or

households. Drawing from his work on the impact of family social capital on influencing educational outcomes among youths, Coleman concludes that family social capital plays an important role in a child's intellectual development. Coleman (1988: 110) defines family social capital as "the relationship between the children and parents and when families include other members; relationship with these as well". Given the fact that 70% of the AIDS-affected youth population in Zimbabwe is orphaned (Ministry of Labour and Social Services 2010), this element of Coleman's model will be used to interrogate how the adolescents living with HIV and AIDS are managing with the lack of family social capital and how this affects adherence to ART behaviour.

While Coleman in his analysis brings to the fore the aspect of single parenthood and its effects on family social capital, in modern-day societies ravaged by HIV and AIDS there are even more complexities in terms of the forms of families existing. In addition to single-parent families, there is also an increase in the phenomenon of child-led households and households led by the elderly. All these forms of families play a significant role in determining the available family social capital for adolescents living in these families. Coleman (1988:111) describes families without the physical presence of adults as lacking the family social capital associated with the availability of adults within families. It is, however, important to note that from Coleman's definition of family social capital, the physical presence of adults or parents in the family is just but one element of determining the availability of family social capital in addition to strong relationships between children and parents.

Coleman’s work on social capital is particularly interesting for this study as he has also devoted time to analyse the “social capital outside the family” (Coleman 1988: 113) available for young children, this is in addition to his analyses of family social capital discussed above. Coleman conceptualises social capital outside the family as consisting of relationships among parents and the parents' relationships with community institutions (1988: 113). In this thesis, I acknowledge that today's society consists of various forms of social networks that give rise to various forms of social capital. This study, using Coleman's ideals on family social capital and social capital outside the family, explores the inter-dependence of these two forms of social capital and how they influence treatment adherence behaviour among adolescents living with HIV and AIDS.

While the work of Coleman is important in the entire social capital discourse, particularly his focus on organisational networks as actors, his work also brings to the fore another dimension that requires further academic scrutiny. In real-life situations, individuals inevitably belong to different organisations which also contribute to their social capital. It is therefore inevitable that different organisation-based networks discharge different norms which may be conflictual on the individual and thereby making life difficult for the individual. For example, school-based networks and religious-based networks to which the adolescent is attached may circumscribe different sets of norms that may be contradictory. Pescosolido, Wright, and Sullivan (1995) refer to this as "discordance in the culture of networks" and they argue that it is important to understand this discordance to understand and interpret the behaviour of individuals in a social network. This takes into cognisance these complexities and attempts to bring out how these complexities shape adherence behaviour among adolescents living with HIV.

Coleman's work is particularly relevant for this study as his analyses also focuses on young adults and their interface with community institutions such as educational institutions. This study will also analyse the adolescents' interfaces with a variety of community-based institutions including community-based HIV service organisations, community health facilities, churches and other community-level government institutions.

3.6 Cyber-based Social Networks and Social Capital

Lin’s analysis of social networks is based on developments in the information technology industry over the years. Lin’s conceptual framework on social capital is used in this thesis to analyse the complexities arising from the growth of cyber-based social networks and the development of forms of social capital among adolescents living with HIV (Lin 1999:28). Lin acknowledges that the critical tenets of the social capital framework have been well articulated by preceding authors like Bourdieu, Coleman and Putnam but he argues that his attention is on the "theoretical controversies" of the model. According to Lin (1999:35). social capital refers to the "resources embedded in a social structure which are accessed and or mobilized in purposive actions".

Lin's analysis of social capital is also based on the conceptualisation of social capital by other writers like Bourdieu, Putnam and Coleman. Lin analyses social capital by looking at two important levels; that is the individual and the group. At the individual level, Lin focuses on

"....the use of social capital by individuals, and how individuals access and use resources embedded in social networks....." (Lin 1999:31). At the group level, Lin focuses on "how certain groups develop and maintain social capital as a collective asset, and how such a collective asset enhances group members' life chances" (Lin 1999:33). It can be argued that Lin does not bring in new ideas on the concept of social capital, but builds on the work of Bourdieu, Putnam and Coleman through his focus on access and utilisation of such capital. Lin's conceptualisation of social capital as espoused in his definition is significant for this study as it touches on both the individual and collective actions in utilising social capital within the structural realm governed by social norms.

An interesting aspect of Lin's work that cannot be ignored for a study whose unit of analysis is the adolescent, is the aspect of cyber networks. Lin's central argument in his thesis on cyber networks is that "the development of cyberspace, cyber-networks represent a new era of democratic and entrepreneur networks and relations where resources flow and are shared by a large number of participants with new rules and practices" (Lin 1999:45). Lin argued that the availability of inexpensive gadgets such as cheap computers and other devices particularly in developed countries that enable internet connectivity and access by many people could lead towards a generation of wider social networks in an increasingly globalised world. According to Lin, there is strong evidence that an increasing number of individuals are engaged in this new form of social networks and social relations, and there is little doubt that a significant part of the activities involves the creation and use of social capital.

Whilst the internet penetration rate in Zimbabwe was 62.9% in 2018 according to the Postal and Telecommunications Regulatory Authority of Zimbabwe (Potraz), youths, particularly those in urban areas, make use of social media platforms such as *Facebook*, *Twitter* and *WhatsApp* at a higher rate compared to those in the rural areas. Thus, the emergence of cyber-based social networks is a reality among the youth. In this thesis, the ideas of Lin on cyber networks are used to attempt an evaluation of the significance of these on ART adherence among adolescents living with HIV and AIDS.

3.7 Situating social networks within the African social setting

As shown in the introduction to this chapter, there is a lot of literature focusing on social networks and their value in African societies and these have largely been biased towards the concept of *Ubuntu*. As already pointed out in the introduction authors like Mbaya (2010) and Shuttle (2001) have argued that the concept of Ubuntu was centered around interpersonal social relationships which provided a basis for individuals to fulfil their capacities. The conceptualization of the concept of *Ubuntu* by African scholars has similar identies to the theorisatiosation of Bourdieu, Putnam and Coleman on social networks and socal capital. For example; Hlatshwayo (2016:154) in addition to the arguments made by Mbaya (2008) and Shuttle (2001) above has argued that the concept of *ubuntu* refers to the capacity of individuals to express companion, reciprocity, harmony and humanity in the interests of building a community with justice and mutual caring. The reference to reciprocity, companion and mutual care are all tenets that can be inferred from the writings of the early theorists on social networks and social capital.

Hlatswayo (2016:154) takes a close look at the concept of *Ubuntu* and social networking on online social media sites like Facebook and argues that social media users subscribe to the concept of Ubuntu as they interact and socialize based on the understanding that they are part of a community of human beings that are bound by the values of comapanionship, compassion, generosity, solidarity and sharing. This argument tallies with the line of thinking persued by Lin as discussed on the section above. Hlatswayo in her conclusion however cautioned that it was not in all cases that social networking exhibited the positive tenets of *Ubuntu* as there are instances where within and between groups social relationships are hostile and discriminatory. This line of thinking has been taken up by contemporary writers such as Maphosa and Keasley (2015:42) who have contended that the concept of *Ubuntu* is now more explicitly expressed within groups and rather not between groups. This analysis by Maphosa and Keasley is interesting and pertinent for this study which focused on adolescents as a group. The study explores the interpersonal social network relationships amongst the adolescents living with HIV and how other groups in their communities relate to them.

3.8 Social Capital Framework and the Public Health discourse

The social capital theoretical framework has been and continues to be applied extensively in the field of sociology, political science and public health. Authors like Holtgrave and Cosby (2003:62) have argued that the social capital framework has been related to several important public health variables such as child welfare, violent behaviour, mortality, and health status. Also, Holtgrave and Cosby (2003:63) highlighted that the general analysis in public health interventions has tended to generate a perspective that "the more social capital, the better the public health measure".

Whilst the above perspective assumes a very simple relationship between social capital and positive health outcomes, other authors like Auerbach, Parkhurst and Cáceres (2011:1) emphasise that the relationship between social capital and health is a complex one. Auerbach, Parkhurst and Cáceres (2011:1) argue that the association between social capital and health outcomes is mediated by other key social variables such as gender inequalities, poverty, social exclusion and income inequalities among others. The authors further argue that any exploration of the correlation between social capital and infectious diseases should include the examination of the interrelations between poverty and income inequality as well. Using a quantitative approach, the authors concluded that the more social capital, the lower the AIDS case rate; the more income inequality, the higher the AIDS case rate (Auerbach et al 2011: 3).

The application of the social capital conceptual framework within the public health sector has also been influenced by the intellectual developments in the field of sociology from which the framework originated and the developments in the HIV and AIDS discourse. The works of Auerbach et al (2011:10) is key in understanding how this has occurred in both sociology and public health. Auerbach et al (2011:11) noted that a paradigm shift from an emergency to a long-term response has resulted in a change in focus from HIV prevention interventions focused on individuals to a comprehensive strategy in which social and structural approaches often employed in sociology are the core elements. The reference to the structure-agency debates, here which is rooted in the sociological field has raised important dimensions for linking social capital and HIV and AIDS. The approach has re-considered the social conditions and arrangements that affect the ability of individuals to protect themselves and others from acquiring or transmitting HIV. Auerbach et al (2011:11) concluded that when this analytical approach is implemented it can help understand how individual agency allows people to act in their interests and additionally their community's best interests.

According to Auerbach, et al (2011:115) there is disagreement about the extent to which an individual's desires, practices and experience are shaped by outside forces (social determinants) and how much they are a reflection of individual decisions to act (social action or agency). The authors, however, acknowledge that there is a common understanding that much of what humans do, think, and desire is influenced, if not determined, by key elements of social life including norms, values, networks, structures, and institutions (Auerbach, et al (2011:16).

3.9 HIV and AIDS and Social Capital

The work of Lyons and Santo (2004) is adopted for analysis in this thesis as it offers a social capital perspective that is grounded in both theory and tested in the HIV and AIDS discourse. The significance of Lyons and Santo's work to this study also lies in the fact that these authors attempt to provide a balance on the positive and negative aspects of social capital on health outcomes. Accordingly, Lyons and Santo (2004:21) state from the beginning that, "we present literature that claims that social capital is both an asset as well as an obstacle to HIV and AIDS". Lyons and Santo were building on the earlier works of proponents of the social capital perspective such as Bourdieu, Putnam and Coleman who in their analysis gave attention to the negative influences of social capital on human behaviour outcomes. For example, Bourdieu noted that like the other types of capital, social capital has the potential to create social inequalities in society.

Lyons and Santo (2004:21) focus on the practical application of the social capital framework by contemporary theorists like Kawachi et al (1997) and Reimer (2002). Lyons and Santo's work is used in this study to highlight the perceived negative impact of social capital on human behaviour. In this regard, these authors have pointed out that the "over-romanticisation" of the positive health outcomes of social capital is the major weakness of literature exploring social capital and health outcomes. Whilst earlier writers picked on the negative aspects of social capital on human behaviour, the same depth of analysis has not been systematically applied to the field of health sciences.

Lyons and Santo (2004: 22) adopt a definition of social capital proffered by Reimer (2002) which considers social capital as "relational" and not an individual characteristic. Central to

Reimer's definition is the notion that social capital is grounded in four types of social relations which are "market, bureaucratic, associative, and communal". Market social relations are those linked with trade and business ties and connections. Market social relations in most cases involve individual traders that share information about emerging opportunities. On the other hand, the bureaucratic social relations are almost similar to market social relations with the only difference that they are envisaged to exist within and among formal institutions. Associative social relations refer to those social relations in which individuals voluntarily involve themselves and these include religious associations and other community-based collectives. Communal social relations involve the simple social networks that exist between individuals and these are in many cases characterised by kinship ties and friendship ties.

For Lyon and Santo, the above types of social relations are important as they "symbolize the ways relationships are organized and managed to accomplish goals" (Lyons and Santo 2004: 22). This thesis agrees with this line of argument as social relations are complex phenomena particularly when they involve adolescents who are highly mobile, dynamic and in search of their social identities. Lyons and Santo have rightly concluded that social relations are "multi-dimensional" as they involve an interplay of various actors.

The ideas of Lyons and Santo will come in handy in this study as the unit of analysis is the HIV infected adolescent who is likely to be engaged in various forms of social relations (market, bureaucratic, associative, and communal). These all have a significant role to play in influencing the available social capital and thus their ART adherence patterns. Lyons and Santo think that age and gender mediate the connection between social capital and HIV and AIDS. These authors state that "both age and gender are factors in the complicated relationship between social capital and ART adherence. However, these factors are rarely addressed in the literature" (Lyons and Santo 2004:11). The issues raised by Lyons and Santo provide the basis for this study to explore whether adolescents of different age and gender experience different forms of social capital which in turn influence different adherence behaviours for HIV and AIDS treatment.

3.10 Conclusion

This thesis adopts an all-inclusive application of the social capital framework. For this thesis, these social factors are analysed within the scope of the theorisations of Bourdieu, Putnam, Coleman, Lyon and Santo and Lin. These authors' ideals on social capital form the premises for analysing the impact of social capital in influencing ART adherence among adolescents living with HIV and AIDS. An amalgamation of the views of these authors in this thesis allows for a comprehensive analysis of the significance of social capital in influencing ART adherence among adolescents as all the critical fundamentals surrounding the social capital framework are adequately addressed by these theorists.

The authors present different variants of the social capital narrative though there are key thematic aspects that are common. For example, all the authors agree that social capital is just but one type of the different types of capitals that exist. Whilst noting that social capital can have both negative and positive influences on human behaviour, the authors vary in terms of their emphasis on either the positive or negative aspects of social capital. For example, Lyon and Santo focus on both aspects of social capital in relation to health behavioural outcomes.

Another important aspect of the social capital narrative presented by the authors is the focus on individual social networking behaviour and behavioural outcomes. Social networking is guided by the expectations, norms and obligations impressed upon the individual by members of the social network. It can be argued that the norms and obligations can arguably have an entrapping effect on the individual who has to act in conformity with the social network members' expectations. The dimension of social networks being based on the development of cyber-space is also critical for adolescents who are the subject matter of analysis for this study. The emergence of cyber-networks also provides the impetus for an analysis of other confounding social factors such as gender, age, class and ethnicity. These factors throughout the sociological discourse are known to play a key role in influencing human behaviour.

CHAPTER 4: METHODOLOGICAL APPROACH

4.1 Introduction

This section discusses the methodological approach to the study. The study is premised on the qualitative research enquiry which informed both the data collection and data analysis processes. The qualitative data in this study was obtained from in-depth face-to-face interviews with adolescents who are living with HIV and are on ART. In addition, qualitative data were also obtained from in-depth interviews conducted with key informants such as parents and guardians of the adolescents, the staff of HIV and AIDS support groups and representatives of two emerging charismatic churches in Zimbabwe. Information from these in-depth discussions was also complemented by data collected from my observations of proceedings at the churches where the adolescents attended. Observations were also made at the places where the adolescents spent most of their time during the day and these included popular markets where some of them were involved in selling. In this chapter, I also discuss the geographical location of the study sites which are Chitungwiza urban and Seke peri-urban communities. The data collection techniques, research strategies, ethical issues, data analysis approaches, field experiences and challenges encountered in the study are also discussed in this chapter.

4.2 Research Methodology and Strategy

This study employed a qualitative sociological method of enquiry to facilitate the collection of in-depth and rich perspectives on the impact of social networks on adherence to ART therapy for HIV positive adolescents. This technique allowed me to obtain an in-depth understanding of how the dynamics of social networking influence adherence behaviours. As contended by Wainright (2007:1) the use of the qualitative approach will allow me to understand the meanings and definitions of social networking as presented by the study participants themselves. In addition, as stated by Goodwin and Horowitz (2002:33), whilst many techniques have been used to undertake qualitative studies, most of them are similar in their emphasis on capturing considerable depth or detail of what is or was going on for something judged as socially significant.

The application of the qualitative methodological approach to social science enquiry for children and young people has been debated by various authors (see for example Kellet 2011; Smith 2002). Whilst most of the authors that have written on the involvement of children and

young persons in research have generally been concerned with ethical issues, other authors such as McCarten and Murphy (2012) have interested themselves with the quality of evidence emanating from the use of qualitative research approach on young adults. McCarten and Murphy have pointed out that "qualitative research is often considered … a more emotive, human response, presenting an accessible narrative for illuminating stories behind statistics" and thus presents an opportunity to capture the subjective experiences of the youths in an unbiased manner as argued by Guba and Lincoln (1981). In this study, the qualitative methodology was applied not only to capture the rich narratives but also to capture the deeply emotional aspects and voices of the adolescents' life stories.

4.3 Sampling Approaches and Selection of Study Participants

The sampling approach and selection of the study participants were informed by data kept at the Life Empowerment Support Organisation (LESO). LESO works closely with the local clinics in Chitungwiza and Seke and they are entrusted with the responsibility to provide community-based support to people living with HIV. As part of this responsibility, LESO keeps registers of all their clients. The registers have details of the clients' name, home address, sex, age and their next of kin. In this regard, two types of registers exist at LESO, one that contains names of clients that are adhering to their treatment schedules and another that contains names of clients that they describe as being lost to follow up. The category of clients that are lost to follow up includes those adolescents that are not adhering to their treatment schedules.

Based on these two registers I identified twenty-two adolescents aged 14-19 years for inclusion in my initial sample. Initially, I also attempted to deliberately achieve a gender balance among the study participants by selecting an equal number of female and male adolescents from those that were adhering and from those that were not adhering. This was however not very successful as there were challenges in obtaining enough study participants. Through a discussion I had with LESO staff members, I then selected twenty-two individual cases that would provide in-depth information that answered my study objectives. As stated by Sandelowski (2000:334), the goal of sampling in any qualitative study is to obtain cases deemed information-rich for study.

This type of research design that included adolescents adhering and those not adhering is meant to understand how social networking can either be an enabler or a barrier to adherence. The study focused on adolescents that were currently attending voluntary community HIV and AIDS programmes at LESO and those that once attended but had stopped for various reasons. It is important to note that some of the adolescents that were not adhering to their ART treatment would occasionally attend activities at LESO since apart from its HIV and AIDS programmes, the organisation also offered free trainings on income-generating activities and entrepreneurial skills. The two groups exhibiting contrasting adherence patterns were used to bring out the differential impact of social capital in influencing adolescents' ART adherence. This strategy was also employed to bring out the wider contextual factors linked to social networking and how this related to adolescents' adherence to ART.

The field data collection strategy for this thesis was done with the assistance of four adolescent research assistants. The research assistants were drawn from the pool of adolescents that attended activities organised by LESO. Initially four adolescents (two males and two females were selected based on their availability throughout the research process. One of the female research assistants later dropped due to pressure from her family that was not comfortable with her participating in activities linked to LESO.

The remaining three research assistants were involved in the identification of where study participants lived, and they also assisted in note-taking and compilation during the interview processes. Most importantly, the research assistants were also part of the study participants and provided me with an opportunity to obtain further in-depth information about their social networking behaviours and that of the other adolescents. The strategy of involving the adolescents research assistants was also my approach to gain acceptability by the group of study participants that initially showed lack of interest due to research fatigue and demanded cash incentives in exchange for information (which could not be provided, see ethical considerations below). The advantages of involving the adolescent research assistants were the ease of access to research participants. While adolescents were easily identified, getting them to participate in the study was a challenge in a society where HIV stigma is high (see the Zimbabwe Stigma Index Research Report 2014). Working with the research assistants also resulted in the collection of high quality, credible and valid narratives as they assisted in validating the narratives.

While the perspective that the use of peer researchers results in high quality, credible and valid narratives can be challenged, I contend that the time spend in making field follow-ups by the assistants resulted in very rich narratives of the adolescents' life stories. The relationship between the research assistants and the study participants was highly 'informalised' making it easier for in-depth data narratives to be validated and divergent views to be reconciled. Since the three researcher assistants attended the same HIV Support Group with the rest of the study participants, this presented a rare opportunity for me to check on the actual practices of the adolescents against the reality portrayed in the narratives.

Apart from the advantages to the research process itself, I observed that the employment of researcher assistants who were adolescents living with HIV had some personal positive effects on them. I noted that there were improvements in their self-esteem and confidence levels. Two of the peer researchers invested their allowances in their education and the third one obtained a position as a research assistant based on the skills and competencies obtained through this research. It is also hoped that this research through its collection of rich narratives will go a long way in generating knowledge about the role of social networking in influencing adolescents' ART adherence and thus provide a starting point for improving the quality of life for all children and adolescents living with HIV.

4.4. Data Collection Processes

4.4.1 In-depth Interviews with selected adolescents

The in-depth interviews were applied to an equal number of adolescents from those that are adhering and those facing challenges to adhere to their treatment regimens. As argued by Hagemaster (1992:122), the use of the life history qualitative methodology allowed for the exploration of each adolescent's individual experiences within a socio-historical context. A total of 22 in-depth individual case-studies were compiled for adolescents aged between 14 and 19 years. The case studies were compiled for four months with follow-ups being made within a period of three months from the date of initial engagement.

As stated by Sokolovsky (1996: 221), the in-depth interview technique is not based on gathering information from a large number of respondents and trying to get reliable and valid results by averaging the data.; The core element of in-depth interviews is rather to understand a particular individual and the impact of social networks on their health decisions. The data

obtained from the in-depth interviews were used to construct a story of the adolescents' adherence to ART behaviour bringing out the impact of social capital as a critical variable in influencing adherence. For this thesis, in-depth interviews provided an excellent opportunity to gain access to the lifeworlds of adolescents and the impact of social networks in influencing ART adherence.

4.4.2 In-depth Key Informant Interviews

I conducted individual interviews with the staff members of LESO. These detailed interviews continued throughout the study process as I had to come back to them on many occasions to seek clarity and triangulate their information with what I was collecting from my interactions with the adolescents. Firstly, I engaged the Director of LESO in a general discussion regarding factors affecting ART adherence among adolescents. Secondly, I also discussed with the Programme Officer who was responsible for delivering counselling sessions and trainings for the adolescents at LESO.

Detailed interviews were also conducted with community-level government institutions such as nurses at the local clinics in both Chitungwiza and Seke. These interviews with key people belonging to institutions provided an opportunity for the generation of knowledge around the kind of social networking involving people living with HIV and the institutions that serve them. To this extent, the type and forms of social capital emanating from social networking and how such social capital influence adherence behaviour among adolescents was explored. Key informant interviews were also conducted with staff in the Department of Social Welfare and Child Protection in Chitungwiza and Seke districts. The interviews with the Department of Social Welfare and Child Protection were prompted by the realisation that the adolescents and their households were receiving various forms of assistance from the Department that included payment for hospital fees.

Key informant interviews were also conducted with representatives of the church leaders of the emerging “charismatic” churches that have sprouted in Zimbabwe over the past ten years. The representatives were from the leading charismatic churches in Zimbabwe which are the United Family International Church (UFIC) and the Prophetic Healing and Deliverance (PHD) church. Whereas my plan was to get appointments with the two leaders of these churches this was not possible as there was a reluctance from their representatives to book the

appointments. After making five attempts to book the appointments and failing, I then resorted to having interviews with the representatives of the leaders of these two churches in Harare and Seke and Chitungwiza as well. The leaders of these two churches are infamous for claiming that they have powers to treat HIV. patients (see for example Togarasei 2010). These interviews were also part of the exploration of how adolescents' social networking with members from community-based institutions created social capital that influenced ART adherence.

In Seke one of the key informants was the local Village Head who provided insights into the role played by traditional structures in the protection of adolescents living with HIV. The Village Head was also interviewed because he was directly involved in a social networking relationship with an adolescent who was head of household. Some of the parents and guardians of my study participants also became key informants in most of the cases where I intended to clarify certain narratives provided by the adolescents. I made use of the opportunity to hold interviews with parents or guardians in cases where they were available during the interview process with the adolescents. My interaction with the parents and guardians of some of the adolescents enriched my research data as I was able to gain insights to cross-check on the authenticity of some of the information provided by the adolescents. The table below summarises the key informants I interviewed and the types of information obtained.

Table 1: Key informants interviewed

Key Informant	**Number of Times Interviewed**
LESO Youth Counselling Officer	4 Interviews-To gain insights into the adolescents' adherence challenges and their social networking behaviours
LESO Director	Three Interviews-Issues on national policy on adherence, the HIV situation in Seke and Chitungwiza and role of the church in influencing adherence
Male nurse at Chitungwiza Council Clinic	3 Interviews-To understand the adolescents' adherence patterns and their networks with staff working at the health facility

Female Social Welfare Officer in Chitungwiza	3 Interviews-To gain knowledge on how the Department was assisting households with adolescents
Two representatives from the Prophetic and Deliverance Healing church and the United Family Inter-Denominational Church	Two interviews (one with each representative)-To gain insights into how church-based social networks were influencing adherence behaviours amongst the adolescents that were members of the two churches
Local Village Head in Seke	One Interview-The role of traditional structures in supporting children living with HIV.
4 Selected parents of adolescents (these were interviewed based on availability and willingness to participate in the study	Five interviews with each parent-To triangulate some of the narratives provided by the adolescents.
Research Assistants	More than 10 interviews with each – these were continuous and sometimes informal discussions

4.4.3 Focus Group Discussions

Two focus group discussions were conducted with LESO staff members. The first focus group discussion was conducted at the start of the interview process. The second focus group was conducted at the end of the interviewing process to triangulate information obtained from the different sources that included adolescents themselves, their parents or guardians and staff members from the local clinics and department of social welfare. The first focus group discussion had 11 people that included seven LESO staff members (excluding the Director who was not available), three women volunteers working with the organisation and one adolescent. The second and last focus group discussion had eight participants that were all LESO staff members including the Director who did not participate in the first focus group discussion.

I designed a focus group discussion tool that had five key questions. I moderated the discussions whilst two of my research assistants took notes of the proceedings. The third research assistant assisted me to probe for more information on issues that were not clear and where the LESO staff members had different opinions on the same issue. The focus group discussions also brought to the fore the different experiences of the LESO staff in their interactions with adolescents living with HIV. During these discussions I allowed the different staff members to share their experiences in terms of their interactions with the adolescents outside the LESO premises. This approach allowed those staff members that networked with the adolescents in their informal spaces to share in-depth narratives about the behaviours of the adolescents in their private spaces, their interactions amongst themselves and their other social networks with the staff of other community-based institutions such as churches and government departments.

Information from the two focus group discussions was used to support data obtained from the in-depth interviews conducted with individual adolescents. The information was also triangulated with that obtained from key informant interviews and the observations I had made on my visit to the marketplace in Chitungwiza and subsistence farming gardens in Seke. The triangulation of data across the three sources of data allowed for the validation of key thematic areas, trends and areas of divergence. As noted by Bryman (1997: 2) this approach, known as methodological triangulation, can also be used to document different interpretations of the role of social networks and social capital on adherence from the vantage point of the adolescents, community people and people linked with institutions that interact with the adolescents.

In the context of this study, focus groups enriched the data collection process by bringing in different opinions of the LESO staff members on how they viewed social networking among adolescents as having an influence on adherence behaviour among adolescents. I noted that the strength of focus group discussions lies in the fact that they allow participants to agree or disagree with each other and this provided insights into how different LESO staff members interacted with the adolescents both in the formal and informal spaces. In addition, I also used the last focus group discussion to iron out the inconsistencies and variations that came out from the interviews with the key informants.

4.4.4 Site Visits and observations

During the time of the research, I attended two church sessions, one for UFIC and another for PHD church with two adolescents. This was an opportunity to observe and get to talk to some of the adolescents that attended these two churches. I also visited Huruyadzo shopping centre where some of the adolescents spent their days engaged in some income-generating activities. As part of the research, I also visited one clinic in Chitungwiza and one in Seke and talked to the nursing staff there. I also had interactions with the Department of Social Welfare staff at their offices which all helped to triangulate information from other sources.

4.5 Data Analysis and Data Coding

This research adopted thematic analysis as the main approach to data analysis. This methodology of data analysis involves various procedures for the identification and coding of the emerging topical issues or themes from the data collected. The thematic approach to data analysis for this research was the preferred methodology because of the large quantities of rich qualitative narratives that were collected. The detailed data analysis procedures and strategies are discussed below.

4.5.1 Data Analysis

In this study, I utilised thematic analysis as the main approach to the analysis of the data obtained from the research process. According to Smith (2000), the advent of thematic analysis in the social sciences was a result of the need to "capture the complexity of human thought and behaviour". As noted by Smith (2000), proponents of the qualitative approaches to data analysis in general focus on the aspect of subjectivity and reject an over-reliance on positivist approaches to data analysis.

The thematic analysis technique was employed to analyse the personal accounts of the adolescents regarding their social networking amongst themselves and with other people, they meet in their day to day lives. As noted by Harvey, (1995) this entailed coming up with descriptive "story-like" narrative accounts containing interpretations, emotions, and expectations of the individuals. Boyatzis (1998) also argues that thematic analysis is appropriate for theoretical investigations that seek to discover emerging social perspectives based on identified themes. The thematic analysis provides a systematic procedure that

allows the researcher to classify and present themes (patterns) that relate to a specific data set. Ryan and Bernard (2003) also highlighted that "...discovering themes is the basis of much social science research" and that without thematic categories, a social scientist will have nothing to describe, nothing to compare and nothing to explain.

During the analysis of data for this study, thematic analysis was employed to systematically flag the enduring thematic areas emanating from the life-stories of adolescents in the study. By and large drawing themes from the in-depth interviews, key informant interviews and observations was also useful for formulating the structure used to present the findings of the study. Another interesting advantage of the thematic data analysis procedure was that it nudged the researcher to constantly look at the data set as a whole, whilst at the same time also following up on the major and sub-themes emerging from the data collected from the in-depth interviews.

Practically, the thematic analysis process started with attempts to gain a holistic understanding of the story of each adolescent. This was then followed by flagging the key themes running through case study materials. This process enabled me to make useful comparisons of key themes across the heterogeneity of the adolescents involved in the study. For example, some themes were more pronounced among adolescents of a specific geographical setting, age, gender and household living arrangement.

The other advantage of the thematic analysis approach was that it ensured greater flexibility in the analysis and interpretation of the data as the tracking of enduring themes made it possible do draw comparisons and cross-reference within the overall discourses on social capital, HIV and AIDS, adolescents and health. This was particularly useful in the final interpretation of the data and writing up of this thesis.

4.5.2 Data Coding

This research adopted the open data coding system expounded by Ryan (2003:17). As stated by Ryan (2003:14), whilst there are various data coding techniques the goal of the open data coding system is to empirically illuminate answers to the research questions. Ryan (2003) further argues that open coding is a powerful technique for social scientists because investigators concentrate their efforts on searching for specific texts from interviews and

discussions which are likely to generate major social and cultural themes around the research topic. The open coding approach adopted for this study is part of a broader social science methodology for analysing themes which Smith (2000) refers to as the inductive approach to the categorisation of themes. According to Smith (2000), the inductive approach allows for the emergence of social themes or categories of themes that are not influenced by the pre-conceptions of the researcher.

In addition, the open coding system also provided an opportunity to develop codes for analysing important data that was not directly focused on the research questions but contributed to the understanding of issues raised by adolescents in their response to the major research questions. By examining the data from a broader and more theoretical perspective, I was able to avoid what Ryan (2003: 24) refers to as "data overfit" which is the problem of only finding what one is looking for in a data set and ignoring other important data. In this regard, I was able to extract and analyse information that affects adherence behaviour which was not necessarily limited to social networks. To avoid the "data overfit" I adopted a stepwise data coding system. This meant that data coding was done progressively from broader thematic categories down to the development of more refined categories, themes, and concepts around the research questions. The refinement of thematic categories and sub-categories was a continuous process throughout the analysis of findings, and this meant that there was continuous construction and de-construction of thematic categories.

4.6 Methodological Challenges Encountered

During the research process, I faced some challenges that affected the data collection processes. A detailed discussion of the challenges and the adopted innovative ways of resolving the challenges are presented in the section below.

4.6.1 Demand for payment to participate in the study

My initial plan for the identification of study participants was to use community-based HIV and AIDS support groups as an entry point. The first two support groups[1] I approached, which I had identified because of their long history of working with adolescents living with

[1] These will not be mentioned here to protect their identity, the identity of their funders and the identity of the adolescents.

HIV, did not facilitate conducting of the study. After having promised to support the study through the identification of adolescents who were willing to participate in the study, I was later given endless excuses as to why the identified adolescents were not available to be interviewed. After a month of pursuing these two support groups, I received an anonymous call stating that the adolescents for the study could be identified upon me paying a "facilitation" fee of one hundred United States Dollars. The caller did not identify himself and the support group he was calling from and none of the two support groups identified themselves with the anonymous caller. The payment or rewarding of any form of incentives presents an ethical dilemma and is also a violation of the ethical standards that guide research at the University of South Africa. The payment of a "facilitation" fee would also set a bad precedence in that other researchers with limited resources would in future have no access to study the adolescents living with HIV and AIDS. Also, this could result in study participants giving out information that they feel reflects the intentions and interests of the researcher. To overcome this challenge, I moved on to seek permission from other community support groups.

4.6.2 Research Fatigue

It is important to note that adolescents on ART in Zimbabwe have been over-researched and most of them are exhibiting signs of research fatigue such as refusing to participate in academic research where there are no financial benefits. Since late 2008, which is also the period that coincided with the emergence of child survivors of HIV due to the ART interventions, the Zimbabwean government through the Ministry of Health and Child Care, working with other development partners, have led researches among this group. Signs of research fatigue among the adolescents included demands for payment to participate in the study, outright refusal to be interviewed and dropping out from the study after the initial engagements. To motivate participation and interest in the study, I provided lunches and other refreshments as a token of appreciation for availing themselves for interviews. An interesting aspect to this was that parents and or guardians of the adolescents did not show any signs of being over-involved in research targeting their children and they exhibited great enthusiasm to have their children participate in the study. The reason given for this by the parents and/or guardians of almost all participants regardless of adherence level was that they hoped the research findings would be used to assist their children to overcome adherence challenges and live healthier lives.

4.6.3 Unavailability of key informants

The emergence of charismatic churches and their claims to cure HIV demanded that I interviewed leaders of these churches. This was even made more pertinent given that data from the case studies indicated that some adolescents that had defaulted on their ART schedules had direct links to the charismatic churches. I requested formal appointments to meet with two leaders of these prominent churches to no avail. In each case, I was asked to state the purpose of the meeting and in all cases, no feedback was ever given. The only information I got on these emerging churches was volunteered to me by church members and lower-level staff in these churches who spoke in strict confidence. This information was thus not official. I attended two sessions at one of the churches where the only information I managed to get were testimonies of people that claimed that they had been healed from other life-threatening diseases such as HIV and AIDS, cancer and diabetes.

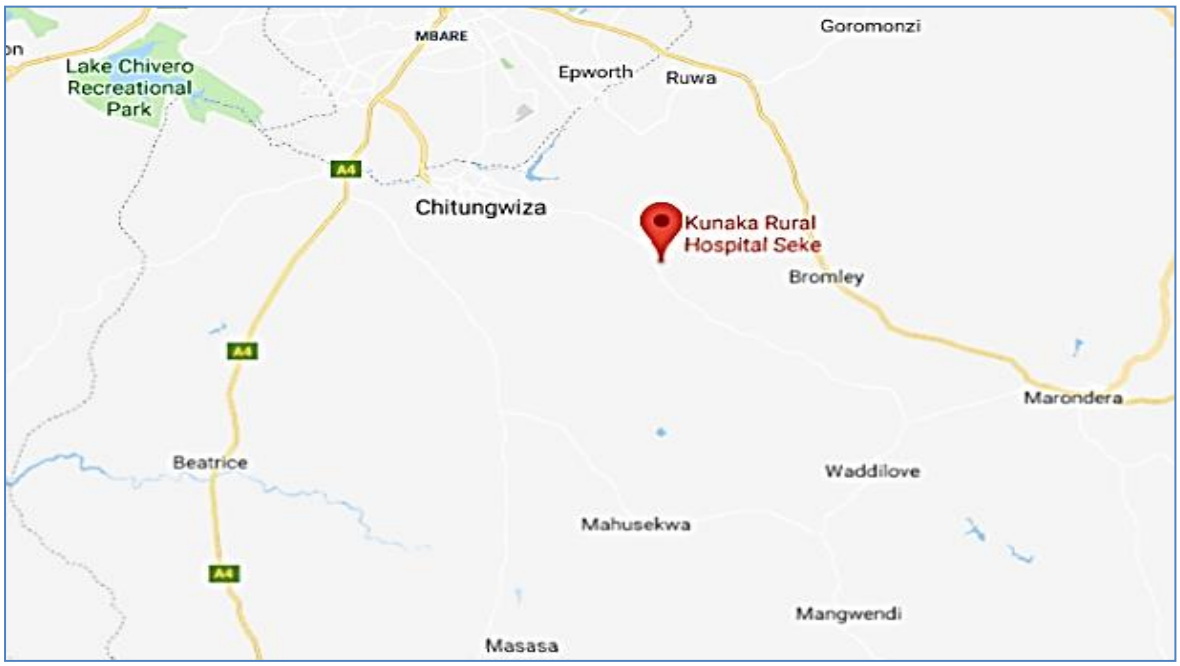
4.6.4 Fear of Stigma by Parents and or Guardians

Parents and or guardians of children targeted to participate in the study exhibited signs of fearing to be stigmatised. Some parents wanted their children to participate in the study in a discreet manner. In one case, the guardians of an adolescent who had volunteered to participate in the study refused permission for her to participate fearing that their family would be stigmatised through her participation in the study. I also learnt that other parents took the participation of their children in the study as also exposing their own HIV status to the whole community. One of the four research assistants I had initially recruited for this study had to drop out from the research process as a result of the pressure from her household members against participating in activities that were linked to LESO.

4.7 Location of Study Sites

The research was conducted in Chitungwiza Town and Seke peri-urban community. Chitungwiza Town developed as a dormitory town to the capital city Harare around the 1960s. The geographical place on which the town is located is formerly part of Seke communal lands. Geographically Chitungwiza and Seke border each other, see map below.

Figure 4: Map showing Chitungwiza and Seke



Source: https://www.google.com/search?q=seke+and+chitungwiza+map&source. Accessed 15/03/2017

Due to high levels of urbanisation, currently, Chitungwiza town is expanding into the former purely rural area of Seke with modern houses now being built in Seke communal lands. As stated earlier, these study locations were selected for the study as they have active community-based HIV and AIDS support organisations that work with a variety of people including adolescents.

Chitungwiza Town is managed by a local authority and the major economic activity is light industrial activities. However, due to the economic downturn experienced by the country since the early 2000s, some of the light industries have closed shop giving rise to a proliferation of informal traders. On the other hand, Seke peri-urban community is well known in Zimbabwe as an area where the local communities practise horticulture and supply fresh vegetables to both Chitungwiza and Harare. The HIV and AIDS data on Chitungwiza and Seke are currently not available in national statistical reports as Chitungwiza is often grouped with Harare while Seke falls under Mashonaland East province.

4.8 Ethical Considerations

This research study was conducted within the confines of the research ethics guidelines of the University of South Africa as enshrined in its research policy. Ethical clearance for the study was granted by the UNISA Ethics Committee before the commencement of the study (see Appendix 1). Informed written consent was sought from all study participants and parents and or guardians of children involved in the research were also requested to grant consent for children younger than 18 years (see Appendix 2). The consent forms were translated into the two most common vernacular languages which are Shona and SiNdebele to enhance common understanding between the researchers, guardians and study participants.

Adolescents participating in the study were provided with information concerning the study and were asked to give assent before participating. The interviewing process was conducted in the preferred language of the participant. In most cases, this was a mixture of Shona and English. Interviewing was also conducted at the place where the participant felt comfortable. It is important to note that 17 of the 22 participants chose to have their first interview away from members of their families or households. The choice on whether to participate or not was respected throughout the study and this was the main reason why the recruitment of study participants from the onset was a challenge. Participants that also expected financial benefits were made aware that there would be no such benefits and were thus advised to make their choice on whether to participate or not based on this information. In the initial recruitment process, one male adolescent dropped out as a result of this.

To maintain the privacy of study participants, a coding system was used to identify each unique participant. This unique identification code was used by the research assistants to make follow-ups on the study participants. In addition to this, participants also provided pseudonyms that they preferred throughout the study.

4.9 Reflections on the use of Research Assistants in the Research process

In this section, I reflect on the contribution of the adolescent researchers I engaged to facilitate the fieldwork. I consider how the inclusion of these fieldworkers in the research process influenced the research process as well as the interpretation of the findings.

My use of adolescent research assistants provided both challenges and opportunities in the construction of the social narratives of the adolescents. My involvement of adolescents living

with HIV as research assistants assisted the other adolescents in opening up on their situations and their lived life experiences. The feedback I got from the study participants was that the involvement of the research assistants whom they already knew gave them the confidence to share with me their experiences even in the presence of a peer who had the same HIV status as theirs. Working with the research assistants also proved to be beneficial to the research process as this resulted in the quick development of trust between me and the study participants. This trust between the researcher and the study participants is extremely important in a society where PLWHIV suffer social stigmatisation. Since the interviewing took place over two months including times for seeking clarifications as the data coding process started, the trust developed with the study participants became an opportunity to gain an even deeper insider view of the life situations of the adolescents.

The relationships of mutual trust between myself and the adolescents resulted in the discussion of other issues outside the research focus. Issues discussed included the social, economic and political problems of the country. Some youths were also interested in knowing if I could link them to employment opportunities in future. During the research process, I managed to provide information that linked some adolescents and members of their households on available social service in their communities. For example, I managed to link a guardian of one of the respondents with the Department of Social Services where they were able to obtain a government Assisted Medical Treatment Order (AMTO) that would help the adolescent in gaining access to free medical attention at the country's major referral hospitals.

As a result of this trust established with the study participants, one of the adolescents took the interviewing process as an opportunity to share the ill-treatment that he was getting from members of his household. The adolescent was able to vent his emotions and after the interviewing process, the youth expressed some relief at having had an opportunity at least to speak about his concerns. I later referred this issue to the Department of Social Welfare in Chitungwiza who send a probation officer to investigate the case.

Whilst the major part of the research process consisted of verbal interviews, the close relationships established between the research assistants and the interviewed also provided an opportunity for me to observe the life of the adolescents in their households and their communities. This was particularly important as it provided the researchers with an

opportunity to observe the relationships between the adolescents and members of their households and thereby obtain critical insights into how this affected their adherence to ART.

My use of adolescents living with HIV as research assistants also had its pitfalls. For example, I discovered that in some cases where the experiences of the researchers were similar to those of the researched adolescents, there was a tendency by the assistants not to seek the intricate details of the life situation of the respondent. This has also been revealed by authors such as Verlag and Hamburg (2009: 7) who argued that in the interview process for most qualitative studies, researchers' assumptions and fears might make then reluctant to discover the "actual new". In such cases, I had to take up the responsibility for further probing and checking with the research assistants to ensure such discussions were correctly written down.

My presence during the introductions and the consent processes had an assuring effect on the interviewees regarding the confidentiality of their responses. In most cases, the youths would engage with me in other discussions after the interviewing process. The relationship created with the adolescents were also important as they provided me with an entry point to establish good relations with the parents and guardians which later on made it possible for me to use some of the parents and guardians as key informants.

4.10 Limitations of the Study

This study was largely qualitative and the sampling methodology for participants and study sites was purposive. The results of the research pertain to adolescents residing in Chitungwiza and Seke and extreme caution is encouraged if any attempts to generalise the findings are made. Users of these research findings must refer to the thematic issues raised, and the content of the rich in-depth insights expressed by the adolescents as opposed to making generalisations about adolescents and the research sites in this study.

4.11 Researcher Reflexivity

My interests in the subject matter of this thesis are as a result of my own personal circumstances and my professional direction of travel. At a personal level, at the height of the HIV and AIDS pandemic in Zimbabwe between 1999 and 2004 when the national HIV prefevalence rate was around 29 percent, I lost two brothers who succumbed to illnesses that were HIV and AIDS related. The peak of the HIV and AIDS pandemic was also accompanied by a peak in HIV and AIDS stigmatisation. The two brothers of mine succumbed to death in my rural community were they had grown up and were my family lived. My family became the talk of the village during the illnesses of my brothers and people from surrounding households began to avoid interacting with anyone from my family. One of my brothers was a Commissioned officer in the Zimbabwe National Army and had the priviledge of being treated at a private military hospital in a city that was only forty kilometers from our homestead. At the private military hospital I was shocked at the level of stigmatisation which the staff exhibited. During one of our routine visits to a local health facility one of the nurses on duty shouted on top of his voice saying;

> *"Mukoma wako aimhanyisa bere ku Harare zvino akarumwa nechekuchera!" (Your brother was busy hooking with prostitutes in the capital city of Harare and he deserves to suffer from HIV and AIDS).*

The level of stigma associated with HIV and AIDS was shocking at that time and when I embarked on this study it provided me with an apportunity to assess the impact of HIV and AIDS stigma on adolescents living with HIV and the coping strategies the adolescents had adopted.

My professional engagement has seen me work both in Southern and Eastern Africa. In East Africa I worked in Uganda which is one of the countries in Africa to have suffered a huge battering in the early years of the advent of HIV and AIDS. I reckon that from the experience in Uganda, HIV and AIDS still has a strong influence on the development trajectory of the country. Thus whilst I agree that a lot has been done to mitigate the impact of HIV and AIDS in communities, the phenomenon still impacts a lot on community processes.

My educational background is grounded in the sociological discourse having obtained an Undergraduate Degree in 1988 and a Masters degree in Sociology and Social Anthropology in 2001. My background in sociology influenced the study methodology for this thesis. My interests in post-modern epistemiologies and its emphasis on individual narratives as opposed to the grand narratives influenced me to select an investigative approach that brought out individual lived experiences of the adolescents that participated in this study.

Most of my professional experience has seen me work on programmes that involve programming on HIV and AIDS. Between 2003 and 2012 I worked on three national level programmes that focused on mitigating the impact of HIV and AIDS on communities in Zimbabwe. The first project I worked on between 2003 and 2007 was funded by the government of Zimbabwe and the United Nations Development Programme (UNDP) and was largely a research focused project that sought to bring out the inter-linkages between HIV and AIDS and poverty in Zimbabwe. It was from this research that I found out that adolescents were to a large extent being lumped together with adults and their voices were not heard. In 2008, I worked on another project that sought to mitigate the impact of HIV and AIDS on orphans in Zimbabwe. The project was funded by the government of Zimbabwe and UNICEF. This project was focused on children and I discovered again that adolescents were not deliberately targeted, only adolescents that were heads of households got involved but those adolescents who were not heads of households were left out.

Between 2011 and 2012 I worked with the Zimbabwe National AIDS Council, which is a constitutional body mandated with the coordinational of the multi-sectoral response to HIV and AIDS in Zimbabwe. I was in the Monitoring and Evaluation Department for the Global Fund supported Round Eight activities. It was during my interaction with statistics generated from the National AIDS Council that I discovered that adolescents were practically being omitted from the interventions. However, at that time some international non-governemental organisations had already realized this gap and were beginning to implement adolescent focused interventions that targeted adolescents living with HIV and AIDS. The AfricaAid Zvandiri project was among the pioneers of this work. For me, the Zvandiri project was a drop in the ocean as most organisations including the National AIDS Council I worked for were largely concerned with the rolling out of a massive national ART programme.
To date I have have also come to realise that the adolescent group is an important population group in any development discourse particularly in African countries where the population is youthful. The emergency of the COVID-19 pandemic in 2019 and the levels of vaccine hesitancy among adolescents in Zimbabwe is clear evidence that adolescents are an important group that needs deliberate targeting in all development intiatives. Coupled with the emerging phenomenon of drug, substance and alcohol abuse among the adolescents in Zimbabwe, this again points to the fact that the focus on adolescents should be intensified for most development interventions to yield maximum impact. As a development practitioner,

my aspirations are for adolescents not to be left behind in the design of any development at community and national level.

4.12
Conclusion

The adoption of a qualitative approach for this study resonated with the research objectives and the specific research questions for this study. The use of a purely qualitative methodology was driven by the need to obtain an in-depth understanding of the lifeworld of adolescents in the study. In addition, this methodology presented an opportunity for an enhanced understanding of the social lives of the adolescents as presented by the adolescents themselves. Previously research work and studies on adolescents were mostly constructed from the views about adolescents that were presented by their guardians or parents on behalf of the adolescents.

The qualitative approach also influenced the choice of thematic analysis as the most appropriate data analysis procedure for the rich narrative data collected. Thematic analysis, though complex and time consuming, was relevant for understanding the key issues and recognition of each adolescent's life story account. From the 22 in-depth interviews in this study, I learned that there were unique issues that pertained to each case and that adolescents are a widely heterogeneous group with different life experiences in the different social networks they were involved in. Whilst similarities could be drawn across some of the life stories, the depth, scope and level of such similarities were always different across the adolescents.

The thematic analysis presented opportunities and advantages of viewing the data holistically whilst at the same time identifying the enduring themes across all the narrative data. The thematic approach also enabled the cross-referencing of data from the narratives to the general body of literature on social capital, adolescents, health and HIV and AIDS. Emerging themes from the narratives were analysed and where some of these fell outside the scope of this study, they were referred to the section on further academic exploration discussed in the conclusion of this study.

Research on HIV and AIDS and particularly among adolescents is not an easy task in Zimbabwe. This is mainly due to the high levels of HIV and AIDS social stigmatisation prevalent in Zimbabwean communities. The selection of study participants was a challenging experience due to the already stated high levels of social stigma and research fatigue among adolescents living with HIV. Researches done by government institutions and other development partners on the adolescents have largely been extractive, leaving no tangible benefits for the adolescents and little or no opportunities for feedback. The problem has also been exacerbated by adults with connections to the adolescents demanding "facilitation fees" to establish contact between researchers and adolescents. This scenario presents serious ethical dilemmas for future research. This study conformed to the ethical standards set by the University of South Africa and the ethical research standards set by the Medical Research Council of Zimbabwe. The study also complied with international bench-marks that guide research among children and young adolescents.

CHAPTER FIVE: HOUSEHOLD SOCIAL NETWORKS AND ADHERENCE

5.1 Introduction

In this chapter, I focus on the social capital provided to adolescents living in different household types and how this influences adherence behaviour. The emergence of social capital available to different household types is determined by the extent to which the different household members belong to different social networks and invest in relations that characterise social capital, such as trust and reciprocity. As discussed in chapter three, people belonging to a social group or collective such as a family and or household can generate social capital that can be depended on as a resource by the group or individual members of the group. In this chapter, I argue that the effectiveness of social capital in influencing ART adherence is dependent on two important factors; which are the type of household where the adolescent resides and the level of collective or individual investments in social networks by the different members of the household. This chapter draws evidence from key informant interviews with grandparents, parents or guardians of the adolescents, interviews with staff members from the Department of Social Welfare and staff members from LESO. Information was also drawn from the in-depth interviews I had with adolescents.

5.2 Household Types and Investment in Social Networks

Findings from the study indicated that there were three common types of households in which adolescents in the study were accommodated. The most common differentiating factor among the different types of households was the aspect of household headship.

5.2.1 Elderly headed households

The first type of common households in which adolescents in the study were accommodated was headed by elderly persons. The role played by elderly people and household headed by the elderly in taking care of sick young adults or orphans in African countries is well documented (Schenk et al 2010). Schenk et al (2010) in studies they conducted in Kenya, Malawi, Rwanda, South Africa, Uganda, Zambia and Zimbabwe showed that the burden of caring for young adults and orphans is often carried by the elderly people within households. The government of Zimbabwe has also recognised and acknowledged that at the national level 60 %t of children orphaned by HIV and AIDS are taken care of in households headed by elderly people (Ministry of Public Service, Labour and Social Welfare Annual Report

2016:26). Whilst there are general perceptions that households headed by the elderly have weak social networks, the elderly headed households staying with adolescents living with HIV and AIDS in Chitungwiza and Seke demonstrated a diversified picture, as will be discussed below.

The households headed by older persons in Chitungwiza and Seke were also differentiated by the gender of the head of household as some were headed by elderly women and others by elderly men. From the demographic information collected from the study participants, indications are that the age range for these household heads was from sixty-one years to eighty-two years. Out of the twenty-two adolescents that participated in the research, fourteen were from households headed by older persons. These households invested and continued to invest in social networks, and this produced and reproduced social capital that benefited the household head as well as the adolescents living in those households. The household heads and their household members belonged to various community social groups that included church groups, community-based income lending and saving schemes and community-based child protection structures. The other platforms for household heads' social networking mentioned by the adolescents included the social cash transfers schemes implemented by the government and other NGOs where their heads of households met every month to receive their monthly stipends.

In the interviews I had with adolescent staying in these households they all mentioned that their grandparents had developed social network relationships with people that they interacted with at the churches and in community-based lending and income saving schemes. The adolescents mentioned that these social network relationships that involved their household heads were important for the day to day living as well as providing them with various opportunities that supported their adherence.

During an interview on the 10th of September 2014, Kudzai a female adolescent highlighted that:

> *"Because my grandmother is a member of the Prophetic Healing and Deliverance (PHD) Ministries' local partnership group, I have received care and support in the form of psycho-social support from the church members and the local leader present in this community. In addition to the psycho-social support from the church, I have also received food hampers from the church and last year I was sponsored by the*

church to attend the national convention of church youths. The church women's local group also runs a successful income lending and savings scheme that has resulted in the further bonding of the women in the church. Apart from the income from the lending and saving processes in the group, the women in the church have also supported my grandmother to provide proper care for me including psycho-social support to her."

In another interview on the 14th of September 2014, a male youth Tinashe also mentioned that:

"My grandfather is a member of the Community Based Child Protection Committee that was set up by a local Non-governmental Organisation. The Child Protection Committee has nine members who are all based in the community. As a result of my grandfather being in that committee and networking with others in that committee, I have been provided with information that has assisted me in linking up with other children in Harare who are also living with HIV. This exposure has assisted me to learn from the experiences of other youths also living with a similar condition as mine.

Households headed by elderly persons were also recipients of remittances from household members and other relatives living and working in other urban areas as well as those out of the country. Adolescents living in these households highlighted that they usually received money and groceries monthly from these kinship-based relationships. According to the adolescents, the relatives who supported their households were morally and socially obliged to do so as that was what was generally expected of them. Further probes confirmed the adolescents' view that their relatives had a social and moral obligation to provide support to their elderly relatives. On the 24th of September 2014, I interviewed Patience in Seke who stated that:

"The money, goods and other support that we receive from my uncles who work in Harare are part of what forms our family culture. We are in a constant process of exchanging and sharing goods and information. We provide our relatives in urban areas with important information, for example, we can provide them with information about their enemies and how they need to be careful with some of our relatives. For

example, we warned our uncle about his enemies that wanted to bewitch him. This information is so important to the uncle and he values such information".

From the evidence presented by the all the adolescents living with elderly heads of household including the quotes shared above, the social networks that involved the household heads with which the adolescents lived were characterised by the consistent exchange of important goods and information. The adolescents from these households opined that exchange of such information was one way which strengthened the social network relations between their grandparents and relatives living in urban areas who in most cases were not privileged to access such information as they were now staying out of the village.
In an interview I had with Divine in October 2014, he highlighted that:

"*Sharing information on one's perceived enemies or witches creates conflicts within the extended family. However, it also strengthens social relations between our grandparents and those relatives with whom the information is shared. Sharing such information is the fuel that drives strong social relations with our kith and kin-based in the urban areas".*

The allusion by Patience and Divine to sharing information about enemies and the belief in witchcraft is a characteristic of many households in the Zimbabwean society, and the transfer of such information is regarded as important as demonstrated above. Two households in Seke communal lands often provided fresh agricultural produce and maize, which is the staple food, to members of the extended family residing in towns. On the other hand, the households living in towns often provided groceries such as cooking oil, baking flour and other groceries to their kin residing in the rural areas. Through these social networks, adolescents staying in these households in rural areas often had the privilege of going to stay with relatives, friends and other connections in urban areas. The same situation was also true for adolescents who stayed in urban areas and would often get an opportunity to stay with relatives or friends of the household head in rural areas. The adolescents residing in these households also benefited from social networks of their household heads by being able to access health care and support in the event of illness. Such social networks were also conduits through which information on job opportunities could be shared.

I had an interview with Tinashe who stayed with his grandfather in Seke on the 18th of September 2014 and he highlighted the following case:

"When I got sick after not taking my ARVs for more than two months in 2013, my grandfather's brother who stays in Harare came and picked me up at night from our rural area. He took me to an affluent hospital in Harare where I received top quality medicines and high-quality counselling from highly qualified personnel. Seeing how stressed I was due to not having a professional job, my grandfather's brother quickly organised a job for me as a security guard in a major supermarket."

In addition to maintaining social relations with their kith and kin residing in urban areas, the adolescents also said that their households had social network relations within their neighbourhoods. According to the adolescents, these social network relations had resulted from their heads of households participating in a government social cash transfers programme where each head of household received twenty United States $20.00 per month. The beneficiaries of the social cash transfer programme had established their social networks. In the key informant interviews with two elderly heads of households, they highlighted that because they meet every last Thursday of the month to receive their monthly social cash transfer stipends, this had resulted in the creation of strong relationships among themselves.

One of the household heads Mr Rino whom I interviewed on the 10th of September 2014, he stated that:

"Pakusangana kwedu ipapo tose tave vana Sahwira". (because we frequently meet, we are all now networked and we are great friends).

Adolescents from these households also corroborated this emphasising that the social networks involving their grandparents had become a strong basis for *"usahwira"* (strong household friendship bonds). The adolescents living in these households also said that the social networks involving their heads of households were also being utilised for sharing important information and knowledge. The information shared ranged from upcoming meetings in their communities, diseases outbreaks and other government programmes.

According to the adolescents staying in these households, the relationships based on *usahwira* were strong and dependable just like those that involved their kith and kin. From the interviews with the adolescents, they perceived the *usahwira* social relations based on voluntary social networking as being opposed to prescribed social relations that emanated from one being part of an extended family. The adolescents also viewed these social relations as more cordial compared to those based on kinship, as relations based on kinship were often fraught with jealousies and petty conflicts (see the views from Patience on page 81).

The adolescents however also mentioned that the social networks based on the *usahwira*, just like those based on kinship ties were characterised by strong unwritten social obligations and rituals of reciprocity, particularly with regards to information sharing and exchange of goods. The adolescents were all of the view that because their heads of households met very frequently, this had made their social networks robust. For example, in Seke the phenomenon of the *"usahwira"* was well pronounced with such households sharing information and basic commodities and providing emotional support during times of bereavement and need. At the time of the research, one adolescent who normally stayed with his grandmother was staying in another household whose household head was a friend of his grandmother.

I interviewed Caleb during the first week of October and during that interview he described the situation as follows:

> *"I came to stay here early last month when my grandmother was urgently needed in Bulawayo (Bulawayo is Zimbabwe's second-largest city located in the south-western part of the country). This place is a second home for me as my grandmother and the grandmother I am staying with here are not different, they have a strong friendship and I am treated the same as when I am at my actual home. As usual, when my grandmother comes back, she will bring some gifts from the urban area to her friend and they will enjoy it together".*

The adolescents staying in the households that were connected by the *usahwira* type of friendship also became entangled in these social networks by default. The entry point for adolescent involvement in the social networks was because the adolescents were normally the ones who would convey information and carry goods between the households. However, the relationships that grew among the adolescents were not as strong as that of the household heads and did not involve any meaningful exchanges either in the form of goods or information. The adolescents in both Seke and Chitungwiza only knew the other adolescents that lived in the households whose household heads were friends to their own but did not mention that those adolescents were their friends. Tinashe, whom I interviewed on the 14th of September mentioned that:

> *"We all know each other but we are not friends. Sometimes we just talk when we meet but no one put an effort to see the other person. Though our guardians are connected*

in a very strong way, it is not the same for us. Each one of us has their own choice of friends."

5.2.2 Totems and Household social networking

Apart from the social networking relationships based on kinship ties and the concept of *usahwira*, there was another form of social networking that was based on relationships inferred or derived from similar totems. Totems in Zimbabwe define a group's identification with a specific animal or its character. As argued by Makgopa (2019), totemism is the use of animals or animal traits as the human being seeks to imitate the animal totem's traits. Makgopa mentions that by identifying themselves with a specific animal or its trait, this becomes the basis by which people categorise themselves into clans. The importance of the social relationships derived from similar totems was well emphasised among the households headed by older persons. This relationship was considered even more important than that of *usahwira.* Social relationships based on sharing a similar totem were given the same importance as blood relationships. The adolescents living in the elderly headed households that were involved in such social relations adopted relationship titles such as brother, sister, niece, nephew or uncle depending on the totems of the other people involved in the social relations.

Theresa, a 17-year-old, has a grandfather who is the household head and is of the "monkey" (Soko) totem. All the male people in their neighbourhood with the *Soko* totem have become Theresa's grandfather's brothers, sons, nephews or uncles. The females are sisters or nieces. Theresa whom I spoke to in early October 2014 stated that:

"I am of the Soko (monkey) totem and all those with a similar totem to mine are my relatives. Although my grandparents came from Hwedza district in Mashonaland East province and some of the people in this community came from Mount Darwin district in Mashonaland Central province; we are now closely related because we share the same totem".

The assertion above was also supported by Caleb during one of the interviews who mentioned that the social networks based on people sharing the same totems were important during social events like marriage ceremonies and funerals. The adolescent mentioned that

people involved in such social relationships were obliged in many ways to offer support during weddings or funerals. For example, he highlighted that it was very common to see a woman who has the same totem with another family playing the role of an aunt, even when the people are not related by blood. According to the adolescent, the role of aunt is normally played by blood relatives, but in their community women that share the same totems with other families can easily play that role. Another adolescent, Tinashe, also weighed in with a similar observation and added that in his community in Seke social relationships based on sharing similar totems were accorded the same value as social relations that involved blood relatives. Tinashe mentioned that people with similar totems were obliged to assist each other in times of need. Using almost the same example given by Caleb, Tinashe highlighted that because many families had lost their relatives to HIV and AIDS people involved in social networks derived from sharing similar totems were obliged to assist during marriages and funerals by playing roles that would normally be played by blood relatives such as aunties and uncles.

In my everyday interactions with the three research assistants that were part of my research team, two of them that were based in Chitungwiza expressed the view that social networks based on sharing similar totems were stronger in the peri-urban area of Seke compared to Chitungwiza which is a purely urban setting. The two adolescents mentioned that the social relationships based on similar totems were less visible in the urban area as some people were not even at liberty to share their totems with strangers in public. According to the two research assistants it was not common to hear someone being referred to by their totem in urban areas as was the situation in rural areas. Patience from Seke compounded this view saying that it was common to have people being referred to by their totems in the rural areas compared to their surnames.

In the interviews with heads of households, it was mentioned that the social relations were characterised by social exchanges among the households, including the exchange of small amounts of basic goods that could be consumed within a few days, for example, sugar, salt, mealie meal or vegetables. The two heads of households that were key informants underlined that whilst the exchange of these small quantities could appear insignificant, they were important for the survival of the households and they were also the cement that helped sustain the social networks.

Mr Chikiri, one of the heads of household whom I spoke to during the last week of September in 2014 mentioned that:

> *"When someone comes to you asking for salt or sugar it shows their trust on you, so we take that as important and when we give, we are showing them our love. For us he who gives also receives".*

In Seke seven households had formed what they called *"gomwe"* in the Shona language. According to the adolescents *"gomwe"* is a group of people with close relations that come together to work on a farming task. The tasks may range from clearing land for production, digging or planting. The seven household heads in the *"gomwe"* in Seke assisted each other to work in their gardens. The adolescents mentioned that they did not participate in the "gomwe" because they also viewed it as a way by their grandparents to spend more time together and socialise. This was also corroborated by the two heads of households who were my key informant who highlighted that the "*gomwe"* was not only for the purposes of pooling their labour but also a social circle where people shared jokes, new developments in their households, family problems and other information. The elderly households involved in the *"gomwe"* only produced food for household consumption. Thus, for example, whilst Seke is well known for market gardening in Zimbabwe and a major supplier of fresh vegetables to the capital city of Harare, none of these elderly headed households were involved in commercial farming activities.

5.2.3 Single Parent Headed Households

The second common type of household in which adolescents for this study were located was that headed by a single parent. As noted by DeLeire and Kalil (2001:3) the academic literature has commonly found that children and adolescents growing up in households headed by single parents tend to have adverse developmental outcomes. Authors like McLanahan and Sandefur (1994:7) have pointed out some of the challenges faced by children that grow up in single-parent families and some of these include lack of self-esteem, increased psychological distress, early initiation of substance use and sexual activity, increased vulnerability to health problems and a greater likelihood of engaging in deviant activities. The authors also noted that the challenges mentioned are often compounded by the

high poverty rates among the majority of single-parent headed households, particularly female single-headed households.

In the study adolescents that were staying with a single parent who was their biological parent, due to the death of the other parent or divorce. Two adolescents stayed with a male single parent who had divorced while the remaining five stayed with their widowed mothers. Five of the households were in Chitungwiza, whilst two were located in Seke communal lands. Evidence from the discussions with the adolescents showed that the household heads ages ranged from thirty-one to forty-eight years.

Investment in social networks by single-parent headed households varied among the seven households, although there were common characteristics in terms of how the households created and re-created different social networks within their local areas and outside their local communities. The five adolescents staying in households headed by single female parents highlighted that the nature of social networks that their guardians were involved with were limited mostly to kinship ties, religious networks and those networks to which their deceased husbands or partners belonged to:

In an interview with Patricia on the 27th of September 2014 in eke, she highlighted that:

> *"We are very close to my late father's siblings and my mother's relatives as well. We now also go to the church where my mother's relatives worship. My father was a member of the local social soccer club and members of the club visit us quite often, while they do not bring anything for us, they just pass through and offer my mother and myself some moral support".*

Despite the seemingly fewer social ties connected with these households, adolescents staying in them argued that they still enjoyed the social capital emanating from their household heads' social networks with kinship and extended family members, church or religious-based social networks, *usahwira* friendship ties as well as social ties based on household heads' productive activities. Two of the adolescents mentioned that because they enjoyed consistent visits from their relatives, that was evidence of the existence of strong social networks with their kin and kith. According to the adolescents, the visits were often accompanied by gifts and other goods exchanges. The two adolescents also said that in their communities, it was a common practice that female-headed single parents tended to be assisted more through their

kinship social networks. This was contrary to adolescents staying in households headed by male single parents who tended to benefit from the social networks constructed around productive activities of the household heads. These social networks were based on relationships that developed at the workplaces of these household heads.

The two adolescents staying in households headed by male single parents highlighted that the social networks for their household heads were based on their work-related social connections that also had a strong inclination towards the *usahwira* like social relationships. The two adolescents were staying with household heads that were working in the informal sector. These two adolescents, Jekirand and Frank, had similar life experiences based on benefiting from the work-related social networking that involved their single parents.

Jekirand is 15years old and stays with his father who is divorced. The father is self-employed in the informal sector. He makes household furniture at Huruyadzo Complex in Chitungwiza. (Huruyadzo complex is a manufacturing and trade centre for informal workers in Chitungwiza town and was set up with support from the government). Jekirand has been attached to his father's friend to learn the carpentry and marketing of the wares. The learning opportunity was availed to Jekirand due to the existing strong friendship ties between his father and the owner of the carpentry shop at Huruyadzo complex. In addition to gaining skills on carpentry, Jekirand also receives a monthly stipend of US$60.00 that he uses to commute to and from work and most of the remainder helps to cover household expenses. Jekirand in an interview on the 21st of October 2014, he reckoned that:

> *"The skills I am getting here from my father's friend show the importance of maintaining good social relations with others. My father would not have managed to send me to a vocational training college, but his social connections have made me realise my dream of generating my own income in future".*

Similarly, Frank, a 17-year-old male, was also engaged by a friend of his father to market clothing items that had been imported for sale. Frank was entitled to a 15 % commission from the sale of each clothing item. In addition to earning the commission, Frank also gained valuable marketing skills without having earned a formal qualification in marketing.

Figure 5: The market from where Frank operates from at Huruyadzo, Chitungwiza

Source: My own camera 21 October 2014

All five adolescents living in single-parent female-headed households benefited extensively from the social capital emanating from their household social relations with their maternal relatives. The relationships were punctuated with reciprocity and exchanges of goods, information and labour. Three adolescents in the sample reported supplying unpaid agricultural labour to relatives, which in some cases involved the adolescent having to stay with relatives during weekends or school holidays. In return, the relatives were obliged to provide tangible materials like food, clothes and financial support. In one of the case studies, Pricilla, an 11-year-old girl staying with her mother who is a single parent, was a beneficiary of different forms of support from her maternal relatives. The support included payments for medical bills, education and general basic living support through provisioning of food and clothing.

The female single-parent headed households were also subjects of sympathy from their different social networks. The Director of LESO mentioned in an interview that they had offered employment to one of the single mothers who was taking care of her 18-year-old

adolescent living with HIV. The adolescent, Divine, was part of the group of adolescents that consistently participated in the activities organised by LESO in Chitungwiza. According to the Director of LESO, the offer of employment was a way of assisting the single mother with the burden of looking after herself and taking care of the adolescent living with HIV. During an interview with Divine, I had an opportunity to chat with his mother who indicated that the offer of employment by LESO was because her husband was a benefactor of the organisation and had strong social ties to the Director of the organisation. Divine also corroborated the view shared by his mother and stated that before his father died, he often made donations to the organisation. This case also demonstrates that social networks initiated by members of the household could even survive after the death of the person who would have initiated the social networking process.

In addition to this, the adolescents suggested that the source of sympathy for single parents also emanated from the fact that community members often associated the single mothers of being victims of HIV and AIDS due to the intransigent behaviour of their late husbands. The adolescents staying in these households also mentioned that it was the general view among their kinship, church and other social network members to express sympathy for them and their parents as they were often labelled already as people in the "departure lounge" (people waiting to die). For example, when I spoke to Junior, a 16-year-old adolescent on the 7th of October 2014, in Chitungwiza she highlighted that;

> *"When we go to church or even visit our close relatives, the feeling is the same. They look at us as victims and you can read from their faces that they view us as sick people to whom they have to help. Sometimes relatives and friends jostle to be seen to be at the fore-front of assisting us, even at times when we do not need any assistance. I am not comfortable with this situation because sympathy is also one of the sources of stigma as people label us as sick".*

As was the case among five of the elderly headed households, three adolescents living in households headed by female parents were consistently supported by remittances provided by relatives working and living in other urban areas and abroad. In two of the three cases where the single parent headed households depended on remittances, in exchange, the household heads would also look after other relatives who were linked to the relative sending the remittances. In the two households, there were members of the extended family staying under the care of the single-parent household head.

The cases above demonstrate the influence of gender in determining the nature of social networks and the impact of the same for adolescents living in female-headed households. This case cements the observations by Masanjala (2006:4) in which he argues that existing inequalities between women and men and their differential access to the labour market affects "rules of the game" used by groups of individuals to organise and regulate social interactions that produce outcomes that affect those individuals and potentially affect others. The remittances underline the importance of social obligations and reciprocity within the discourse and realities of social networks and social capital. For example, Tinashe was staying with her mother and her uncle, working in South Africa, remits money to the family. According to Tinashe and her mother, the support they are getting from the uncle is based on the investments in social relations by Tinashe's late father who helped the uncle to get a job in South Africa. In this regard, Tinashe and her mother felt that the uncle had a social obligation to support them.

Thus, despite the traditional view that the HIV and AIDS epidemic undermines social capital and that death and sickness erode social networks (see for example Masanjala: 2006:7), kinship-based social networks tended to thrive and be used by adolescents for their survival. The endurance of social networks beyond the death of the person that actively participated in the social network was an element in one of the case studies highlighted above. This shows that social networks tended to adjust and are dynamic to changes in household composition. The development and sustaining of social networks based on *usahwira* and those based on the work or productive relationships of household heads are clear indications that individuals and adolescents can depend on alternative lines of social networking to survive.

5.2.4 Adolescent Headed Households

The third type of household in which adolescents that participated in the study were located is those headed by adolescents themselves. These households are commonly referred to as child-headed households in academic and development literature (see Germann 2005). According to Hosegood (2009: 13), the phenomenon of child-headed households in sub-Saharan Africa is not a new one. The prevalence of the phenomenon of child-headed households however rose with the advent of the HIV and AIDS pandemic in the late 1990s. Most development specialists and researchers have characterised child-headed households as

poor and suffering social stigma as a result of the situation emanating from the loss of their parents. For example, Coleman (1988:111) argued that households that are affected by the physical absence of adults tend to have structural deficiencies defined by the lack of social capital that is associated with the investments in social networks. Mushati et al. (2003) have also contended that households that experience HIV related deaths of parents experienced a substantial loss of income and erosion of capital assets thus seriously undermining the economic viability of such households.

Foster and Williamson (2000: 275-284) have also added that most of the literature about child-headed households has focused on their psycho-social needs and this is mainly because academics and development practitioners studying such households have identified psycho-social problems as the main challenge facing such households. Over the years there has been a paradigm shift towards the coping strategies of child-headed households in the face of HIV and AIDS. Burton (2007:334) highlighted that social capital can facilitate access to resources and lessens a child's responsibility in meeting the family needs. In studies focusing on the role played by social capital in the survival of child-headed households, Burton argues that adolescents that are not part of any social networks often carry the burden of taking care of their own needs as well as those of their household members. This he argues is not the case for adolescents that are well networked and that benefit from the social capital emanating from their engagement in various social networks.

As argued by Schenk et al. (2010), the fact that children in many parts of rural sub-Saharan Africa are trained from an early age in a variety of life skills to prepare them for life's struggles enhances their agency so that they can to some extent determine their destinations in life. Burton (2007:330) also contends that whilst in many cultural settings children take on important roles that contribute to household social and economic well-being; it is different when they take up adult roles such as being the household financial manager or primary care provider for their siblings. According to Burton (2007:329), this is non-normative, and she calls this "adultification" of children which is a situation whereby young people are forced by circumstances to take up adult roles and responsibilities owing to structural changes in household composition. These changes may include the death of parents or a long-term absence of parents or guardians in the household. In this study, I consider that adolescents heading households have gone through the process of adultification.

In this section, I focus on the significance of social networking by adolescents who are household heads and members of adolescent headed households. The implications of such social networking on ART adherence for children or adolescents in adolescent headed households will be tackled in a different section in this chapter. For this study, I prefer to use the term adolescent headed households as the participants in my study were adolescents aged between thirteen and nineteen years.

In my study sample, two adolescents were heads of household. One of the adolescents was aged 16 years whilst the other one was aged 18 years. In the context of this study, an adolescent headed household is considered as one if children aged below nineteen years of age are solely responsible for the day to day management of the household due to the permanent absence of both parents and or other another adult (Germann 2005:16). The two adolescent headed households in this study were due to the death of both parents and one was in Seke and the other one in Chitungwiza.

The adolescent (Jairos) staying in Seke was male and 16 years old. His parents had passed on between 2008 and 2011, and he suspects that they both died of HIV related diseases. He stayed with four other siblings who were all enrolled at the nearest primary school in their community. All the household members were also enrolled on ART at the local health facility. Jairos had dropped out of school whilst his other four siblings were enrolled at a primary school five kilometres away from their household. Jairos and his siblings had no relatives that stayed in Seke communal lands as their parents had migrated into Seke from Hurungwe district that is in western Zimbabwe in Mashonaland West province. The distance between Seke and Hurungwe district is about 500 kilometres. Before the death of their parents, their family had kept social network ties with their relatives staying in Hurungwe. However, after the death of their parents, these social networks had gradually deteriorated. Jairos and his siblings had not visited their relatives since the death of their parents and their paternal relatives had also never visited them.

When I interviewed Jairos on the 18th of October 2014, he commented that:

> *"We would have wanted to visit our relatives back in the village where my father was born, but we have no money for bus fares. It also looks like our father's relatives are facing the same financial problems as they have also not visited us."*

In the absence of social networks based on kinship and the extended family, Jairos and his siblings developed social network relations with people that held influential positions in their community. For example, Jairos and his siblings had close relationships with the local Village Head who was a representative of the traditional local governance structure. Jairos and his siblings referred to the Village Head as their "father". Other members of the Village Head's household were referred to as brothers and sisters by Jairos and his siblings. The relationship between Jairos's household and that of the Village Head like other social network ties was also defined by exchanges and fulfilment of some social commitments from both parties involved. The social relationship was family-like with the Village Head acting as the pseudo parent for Jairos' household. In the interviews that I had with the Village Head, he highlighted that Jairos' siblings were the same as his children and that whenever he bought his children some clothes, he would make sure that he also buys for one of Jairos' siblings.

During one of my visits to Jairos, I passed through the village head's home and found Jairos assisting the Village head repair his fence for a garden that the Village Head operated. Jairos highlighted that he was assisting the Village Head just like any other son would assist his father to undertake some household chores at home. According to him, whilst he would normally charge a fee for his labour, he would not charge the Village Head as he felt that he was an extension of the Village Head's family. According to Jairos, the Village Head was assisting with important engagements on behalf of his household such as meeting with the Headmaster of the local primary school where his siblings learn and negotiate for the staggered payment of their school through the three months of the term.

Whilst Jairos is a school dropout, he is involved in community-level employment which is referred to as *maricho. Maricho* is the local name referring to mostly paid labour in the community that involves working in the fields, gardens, herding cattle among others for a daily wage normally in the range of US$7.00 to US$10.00. The social relationship between Jairos' household and that of the Village Head also included exchanges of information regarding community-level employment opportunities.

The relationships between this household and that of the Village Head obliged the Village Head and his household members to offer social support and protection to the adolescent headed household members. Jairos commented that in most cases the Village Head would

negotiate with other villagers where he provides labour to ensure that he is paid an appropriate wage and that he is also paid on time. He commented that:

> *"The problem I used to face was that people in this community I worked for always cheated me. Sometimes I would be paid a lower wage compared to what other maricho were being paid. My payment could also be delayed by a week. But once my "father" (the Village Head) got involved, the situation has changed. He negotiates the wage on my behalf, and I am now always paid on time. He also advises me not to work for certain individuals in this community who are in the habit of refusing to pay those who do maricho for them."*

The other form of support received by adolescent headed households was social protection from greedy relatives or non-relatives who tended to expropriate the property and land belonging to adolescent headed households. Jairos and his siblings were recipients of such support from the Village Head. When I visited Jairos in November 2014 in one of the fields he was working in, he highlighted the case below as an example of such social protection from the Village Head.

> *"After the death of our parents, my father's cousin came from Hurungwe and started ploughing our farming land without my permission. We grow vegetables and maize for our consumption and sale. The farming land has been our main source of income, even before my father died. We use the income from our farming activities for paying our school fees and paying charges at the local clinic when the need arises. Before the death of my parents, we would realise an average of US$60.00 per month. When my father's cousin started ploughing the field, I reported the matter to the local village head. The Village Head summoned him to his court where he fined him two goats and a chicken for his behaviour. Today my siblings and I can farm on our land without any disturbances and the money we realise is enough for my siblings' educational needs and our health care".*

Figure 6: The farmland that was operated by Jairos and his siblings which was a source of income for the adolescent headed household

Source: My own camera 14 November 2014

In the urban area of Chitungwiza, the adolescent headed household relied on social networks with close kin and members of the extended family. As was the case with households led by the elderly and single parents, the social capital networks based on kinship involved both the flow of material goods and important forms of social support. While the rural adolescent headed household depended on social networking with members of the traditional governance for social protection, the adolescent headed household in Chitungwiza depended on close relatives to provide such forms of protection.

Tecla is a sixteen-year-old girl who is the head of household following the death of their parents. She stays with her two siblings, a brother and younger sister. When their parents died, they were running a successful tuckshop at the place where they rented. The returns from the tuckshop were used for paying rent, school fees and other household needs. The tuckshop was strategically placed just a few metres from their rented place where they live but about two kilometres from the nearest business centre. People in the neighbourhood found it convenient to buy from the tuckshop. Following the death of their parents, the landlord at the place they rented attempted to grab the tuckshop from Tecla and her siblings. While the landlord succeeded in evicting them from his house, he was not able to grab the

tuckshop because it was not situated within the perimeter of his housing stand. Tecla got the assistance of her mother's relatives to fight the landlord who wanted to grab the tuckshop from her. For a month, her mother's relatives stayed with them to ensure that they had secured the tuckshop. The relatives also went with her to the Chitungwiza Municipal offices and registered the tuckshop in her name.

Figure 7: The small tuckshop that Tecla operated in Chitungwiza

Source: My own camera 16 November 2014

Unlike the households headed by elderly persons and those headed by single parents, the two adolescent headed households had fostered social network ties with persons that worked in institutions that were involved in offering direct support to adolescent and other child-headed households[2]. The two adolescent headed households were recipients of various forms of government and other development partners' assistance. Monthly the two households received food packs and they were also eligible for government medical health assistance. The people that the adolescents who were heading households networked within both Seke and Chitungwiza comprised of people working in the Department of Child and Social Welfare, government and Municipality Clinics and people working for local NGOs.

[2] In Zimbabwe, the government and other development partners have prioritised child-headed households in their development plans and policies.

The adolescents that were household heads and the siblings staying with them had developed social networks with people from the institutions mentioned above. For example, in Seke, Jairos's siblings often received gifts from a lady that worked with the Department of Child and Social Welfare at Seke district offices. The gifts included dolls, sweets, biscuits and toys. Jairos commented:

> *"One of my siblings has a friend in the department (Department of Child and Social Welfare). She sometimes brings her goodies and she does not spend more than three months without coming here to see my sister. Even if she has nothing to bring for my sister, she always pays a visit and spends a few minutes with us here. Last time she came here she taught us a game that we still play."*

The adolescent heading a household in Chitungwiza (Tecla) had robust social ties with a staff member of LESO. Whilst they had started knowing each other from LESO the adolescent's social ties with the staff member had grown stronger outside the parameters of the LESO organisation and had become informal. When I spoke to Tecla on the 16th of November 2014, she described the relations as follows:

> *"Mr Langa is now our family friend. Whenever he is coming from work, he passes through the tuckshop and greets us. We even share with him secrets on how we are investing our income and profits from the tuckshop. He also gives us some business advice. For example, the last time he passed through the tuckshop he advised me that there was a wholesaler in town where commodities were being sold for lower prices. I went there one time and that is where I got the bulk of my stock last time".*

The social network ties between adolescent headed households and people working in institutions that supported the welfare of child-headed households had important implications for adolescents' ART adherence as shall be discussed in sections below. The existence of such types of social networks is congruent to the views expressed by Lee (2014) where she emphasised the fact that recognising social relationships that are supportive to children and youths is critical, as these can be further cultivated, thus enabling young people's ability to cope with hardship.

The social network relationships that the adolescent headed households developed with people working in institutions that supported them were also important in building trust between the adolescents and the institutions that the people worked for. Trust is one of the

key elements of social networking relations (see discussions in chapter three on Theoretical Framework). The relationship between Jairos and his siblings in Seke and a female staff member working for the Department of Child and Social Welfare illustrated the development of trust between Jairos, his siblings and the institution (the Department of Child and Social Welfare). Jairos highlighted that:

> *"We now have faith in the Department of Child and Social Welfare, they stand for the rights and protection of children and if I am abused or if my friends are abused, I know that the solution lies with the Department of Child and Social Welfare. The people that are employed there really care about children's wellbeing and they stand up and speak for the rights of children."*

The case of the social ties between Tecla and the staff member at the local support group provides further evidence of the exchanges, particularly information exchanges on opportunities that characterise social network relations. In addition to the social network ties with personnel working for government departments and development partners, the two adolescent headed households also had social network relationships with people involved in other local-level institutions such as schools and churches. Social network ties with people in these institutions were also characterised by the flow of material resources, knowledge and information. The two adolescent households in the study sample reported that their household members received most of their psycho-social support from their school mates, teachers and local church leaders.

In the Seke case, Jairos and his siblings worked together in their garden and this increased levels of trust among the children. In Chitungwiza Tecla and her siblings also shared roles and responsibilities in running their tuckshop. For the Seke household, the working together in household income-generating business did not only build trust but also generated a sense of closeness among the children. In this regard, Jairos mentioned that:

> *"We are one family and we stand for each other. The work we do together and the returns we get are all for the good of us. We have put our heads together since our parents died and this is what has kept us going."*

In the Chitungwiza case, the sharing of household responsibilities among the children was described as a sign of closeness and care among the siblings. Tecla mentioned that as the head of household such daily routines helped to consolidate the relationships between the

adolescent household head and his siblings. In addition, to being close together, the adolescent household head also highlighted that the closeness brought a sense of obligation to take care of each other. Tecla stated that:

> *"Holding money daily is not easy, it needs high levels of responsibility and trust. We take turns to work in the tuckshop, but every one of us delivers to everyone what they would have honestly got from the business. We also sit together and decide on what use we want to put the money to. While I am the elder, I involve my other siblings to ensure that we remain united and work together. We know we have to be together and work for each other."*

The evidence above shows how children living with HIV are not passive recipients of external care and support, but that they can construct and sustain social capital within their households.

5.3 Adherence Behaviours

Adherence behaviours amongst all the adolescents tended to be influenced by the type of household in which they stayed. In the section below I discuss the adherence patterns for adolescents in the different households.

5.3.1 Adherence behaviours in households headed by the elderly

The adherence behaviours by adolescents staying in households headed by elderly persons varied widely. Four of the five adolescents staying within the five households headed by the elderly that had social networks built on strong kinship ties, ties with the local churches, and social network relations with people in the child protection structures of the communities in which information exchanges and remittances occurred, had not missed their clinical appointments and consistently placed their prescription refill requests on time. The four adolescents also reported that they had consistently taken their ART drugs in the last three months preceding the research. The various social network relationships that had been initiated by the household heads facilitated adherence in many ways among the adolescents.

Only one out of the five adolescents had failed to adhere to his treatment schedule for two months before the interviews. However, at the time of the interview, the adolescent had resumed his treatment after the support from a relative that stayed in the urban area. The

adolescent was taken to Harare, the capital city for treatment and received specialised counselling on the dangers of not adhering to ART at a private hospital in Harare.

The adolescents staying in households headed by elderly persons that were recipients of the government social cash transfer programme benefitted from the social networking by their household heads. For example, all nine adolescents from the sample pointed out that their household heads often lent each other funds to enable the adolescents to collect their monthly drugs at the local clinic. In the three months preceding the research, the adolescents reported that the lending of funds among their household heads ensured that they did not miss their monthly clinic appointments. The adolescents mentioned that it was the level of trust and friendship that facilitated the lending of funds among their household heads. The relationship among the household heads constructed on the concept of *usahwira* or sharing the same totem allowed the household heads to coalesce and assist each other to meet the health needs of children staying in their households.

Caleb, the adolescent who was temporarily staying with his grandmother's close friend (*sahwiras*) highlighted that in instances where he did not have the cash to go to the clinic to pick up drugs, his grandmother's friend would provide him with the money. The strong friendship social networks built around the concept of *usahwira* or relationships defined by similar totems were depended upon as sources of support to enhance the adherence of adolescents living in these households.

In addition, the adolescents also noted that because of the strong friendship ties between their household heads, there was an important aspect related to knowledge and information sharing among the elderly household heads on issues about HIV and AIDS and its impacts on society in general. Two adolescents staying in Seke mentioned that they were surprised at the depth of knowledge their elderly household heads had about HIV and AIDS and on new knowledge on the health needs of the adolescents in their households. The adolescents also mentioned that their elderly household heads exchanged and shared information on the symptoms of most opportunistic infections that affected people living with HIV. Information and knowledge exchanged also included healthy living tips for people living with HIV and other information related to the availability of drugs at the local health facility. The increase in knowledge and awareness on issues around HIV and AIDS by elderly household heads

resulted in the heads of households supporting the adolescents to adhere to their treatment regimens.

The social cash transfer program formed a platform on which several social networking activities were initiated and these social networking activities supported adolescent adherence to ART treatment. Apart from the formalised exchange of the cash transfers to the elderly households, the relationships between the elderly household heads and people working for the agencies delivering the cash transfers opened other avenues for social networking. Just like the social cash transfer program had created important opportunities for household heads to interact, the same had happened between the household heads, the adolescents and the people working for the agencies that were responsible for issuing the monthly cash transfers.

The elderly people that were heads of households benefitted from their social relations with personnel working for the agencies that delivered the social cash transfers as they received continuous mentoring and capacity building skills in caring for the adolescents living with HIV. Thus, apart from the exchanges of social cash transfers, these relationships were also critical for access to other forms of social support such as the knowledge and skills transfer mentioned above. The four adolescents that testified that their grandparents had also gained vital knowledge on many issues around the care of PLWHIV through their social networking with people working for the local government institutions and local NGOs. This included the importance of clinical appointments, consistent and correct taking of ARVs and the need to eat a balanced diet as a way of positive living. The mentorship extended to the elderly household members also motivated them to improve on the quality of care for the young adults that were under their care and this contributed immensely to the adolescents adhering to their treatment schedules.

The adolescents staying with household heads that were recipients of the social cash transfers indicated that they had received some form of psycho-social support and counselling from the people that worked for the non-governmental organisation that was delivering the cash transfers to their household heads. The adolescents also mentioned that because of the relationships between their household heads and people working for the cash transfer agencies, they had been provided with knowledge and information that linked them with essential services and referral systems such as government health care institutions and other

private health care institutions. As argued by Raymond-Flesch et al (2017:2), when social capital has the potential to link its beneficiaries with external institutions there is an excellent opportunity for the maximisation of benefits. The central point of this perspective is that for example in the case of the elderly led households, the social network ties involving their household heads had provided a useful link for the adolescents to other external institutions that supported adherence to ART.

5.3.2 Adherence behaviours in Households Headed by Single Parents

Adolescents that stayed in households headed by single parents showed different patterns of adherence. Comparatively, these adolescents had adherence challenges and were not adhering to their treatment schedules compared to those adolescents that stayed in households headed by older persons. The adolescents in single-parent households had stopped taking their ART drugs for three months before the research and they had also missed their clinic appointments. These adolescents were staying in the Seke and one was in Chitungwiza. The adolescents that were not adhering to treatment highlighted that because their relatives often felt that they were victims of HIV they felt highly stigmatised. The adolescents also mentioned that despite the flow of various forms of support through the social networks involving their relatives, those kinship relations were not comfortable being associated with their HIV statuses. A 15-year-old female adolescent named Pricilla had missed her monthly clinic appointments in the last three months preceding the research. She said that her mother's relatives confided in her that if she continues to be seen at the Opportunistic Infection Clinic[3] (OIC) on the day that people collected their ART medication, she and her mother will be labelled as carrying the deadly HIV that causes AIDS. According to Pricilla, her maternal relatives believe that being labelled as living with HIV and AIDS is not good for the family's reputation. Pricilla also highlighted that the relatives had threatened to withdraw any form of support to her and her mother if she continued attending the local OI Clinic. The kinship-based social networks by single-headed households therefore produced different ART adherence outcomes for adolescents.

[3] In Seke there is a monthly day dedicated for people living with HIV and AIDS where they undergo medical reviews, counselling and pick up their drug consignment for the following month. This day, often the last Wednesday of the month is referred to as the Opportunistic Infections Clinic day.

The adolescents that were also not adhering, also highlighted that the fear of stigmatisation by their social relations affected their adherence to their treatment schedules. While in the case of Priscilla, the fear of being stigmatised extended to members of her extended family, in the case of these three adolescents it was their inert fear of stigma that dissuaded them from fulfilling their clinical appointments. In separate interviews, the adolescents highlighted that they feared that someone would see them attending the OIC and then spread the information that they were living with HIV. Two of the adolescents also stated that they could not trust the nurses at the local clinic with confidentiality of information on their HIV status.

To get further insights into the effects on social stigma on ART adherence I asked the adolescents to provide more information on which of their social relations they thought would be affected if knowledge of their HIV statuses is leaked. The three adolescents believed they would lose their friends as no one in their community would want to openly associate with a person living with HIV. According to these three adolescents, it was difficult for people in their community to accept that a young person with HIV would have been born with the virus. The general perception in the community was that young people that were living with HIV were delinquents that had got infected through reckless casual sex.

The stigmatisation of PLWHIV in Zimbabwe and mostly in rural and peri-urban areas is an issue that complicates the lives of people struggling to adhere to ART as explained by the four adolescents. The source of stigmatisation was the community that labelled and stigmatised those people with relatives that were living with HIV. In turn, those relatives that were stigmatised by the community members would also stigmatise their relatives living with HIV and thereby affecting their treatment adherence.

Evidence from the case of Pricilla above illustrates that in some circumstances, social networks were a hindrance to ART adherence for adolescents living with HIV and AIDS. From this case it is clear that whilst social network relations are based on norms of trust and obligations, the relations are defined by social sanctions. For example, the threat of withdrawal of support from Pricilla and her mother is concrete evidence of sanctions that can be applied in social networks to force certain types of behaviours among people. In the cases

above, however, the sanctions are being applied to achieve a negative adherence outcome for the adolescent living with HIV.

Shamiso[4] is a 14-year-old girl staying with her mother and three other children in her household. Her mother is employed in the Zimbabwe National Army and she also runs flea markets in Chitungwiza. Her mother has managed to maintain social network ties with both her late husband's relatives and her own relatives. Despite the availability of various forms of support from these social networks, Shamiso indicated that she suffers from lack of emotional support as her mother and all the relatives do not even want to talk about her HIV status nor be associated with the subject. They have also blocked her from joining the local community HIV and AIDS support group.

However, at the time of the research Shamiso sometimes clandestinely attended HIV and AIDS counselling sessions conducted by the community support group without the knowledge of her household members. Shamiso pointed out that despite her mother knowing her condition, she had not supported her to take her medicine and attend her clinical appointments as she feared that people would start to point at her as living with HIV. Shamiso's mother and her relatives are also opposed to having Shamiso attend the Community Support Group sessions as they are afraid that their family will be stigmatised in the community. At the time of the research, staff members of the Community Support group led by the Director reported that they had made several attempts to engage Shamiso's mother and their other relatives, but the engagement efforts had been met with fierce resistance and threats of violence.

In an interview with the Director of LESO, she highlighted that social stigma was rife in Seke and the main reason for this was that female single parent in both Chitungwiza and Seke were often viewed as having loose morals or being prostitutes. Those whose husbands or partners had died were often labelled as HIV carriers. The adherence to ART amongst adolescents staying in the single-parent headed households was also therefore affected by these perceptions and the social stigma attached to single-parent heads of household.

[4] Initially, Shamiso had been recruited and trained as one of the Research Assistants, she later dropped out for fear of being victimized by her mother and other relatives if they discovered that she was working with the local support group in facilitating my research.

In other cases, social networking by single-parent household heads played a significant role in promoting ART adherence in the face of stigma. Kudakwashe is a 17-year-old male adolescent staying in Chitungwiza with his mother. Kudakwashe was in a similar predicament as that of Pricilla above as their relatives were also not comfortable seeing her attending the Opportunistic Infection Clinic due to the fear of stigmatisation. However, to avoid what Kudakwashe referred to as the "embarrassment" of queuing for drugs at the local clinic, his uncle made an informal arrangement at the local clinic and he had his monthly drugs delivered to him at home. In an interview with Kudakwashe on the 13th of November 2014, he mentioned that:

> *"My uncle is well connected with the sister in charge at the clinic. Normally whilst I should be getting a one-month supply of my ARV drugs, I am usually provided with a three months' supply. For me, the greatest advantage of this is that I do not have to go and be seen by everyone that I am taking ARVs and the embarrassment that this can bring to me, my mother as well as my other relatives. However, the disadvantage is that I have also missed my monthly clinic appointments where I could have benefitted from the medical reviews and counselling."*

In the case above, social networking with kinship relations provided an opportunity to circumvent social stigma and thus enhance ART adherence among adolescents in the process. Another element of social networking that can be drawn from the above case study is that the fear of social stigma by people involved in a similar social network generated innovative ideas that were used to overcome stigma which is a key barrier to adherence. In one of my follow up trips to Kudakwashe's home, I managed to have a conversation with Kudakwashe's mother who also substantiated the fact that her relatives' and her fear of being stigmatised had played an important role in supporting Kudakwashe to consistently and correctly take his prescribed ART drugs. She highlighted that;

> *"I cannot afford to have my child fall sick and then people in this community start to point fingers at him and myself. I am under scrutiny already as people in this community already know that my husband passed on a few years ago. "Muno matinogara vanhu vachiri kuti vakangoona munhu akafirwa kana kuti vana vawo varwara zvonzi vatsikwa nenzou" (In this community people still use derogatory terms to refer to people living with HIV. The good social relations that I have maintained with my brother since my husband died have resulted in him supplying my*

child his drugs at home. This has protected Kudakwashe from being stigmatised by his colleagues at school and people in this community as he no longer goes to attend the monthly Opportunistic Infection Clinic where all the people living with HIV congregate every last Wednesday of the month. On my part, I make sure that Kudakwashe takes his drugs every day without fail to avoid him falling sick".

The above citation has highlighted the promotional role of social networks in enhancing ART adherence among adolescents even in circumstances where other barriers for adherence such as social stigma exist.

The two adolescents (Jekirand and Frank) who stayed in households headed by single male parents had consistently taken their prescribed drugs and were attending their clinical appointments regularly. They were benefiting from the social networks emanating from their household heads connections at their workplaces. The social networks that had been developed by their parents were facilitating their adherence to ART in many ways. In the case of Jekirand, the monthly allowances of sixty dollars he was getting from his attachment at the workplace of his father's friend provided him with a starting point for adherence to his ART schedules. Jekirand noted that since he worked most of the time with his father's friend, he would constantly remind him to take his ARVs every day. I spoke to Jekirand on the 21st of November 2014 and he highlighted he had learnt from his father's friend that:

"I have come to understand from my father's friend that treatment adherence is not only about taking drugs but also about the food requirements that are needed when one is on treatment. During lunchtime, I can go and look for well-cooked food, and he discourages me from eating fast food. This has assisted me in a great way as I have not suffered from the side effects of taking ARVs which some people living with HIV often suffer from."

A similar situation was also expressed by the other adolescent (Frank) who assisted his father's friend in marketing second-hand clothes. He highlighted that social network relationships based on the *usahwira* often involved open and honest discussions on their health and the health of members of their households. Frank added that issues of HIV and AIDS were talked about openly and people living with HIV were openly encouraged to adhere to their treatment regimens for them to realise positive health outcomes.

5.3.3 Adherence Behaviours in Adolescent Headed Households

The adolescents that were household heads did not have problems taking their ART therapy and fulfilling their monthly clinic appointments. For a start, the close relationships that the adolescents had with members of their households who were their siblings promoted adherence behaviour in many ways. The two adolescents and their siblings, all of whom were on ART, had a responsibility towards each other to ensure that they adhered to their treatment regimens and avoid falling sick. In separate interviews, Jairos and Tecla (the adolescent household heads) argued that they encouraged each other to adhere to their treatment regimens to avoid a situation where one of them falls sick. The two added that if one of them fell sick, it would result in the reduction of household labour needed to run their household productive activities.

The discussion above highlights the importance of cordial social relations at the household level and how they influence adherence to ART therapy. While most of the literature on social networks (see for example Bourdieu, Coleman, Putnam) has tended to focus on social networking behaviours between members of different households, the evidence above demonstrates that social networking can also happen among individuals staying within the same household. In the cases discussed above, social networking among adolescents and their siblings promoted positive health behaviour outcomes. The cordial social relations within the households headed by adolescents also provided a shield against social stigma in their communities. The strengthening of the family social ties was based on the expectation among the children that they needed each other, and they would depend on each other for assistance during times of need and hardship.

The social network ties that the adolescent headed household in Seke had developed with the village head provided a platform from which the adolescent and members of their households could support their adherence to ART. For example, the intervention by the village head that prevented relatives from grabbing the agricultural land of the adolescent headed household ensured that the household continued to produce from the land they inherited from their parents. Jairos mentioned that:

> *"The money we raise from farming is the cornerstone for funding our health needs. It is the money that we also use to pay for transport to go for our monthly clinic*

appointments and picking up our drugs supplies. In early 2014 when my sister suffered from a bad cough, we used money obtained from selling vegetables to buy the expensive drugs that were needed. We also funded her bus fares for the check-up visits at the clinic."

The social networks involving the adolescent household heads and community leaders played an important role in promoting the livelihood base for such households which in the long term supported ART adherence among adolescents. Seke, where the adolescent (Jairos) referred to the village head as "father" is a demonstration of the importance attached to the value of the social network that existed between the adolescent and members of the village head's household. The involvement of the village head in negotiations for the wages of the daily work *(maricho)* done by Jairos to sustain the livelihoods of his household, also supported the adherence to ART by the adolescent and his siblings. Money from *maricho* was used to pay for bus fares to the clinic for drug pickups.

Figure 8: One of the fields where Jairos worked for *maricho* in Seke

Source: My own camera 16 November 2014

Similarly, in Chitungwiza, the kinship network ties that existed between the adolescent (Tecla) household head and their relatives had resulted in the relatives protecting the adolescent and members of her household from the landlord who had attempted to grab their tuckshop. The protection of the adolescent headed households' livelihood base went a long way in supporting the adolescent ART adherence. In the case of Tecla, proceeds from the

tuckshop were used to meet costs associated with the monthly clinic appointments and drug pickups.

The evidence from the adolescent headed households indicates that adherence to ART therapy can be an outcome of the agency of the adolescents living with HIV and their interactions with other actors in the social environment. As highlighted above, the social ties with individuals that are strategically placed and connected with services that are relevant for the well-being of adolescents and members of their households show that the adolescents were active agents in the development and sustenance of important social ties. The flow and exchanges of new knowledge and information is a cornerstone on which adherence behaviours by adolescent household heads and their siblings are anchored on.

5.4 Conclusion

Adolescents placed in different types of households were exposed to different forms of social networks that involved their household heads. The differences in household headship also determined the nature of the social networks that members of the household, including adolescents living with HIV, were exposed to. However, all the households, regardless of their headship, had social networks with their kin, extended family members, close friends (*sahwiras*) and members of other community based social groups or organisations.

Adolescents staying in the different households benefited from the social investments developed and maintained by household heads, members of their households and other people that had social links with their households. Evidence from this chapter also demonstrated that adolescents that were heads of households were active agents that could invest in social relations and social networking. Such investments in social networking and social relations by the adolescents that were household heads enhanced adherence to ART therapy in a variety of ways as the social capital generated from such social networking provided a strong base for resolving the key adherence barriers such as stigma, lack of resources to fulfil clinic appointments and drug collection appointments.

The existence of external forms of assistance for households also created social platforms that enhanced social networking among members of different households in the community. For example, the social cash transfer programme in both Seke and Chitungwiza targeted at labour

constrained households led by the elderly created social spaces for social networking and the creation of social capital for those households. The fact that the household heads would meet regularly when they receive their monthly social cash transfer stipends, strengthened their social ties. Such social ties in some cases became a strong basis for *"usahwira"* (strong friendship bonds) that was accompanied by strong unwritten social obligations and rituals of reciprocity in terms of information and goods exchange.

The exchange of goods involving people in the same network is an important aspect that this chapter has demonstrated. The exchange of goods was often accompanied by the exchange of information as well. For example, where households in the urban areas shared material goods such as groceries, this was often reciprocated with sharing of information by their social network members based in rural areas. It is the exchange of goods and information that then induced a sense of obligation for all the people involved in a social network. The exchange of goods is reflective of the anthropological discourse on gift giving where the material gifts resemble more value in terms of strengthening social ties. As argued by Sykes (2005), the exchange of goods and gifts confirms the existence of a relationship between people.

As discussed in chapter three (page 32) authors like Lyon and Santo (2002) and Putnam have pointed out that there are critical elements that characterise social network relations and these include reciprocity, exchanges and trust. As demonstrated in this chapter (see page 66), there is evidence that members of households where the adolescents stayed were involved in exchanges of goods and information. For example, in the case of Devine discussed in this chapter, the exchange of information that involved his household members and relatives in the city saw the exchanges in return in the form of groceries from those relatives in the city. The social exchanges in the form of information sharing also reflected the building of trust which is another critical element of social networking expounded on by authors like Lyon and Santo. As demonstrated in the interview with Mr Chikiri (see page 70), he highlighted that the exchange of small groceries among the heads of households was a way of showing trust for the people involved in the social network. This phenomenon is also strongly linked to the aspect of *Ubuntu* among people involved in the social relationships. As highlighted in chapter three, the concept of *Ubuntu* considers gestures of goods exchange as symbolising solidarity, compassion and muatual care for those people involved in social networks.

Exchange of information and material goods also took place among the adolescents involved in the social networks. Adolescents like Jairos shared their agricultural products with staff members at the clinic whom they had social ties with. The exchange of agricultural products was reciprocated by the staff members with information on drug stock-outs and other favours that the adolescents enjoyed from the staff members manning the local clinics.

Adolescent headed households had different forms of social networks. In most cases, the adolescent headed households had social networks with people working for institutions that have a role in supporting the welfare needs poor households in the community. In addition, the stigmatisation that the adolescent headed households and their members faced fostered closeness among the adolescent household head and the other children in the household. Such closeness became the centre of close cooperation among adolescents in those households. This was not the case with single-parent households as in some instances the single parents would not support the adherence needs of their children as was demonstrated in the case of Shamiso. In the other cases, the threat of sanctions including the withdrawal of support by members of the social network ties implied that such solidarity was not difficult to achieve.

Another important dynamic from this section is the agency that is exhibited by adolescents in their attempt to cope with adherence to ART challenges and social stigma. For example, the two adolescent headed households in the sample had small scale income generation projects that enhanced their livelihood systems.

CHAPTER 6: SOCIAL NETWORKING NORMS AND RULES AMONG ADOLESCENTS

6.1 Introduction

This chapter discusses the social networking activities among adolescents living with HIV and AIDS and how this influenced ART adherence patterns. The analyses will focus on two types of social networking behaviours. The first type of social networking behaviour is the one that focuses on those adolescents in the study sample that were socially connected (endogenous) primarily because they were attending HIV and AIDS counselling sessions at the Life Support and Empowerment Organisation (LESO). The second type of social networking behaviours that are discussed in this chapter is the one which involves the adolescents and other people that are not categorised as adolescents in this study (exogenous). Specifically, I will provide an in-depth analysis of the adolescents' social networks with members of the community support group and people working for formal state health and welfare institutions and how this influences ART adherence behaviour among adolescents living with HIV.

In my analyses of both the endogenous and exogenous networking behaviours, I set out to focus on the abilities of the adolescents to voluntarily initiate and enter social network relations that result in the construction of a social capital base that influences adherence to ART therapy. The differentiation between endogenous and exogenous social networking behaviours was very clear-cut for the analysis involving the adolescents and the personnel at formal health and welfare institutions but tended to be distorted when the analysis is done for personnel working at LESO, the local support group. This was mostly because the interactions between the adolescents and LESO personnel were more frequent and intense as they involved both the formal interactions within premises and informal outside LESO premises. In my analysis of the two types of social networking behaviours, I draw on evidence generated from the in-depth narratives of individual adolescents, evidence generated from key informants and the focus group discussions with LESO staff members. The evidence above is also supported by the information I gathered from the interviews I had with the staff at local health and social welfare institutions in both Chitungwiza and Seke.

6.2 Social Networking Among Adolescents Attending LESO activities

Fifteen adolescents had social networks emanating from their interactions at activities organised by LESO. These adolescents had very close social relationships that reflected the concept of *usahwira* or close friendship. Unlike the elderly household heads described in chapter five, the adolescents did not refer to their close friendship as *usahwira* as the elders did, but they used different terms to describe their close friendships. The most common names that the adolescents described their close friendship with were *mafesi* or *gen'a.* These descriptions were used both among urban and rural adolescents. Whilst there was no agreement among the adolescents as to the genesis of the word "*mafesi*" either in the local Shona language or the English language, the adolescents were all agreed that the word "*gen'a*" could be an adulteration of the English word gangsters.

The fifteen adolescents' broad social networking was thus based on that close friendship which they referred to as "*mafesi*" or "*gen'a".* A defining characteristic of the social networking behaviours among the adolescents were the unwritten rules and norms that were practised by the adolescents. As in the case of the traditional *usahwira* relationships for adults discussed in chapter five, the norms, rules and ritual obligations were important for sustaining the social network relations.

Figure 9: The LESO office premise in Chitungwiza

Source: My own camera 03 October 2014

One of the most important norms among the adolescents was based on what all of the adolescents referred to as the non-disclosure rule. All the adolescents mentioned that they believed in a Shona idiom of *"kusafugura hapwa"* (do not share your secret) in the Shona language. From the in-depth interviews with the adolescents, they mentioned that the non-disclosure rule based on the concept of *kusafugura hapwa* had now gained a deeper meaning amongst the adolescents living with HIV as the virtue of keeping secrets was highly regarded in their social networks. Tinashe, who was one of my research assistants emphasised that:

> *"Kusafugura hapwa is what makes a real person to us, it shows a person can be trusted among ourselves". Ukafungure hapwa (if you share your secrets) you can affect the entire lives of people living with HIV in this community".*

All the adolescents in the study sample mentioned that they were bound together by the non-disclosure rule. According to this norm, adolescents that were socially networked because of their interactions at LESO agreed that they would never open up on their HIV status to anyone outside their social networks. The non-disclosure rule imposed an obligation on each of the adolescents not to disclose his or her HIV status, particularly to ordinary community members as the adolescents believed that social stigma was rife among these people. All the

adolescents that were part of these social network circles agreed that disclosure should only be limited to one's immediate family members and those close people that were involved in providing them with care and support.

In the in-depth conversation with the adolescents, it was also mentioned that the other important obligation that the adolescents in these social networks followed was based on the concept that the adolescents referred to as *"hatizivani uye hatina kumboonana" (we do not know each other, and we have never met before).* The loose translation of this concept is that whilst the adolescents interacted with each other at the community support group functions, that interaction was only confined to that space and was not supposed to extend outside the premises of LESO. According to Jekirandi, the *"hatizivani uye hatina kumboonana" (we do not know each other, and we have never met before)* helped them as adolescents living with HIV to cement the non-disclosure rule whilst at the same time building high levels of trust among the adolescents.

In my in-depth interviews with the adolescents, I discovered that the *"hatizivani uye hatina kumboonana"* was also an important phenomenon that characterised the nature of social networking amongst the adolescents in their own interactions. For example, the adolescents would not greet or start a conversation in public unless there was a prior arrangement or if they are meeting within a larger group of people such as a church gathering or a community event. For example, when I moved around with the four research assistants, they would not greet any of the adolescents in the community as part of observing this rule. As pointed out in chapter four, whilst the research assistants assisted with the identification of some of the study participants, they required time to meet and discuss in their own private space in advance. Also, in one of my interactions with Jekirandi, when I asked him if he knew any of the colleagues, he interfaced with at LESO, he initially denied even knowing the existence of the organisation. He only, later on, revealed to me that he was part of the youths attending sessions at LESO after being alerted by one of my research assistants that I was a student working on a research project on ART adherence.

In the several discussions, I had with the Director of LESO she also corroborated this and highlighted that most interactions among the adolescents tended to be limited to the LESO premises and to the social media groups that the youths had set up with the assistance of LESO. In the focus group discussion with LESO staff members, a staff member Mr Langa

highlighted that from his interactions with the adolescents during the group counselling sessions, he had discovered all the adolescents believed that if their interactions were done in public spaces, once one of them gets their status revealed, it would result in the whole social circle having their HIV status known.

The staff members at LESO revealed to me during one of the focus group discussions that the norms and practices adopted by the adolescents concerning non-disclosure of their HIV status were by and large a reaction to the pervasive social stigmatisation of their communities. This was also highlighted by several adolescents during the in-depth interviews. Pride, who was 18 years and stayed in Chitungwiza, pointed out to me that people in his community people used derogatory terms to describe people living with HIV. In an interview with Pride on the 26th of October 2014, he said:

> *"Vanhu vemuno mu Chitungwiza ukanzwa vachiti munhu akatsikwa nenzou vanenge vachitoseka kuti munhu iyeye ane HIV"* (people in Chitungwiza use descriptions like a person has been crushed by an elephant in reference to people whom they think are living with HIV).

The other adolescents also mentioned that in addition to describing people with HIV as "having been crushed by an elephant", other terms used by the communities included referring to people with HIV as people who were in the "departure lounge". The reference to the "departure lounge" by people in the community was very negative as it reflected their belief that people living with HIV were only waiting to die very shortly. The existence of high levels of stigma in Seke and Chutngwiza also came out strongly in the focus group discussions with LESO staff. The staff members mentioned that the use of terms like *"akatsikwa nenzou"* (crashed by an elephant), *"ari mu departure lounge"* (they are in the departure lounge waiting to die) and *"vari pachirongwa"* (they are on ART) were some of the common negative descriptions people in the communities used to describe people living with HIV.

In an interview with the Director of LESO, she indicated that social networking among the adolescents supported non-disclosure of HIV status and has serious implications for the global fight against new HIV infections. All the participants in the LESO staff focus group

discussions also agreed that the close social networking amongst the adolescents was affecting their efforts to encourage people living with HIV to disclose their status as one of the ways towards sustaining HIV prevention and fighting HIV and AIDS-related social stigma.

The evidence above illustrates the negative aspects of social networking as has been argued by such authors as Fujimoto and Valente (2015: 173) and Browning, Soller and Jackson (2015:162). The non-disclosure behaviour among the adolescents that is reinforced in their social networks contradicts the HIV care and prevention discourse that places importance on HIV status disclosure as a way of fighting new HIV infections. This, therefore, implies that whilst efforts are being put in place by government and development partners such as LESO to reduce the HIV prevalence rates, the rate of new infections could increase in future given that the adolescents are not disclosing their status even to people who are their potential sexual partners.

Apart from the fear of social stigma, the adolescents also highlighted that societal expectations for them to engage in social activities weighed in on them not to disclose their HIV status. For example, information from the in-depth interviews showed that all the adolescents deemed themselves ready for dating and some ready for marriage but felt that if their HIV status is known that would jeopardise their chances of dating or getting married to someone. The adolescents also highlighted that the pressure sometimes came from their peers, parents and guardians who expected them to be having love relationships. In an interview with Tinashe, who was 18 years, he complained that his grandmother was always in the habit of enquiring on whether he had found a girl suitable for marriage. Through the in-depth interviews the adolescents revealed that with the high levels of stigma in their communities, it was difficult to date anyone if one discloses that he or she is living with HIV.

An illustrative case is that of Theresa, a 17-year-old female. Theresa had adhered to her treatment schedule until she reached 16 years when she met her first boyfriend. She did not disclose her HIV status to him because she feared that he would leave her. During the early days of the relationship, Theresa continued to adhere to her ART treatment schedule. She explained that:

"As our love matured and I began to spend more time with him, I started to default on my ART treatment. I also did not want him to see me with the drugs, so I stopped the treatment. I did not even take care to continue collecting my drugs. During our first sexual encounter, my boyfriend was quite happy to learn that I was still a virgin and he initiated traditional marriage proceedings. After nine months into the marriage, my boyfriend, now husband fell sick and demanded that we undergo an HIV test from which we both tested positive. That was the end of our relationship and I was lucky that I did not get pregnant. I have now resumed my ART treatment, but I have been elevated to the second-line drug treatment as I was no longer responding to drugs on the first line of treatment."

The societal expectations highlighted by the adolescents above are an important phenomenon to note in the Zimbabwean context. The issues of child marriages and forced marriages in Zimbabwe are an enormous challenge. The Zimbabwe Multiple Indicator Cluster Survey Report of 2019 highlighted that the percentage of women aged between 15-49 years who married before their fifteenth birthday was 32.6%. Evidence from previous research work by Mukanangana, Moyo, Zvoushe and Rusinga (2014:110) also show that in Zimbabwe almost 55% of the early marriages are forced. The reasons for child marriages and forced marriages are many but most authors and researchers have blamed these on social, economic and religious factors (see for example the work of Walker, 2012).

While the fifteen adolescents networked at the LESO facilitated activities, there were also sub-groups where the adolescents would form smaller cliques based on engagement in similar social-economic activities or interests. Among the fifteen adolescents, there was a distinct sub-group of three male adolescents who had their social network circle that was derived from their involvement in the informal sector in Chitungwiza. Whilst these three attended activities organised by LESO, they were also socially connected as a result of their everyday experiences in the informal sector. As in the bigger group of adolescents, the norms that supported secrecy and HIV status non-disclosure were also strictly enforced in the sub-group. In the sub-group however, the levels of trust were comparatively higher compared to those in the bigger group.

Within the sub-group, the norms and rules of secrecy covered broad areas and not only non-disclosure of their HIV status. For example, in one incidence the adolescents experimented

with using traditional medicines which they had obtained from the informal market for HIV treatment and they had set aside their ART drugs for a period spanning over three months. The behaviours by these three adolescents were also subjected to the norms of secrecy including not disclosing to the larger group of adolescents.

On the 21st of October 2014 when I interviewed, Frank, he highlighted that:

> *"In this smaller group we are even more strict, and the level of trust is also very high. I am confident that my attempt to seek other forms of treatment will not even get to the other colleagues I meet at LESO because the same rule of non-disclosure applies to the three of us here."*

Thus, what happened in the smaller group remained a secret to the larger group of adolescents that these three were also a part of. These three adolescents had developed their sub-level social network that was supporting their interests and intentions then. This type and form of social networking resulted in the emergence of a form of social capital that was a preserve of a few individuals participating in that type of social networking. Authors such as Van Staveren and Knorringa (2007) have described this as 'alternative' social capital emanating from those social networks which might exist outside the larger mainstream social structures and networks. Such alternative networks can apply to groups engaged in illegal activities, for example, gangs, but could also apply to social or political activist groups, or those engaged in non-biomedical health systems.

The impact of adolescent endogenous social networking on ART adherence showed that the norms that sustained social networking produced different adherence outcomes. The evidence from the case studies also showed that the norms of non-disclosure created an effective escape route from the social stigma that is pervasive within the communities in which the adolescents live. The endogenous social networking amongst the adolescents was also an effective way to promote adherence to ART amongst the youths that were participating at spaces created by the local HIV and AIDS support group. However, it can also be argued that the non-disclosure norm among the adolescents only led to conditional adherence as indicated in the case of Theresa who stopped taking her medicine when she fell in love. Theresa's case also demonstrates that the non-disclosure behaviour distorts the ART treatment programme as non-adherence results in drug resistance that can lead to increased HIV and AIDS morbidity. In addition to distorting the national ART treatment programme, non-disclosure is

also a fertile ground for the generation of new infections among youths in the country. In the case of Theresa, the boyfriend/husband became infected because of the non-disclosure of HIV status by an infected person.

6.3 Social Networking with people from support institutions

In this section, I focus on the social networking behaviours of adolescents with people who are not necessarily adolescents but had developed social network ties with them. These are members of staff from institutions that the adolescents interacted with frequently in their quest for adherence to ART treatment. These staff members featured prominently in the in-depth interviews with the adolescents. As a result, key informant interviews and group discussions were also conducted with these staff members in both Chitungwiza and Seke to flesh out this dimension of ART adherence. In this discussion, I centre my analysis on the individual adolescents and the household in which they stay. This, therefore, means that I will discuss individual adolescents' relations with staff members at formal institutions and the relationship of their households to those institutions as well where it is relevant.

LESO is a community-based HIV and AIDS support organisation with a presence in both Chitungwiza and Seke. Community-based HIV and AIDS support groups are a common feature in all communities affected by HIV and AIDS in Zimbabwe in both urban and rural areas. The early forms of such support groups were the Home-Based Care Support groups that were established by Non-Governmental Organisations (NGOs) in the country to provide care for people bed-ridden by HIV and AIDS. The advent of ART has resulted in the extensive expansion of the home-based care system with the sprouting of many small and sometimes informal community support groups that encourage people to adhere to their ART treatment and to live healthy lives. Participation in the activities of the community-based support organisation is purely voluntary. Many of these support groups continue to receive donor support to sustain their activities.

In Zimbabwe in general and particularly in the two study sites, the institutions that are important for adherence are the local health facilities or clinics where the adolescents receive their drugs. In addition to the clinics, some of the youths in the study also had ties with the Department of Social Welfare that provides the adolescents living with HIV with funding to meet their transport costs, diagnosis costs and other treatment associated costs. This

assistance from the Department of Social Welfare is formally referred to as the Assisted Medical Treatment Order (AMTO) and is part of the government of Zimbabwe's social protection system extended to people in need of continuous medical attention. The adolescents' and their households' relationship with these institutions is not voluntary but it is based on the health needs of the adolescents imposed on them due to their HIV status.

6.3.1 Adolescents Social Networks with Staff at Community Support Groups

LESO is one of the most visible HIV and AIDS community support groups operating in both Chitungwiza and Seke. The organisation was started in 2004 by a group of women that were living with HIV. At the time of its inception, the organisation was focused on providing home-based care and support to its founding members who were all living with HIV. However, around 2008, the organisation started receiving donor funding that enabled the members to extend their HIV care and support services beyond its membership in both Chitungwiza and Seke. At the time of the research, LESO was a recipient of funding from two international donor organisations and had a staff complement of nine full-time officers plus eighteen volunteers.

As mentioned in chapter three, all the adolescents in the study sample were linked to LESO through their participation in activities facilitated by the organisation. During a focus group discussion with staff members of LESO, it was indicated that all the youths in the study sample had participated in at least one activity organised by LESO. This was also corroborated by the youths in the study sample who mentioned that they had at least participated in an activity organised by the organisation. Staff members of the organisation highlighted that the participation by the youths in the activities they organised had resulted in the development of social relations between the adolescents and staff members of the organisation.

According to all twenty-two adolescent research participants, the social networking that evolved between them and staff members of LESO was highly informal. For the adolescents, the organisation could not bind them in any formal way as their participation was voluntary without any formal obligations to the organisation. In my first interview with the of LESO on the 9th of September, she mentioned that:

> *"Our relationship with these youths is highly informal, flexible and negotiated. We cannot establish any formal relationship with them as they often come and go and there is no way we can force their participation in our activities."*

To reinforce the above sentiment, the adolescents mentioned that the same norms that governed their peer-to-peer social networking also applied to their social relations with staff members of LESO. The concept of *"hatizivani uye hatina kumboonana" (*we do not know each other, and we have never met before) also applied to the social relationships between the adolescents and the LESO staff members. In the focus group discussion, with LESO staff on the 11th of September 2014, Mr Langa a staff member stated that:

> *"All the adolescents that we interact with here are different but a common character amongst all of them is that they do not want to disclose their HIV status. The adolescents do not want their relationship with the support group to extend into the community. This means that we have agreed that we don't greet or start a conversation with the youths in the community unless that discussion or greeting process has been initiated by the adolescents themselves. For example, one of the rules of engagement I now know is that when we meet with them outside the premises of the support group, I should never indicate that I know them or that I have met them somewhere. This means that outside the premises of the support group, we pretend that we have never seen each other before and that we don't know them. This is an unwritten rule but a very important one because failure to respect this rule can have devastating consequences for me as a staff member of LESO or even for the organisation."*

In the same focus group discussion, the Director of LESO also highlighted that:

> *"We have noted over time that all the youths we deal with here are not comfortable to interact with any LESO staff member outside these premises. It is something we have come to accept for our relationship with the youths to continue".*

During the focus group discussions, the Director of LESO however also mentioned that the norms of secrecy that governed their relationships with the adolescents created contradictions with the objectives and principles that LESO as an HIV and AIDS support group was advancing in the community. She stated that:

"The primary focus of our work with adolescents living with HIV is to support them to adhere to their treatment schedules. however, this is only a small part of our broader vision which was to drive a comprehensive HIV and AIDS prevention agenda amongst the youths that could contribute towards the prevention of new HIV infections".

In the same focus group, the LESO staff members stated that it was important to respect the informal rules of engagement with the adolescents as this guaranteed their continued participation in their activities. The LESO staff members all agreed that the norms of secrecy governing their relationship with the adolescents had produced positive health outcomes for the youths who were all showing signs of adherence to their ART treatment schedules. The observance of secrecy had built trust and respect between the adolescents and the LESO staff. To this extent, Mr Kuziwa the accountant at LESO maintained that:

"So far, I think that we are on course to accomplish our primary objective as their organisation, we have created space where the adolescents can come in as and when they want and obtained information on the advantages of adhering to their ART treatment. Most importantly, upholding of norms of secrecy in their relationship with the youths has resulted in the development of relationships of trust between ourselves and the youths".

The structure of social networks between LESO staff and the adolescents outside the organisation's premises varied. This is illustrated by the case of Tecla, who ran a tuckshop business in Chitungwiza. In an interview on the 16th of November 2014, Tecla stated that:

"I have very strong social relationships with staff members at LESO, particularly with Mr Langa. Our relationship has grown to the extent that we share information on emerging business opportunities and new markets".

In the case of Tecla, Mr Langa would pass by her tuckshop and bring her pamphlets with the latest information and other developments on HIV and AIDS. The pieces of information that were often shared with the youths were case studies on how other adolescents in Zimbabwe and other parts of Africa were managing to adhere to their ART treatment schedules.

In an interview during the last week of September with Mr Langa where he highlighted that:

"It is important to keep cordial relationships with the adolescents outside the formal engagements at LESO as it is the fastest way of sharing the latest information on HIV and AIDS with the adolescents".

The same information was also passed to other adolescents outside the LESO premises by other LESO staff members who maintained social relationships with the adolescents who participated in their activities. According to Mr Langa, he had developed such social relations with five other youths in the sample and in each of the cases important information that supported adherence to ART treatment was shared. The same rules of engagement also applied to the social networking that happened outside the LESO premises. The conduct of the LESO staff was still guided by the *"hatizivani uye hatina kumboonana" (we do not know each other, and we have never met before)* concept which implied that sharing of information with the adolescents was not only targeted at the youths who attended the LESO activities but the general population within which the adolescents lived.

According to the evidence from the in-depth discussions with the adolescents, this mode of targeting was appropriate as the targeting of the entire population meant that their HIV status remained unknown. All the youths and the LESO staff members mentioned that this was mainly because LESO as an organisation was already highly stigmatised in the community and any association with their staff members or their activities would result in one being labelled as living with HIV. This issue was also evident during the interviews as one of the adolescents, Jekirandi, denied any knowledge of the existence of LESO. However, after some time during the interview, the adolescent revealed that he knew LESO and had participated in their activities.

The adolescents and the LESO staff members were comfortable with the social network relationships that happened outside the LESO premises as this was advantageous to everybody. The LESO staff in the focus group discussion affirmed that the extension of the social relations outside the LESO premises provided them with an excellent opportunity to achieve their primary goal of supporting the adolescents to adhere. Apart from the regular sharing of information, the LESO staff members could also visit the adolescents at their homes or their workplaces and check on whether the youths were facing any challenges in adhering to their treatment. In the case of Jekirandi and Frank, the LESO staff members who

supported these adolescents would visit them at their workplaces in the informal sector at Huruyadzo. They, however, had to disguise themselves as a potential buyer whilst in the process checking on how the adolescents were adhering to their ART therapy.

The staff members of LESO were in a real dilemma as a result of the norms that governed their interactions with the adolescents both within and outside the organisation's premises. The Director of LESO concluded in her interview that in Zimbabwe at policy level, health-related institutions are bound by statutory requirements to maintain the privacy of their clients; on the other hand, the national HIV and AIDS prevention guidelines encourage HIV status disclosure on a voluntary basis as a means of fighting HIV and AIDS-related stigma. The voluntary disclosure of one's HIV status is being utilised by the adolescents to their advantage to have their HIV statuses remain a secret.

According to the LESO Director and her staff members, the culture of HIV status non-disclosure among the adolescents posed a potential danger of the escalation of new HIV infections among the youths in the long term. This potential danger was also highlighted in information obtained from all the twenty-two study participants who reiterated that they all intended to marry partners that are HIV negative and would never disclose their HIV statuses. Staff members at LESO mentioned that since 2011 they had recorded at least two cases of adolescent girls living with HIV that fall pregnant or get married. The relationship that binds the community support group staff and the adolescents based on the unwritten social norms that enforce non-disclosure thus support short term adherence and lead to poor adherence in the long term. This, therefore, defeats the long-term community support group vision of preventing new HIV infections.

6.3.2 Adolescents social networks with staff at Health Service institutions

Social capital has been proven to either attract people to medical services or draw them away from such services. The evidence from the in-depth interviews with adolescents in the two study sites indicates that all twenty-two adolescents had cultivated social relations with personnel working at clinics that the youths attended for their monthly clinical appointments. The nature of social relationships between the adolescents and health facilities personnel in both Chitungwiza and Seke differ based on whether the adolescents attended their monthly clinical appointments on their own or not. In the sample, seventeen adolescents frequently

attended the clinic appointments on their own and these had developed comprehensive social network relations with staff at health facilities. The other five adolescents who were often accompanied to the clinic to pick up their drugs and attend their monthly clinic appointments had not developed social network relationships with staff members at the health facilities. This scenario was more likely among younger adolescents (aged between 14 and 15 years) who attended routine counselling sessions and drugs pickups often accompanied by their parents. These adolescents tended to utilise the social network relationships that their parents or guardians developed with personnel at health facilities. Two adolescents had, however, told me that they only got to know their HIV status in the last three years before this research as their parents had colluded with health personnel in Chitungwiza to lie to them that they were taking life-long drugs because they had heart ailments. It is interesting to note that due to the pervasive nature of social stigma related to HIV and AIDS in Zimbabwe, the social networks that involved health facilities personnel and parents and or guardians of adolescent living with HIV were sometimes used to mask the HIV status of the adolescents.

In the first case, the misinformation of the adolescent as to the true ailment that she was suffering from was based on an agreement between the parent and the health facility staff that it was better to defer disclosure of the true ailment that the adolescent was suffering from till the adolescent was old enough and successfully counselled. In the other case, the parent had developed strong relationships with personnel at the health facility and had agreed that as a way of protecting their household from being stigmatised, it was better that the child's ailment was not revealed to her. In the in-depth interviews I had with the two youths, they highlighted that they were anticipating that through their consistent adherence to their treatment regimens, one day their heart ailments would be totally healed, and they would stop taking the drugs.

The effect of social networks that developed between parents of the adolescents and personnel at health facilities and how this promoted adherence to ART treatment among adolescents is highlighted in the above cases. The downside to these cases was that the adherence to ART was based on false information regarding the actual nature of the ailment that the adolescents were suffering from. In the key informant interviews I had with personnel at Chitungwiza clinic, their view was that the misinformation was a process in the journey towards disclosing the true information in the long term. The health facility staff also

highlighted that the deferment of disclosure assisted the adolescents to continue taking their drugs and sticking to their treatment regimens, whilst they worked on a counselling strategy to facilitate disclosure to the youths.

The two cases above were completely different from the scenario where individual adolescents initiated social networking relationships with personnel at health facilities. The social networking relationships between the adolescents and health personnel was a result of the continuous interactions involving the adolescents and health personnel during drug collections, monthly clinical appointments, formal counselling sessions and other community support services provided by the health facility personnel to people living with HIV in both Chitungwiza and Seke. Amongst the seventeen adolescents that had developed social relations with health facility personnel, all of them knew at least two nurses that operated the Opportunistic Infections clinic that catered for people living with HIV.

The social relationships between the adolescents and the personnel at the health facilities were guided by the Health facilities client services charter. At the same time, these relationships were also informal and punctuated by joking relationships and close friendships that characterised the social networks among adolescents, and adolescents with staff members at LESO. As was the case with social networks involving adolescents on their own and adolescents and LESO staff members, an enduring characteristic of the social relationship was the high level of trust that existed between the adolescents and the health facility personnel. With regards to the norm of secrecy, the adolescents trusted the health facility personnel to uphold the confidentiality ethos as this was enshrined in the health facility service charter. The seventeen adolescents all stated that they had confidence and trust in the conduct of the health personnel. They all believed that the staff members would uphold client confidentiality and not reveal their HIV status to anyone without their consent.
From an interview with Kudzai, a 16-year-old adolescent on the 15th of September 2014, I gathered that the adolescents also trusted the efficacy of the knowledge of the health facility personnel. She stated that:

> *"We trust the health personnel because they are well trained, they have more knowledge and they have the hands-on experience regarding different diseases".*

From my interpretation of the information from the in-depth interviews, I concluded that the trust in the knowledge of the health facilities personnel was also an important element that strengthened the social networking between the adolescents and the health workers.

When I interviewed two elderly heads of households that were part of my key informants, they intimated that health facility personnel used their social networking with the adolescents to provide important information related to other sources and forms of assistance for people living with HIV. The two mentioned that adolescents in their household had accessed other forms of assistance passed to them by personnel at health facilities. The two mentioned that in Seke health personnel referred adolescents to other health support services offered by private players in the health sector such as Non-Governmental Organisations and/or private health institutions. This was corroborated by evidence from the key informant interviews with Health personnel from Chitungwiza and Seke, who cited that whilst their primary mandate started and ended with the provision of medicines and counselling of the adolescents, they had taken it upon themselves to provide additional information on other existing services that supported the well-being of adolescents living with HIV.

Pride was referred to the Department of Social Welfare by personnel at Chitungwiza clinic. Pride had developed complications arising from various opportunistic infections and required specialist treatment. The health facility personnel linked Pride and his grandmother, who was his guardian to the Department of Social Welfare through formal written communication. Pride was provided with an Assisted Medical Treatment Order (AMTO) that facilitated his access to specialist treatment at a government hospital in Harare for the opportunistic infections he was suffering from. Pride and his household were also linked to a Non-Governmental Organisation (NGO) that specialised in the provision of essential services to poor households with persons living with HIV. The household started to receive monthly food rations and the head of the household was provided with an employment opportunity at the premises of the local NGO.

The case of Pride demonstrates the utilisation of social networks to facilitate connections with other important livelihood support systems run by the government and other development actors such as NGOs. The social networks between the adolescents and health facility personnel can be characterised from Coleman's model of social capital in which he

conceptualises the social relationships between individuals and "corporate" actors. As noted by Coleman (1988:98) corporate actors or organisations can be actors just like persons and relations among corporate actors and individuals outside them can constitute social capital. The importance of such social networking relationships between the adolescents and the health personnel was stressed by one male nurse, Mr Nheta. In an interview with him on the 3rd of October 2014 in Seke, he who highlighted that:

> *"Having drug stocks in the clinic is desirable but being satisfied that people are coming in to routinely collect their drugs and adhere to their treatment schedule is even more desirable and satisfying. For me, it is costly to lose one individual through non-adherence. It is better to deliberately invest in social relations that attract people to the health facility, and we retain them on treatment."*

The investment in social network relationships was therefore beneficial to both the adolescents and health personnel as social relations and networking was a strategy that helped retain HIV patients on treatment.

6.3.2.1 Social networking rules of engagement between adolescents and Health staff

The social networking discussed above was situated within the official spaces of the health facilities. However, the social networking between adolescents and health staff adopted a different form when social networking was done outside the official spaces and premises of the health facilities. The adolescents highlighted that relationships outside the health facility premises were characterised by the respect to a set of unwritten norms, rules and rituals. The adolescents stated that the nurses and other health facility staff involved in such social networks adopted different identities in those social spaces outside the formal health facility spaces. In Chitungwiza personnel working at the clinic involved in social networking with the youths were often referred to using street lingo such as *dhara redu* (Our Big Daddy for male staff) and *Chimhamha chedu* (Our Big Mother for female staff).

The adolescents mentioned that the titles above for the staff involved in the social networking relations were earned identities as they reflected what the staff members brought into the social relations. For example, the "*dhara redu"* and *"chimhamha chedu"* titles were reserved only for those staff who facilitated the movement of material resources such as money, food and other goodies in their social networking with the youths. In addition, the titles were also

used to describe health facility staff members who were always ahead in terms of new information within the health sector, particularly information on drug stocks and availability of new HIV drugs on the market.

Five of the adolescents, including those that were involved in their sub-group social networking discussed at the beginning of this chapter, had developed close social networking relationships with staff at health facilities. Using the adopted identities outside the formal health facility spaces, the relationships between the adolescents and the health staffers resembled that of *usahwira.* The social relations involved the reciprocal exchange of goods and information and sometimes this was done in discreet ways. In my interactions with the five youths that had developed intimate relationships with staff at health facilities, the youth intimated that they often paid some tokens of appreciation to the staff at the Opportunistic Infection Clinic. In return, they received their drugs, counselling and other services outside the health facilities premises to minimise the risk and embarrassment of being seen by community members at the Opportunistic Infection clinic and be labelled as having the deadly HIV virus.

The adolescents also indicated that through their social networking relations with the staff at health facilities they were privileged to have current information on the level of drug stocks at the health facilities. Jekirandi, who was one of the youths involved in the close relationships with the health facility staff in Chitungwiza, stated that:

> *"The provision of vital information related to the levels of drug stocks at the health facility is very important for me and other adolescents living with HIV given the high incidences of drug stock-outs in Zimbabwe due to shortages of foreign currency to procure ART drugs. Having this information in advance will assist me to make prior arrangements with our mudhara wedu and chimhamha chedu to have our drug stocks put aside and delivered to us."*

The youths also indicated that the quality of care and attention that they received from the health personnel outside the official health facility spaces was much better compared to that which they received inside the health facilities. For example, all five youths mentioned that the health staff were often more relaxed and tended to spend more time talking to them when they met them in their private spaces outside the health facility. The youths also maintained

that their social relations with the health staff had benefited them in that they could now negotiate flexible times to come for their monthly clinical appointments. Thus, instead of attending on every last Thursday of the month, the youths would avoid this day as it was a source of social stigma to be seen attending clinic sessions on this day. One of the female adolescents, Tecla, stated that:

> *"For me and my peers to survive comfortably, we link up with those people who work at the local health facility. Outside the formal system, the staff members are more relaxed, and they are not in a hurry, that is when we get in-depth and new information. In my case, I get new knowledge on "dos and don'ts" based on my HIV status. I now also know the function of different no cost local herbs that help to reduce incidences of opportunistic infections. This knowledge is often not shared in detail during our visits at the health facility as the personnel are often too busy and will be rushing the procedures".*

A similar scenario also prevailed in Seke as Jairos highlighted that his social networking relationships with staff at the local clinic had resulted in him and his siblings getting preferential treatment from the health personnel at the clinic. Jairos claimed that his close relationships with the staff had assisted him to have access to medical goods and drugs that were very expensive on the open market and those that were hard to get within official health facility channels. The scenario above has implications for equitable access to ART drugs for PLWHIV as those outside the social network will not have access to the drugs. The social networks, therefore, provided an advantage for the adolescents involved in terms of accessing high-quality health care services and ensuring access to drugs.

Jairos also highlighted that through their social relations with nurses at the health facility, the nurses were also free to utilise some skills and experiences that they were not allowed to practice within their formal job descriptions at the clinic. For example, in informal social relations, nurses could perform diagnoses that are the preserve of medical doctors in the formal sphere. In addition to the performance of unofficial medical diagnoses, the nurses also performed drug prescriptive functions. According to Jairos, the nurses were also performing these services to all those who required it in the community in exchange for a small fee.

Frank mentioned that his relationship with health personnel had created opportunities for them to economically benefit from the channelling of drugs from the formal health system

onto the black market. Frank mentioned that the health personnel often paid him in kind for delivering ART drugs to affluent individuals in the community who obtained their drugs outside the formal health system. Frank mentioned that he would often get double benefits as the affluent persons, mostly business people, to whom he would deliver the drugs also paid him in cash or sometimes in kind.

The social networking relations between the adolescents and nurses were governed by strict norms and rituals that emphasised secrecy as the basic rule of engagements. According to both Jairos and Frank, this was mostly because if such transactions were discovered by health authorities, their *"dhara redu"* (our Big Daddy) and *"chimhamha chedu"* (Our Big Mother) would be liable to public prosecution and lose their jobs in the process. In a discussion with these two youths, it was disclosed that the health personnel gained part of their living expenses from such transactions and on the side of the youths they also benefitted financially as they often received payment from the transactions. Frank justified their practice and that of the nurses saying:

> *"In Zimbabwe, the economy is down, there are no jobs for us and those working are also facing hardships. Unemployment is above 90 %cent so as youths we can take up any activity that gives us money. Those nurses at the clinic are providing us with such an opportunity to make money and we thus assist them in that process by making sure that we keep their practice a secret".*

Jekirandi, who also operated from the Huruyadzo informal market in Chitungwiza, narrated an interesting story of how he was using his social network ties with staff members at the Chitungwiza clinic to earn some extra income. Jekirandi highlighted that:

> *"I am a worker! I work outside the formal health systems and I do a special function. At Huruyadzo those who know my special work call me Doctor JK. Whilst I am not qualified as a medical practitioner, I can diagnose, prescribe and most importantly I can supply the drugs. I supply real drugs and not fake ones. I am also tutored on a day to day basis by my connections at the clinic on how to administer the drugs. Myself and my patients we are not affected by drug shortages, I do not even know what drug stock-outs are, the solution to those problems is being connected to the right person at the right time. I make big money as most people who do not want to be*

seen going to the clinic and waiting in the queue to collect drugs always come to me for their health needs."

The information above was however denied by health facility personnel during the key informant interviews I had with them. The staff mentioned that they could not engage in such activities as that was against their professional ethics and they risked losing their jobs. The nurses in charge of Chitungwiza and Seke clinics however indicated that they had received information from private sources that such under-hand dealings were being perpetrated by certain staff members. The nurses in charge of the two health facilities however acknowledged that sometimes their staff were involved in very close relationships with patients and this was often done in private spaces which they had no control over.

6.3.2.2 Implications for Adherence

Evidence from the in-depth interviews and discussions with key informants at health institutions demonstrates that the social network relations played a significant role in enhancing adherence to ART. The informal relations involving adolescents and personnel from health institutions had many dimensions that included the exchange of goods and information. The exchange of important information related to the availability of drugs ensured that adolescents would have a continuous supply of drugs that enhanced their adherence to ART therapy. The sharing of additional information by health staff, particularly on the efficacy of locally available herbs and their positive health outcomes was also important as a way of improving the general health of the adolescents living with HIV.

The informal networks were also a common way through which adolescents negotiated their way around what I refer to as corporate stigma. I contend that corporate stigma in the context of this study is the stigma that arises from the functions of an institution and in this case the health facility. There are various ways in which corporate stigma can be built and sustained over time. As stated earlier in chapter five, in the cases of both Chitungwiza and Seke clinics, the last Thursday of each month was reserved for attending to all people living with HIV and those affected by tuberculosis (TB). Attending clinic on these days is thus associated with being afflicted with HIV and/or tuberculosis. It was therefore through their social networking with clinic staff they sometimes avoided attending clinics on these days which were highly stigmatised in the community.

6.4 Social networks with staff in the Department of Social Welfare

Adolescents in Chitungwiza and Seke who were in households headed by the elderly and those headed by adolescents, all had social networking relationships with staff members at the Department of Social Welfare. As was the case with the form of social networking with personnel working at health facilities, the social networking had developed as a result of the long-term interactions between the adolescents and members of their households with the Social Welfare Department. The interactions were mostly a result of the functions of the Department of Social Welfare in the delivery of various social services targeted at vulnerable people in both Chitungwiza and Seke.

According to the Department of Social Welfare's National Action Plan for Orphans and Other Vulnerable Children (NAP for OVC) programme document, the Department of Social Welfare in Zimbabwe has the Constitutional mandate to oversee the implementation of social protection programmes that target households headed by the elderly and those headed by children. According to the same document, since 2010 the Department of Social Welfare started implementing a five-year social cash transfer programme that targeted poor labour constrained households. At the same time in 2010, the government of Zimbabwe shifted from a child-centred to a family centred approach in the provisioning of social protection services. It was under this programme that adolescents living in households headed by the elderly and those that were household heads began developing social networks with personnel working in the Social Welfare Department (this is discussed in detail in the next paragraph).

In one of the cases (Pride), the relationship between adolescents and personnel within the Social Welfare Department was characterised by interactions during the issuing of the Assisted Medical Treatment Orders (AMTOs) and in some cases food supplements. Other adolescents like Jairos also perceived the social network ties with Social Welfare staff as not as robust as that with health personnel. According to these adolescents, the Social Welfare staff were more involved in the social cash transfer programme that targeted the elderly and there were very few social welfare programmes that targeted the adolescents. The adolescents mentioned that the greatest factor affecting social network building with Social Welfare staff was the seeming lack of material resources that strengthened social relations. This view was also shared by a female staff member, Ms Njiva, working for the Department of Social Welfare during a key informant interview who stated that previously the Department used to

run a lot of social assistance programmes and gave hand-outs to people in need, including people living with HIV. She added that from around 2010, most of these had stopped except for the AMTO due to the lack of adequate funding from the government. When I spoke to Mrs Njiva on the 15th of October 2014, she highlighted that:

> *"As the Social Welfare Department, we are facing challenges in fulfilling our mandate for the provision of social welfare assistance, budgetary allocations have not been enough. We have been reduced to an institution that just refers cases to mostly NGOs or churches that are still able to offer assistance to vulnerable groups in the communities".*

Evidence from the in-depth interviews with the adolescents that had benefitted from the Social Welfare Department demonstrated that the adolescents were more inclined to develop meaningful social networks with people in which there was the provision of different forms of resources such as information, knowledge and material resources. One adolescent, Pride, mentioned that the development of close social relations with the Social Welfare staff was also hindered by what he referred to as "common perceptions" by friends and close relatives who viewed such relationship as devoid of any meaning. Pride mentioned that in the past when the Social Welfare Department was well resourced, household members could benefit from having a sick person residing in the household.

In cases where there were meaningful social relations with the adolescents, it was as a result of the individual staff members from the Social Welfare Department investing in such social networks with individual adolescents and members of their households. To sustain these social relations, the staff members would invest their monies. In one case of Jairos's household, a staff member from the Department of Social Welfare had developed close relationships with Jairos and siblings in his household. In the key informant interview, I had with the staff member she mentioned that her close relations with Jairos and his siblings were as a result of the personal sympathy she had for the young children staying with Jairos. She highlighted that the sympathy had arisen from her previous interactions with the household members when the Social Welfare was still fully functional. She, however, mentioned that the social relationship with the household members had grown from that based on the functions of the Department of Social Welfare. She highlighted that the relationship was now

purely a friendship based on sharing common jokes, information and knowledge on general issues in the community.

Testimonies from Jairos' siblings indicated that Mrs Njiva often taught his sisters several games and, in some instances, brought gifts to the household members. As was the case with social network relationships involving adolescents and health personnel, social network relationships with Mrs Njiva from the Department of Social Welfare also involved linking the adolescents with other service providers. In the case of Jairos and his siblings, they had been linked to an NGO that provided psycho-social support to people living with HIV. Jairos and his siblings had attended two psycho-social support sessions with the NGO. Another adolescent, Divine, had been provided with information that had linked him to AfricaAid, an international organisation that provided spaces for adolescents living with HIV to interact, share experiences and encourage each other to adhere to their ART treatment schedules.

The information on these other service providers was passed onto the adolescents outside the formal spaces of the Social Welfare offices. According to the evidence of one of the staff members from the Social Welfare Department who was a key informant in this study, the decline in levels of interfaces was due to two main factors. She mentioned that firstly, the Social Welfare Department was highly incapacitated in carrying out its mandate due to the economic challenges that the government of Zimbabwe was facing at the time of the research. She mentioned that the staffing levels were only at twenty percent of the official staff establishment. She mentioned that as a result of understaffing, the available officers had a huge workload and thus their interactions with their clients were minimal. The limited interactions had resulted in the curtailment of the development of intense social relations between the adolescents and staff members working in the department.

According to the staff member mentioned above, the second major factor for the utilisation of informal spaces in information sharing was that the Social Welfare staff members had an obligation to make community support visits once every quarter to their clients. As a result of the incapacitation discussed above, the staff members were no longer able to undertake the scheduled visits. At the time of the research during the last quarter of 2014, the staff members had not made any such official visits in the communities.

6.4.1 Implications for Adherence

As stated earlier on in chapter two, adolescents are not a homogenous entity and as such the incapacitation of the Department of Social Welfare to undertake its constitutional mandate had differential outcomes on the different adolescents. As in the case of Jairos's siblings, the young adolescents often enjoyed joking relations with individual staff members. Among the adolescents that stayed with elderly household heads, the networking was often abridged with the elderly households' heads providing the link that could result in the establishment of social relationships between the adolescents and the staff. A case in point is that of Tinashe who was introduced to a Social Welfare staff member by his grandfather. The social network relationship between Tinashe and the Social Welfare officer grew to become a close relationship to the extent that Tinashe benefited from knowledge and information sharing. The instances discussed above show that the social networking involving the adolescents and social welfare staff aided adherence to ART. The utilisation of informal spaces by Social Welfare staff to connect with the adolescents has also contributed to them adhering to their treatment. An example is that of Jairos and his siblings in Seke who had close social relations with a social welfare staff member who frequently visited their place. As was the case with social network relations with Health staff, the informal spaces were utilised for exchanging information that supported treatment adherence.

6.5 Conclusion

The social construction of rules and obligations guiding social networking among adolescents sustained a culture of secrecy among adolescents. The culture of secrecy was a common cause for ART adherence in the short term whilst in the long term, the culture of secrecy gave rise in some cases to long term non-adherence. Within the closed social network systems for adolescents, the norms and rituals around their HIV statuses assisted adolescents to support each other to adhere to their treatment schedules.

This chapter has also demonstrated that the strength of sanctions, rules and norms that supported HIV status non-disclosure, all worked towards short term adherence to ART among the adolescents. The culture of secrecy was not limited to adolescents only, but also to health facilities personnel and parents and or guardians of adolescent living with HIV. The norm of secrecy in some cases would transcend beyond the adolescents' social network ties with institutional staff members to also include the parents and or guardians who did not want

their children's HIV statuses revealed. The question of non-disclosure by adolescents living with HIV and its failure to sustain adherence behaviour in the long term is also an issue that permeates the findings of this chapter. The culture of non-disclosure is an important one as it highlights the high levels of HIV stigma in the society. Non-disclosure by adolescents is a serious factor that contributes to the rise in new HIV infections, drug resistance and increased AIDS morbidity in the country.

An important dimension highlighted in this chapter is the formal and informal relationships that exist between adolescents and staff members working in formal institutions that support the health and welfare needs of people living with HIV. However, because of the enduring norms and rituals surrounding the non-disclosure of HIV status that governed such social networking relationships, long term adherence amongst the adolescents was not guaranteed. The fact that LESO recorded at least five adolescents living with HIV who fell pregnant each year demonstrates that long term adherence was a huge challenge amongst adolescents. The issue of long-term adherence among adolescents is something that could warrant further research of a longitudinal nature among the same cohort of adolescents in the study.

The intimate social relations involving adolescents and health institutions staff and the building of a robust social capital base that resulted in the pilfering of important drugs and medicine from the formal health delivery system would also in the long term deprive other adolescents and the general population living with HIV who are outside those informal social networks from access to ART drugs. For example, the case of essential drugs finding their way into informal markets and depriving the formal system meant that other adolescents and people living with HIV would be deprived of the lifesaving drugs.

CHAPTER 7: ADOLESCENTS SOCIAL NETWORKS WITHIN CHURCH CIRCLES AND IMPLICATIONS FOR ART ADHERENCE

7.1 Introduction

In this chapter, I discuss the findings on adolescents' social networks in the religious groups they belonged to. The religious institutions presented another common platform from which adolescents developed social network relations amongst themselves and with other people whom they met at those religious institutions. The analysis in this section focuses on the twenty-two adolescents who all indicated that they belonged to different religious groupings and that they had social networks they had developed with people they interact with at those religious settings. This chapter presents evidence that social networks developed by adolescents within religious institutions had an impact in terms of influencing ART adherence behaviours amongst adolescents.

The role of religious institutions in influencing ART adherence behaviour has been shrouded in controversy over the years (see for example Skovdal et al. 2011, Smith C. 2004, Coleman and Hoffer, 1988). For example, Smith (2004: 261) stated that adolescents can form very close social network relationships with other adolescents, church pastors and other adults within the congregation and this presents an excellent opportunity for adults to monitor the activities of the youths and influence positive behaviour outcomes. Everton (2016) observed that “social ties play a crucial role in bringing people of the same faith or religion together”. Also, Everton (2016) noted that religious-based social ties seemed not only to protect adolescents from bad social behaviours but also seemed to promote health-related outcomes and prosocial behaviour.

Smith and Denton (2005) argued that religious institutions provided a platform for the formation of robust social network relationships. The two authors argue that as a result of the robust social network relationships there is often pressure on people involved in such social networks to participate in church activities even when they have little or no desire to do so. The two writers also contended that in some cases people even attend and participate at various church activities, not for religious rewards but to avoid the sanctions they would incur if they did not.

Other authors like Bjarnason (1998); Gonzalez (1999) and Jessor et al (1995) have tended to take a middle path by emphasising both the positive and negative influences of religious affiliation on health outcomes (refer to the case of Priscilla discussed in chapter five).

7.2 The Church and HIV in Zimbabwe

The significance of the church[5] in relation to the HIV and AIDS in Africa and Zimbabwe has been articulated by several writers, see for example Zacharia (2010), Chitando (2011) and Mhlanga (2016). According to Zacharia (2010:68), the traditional church framed and characterised HIV and AIDS from a perspective of morality and promiscuity. Mhlanga (2016) also added that as a result of the early framing of HIV and AIDS from a purely moralist and promiscuity perspective the traditional church's approach to HIV and AIDS bordered around mocking the victims of HIV and AIDS and a strong belief that affliction with HIV was a punishment from God on immoral people. Mhlanga contends that the church's conceptualisation of HIV and AIDS therefore shaped its overall response strategy towards members of the church when they got affected by HIV. In worst cases, Mhlanga argues that the church's strategy was to excommunicate people living with HIV on the basis that they brought shame and discomfiture to the church. However, over the years these mainstream churches have softened their stance but as noted by Chitando (2011) the church remains a source of HIV and AIDS stigma up to this day.

Traditionally in Zimbabwe, the African Independent churches[6] particularly the Apostolic church was often cited as a classical example of how the church resisted the adoption of modern medical practices in preference for faith healing even before the advent of HIV and AIDS in the 1970s (Skovdal et al 2011). According to Skovdal et al (2011) the independent churches in Zimbabwe, particularly the Apostolic church, traditionally had a notorious history of resisting medical approaches to illness and was well known for discouraging its followers from taking any form of medicine including immunisations for their children. The apostolic churches were among the first religious groups in Zimbabwe that promoted faith healing as a solution to all forms of illnesses and when HIV and AIDS became prominent in the late 1990s the apostolic church included HIV and AIDS in the basket of illnesses that they

[5] The church in this context refers to the mainstream Christian churches such as the Roman Catholic, Anglican and other branches of the protestant church. It does not refer to African Independent churches such as the apostolic churches.

[6] These are indigenous churches that were started by African leaders and in Zimbabwe, these include Johane Marange, Johane Masowe, Jekinishen, Zion and many others that broke away from these main churches.

could cure. In my study sites of both Chitungwiza and Seke, the Apostolic church has a strong presence.

The religious terrain in Zimbabwe has shifted since the turn of the millennium with the emergence of strong prophetic driven charismatic churches. According to Chitando, Gunda and Kugler (2013:9) the emergence of the charismatic churches is characterized by the performance of various miracles, prophecies, healing and claims of deliverance from evil spirits. According to Chitando et al. (2013), the founders of these churches refer to themselves as prophets and tend to equate themselves to the Prophets of the Old Testament in the Bible. At the time of this research, anecdotal evidence indicated that the most common charismatic churches were the United Family International Church (UFIC) founded by Emmanuel Makandiwa and the Prophetic Healing and Deliverance (PHD) ministry founded by Walter Magaya. For this study, it is important to note that both UFIC and PHD churches have strong roots in Chitungwiza in the sense that the founders of these churches began their ministries in Chitungwiza town. Today the UFIC has its 30,000-seater church located in Chitungwiza.

Figure 10: The United Family International Church (UFIC) centre in Chitungwiza

Source: My own camera 16 March 2018

Whilst not openly campaigning against the use of modern medical practices for dealing with the diseases and illness, the emerging charismatic churches preach a vigorous gospel of faith healing that is often accompanied by unproven claims to heal HIV and AIDS. As a result of their claims to faith healing, the charismatic churches draw their memberships from all sources including people from other churches and those who practice African traditional religion.

As argued by Mapuranga et al (2013:299) apart from their claim to miracles and healing power, the leaders of these churches also preach a gospel of prosperity in which followers are promised several miracles that result in them getting rich within a short space of time. Other authors like Chitando have described the leaders of these churches as *gospel-prenuers* meaning those leaders who focus on the gospel of prosperity.

Within the Zimbabwean context, the impact of these emerging churches on ART adherence has not escaped the scrutiny of government, policymakers, development partners and other stakeholders within the HIV and AIDS discourse. For example, in 2014, the Minister of Health and Child Care was quoted in an online newspaper article as having issued a warning to the charismatic prophetic church leaders who stopped people living with HIV from taking their ARVs (see Https//www.3.mob.com/news/Parirenyatwa-deliver-blow-prophets). At the time the Minister threatened to arrest all prophetic leaders who claimed that they have powers to heal HIV patients In 2016 the national chairperson of the Zimbabwe Network for People Living with HIV (ZNPP+), which is the largest national organisation representing the interests of people living with HIV, also noted with concern that about 35 % of their members had stopped taking their drugs due to the influence of the charismatic church leaders who claimed to heal people living with HIV. Other development organisations such as UNICEF and UNAIDS have also issued strong statements condemning the charismatic church leaders' claim to have powers to cure HIV.

7.3 Charismatic Churches and Social Relations with Government Officials

Whilst this study focuses on the social networking behaviour of adolescents living with HIV and AIDS and its implications for their adherence to ART, it is important to highlight in this section the social networking relationships that existed between the charismatic church leaders and government officials. This discussion is important for the objectives of this study

as it answers critical questions around why the government tolerates the charismatic churches with their un-proved claims to healing HIV and AIDS. According to interviews I had with the Coordinator of LESO, the claims to faith healing of HIV and AIDS by the charismatic churches was contributing to large numbers of people living with HIV absconding from their ART treatment.

As shown in the foregoing discussion, the charismatic church leaders enjoyed an uneasy relationship with the government, particularly the former Minister of Health and Child Care. It is important to note that the former President is also quoted in an online newspaper article (https//www.voazimbabwe.com/a/Mugabe-prophets-ripping-off-unsuspecting-zimbabweans/4096049.html) accusing the charismatic church leaders of performing fake miracles and engaging in self-enriching behaviour at the expense of desperate and sometimes sick members of the community.

In the two separate informal interviews, representatives of the church leaders acknowledged that their churches' relationship with the government was not cordial as the threat of a government crackdown on charismatic churches in Zimbabwe could materialise at any time. In the informal discussions, it was mentioned that as a strategy to avoid the government crackdown on their churches they had invested strongly in sustaining good social relations with senior government persons such as Ministers and important people in the leadership positions of the ruling ZANU PF party. It was also pointed out by the church's senior leadership that social relationships with government officials involved exchanges of gifts, money and other pleasantries. Both the UFIC and PHD leadership claimed that in some instances their social network relations with government officials were so close that some government Ministers borrowed money for their political activities from the charismatic church leaders. The church leaders, in turn, were said to be comfortable with such situations as they perceived that as an opportunity to have the Ministers speak positively about them in cabinet meetings and parliament and thus assist them to escape a government-sponsored crackdown. The church leaders also leveraged their social relations with senior government officials to claim the authenticity of their miracles to the general public and publicise their work.

Expressing the church's relationship with government officials during an interview on the 4th of November 2014, Mr Kurai the PHD church representative stated that:

> *"My brother, what we are doing is buying our space to operate. The gifts and loans we give to the ministers are meant to have the senior government people speak to the president about us in a positive way. We fear that the president may just wake up one day and close all the new churches like what has happened in Zambia".*

The leadership of the two churches reasoned that the social relations provided the charismatic church leaders with important information on the government position regarding the controversies emanating from their leaders' claims to faith healing of HIV and AIDS which was contrary to government public health policies. A similar sentiment was expressed by Mr Hwata, the UFIC representative on the 5th of November 2014 who mentioned that:

> *"The investment in robust social relations with government ministers is crucial in facilitating our protection from the risk of a state-sponsored crackdown and it is the cornerstone upon which the survival of our church is built".*

Apart from the informal type of social relationships that existed between the church leaders and government officials, the church leaders also established formal relationships with the government. The two churches were among the government's most prominent local donors. For example, the PHD Ministry donated money and goods worth over one million dollars to the country's largest referral hospital. The goods were received by the Minister of Health and Child Care on behalf of the government. The receiving of these goods by the government indicates a contradiction between government and its practice. This is because charismatic churches were claiming that faith healing would heal all diseases including HIV and AIDS, yet on the other hand, they were supporting institutions that adhere to modern medical practices.

In practice, as shall be demonstrated in the sections below, this contradiction was also reflected in the behaviour of adolescents who in a way tried to balance faith healing and modern medical practices. For instance, some adolescents would try faith healing and the same times also keep a subtle link with clinics and other health facilities where they collected their ARVs. In the event of a failure in faith as was usually the case, the adolescents would revert to modern medical practices.

7.4 Adolescents' social networks within Charismatic Churches

Among the twenty-two adolescents, fifteen had been in contact with either the UFIC or PHD churches which are the two common charismatic churches. The remainder were members of the mainstream or orthodox churches such as Roman Catholic, Anglican and the United Methodist Church in Zimbabwe. Amongst the adolescents who had been in contact with the UFIC and PHD churches, only five said they had been introduced directly by their own social network connections. The remaining ten had been connected to the churches through members of their households who belonged to these churches or people in social networks to which their household members belonged. The adolescents mentioned in the in-depth interviews that the way they had been introduced to the churches was important in shaping their social networking behaviours in terms of who they interacted with, the strength and durability of such social networks. In separate discussions with the adolescents, they opined that it was important to have people who are already part of your social networks in the churches as these social connections assisted to familiarise oneself with the church rules. Jekirandi who was introduced to the PHD church by Frank said that:

> *"It was good for me to be introduced to the church by someone I already knew, it helped me get used to the church rules and what was expected of me. The introductions also made it easier for me to connect with other people I had not met before".*

The adolescents that were introduced by members of their household or friends that were members of the two churches highlighted that both the UFIC and PHD churches ran a partnership scheme that made it easier for new entrants to the church to connect with existing members of the church. According to the adolescents, the partnership arrangement operated like an informal social group in which members were very close to each other and supported each other in various ways. In the key informant interviews with the representatives of both UFIC and PHD, they described the partnership arrangement as a "buddy system" in which church members were brought together as a result of their belief in the healing powers of their church leader or "*papa*". The church representatives further stated that the partnership arrangements were bound by the rules and norms that their church leaders pronounced from time to time. The representatives also acknowledged that they had observed that the partnership arrangement had become a platform from which social relationships among the congregants had been established. Mr Hwata, the representative from UFIC said:

"I have seen different members of the partnership arrangement offering each other social support in times of need such as times of bereavement. For us as a church, we take this as a good sign that our church members are united".

During the key informant interviews with the church representatives of both UFIC and PHD, they mentioned that their church leaders had appointed representatives represented them in the partnership arrangements. This was also confirmed by the adolescents who attended the churches who argued that it was an advantage to have close social relationships with the representatives of the prophets in the partnership arrangements. These representatives were part of the church leadership and it was believed by the adolescents that they had the privilege of talking to the prophet or church leader as and when they wanted to. One of the adolescents, Pride, in Chitungwiza had developed a comprehensive social network with other youths in the partnership arrangement and was well known to the representative of the UFIC church leader in the area he stayed. The adolescent was the first to have a face-to-facecontact session with the leader of the UFIC church.

Apart from the benefit of accessing the church leader and thereby receiving a blessing or healing, there were also other benefits that accrued to an individual who was part of the partnership arrangement in both UFIC and PHD. The partnership arrangements in both churches had a common system whereby members of the partnership arrangement contributed an amount equivalent to US$20.00 per month. According to adolescents that joined the schemes, the monies contributed were kept in the trust of the church leaders' representatives at the community level. The money could be lent out to members as loans and they were also used to assist members that faced social problems such as bereavement, poor health or problems with sending their children to school.

From the informal discussions I had with selected leaders from the two churches, it was also elaborated that the partnership arrangement was the mechanism through which church members living in the same community got to know each other well. They also mentioned that the partnership arrangement had given rise to a modern form of *usahwira* (traditional strong friendship) in which members involved assisted each other in many ways even outside the confines of the church. According to the church leaders, the partnership arrangement had resulted in other benefits to members such as employment opportunities for youths in the

church, access to external or bank loans through connections in the church and access to both public and private tenders as a result of being connected by members of the partnership arrangement.

The church leaders highlighted that since the partnership arrangement was managed by the prophet's representative at the community level, the individual member contributions were utilised in such a way that there was consensus among the church members on the identified need and the level of support required. Representatives of the church leaders stressed that from time to time the church leaders made free donations to people in the partnership arrangement. This was corroborated by adolescents that had become bona fide members of the two churches who told me that they had received loans for use in initiation of their income-generating activities. The principle of church youth involvement in income-generating activities among the emerging charismatic churches is very common in Zimbabwe. This has led to other scholars such as Chitando and Gunda (2011) labelling the church leaders 'gospel-preneurs'.

In interviews I had with adolescents that were attending the churches in search of a miracle healing, they intimated that the first step towards getting closer to the church leader and being known by the church leader was to be part of the partnership arrangement. This was also in addition to creating and sustaining social relations with the *papa* or church leader's representative at the community level. All the adolescents that were attending the churches testified that representatives of the church leaders for both UFIC and PHD churches were highly sociable people. To prove this to me, the adolescents indicated that the church leaders' representatives had all visited them and talked to each of them individually. The adolescents were also of the belief that in addition to the potential of receiving a miracle healing, the church leaders' representatives assured them of other benefits that could be reaped from having social interactions with them at the community level. This view was supported by the case of one female adolescent in the sample who had been helped by women in the partnership network to attend a national youth convention. The adolescents attending these churches viewed their social relations with the church leaders' representatives and the church leaders themselves as having the potential to benefit them in future. In an interview with Caleb an adolescent in Seke, he commented that:

"There are many testimonies of people who have benefited from the partnerships and the relationship with the papa's representatives. The papas are people of means, they are rich, and they can bless people in many ways, including providing for their material wellbeing. I know that one day it will be my turn and Papa (church leader) will bless me and my family abundantly. Even all the afflictions that my family members are suffering from will one day be a thing of the past".

From the discussion above it is clear that social networking within religious spaces was based on the belief for potential future benefits and not immediate social benefits. Such social networking was characterised by high levels of trust and faith in the church leaders and their representatives.

7.4.1 Norms governing adolescent social network relations in charismatic churches

According to the adolescents that attended the charismatic churches, the same norms and social regulations that governed their social networking in other platforms were also applied. The adolescents maintained that the norms of secrecy were upheld as no one was supposed to know their HIV statuses. The adolescents, however, noted that the churches were better for the maintenance of secrecy of their HIV statuses as large numbers of people attended the churches and it was easy to remain anonymous. The religious-based social capital emanating from the emerging charismatic churches was also not devoid of social sanctions and relationships that fostered mutual obligations. As highlighted earlier on, the proliferation of the churches in Zimbabwe is based on the prosperity gospel that is preached within those churches. This is in addition to the claimed miracle healing powers that are supposedly possessed by the *papas*.

7.5 Adolescents Social Networking within Charismatic Churches and ART Adherence

In this section, I focus on the influence of church-based social networking behaviours among adolescents that attended the UFIC and PHD churches. It is important to note that all the adolescents that attended these churches were initially adhering to their ART schedules and due to their social networking behaviours, different adherence outcomes emerged. In some cases, social networking patterns promoted adherence behaviours. In other instances, social networking within these churches tended to dissuade adherence by adolescents to ART. As has been documented by other scholars (see for example Hawe, et al 2000; Ferlander, 2007)

the social capital that emanates from individual social networking sometimes plays a dual function in promoting positive health outcomes and in some instances also promoting negative health outcomes.

7.5.1 ART adherence behaviour among adolescents attending charismatic churches

This section presents evidence that largely supports Elder's (1998a, 1998b) and Pescosolido's (1992:1096) argument that individuals are "socio-syncratic," which means that people are not puppets of the social structure and that individuals can be rational and calculative as their behaviour is dictated by both their reaction to the social networks in their environment and their conceptualisation of the social processes at play. Some of the adolescents that were attending the UFIC and PHD churches found space to make decisions on their health without the interference of the social networks that they had developed within the churches. The adolescents believed that the church-based social networks had resulted in the realisation of other benefits and not the intended primary benefit of receiving a miracle healing that would result in them being HIV free.

The adolescents who shared this belief highlighted that during the time they had attended the two churches and had been part of the social networks that emanated from their participation in the partnership schemes, they had benefitted from being linked with employment opportunities, soft loans to start small businesses and other freebies such as monthly groceries. This group of adolescents were also clear that the *papas* or church leaders had no powers to cure them of their HIV. In an in-depth interview with Frank of the adolescents who attended the churches, he strongly stated that:

> *"According to the knowledge that was passed on to us at LESO and the clinics, HIV has no cure now. We hear that scientist all over the world are still trying to find a solution and the nearest they have come to that solution is the manufacturing of ARVs. I come to papa just like any other person seeking blessings to prosper in life and I believe that papa has the powers to make me prosper. However, I do not think that papa can cure HIV and I do not want to take the risk of stopping my medication and falling sick".*

The other important aspect to note is that these adolescents were also members of other community based social network groups. The seven adolescents mentioned above were all

members of the social network group that participated at the activities organised by LESO. Therefore, whilst the adolescents were now involved in the church-based social networks that fostered a strong belief in the healing powers of the church leaders; these adolescents still referred to the knowledge gained from their participation in other social networks such as the LESO group. The seven youths, instead of considering the mirage of receiving a miracle healing, were now focused on what they could potentially benefit from their involvement in the social networks that were based on the two churches' partnerships arrangement schemes. An analysis of the case above indicates that the adolescents' adherence behaviour was not always determined by the norms and social values of only one of the social networks that they belonged to. The adolescent's adherence behaviour was determined by the knowledge that they obtained from different social networks that they interfaced with.

The youths mentioned above also highlighted that their attendance at the churches was not entirely voluntary but rather a result of the pressure from their household members or their household members' social network connections. The social norms that governed their social networking behaviour at such foras as the LESO also governed their adherence behaviours. In the discussions with the seven adolescents, they mentioned that the social contract amongst themselves that emphasised secrecy and non-disclosure of their HIV statuses and strict adherence to their ART treatment schedules still governed their behaviours, even when they engaged with other social networks that were either based on church attendance or the economic activities that they participated in. One of the youths, Frank, highlighted that;

> *"While we get pressure from our friends that we have be-friended within these churches we still use the same rules that control our interactions in our group at LESO. The truth is that we have no evidence that supports these claims to curing HIV and AIDS by the papas. Their claims have not been proved, so, for now, we stick to what we are taught at LESO".*

Another adolescent among this group, Devine mentioned that the two churches had provided a very important platform for the development and sustenance of social networks that had the ripple effect of reinforcing their adherence behaviours. Devine's case is presented below to highlight these adolescents' perspective with regards to social networking within the churches.

Devine is an adolescent staying with his single mother. His mother is a member of the PHD church, though she is also employed by LESO as a community worker. Devine is one of the adolescents that attend the UFIC and PHD churches without being bona fide members of the churches. Initially, Devine was convinced by his mother to attend the PHD so that he could receive a miracle healing. Devine joined the partnership scheme at the community level and was assisted by his mother to consistently make his monthly contributions to the partnership arrangement scheme.

Devine applied for a soft loan and the church's leaders' representative approved that the adolescent be given US$450.00 to embark on a poultry project. When Devine had set up the project site on their residential stand in Chitungwiza, the church leader visited the project site and prayed for the success of the project at an occasion that was attended by members of Devine's partnership scheme. According to Devine, the church leader then made a call that the chickens produced from Devine's project were supposed to be sold to members of his partnership scheme as a way of expressing solidarity and support to the adolescent who was inspiring other youths.

During his visit to the project site, the church leader made an order for ten chickens that he paid in advance for double the price of a single chicken. The church leader stressed to the partnership scheme members that they had an obligation to buy chickens from the project Devine was implementing. According to Devine, the church leader's message was in line with the ethos of the prosperity gospel that formed the foundation of the church. In the in-depth discussions I had with Devine on the linkages between his church funded project and adherence to ART, he mentioned that:

> *"Adherence to ART is not only about taking the pills; it is also about maintaining the right nutritional balance. From my project, I can raise funds for the purchase of food items that support my healthy living lifestyle".*

The case above highlights the impact of church-based social networks in supporting adherence to ART. The fact that members of the partnership scheme were obliged to support income-generating activities performed by the adolescent ensured that there was a ready market for the products from the project. According to the adolescent in the case study above, the income returns from the project were used for the purchase of household food items which enhanced both his household food security and resulting in him accessing a balanced

diet which is a critical requirement for people living with HIV and AIDS for improved ART adherence outcomes. As highlighted above, the adolescent now had access to cash resources that enabled him to fulfil his monthly clinic appointments without fail, thereby leading to positive ART adherence by the adolescent.

The impact of church-based social networks in the case above is positive in supporting ART adherence among adolescents living with HIV. It is however important to note that the church-based social networks have a rather indirect effect on positive adherence behaviour as demonstrated in the case above. The church-based social networking that happens within the partnership arrangement schemes at community level support the sustenance of livelihood income generation projects that in turn supported adherence. Therefore, rather than focusing on the direct benefits of social networking, there are also indirect benefits that can also be experienced.

In another case, a 16-year-old adolescent, Tinashe, was attending the PHD church at the instigation of his grandmother who anticipated that he could receive a miracle healing. The grandmother who was the caregiver and was the head of the household was part of the church's partnership arrangement scheme. The adolescent, Tinashe, had also been helped by his grandmother to join the scheme, with the grandmother making the initial monetary contributions on behalf of the adolescent. However, after four months with Tinashe attending the church, he had not experienced healing and neither had he met the church leader in person. It was generally believed that a one-on-one encounter with the church leader could bring instant healing. However, during the four months, Tinashe got an arranged employment opportunity in the church where he started to work as a clerk at a guest house owned by the church leader. Thus, instead of obtaining the expected healing, Tinashe was provided with another opportunity that could assist him and his household members' livelihoods.

According to Tinashe, in offering the job to him, the church leader announced to him and his grandmother that the employment opportunity availed to him was a result of his participation in the church partnership arrangement scheme. However, according to Tinashe, the employment opportunity had not met his original expectation and that of his grandmother who had introduced him to the church with the primary objective of receiving a miracle healing of the HIV condition. The other adolescents attending these churches highlighted that

the church leaders were always in the habit of availing short term employment opportunities within the church and offering gifts to congregants. The adolescents mentioned that the offering of employment opportunities fostered a sense of obligation on the part of the adolescents who would reciprocate this gesture by demonstrating unquestionable faith in the healing powers of the *papas.*

7.5.2 Non-Adherence among adolescents attending charismatic churches

As discussed in the section above, adolescent networking within charismatic churches was based on what some of them perceived to be an opportunity to access financial resources for income generation projects and the fervent expectation of a miracle healing. Amongst the adolescents that were attending the PHD and UFIC charismatic churches, seven of them expressed that they were not after the potential material benefits from the churches but were engaged with the churches in anticipation of spiritual healing. When I attended church sessions at both the PHD and UFIC churches there were several testimonies of miracle healing including those involving people who claimed that they had been healed of their HIV conditions. During the first week of November 2014, I attended one of the PHD church services where the leader asserted that miracles would only follow those congregants who had strong faith and trust in his healing powers. The church leader stated that:

> *"Some of you have been here for more than three months and you have not received your healing or blessings due to your weak faith and trust in me as the man of God. What are you waiting for? Just increase your level of faith and you will be healed instantly. Your weak faith is the stumbling block and it is standing between you and your healing".*

The social networking behaviours of the adolescents that sincerely believed in the healing powers of the *papas* were largely different from those discussed above who strongly believed that the church leaders could not heal HIV and AIDS. Whilst the adolescents that believed that the *papas* could heal them of HIV and AIDS were also partaking in the partnership based social relations, they had also developed other social networks within the church with individuals that strongly believed in the healing powers of the church leaders. Such individuals included those who claimed to have received healing miracles from the church leaders and were members of the leadership structures of the two churches at the national level. The seven adolescents that were involved in these social network relations highlighted

to me that their social relationships with these individuals whom they referred to as people of "high-level faith" were governed by strict religious obligations and rituals that governed behaviour within those social relationships. Three of the adolescents that were in such a social network relation with one of the church elders at the UFIC church claimed that one of the obligations demanded of them was to put total trust in the healing powers of the church leader. The other five adolescents that attended the PHD church also underscored that their social relations with the people of "high-level faith" were based on a shared belief that the church leader had special powers to heal all diseases including HIV and AIDS.

The adolescents stressed that in those social network relations with the church elders, continuation on any form of medication after being prayed for by the church leader was viewed as a lack of faith and trust in the healing powers of the *papa*. Continuation on any form of medication was not tolerated in such social circles. This phenomenon is not peculiar to Zimbabwe as Norder et.al (2015) in their study in South Africa also noted that in some religious settings church leaders condemned the continuation on drugs as an exhibition of lack of faith. The adolescents emphasised that because such social network groups were often smaller than those based on the partnerships scheme, people in the social networks involving people of "high-level faith" often knew each other at a personal level. The adolescents who had become members of the churches emphasised that their social networks with the people of high-level faith were characterised by smaller prayer groups. The smaller prayer groups were usually made up of between five and seven people. The five adolescents that were members of the smaller prayer groups indicated that apart from the main church services held at the church on Sundays, members of the prayer groups often met three times a week on Mondays, Wednesdays and Fridays. The configuration of social relations within the smaller prayer groups was different from that of the larger church group that was based on the partnership arrangement scheme. According to the five adolescents that were members of the prayer groups, the social relationships within these groups were more intimate and personal.

The adolescents highlighted that even the way people greeted each other in those groups showed the intimacy of social relations. For example, male and female adolescents referred to each other as brother or sisters. The elders that were part of the prayer groups were referred to as parents by the adolescents. The adolescents that were part of the sample argued that the prayer groups resembled close-knit family groups. However, when I asked the adolescents

whether they had disclosed their HIV status within the prayer groups, they all indicated that they would not disclose. According to the adolescents, when they discussed their problems with other members of the prayer groups, they would highlight that they had health problems but would not mention their HIV status. I interviwed on the 2nd of November 2014 in Seke and he revealed that stigma was also rife in the church. He remarked that:

> *"Church iri muvanhu, uye vanhu ava ndivo zvakare vanosarudza vanhu nekuseka kuti uyo ane chirwere che AIDS. Nokudaro mu church mune zvakare rusaruro nekuseka vaya vanorwara kana kufungidzirwa kuti vane HIV, ndokusaka ini ndisingataure zvandiri pamusoro pe HIV". (The church is part of the community we live in and as such, it is not free from stigma when it comes to issues of HIV and AIDS. This is the main reason why I will never disclose my HIV status to anyone).*

The adolescents were however of the view that unlike other social relations in which there was some resemblance of power balances in the relationships, their relationships with the elders of "high-level faith" were characterised by unbalanced power relations with the elders exercising greater power and control over the adolescents. The adolescents mentioned that there were strict rules that governed the social interaction processes within the prayer groups. One of the strict rules was the demand by the elders of "high-level faith" for total trust and faith in the healing powers of the *papa*s. According to the adolescents, this tended to exert a lot of social pressure on the members of the prayer groups to discontinue their medication. Proud, 18 years of age narrated that:

> *"As the days and months went by, I started to feel the pressure from elders in the group. At the same time, I also began to feel that my lack of a miracle healing was due to my little faith and lack of trust in the powers of the Prophet. With a lot of people including those coming from outside the country testifying that they had been cured, I began to feel that my continuation on ARVs was the reason why I was not being healed. So, I had to stop taking my ARVs and stop attending the monthly clinical appointments"*

The adolescents that were now members of the PHD and UFIC also confirmed the fact that there was social pressure from the elders of "high-level faith" and this was the main reason why most people including those on ART were defaulting on their treatment schedules. In

addition to putting pressure on the members of the prayer groups, the elders of "high-level faith" also gave themselves the responsibility to enforce the group rules through punitive sanctions but also persuasion. According to the adolescents that were members of the prayer groups one of the most common punitive sanctions employed by the elders of "high-level faith" against deviant group members was labelling the deviant members as agents of the devil.

Proud, when he stopped taking his ARVs and practised faith, as demanded by the elders of "high-level faith", started suffering from a glut of opportunistic infections that left him bed-ridden for four consecutive months. According to Proud when he stopped going to the church and resumed his ART treatment, his sisters who continued to attend the church informed him that the elders in the prayer group were labelling him "unrepentant" and an agent of rival churches sent to destroy the church from within. This was also confirmed by the other adolescents in the sample that were attending the PHD and UFIC churches who elaborated that Proud was often cited in the UFIC church as an example of sinful congregants who doubted the healing powers of the prophets. The other youths argued that the labelling of Proud was driven by the fear among the church leaders and elders of "high-level faith" that the adolescent would testify negatively and communicate to others within and outside the church that the *papa* did not possess any healing powers.

Apart from the use of punitive measures to sanction behaviour in the prayer groups, the elders also used persuasion to keep group members together. The persuasion was often accompanied by the issuance of personal gifts to members of the prayer groups, support to their households in the form of monthly groceries and sometimes monetary rewards. All the adolescents that had become members of the PHD and UFIC churches attested to the fact that either themselves or their households had received some form of groceries or monetary support. The adolescents discussed in the section above (those that did not believe in the healing powers of the *papa*s but in the supremacy of the knowledge passed onto them at the community HIV and AIDS support centre (LESO), often argued that the adolescents that had become members of the PHD and UFIC churches had been captured by the churches and were no longer at liberty to make their own decisions independent of the churches. In a focus group discussion with the staff members of LESO, the same sentiment was shared, where

they reinforced the argument that the churches had “captured” the adolescents and were using gifts to persuade them from continuing ART.

Another interesting phenomenon around the prayer group social relations was the fact that the social network relations from the prayer groups often extended to other household members that were not members of the prayer groups. For example, amongst the adolescents that were members of the prayer groups, members of their households had become involved in the activities of the prayer groups. This was inevitable mainly because the prayer group members often visited each other in their households for morning or evening prayers.

As discussed in chapter two, whilst Coleman (1988: 132) argued that resource flow in social networks supported positive behaviours within social groups, the paragraph above has shown that the flow of resources amongst the members of the prayer groups did not result in positive health outcomes for the adolescents as the emphasis on faith was not supportive of adherence to ART treatment. Jairos who was a household head highlighted that when one of his sisters became a member of the PHD prayer group in Seke, his dilemma was whether he should continue allowing her to be part of the prayer group when she was not receiving a miracle healing. On the other hand, his household was receiving some gifts and food support from the members of the PHD prayer group where his sister was a member. According to Jairos, there was also a lot of social pressure from the leaders of the prayer groups who continued impressing upon him as the head of household that his sister had little faith and thus the lack of miracle healing. When I asked Jairos about whether he believed in the miracle healing, he highlighted that from the knowledge gained from their interactions with health personnel at Seke clinic, currently, there was no cure for HIV and AIDS.

7.5.3 Emerging Charismatic churches and Orthodox churches: A comparative analysis

The discussion in this section focuses on the differences in social networking between adolescents attending charismatic churches and those attending orthodox churches such as the Roman Catholic, Anglican and Methodist churches. During in-depth interviews with the adolescents that were members of these churches, they highlighted that the churches maintained a conservative approach to issues around HIV and AIDS, sexuality and other reproductive health aspects. The adolescents mentioned that in these churches there were robust youth wings in the church where the youth discussed a lot of issues such as personal

hygiene, good educational practices and health-related issues. Discussions on HIV were limited and focused on preventive aspects such as abstinence. There was no mention whatsoever on issues to do with coping strategies for adolescents living with HIV. Kumbirai a female during an interview in Chitungwiza in September 2014 pointed out that:

> *"As youths in the church, we do not discuss issues of HIV and AIDS. The general view is that HIV attacks those that are promiscuous. The issues of children born with HIV are known even among the youths, but the general thinking is that such youths are not within the church."*

According to the adolescents, social networking amongst the church members and among the youths in the church was mainly private and there were no deliberate efforts by the church to support such efforts as was the case with the charismatic churches. Thus, when compared to the charismatic churches, there were no deliberate efforts on the part of the orthodox churches to support functional social networks.

7.6 Conclusion

The charismatic churches provided an important platform where the adolescents could continue to strengthen their social networking activities. The churches were also avenues which enabled the adolescents to create new social relations with other people such as representatives of the church leaders. This was however not the case among the adolescents that were members of orthodox churches. The adolescents, however, were all agreed that whilst the church-based social relations were also important, they regarded their social networking with people at LESO and people at health institutions as superior to the social relations at charismatic churches. Some of the adolescents that developed social network ties with members of the church including the representatives of the church leaders were also aware that the social network ties could be potential conduits for material benefits to flow to them.

The fact that the adolescents that were brought to the charismatic churches by their peers or household members still valued their social networks developed at LESO as superior is evidence that individual adolescents maintain their agency when it comes to making informed decisions about their health. The adolescents that regarded knowledge from the LESO as superior to the healing proclamations given by the church leaders made conscious decisions to continue adhering to their ART treatment schedules. An interesting dimension to this is the

fact that the same adolescents were utilising the benefits from their social networking to enhance their adherence to ART. The adolescents that obtained loans from the partnership scheme and managed to engage in successful income-generating projects were now in a position to buy food supplements that are useful for their ART adherence. The flow of material resources through church-based social relations supports the narrative that social networks can generate useful social capital that plays an important function in promoting positive health outcomes. In other instances, the emphasis on faith healing and the claim by charismatic churches that they could cure HIV presented a scenario whereby adolescents would abandon their prescribed ART drugs and trust the faith healing. The long-term outcome of this behaviour was treatment failure for the adolescents already initiated on ART. The social networking in these "high-level faith" unlike that of the group discussed above, was not primarily based on the expectation of an exchange of goods and information and availability of opportunities but also on the anticipation of a miracle healing. The realisation of material goods in such social networks was regarded as an additional benefit but not the primary expected benefit.

An important characteristic of the social networking by adolescents that believed in the healing powers of the church leaders is the exhibition of high levels of trust and the application of punitive measures for punishing the lack of faith in the healing powers of the *papa*. The threat of the punitive sanctions on those trying to doubt the healing powers of the church leaders demonstrates the fact that like other social networks, the church-based social networks were also governed by unwritten rules, norms and rituals that to a larger extent determined the behaviour of members engaged in that social network. Also, the norms and sanctions that guided the behaviour of individuals in the religious-based social networks were not only enforceable through punitive sanctions but also persuasion.

An enduring theme in this chapter is that different social networks have different strengths and power when it comes to influencing individual behaviours. The different social network systems derive their different strengths from the knowledge bases on which they are founded. In the case of social networks based on scientific knowledge such as the scientific facts on HIV and AIDS, such social networks often had an impactful influence on individual behaviours. The adolescents that were convinced that the prophets could not heal HIV and AIDS relied on the information and knowledge obtained from their social networking at

LESO. In this way, social networking at LESO overrode the effects of the religious-based social networks that was founded on faith. The strength of social networking based on scientific facts was demonstrated when those adolescents that expected healing would continue or go back to their ART regiments following failure to receive a miracle healing.

CHAPTER 8: CYBER-BASED SOCIAL NETWORKS AND INFLUENCE ON ADHERENCE BEHAVIOUR

8.1 Introduction

In this chapter, I present findings on the utilization of electronic gadgets such as mobile phones, laptops or computers by adolescents for initiating and maintaining social networks on such social media platforms like *Facebook* and *WhatsApp* and their influence on ART adherence. Whilst there are other social media platforms that are popular in many parts of the world such as Twitter and Instagram, this chapter only focuses on the use of WhatsApp among the adolescents in Chitungwiza and Seke because this was the most used platform by adolescents in the study. According to Byron, Albury and Evers (2013:35), the term social media is subject to many interpretation and definitions by different writers. Byron et `al (2013:35) define social media as referring to digital platforms that enable personal profile creation, friends' invitation, text messaging, video, pictures and document sharing. Examples of social media platforms are *Facebook, WhatsApp, Twitter, Instagram* among others. Other writers like Xiaolin, Mauricio and Saonee (2013:1) regard social media platforms as digital or online virtual spaces that enable individuals to create, share, and exchange personal information and ideas. The two definitions above will be used in this chapter to discuss how adolescents' use WhatsApp for instant text messaging, sharing of videos, pictures and other information. This chapter will also discuss how the use of WhatsApp as a social media platform influences ART adherence behaviour among adolescents.

8.2 Adoption of Social Media by adolescents in Zimbabwe

As claimed by Banaji, Livingstone, Nandi and Stoilova (2018:432), the use of social media platforms among the youth in the global North has been well documented and there is also an acknowledgement that social media is gaining popularity amongst youths in the global South. Banaji et al (2018:432) also argue that the adoption of electronic or digital devices has dramatically changed the way youths across the globe access health information and communicate with each other. In Africa Nigeria, South Africa and Kenya are reportedly the top three countries with an internet penetration rate of above 70% (Banaji et al 2018). The reasons for the adoption of social media by adolescents in many parts of the world differ and these have been debated by different authors. Boyd (2008:210) argues that social media networking is often driven by users who intend to make their networks visible. Boyd further

contends that other than considering social media platforms as spaces where relationships are initiated, social media fact supports existing social network relationships. This argument will be further assessed in the sections below by focusing on evidence from the study areas.

According to the Post and Telecommunication Regulatory Authority of Zimbabwe (POTRAZ), the internet penetration rate in Zimbabwe is currently at 32 %. As noted by authors like Chiridza, Yorodani, Sigauke and Katsaruware (2016: 1), the use of social media in Zimbabwe among the youths has become highly pervasive with most youths predominantly using the *WhatsApp* social media platform. Chiridza et al (2016) in a study among adolescents attending different universities in Zimbabwe, discovered that 80 % of the students were active on *WhatsApp*. The adoption of social media platforms such as *WhatsApp* by youths in Zimbabwe has been attributed to numerous reasons by various authors. Van der Band and Van der Bank (2015:23) have argued that the adoption of social media by the youth is chiefly as a result of the fact that currently in Zimbabwe no media law regulates conversations that take place over such platforms. Chiridza et al (2016) have also contended that *WhatsApp* has become very common among young people in Zimbabwe because it is the most accessible social media platform that can be easily operated on weak internet connections that are run by mobile telephone service providers. Chiridza et al (2016) pointed out that the high use of *WhatsApp* is due to its affordability as a platform for sending text messages, images, videos, user location, audio messages to individuals or groups in real-time. This WhatsApp platform has also become important among the youths for receiving and making calls across the globe at no or very little cost.

8.3 Use of social media by adolescents in Chitungwiza and Seke

All the adolescents in the study had access to a gadget that enabled them to connect to *WhatsApp.* Seven adolescents mentioned that they had access to *Facebook*. The adolescents in the study mostly used mobile phones to access *WhatsApp*. Whilst the twenty-two adolescents had access to a mobile phone that enabled them to connect to *WhatsApp*, a significant number, only seventeen owned mobile phones. For those that owned the mobile phones, twelve had the phone given to them by close relatives while the rest had bought the phones themselves. Those that did not own a mobile phone would normally use their parent's or guardian's mobile phone or sometimes borrowed one from a friend to use *WhatsApp*. Five adolescents in Chitungwiza also had other gadgets such as laptops or computers which they

used to connect to *WhatsApp* and other social media platforms like *Facebook* and *Twitter*. From the interactions I had with the adolescents in the study who owned mobile phones, it was evident that they belonged to several *WhatsApp* groups. There were however two major groups to which the adolescents belonged part. The first *WhatsApp* group was formed by LESO to service its various clients with sexual and reproductive health information. The other major group formed by the adolescents living with HIV and AIDS was called Chitungwiza and Seke Shining Stars.

8.3.1 Organisational Based Social Networking on WhatsApp

All the adolescents in the sample were members of a *WhatsApp* social networking group that was created by the Director of LESO. According to the Director of LESO, the objective of setting up the group was to enable the organisation to share information in real-time with people that the organisation interacted with. The *WhatsApp* group was therefore not only focused on the adolescents but all the people that the organisation was working with. In an interview with the Director of LESO, she stated that the *WhatsApp* group was not meant for social networking, but it was a business platform where the organisation could officially communicate with its clients. The LESO *WhatsApp* group was governed by rules of operation and these were enforced by the LESO staff members. Some of the rules included that no group member could post anything onto the group without first sharing with the group administrator who was the LESO director. According to the Director of LESO, this was aimed at prohibiting the posting and sharing of obscene messages, images and videos. Another group rule was that no one was allowed to post any information advertising merchandise for sale. Violators of the rules above were given a warning before expulsion, but those that had shared obscene images, video materials and or messages would be automatically expelled from the group. In the focus group discussion with LESO staff members, it was mentioned that the *WhatsApp* group was an easier way of mobilizing their clients to come for an organized event or meeting. The staff members stated that there was an instance when one of their donors requested for an emergence meeting and asked that community members that engaged with the organisation also participate in the meeting. The staff members send a text message on the *WhatsApp* group and within one and half hours forty-seven people had heeded the call and attended the meeting. During the focus group discussion with LESO staff members on the 11th of September, an assistant to the LESO Director, Mrs Mhepo had this to say:

"One of our donors wanted to meet with us and asked that they also talk to people that benefit from our programme activities. At first, we were stranded as we pondered on how we could call community members to quickly converge over a very short space of time. We then decided to try the WhatsApp group and send a message to all group members. We were surprised by the turn-up, in about one and a half hours there were more than forty people".

The LESO staff members were all agreed that the *WhatsApp* group was an effective way of quickly mobilizing people to attend emergency meetings. When I asked the staff members what they thought had facilitated the quick mobilization of their clients over the *WhatsApp* group they mentioned that because the individuals had expanded *WhatsApp* social networks that had grown from the initial group, they had also self-mobilised themselves. According to the staff members, this was a sign that apart from the social networking on the LESO *WhatsApp* group, there were also other social networking activities on WhatsApp that involved the group members but outside of the LESO created platform.

During the focus group, discussion LESO staff members also indicated that the WhatsApp group kept the organisation networked and engaged to its clients daily. One way in which the organisation kept engaged with its clients was through rolling out monthly opinion surveys on any topical HIV and AIDS issue. At the time of the research, the organisation had conducted a survey in which they asked the opinion of group members on whether HIV status disclosure was important in fighting HIV and AIDS. According to the Director of LESO, the opinion surveys in addition to keeping the organisation continuously networked with its clients were also an important way of enhancing learning on HIV and AIDS. During an interview with the Director on the 9th of September 2014, stated that:

"The WhatsApp group is a special way of servicing our people. We strive to keep connected with all the people that we work with; this group has been wonderful as we are kept in touch with our friends (those we work with) daily".

Other staff members mentioned that outcomes form the opinion survey had assisted the organisation to come up with tailor-made courses for their clients on important HIV and AIDS issues.

LESO staff members had mixed views regarding the use of their WhatsApp platform for social networking among adolescents that were part of their group. Some staff members were

of the view that the WhatsApp group was also being used by individuals in the group for their social networking. One of the staff members mentioned that a case had been brought to her attention whereby an adolescent within the group was extracting details from the WhatsApp group and using these to initiate social relations. She said that in the case she had handled a male adolescent in the group had extracted personal information from the group of a female adolescent[7]. Using these details, the male adolescent had tried to initiate a love relationship with the female adolescent. The story came to light after the female adolescent complained to the LESO staff that a stranger had violated her privacy and that she strongly suspected that the stranger had obtained her details from the LESO WhatsApp group. According to the staff member, whilst this was the only case reported, there could be other cases that were not reported that could have taken a similar form.

Male staff members at LESO corroborated the case above and stated that from their interactions with male adolescents, they had evidence that male adolescents were in the habit of studying the WhatsApp profile pictures of female adolescents and extracting their details like names and profile pictures. They would then use these details to send messages to the private inboxes of female adolescents proposing love and initiating personal social relationships. The male staff members argued that it, therefore, implied that the LESO WhatsApp platform was now being manipulated by individual members of the group for their benefit and social networking activities.

The adolescents that were part of the LESO group also had mixed views on the operations of the LESO WhatsApp group as a platform for social networking. In interviews with the adolescents, they strongly regarded the LESO *WhatsApp* group as a platform where information sharing took place. It was highlighted that the key information products and messages they had received on the WhatsApp group included useful information on changes in health policies, new publications on HIV and AIDS and messages on HIV and AIDS prevention and treatment, among others. Seven female adolescents in the study also revealed that they had received information on other sexual and reproductive health issues. The seven adolescents stated that information about their rights to access sexual reproductive health services was also shared on the platform. Patience mentioned that:

[7] The female adolescent was not part of the study participants, but the male adolescent involved was part of my study sample.

"It was through a post on the LESO WhatsApp group that I got to know of my rights to access sexual and reproductive health services that are offered by the state. For example, I learnt that the state should provide us (young girls) with information and education on the availability of such services as assistance to girls that would have fallen victims to rape".

There were however other adolescents that regarded the LESO WhatsApp group as a platform from which social networking among individual adolescents could be initiated. The adolescents that believed that the platform was also useful for initiating social networking made an important distinction in which they highlighted that such social networking manoeuvres were targeted at those adolescents that were not already part of their social networks. Tinashe in Chitungwiza had this to say:

"Mdhara (elder) we do what we call fishing on the LESO group, we identify a potential person for starting a social relationship, in most cases, this would be a person of the opposite sex. We then go on their WhatsApp profile on the group and take out the phone number and sometimes profile picture, this is what we refer to as fishing. We then send a personal message to the identified person of interest and then a social relationship is already in the making. This is something we do for those girls that are not part of our existing social networks".

Despite their different views on the usefulness of the LESO WhatsApp group for social networking, all the adolescents believed that the LESO *WhatsApp* group was not a platform for effective social networking. The adolescents were concerned that there was too much control in terms of the content that was shared on the group. Kumbirai stated that:

"Most of us are not happy that it is the Director and her staff members that run the group. We could be happy if one of us was also a member of the administration team so that we could also contribute to the decision making regarding which items or pieces of information are shared".

The adolescents also stated that because the LESO WhatsApp group was more of a business platform for sharing important messages it made the social relationships on the group more formal and business-like. One of the adolescents shared that;

"Most WhatsApp groups that we belong to involve the sharing of jokes and some breaking news, the LESO group is too serious, no jokes are allowed, and the management also controls how people network with each other".

The adolescents that were my research assistants mentioned that adolescents that were living with HIV were not comfortable with the LESO group as they felt that being associated with the LESO group could be interpreted by members of the public as evidence of one's positive HIV status. As discussed in chapter six, the adolescents argued that this was because LESO was already a stigmatized institution. My four research assistants who all owned mobile phones stated that their phones were sometimes subject to random scrutiny by members of their households. Apart from members of their households, the adolescents also mentioned that as they sometimes lent their mobile phones to their acquaintances chances were that they could snoop into the LESO *WhatsApp* group and this could lead to a strong suspicion of their positive HIV statuses. The adolescents that participated in the study formed their own WhatsApp group as a reaction to the shortcomings of the LESO group discussed above. The section below discusses the findings on the adolescents social networking on their own WhatsApp group.

8.3.2 Adolescent WhatsApp Groups and Social Networking

The adolescents in Chitungwiza and Seke had a *WhatsApp* group called the *Rising Stars*. The group had other adolescents that were not part of those adolescents that attended sessions at LESO. At the time of the research, the group had thirty-seven members including all the twenty-two that were part of the study population. Whilst I could not confirm it, according to the twenty-two adolescents that were my study participants, all the group members were living with HIV. Unlike the LESO *WhatsApp* group that included adults, the Rising Stars *WhatsApp* group only consisted of adolescents. Adolescents from both Chitungwiza and Seke that had access to mobile phones were members of the group.

Information from interviews with the adolescents shows that there were many reasons for the formation of the Chitungwiza and Seke *Rising Stars WhatsApp* group. One of the reasons proffered by the adolescents was that the group was designed to facilitate continuous social networking amongst the adolescents that had got to know each other from their participation in activities organized by LESO. According to the adolescents, the *Rising Stars WhatsApp* group was therefore not a platform for initiating new social networks but for the

strengthening of existing social networks for adolescents that already knew each other. One of the adolescents, Precious, pointed out that:

> *"As young people, we wanted free space for interacting with each other and strengthening our friendships. We wanted to create a group where members get to know each other more intimately and develop personal relationships. For us, as young people, WhatsApp is for having fun and sharing jokes designed at deepening our social ties".*

The above discussion gives credence to Boyd's (2008:210) argument that social media supports existing social relationships. This view is also shared by other writers like Ellison, Steinfield, and Lampe (2007) who argued that most social networking sites including Facebook are used to maintain existing offline relationships or solidify offline connections among people that already know one another. The authors above also argued that in some instances weak social ties among individuals can be strengthened using online social networking sites such as WhatsApp or Facebook.

It was clear from the interviews with the adolescents that the Rising Stars WhatsApp group was a reaction to the shortcomings identified by the youths on the LESO WhatsApp group. During interviews with the adolescents, it was pointed out that the *Rising Stars WhatsApp* group allowed the youths to freely share, post and comment on any image, video and message posted on the group.

Marble, a participant in the *Rising Stars WhatsApp* group pointed out that:

> *"Everyone of us is free to share anything on the group like jokes, cartoons and other messages shared from other groups. We have no limits on what is shared, even other jokes that are not allowed on groups where there are adults, in our group those jokes or even videos are shared.*

There was a strong belief by the adolescents that the *Rising Stars* WhatsApp group was a way of strengthening their resolve to keep their HIV statuses a secret. According to the adolescents, the name of the group was specifically chosen to disguise any linkages to the subject of HIV and AIDS. When I viewed the *Rising Stars WhatsApp* group icon on the mobile phones of my research assistants who were also respondents in the study, I discovered that the group icon had a football/soccer ball on it. When I asked the four adolescents to

explain the link between the symbol/icon for the Chitungwiza and Seke Rising Stars, Shamiso said:

> *"The soccer ball on the group icon is our way of not wanting to have a direct connection between the group and our HIV status. This helps us a lot in keeping our HIV status a secret as people will think that the group is for a football team that we support. In my case, I know that no one in my household is interested in soccer so they will not read the content of the Rising Stars WhatsApp group"*

The adolescents mentioned that one of the reasons why the LESO *WhatsApp* group was not popular among adolescents was that the group icon had a sign of HIV and AIDS positive living.

The adolescents argued that the creation of the *WhatsApp* group was necessitated by the need to put controls and limit participation to only those adolescents that already knew each other's HIV status from their participation at the LESO activities. The adolescents claimed that the LESO *WhatsApp* group did not have such controls as it admitted all the clients of LESO regardless of their HIV statuses. To this extent, the adolescents feared that their privacy could easily be violated on the LESO *WhatsApp* group compared to the *Rising Stars WhatsApp* group whose membership was limited to the young people who already knew each other.

The adolescents noted that their social networking on *WhatsApp* was also their way of improving the quality of their relationships, particularly strengthening the levels of trust. All the adolescents claimed that members of the *Rising Stars WhatsApp* group could easily borrow and lend each other money which they highlighted as a sign of the improved trust and bonding amongst the adolescents living with HIV and AIDS. Kudzai, who was an active participant stated that:

> *"What we now see among ourselves is that there is an increased trust for each member of the group. People now borrow each other money which is something that never used to happen before the in-depth interactions on the WhatsApp group".*

Tecla added that it was easier for her to give airtime credit to other young people that were in the Rising Star WhatsApp group as she was assured that they would always pay back on time. She pointed out that:

"I have never had a credit payment problem with my friends in the Rising Stars WhatsApp group. I trust them and they deserve that trust because they always pay me back on time for every credit that I give".

The other reason pointed out by the adolescents for forming their own specific WhatsApp group was that the group was also aimed at providing peer-to-peer support in real-time. The adolescents said that support in the form advice on HIV and AIDS, sexual reproductive issues and emerging economic and social opportunities were also shared on the WhatsApp group. Most of the adolescents in the group mentioned that the group was a useful platform from which members reminded each other of the importance of taking drugs at the prescribed times and reminders for fulfilling clinic appointments.

The strengthening of social ties amongst the adolescents in the study tends to disapprove the contentions of earlier writers like Hampton et al (2011: 130) that the adoption of cyber-based technologies and means of communication would increasingly result in individuals socially isolating themselves from friends and relatives as they invest more time and resources in virtual spaces.

8.3.3 Rules and Norms governing Social Networking on WhatsApp

The adolescents that were networking on the Chitungwiza and Seke WhatsApp group specified that participation on the group was subject to rules of contact agreed by members at the formation of the group. According to the adolescents the most important rule was interacting in a manner that supported their stance on non-disclosure of HIV status to non-group members. As such the adolescents argued that to put into effect this rule, the group members were not allowed to use icons and or symbols that were publicly associated with HIV and AIDS on the group identity. One of the founders of the group, Tinashe, argued that this rule was important as they did not want their group to be associated with issues of HIV and AIDS as this could easily lead to members of the group being stigmatized in the community.

The second important rule according to the adolescents was that the selected group administrators were supposed to send out a reminder to all group members once every week reminding them of the need to adhere to their ART treatment schedules. According to the

adolescents that were my research assistants, the reminder was a standard message sent on the *WhatsApp* platform and read as follows;

> *"We all love each other and don't want to lose each other, remember to take your seed of life".*

The adolescents mentioned that the message above was also carefully designed to make it free from stigmatisation if a member's mobile phone is read by people that are not meant to receive the message. In the detailed discussions, I had with the individual adolescents it was mentioned by all the participants that the group members had an obligation to keep connected on the *WhatsApp* as a way of demonstrating love for each other. The adolescents argued that through this rule it had been easier for them to make follow-ups on group members that would have suddenly disappeared or gone quiet for long.

The adolescents mentioned that the third important rule was that each member was expected to share their experiences with local health facility staff when they went for their monthly clinical appointment. According to the adolescents, such experience sharing was important as it provided them with information on the availability of drug stocks at the local clinics. Other adolescents stated that sharing of experiences was important to them as it was their way of constantly checking on the attitudes of the clinic staff members. The adolescents in Seke revealed that the attitude of a certain female nurse at their clinic dissuaded them from attending their monthly clinical appointments when she was on duty. The adolescents also highlighted that these experience sharing was also their way of reinforcing adherence to ART treatment among group members. Frank mentioned that:

> *"When Pride took three months without sharing his clinic experiences, we could guess that all was not well. That is when we heard that his grandmother had taken him to the UFIC church for miracle healing. For once, we then all knew that Pride was no longer adhering to his treatment schedules".*

The adolescents highlighted that the fourth important rule of engagement on the Chitungwiza and Seke Rising Stars WhatsApp group was that all members were expected to be active on the group through either sharing of jokes, sharing breaking news, sharing videos on positive living for people with HIV and AIDS. Tinashe joked that:

"We don't carry passengers (people that sit idle like on a bus) in this group. We want people that are active, at least forward a message or joke from another group just for us to know that you are alive".

The fifth important rule according to the adolescents was that admission of additional members into the group was based on an introduction to the group by a founding member. According to the adolescents, this was a mechanism that was important to close out the group to people with other intentions other than those the group members had agreed on. The adolescents argued that due to the high levels of stigma they had closed the group to only those people they had intimate details on regarding their HIV statuses.

Whilst these were the highly respected rules the adolescents also said that other rules prohibited the sharing of obscene materials on the WhatsApp group. However, the adolescents were quick to add that the rules pertaining to the sharing of obscene materials were often not followed by members. The female adolescents in the group said that their male counterparts were notorious for breaking the rule on sharing of obscene materials. Patience made the following remark on the sharing of obscene materials on the group:

"The boys in the group are sometimes mischievous, they share nudities, yet we agreed that such things should not be shared. It is not good for us girls as this sometimes get us into trouble with our parents. One of my friends in this group was nearly beaten up by her mother when she came across the pictures on the WhatsApp group".

Shamiso concurred with the view shared by Patience and added that:

"The boys in the group find it fashionable to share pornographic videos, however, it is not true that the girls do not like them. The problem I see is that sometimes the girls forget to delete the videos they are seen by their parents or guardians and that is when the problem starts".

It is important to note that the rules governing the adolescents social networking on *WhatsApp* were almost similar to those discussed in chapter six. The importance of these rules and their significance in shaping ART adherence behaviours among the adolescents will be discussed in a specific section in this chapter.

8.3.4 Adolescents Social Networking on Other WhatsApp Groups

Whilst the Chitungwiza and Seke Rising Stars was the main WhatsApp group where the adolescents in the study sample were active, there were other WhatsApp groups that individual adolescents were also involved with. These groups ranged from church groups, soccer supporters' groups, political party supporters' groups, family WhatsApp groups, among many other groups. In the in-depth discussions I had with the four adolescents that were my research assistants, it was clear that one's participation in the different groups was based on personal interests, line of business and family associations. One of the most striking similarities among all the adolescents that had access to the WhatsApp platform was that they all belonged to some WhatsApp group that they referred to as a family group. In the discussion below I will focus on the WhatsApp groups that involved close relatives and families of the adolescents as the social networking activities on this group had implications attached to the adolescents' adherence to ART behaviours.

An interesting aspect of the adolescents social networking on *WhatsApp* within the family group was that it often involved their guardians or parents that were the head of households. For the adolescents that lived in households headed by the elderly, the *WhatsApp* group was often an official way of communicating with close relatives and other members of the extended family. In an interview with Tinashe, he argued that the *WhatsApp* had become a convenient way through which his grandmother communicated with their relatives dotted across the country and in neighbouring countries. He commented that:

> *"At first my granny just like any old person in the community did not understand social media or WhatsApp. Now that everyone is almost using it daily my grandmother now asks me to send messages to our relatives through WhatsApp. The messages range from simple greetings in the morning or evening to our close relatives living here in Zimbabwe and those working in neighbouring countries like South Africa".*

According to adolescents living in households headed by single parents, their parents were involved in their social networking activities on *WhatsApp* but with a different interest. The adolescents remarked that their parents were interested in mostly finding out whom they interacted with on *WhatsApp* and sometimes wanting to read the content of the messages shared on *WhatsApp*. When I asked the adolescents the reason for this interest from their

parents, they stressed that because *WhatsApp* is notorious for use in sharing of obscene images, messages and videos, the parents are interested in monitoring the existence of such materials on their mobile phones. Tapiwa who stayed with her mother who was a single parent said:

> *"My mobile phone is subject to random searches by my mother. The other time I secured it with a password and I was in serious trouble. She thinks that I am up to no good with my friends on WhatsApp as she suspects that we may end up sharing bad images like nudities or dirty jokes".*

In the case of adolescent headed households, use of the *WhatsApp* family group was mostly limited to communications related sharing messages on funerals, weddings or other happy occasions. As discussed in chapter five, most adolescents headed households maintained weak social network ties with members of their extended families and their social interactions on *WhatsApp* reflected this. According to Tecla, the adolescent head of household in Chitungwiza, their use of the *WhatsApp* group was mostly to listen in on conversations between other members of their extended family. Tecla intimated that she and her other siblings did little of sharing messages or even jokes. According to Tecla the sharing of jokes and how they are received on the *WhatsApp* is dependent on one's relationship with relatives on the *WhatsApp* group. She cited that:

> *"I used to share some jokes on the WhatsApp but no one ever seemed to have seen them even though the message would have been read. And then I discovered a pattern where when some relatives shared even an old boring joke, a lot of people would comment on the joke and express interest. So, I learnt that whether one's joke is liked or not depends on the strength of their relationship with relatives in the group".*

The family *WhatsApp* groups were however highlighted as important means of at least keeping close to family members and other extended family members. The adolescents added that the *WhatsApp* groups had strengthened their social relations. As was the situation with the strengthening of existing social relations in the adolescent created *WhatsApp* group, the adolescents highlighted that the family *WhatsApp* group played a similar role. According to all the adolescents *WhatsApp* messaging cheap and had assisted a great deal in strengthening family ties. In an interview with Pride from Chitungwiza, he stated that:

> *"My grandmother's relatives were a little bit distant from us as we grew up, however as we started to get in touch over WhatsApp our relationship became strong. The*

daily communications mean we are more in touch and closer to each other than we were before".

The family *WhatsApp* group was also highlighted as a means of maintaining the cultural obligations towards inter-connectedness with relatives. A strong and enduring sentiment among all the adolescents was that from a traditional cultural perspective there is an obligation that binds relatives to relate to each other continuously. In light of this sentiment adolescents in both Chitungwiza and Seke maintained that *WhatsApp* reinforced this obligation towards maintaining interconnectedness among close relatives. To the adolescents, there was no reason why a relative could not be connected to other relatives given that *WhatsApp* was a cheap option for maintaining family relations and interconnectedness as it did not require people to move from one place to another visiting their relations as was done in the past before the advent of social media platforms. During my interview with Patience, she confirmed the following:

"As Africans, an important part of our culture is keeping warm relations with one's relatives; so, this WhatsApp has assisted us and our relatives to keep in touch with each other".

When I asked the views of the adolescents regarding the relevance of the family *WhatsApp* group to their health situation, the adolescents were all agreed that the family *WhatsApp* groups were not very useful. The first key reason was that the family groups were mainly for sharing of important family messages related to the illness of a relative, deaths and parties. Secondly, the adolescents also argued that since people were not open with their HIV statuses, there was no way even people with knowledge on HIV and AIDS issues could share on the family groups. The adolescents also added that the social relationships within the family *WhatsApp* groups were punctuated by power struggles and suspiciousness that characterized the family relations outside the group. The adolescents that lived with their single parents specifically added that the suspiciousness also emanated from their parents' suspiciousness towards their relatives particularly those whom they suspected of spreading rumours about their children's HIV statuses.

8.3.5. Private WhatsApp Social Networking among adolescents

Apart from the social networking group, adolescents indicated that they used the WhatsApp platform to link with their peers on an individual level and discuss and share personal issues.

The adolescents stated that whilst the group was the entry point it had also led to the strengthening of peer-to-peer social relations. Their one-on-one social networking involved connections with close relatives, sources of assistance such as personnel from government departments, including the local health facilities/clinics and the Department of Social Welfare personnel. Adolescents in the study had one-on-one *WhatsApp* connections with at least three of the key persons who were a close friend, relative or a person supporting their well-being and livelihoods.

The adolescent headed households in both Chitungwiza and Seke had a *WhatsApp* connection and maintained strong social relationships with a person that provided them with social support or any other type of support that sustained their livelihoods. In my interactions with adolescents from Seke, I discovered that the female adolescents tended to maintain strong social relations with female acquittances or relatives that provided them with useful information on their sexual and reproductive health needs. For example, in the household that was headed by a male adolescent (Jekirandi), the female siblings in the household maintained close social relations with a staff member from the Social Welfare department. In some in-depth discussions with Jekirandi, he mentioned that the Social Welfare staff member played the role of an aunt or *tete* in the local language to his sisters. Among the Shona people in Zimbabwe, *tete* is a female relative with responsibilities for providing advice to girls as they transition from being girls to womanhood (Dodo, Dodo and Zihanzu 2017:51). The *tete* plays a key role in assisting girls to choose the right man for marriage and is normally responsible for settling disputes that may arise between her married relative and their spouse (Dodo et al 2017).

According to Jekirandi this role included advising his sisters on many things including menstrual hygiene, grooming the girls in their transition to womanhood and advice to the girls on the dangers of pre-marital sex and early pregnancies among other things. A similar scenario also obtained with adolescents in Chitungwiza where female adolescents used the WhatsApp platform to maintain a close link with their aunties or relatives that were playing the role of the aunt. In the interview with Tecla, she mentioned that:

> *"Since our parents passed on and we lost touch with my father's relatives my little sisters and I now depend on guidance from my mother's sister who provides us with guidance on how we can grow up as responsible girls. We connect with her on*

WhatsApp and she also assists us with many tips on how to deal with boys who come to us asking for love".

Whilst this was the case with adolescents that were heads of households, a different situation obtained for those adolescents that were staying in households headed by single mothers. According to both male and female adolescents living in households headed by single mothers, they maintained close ties with people that they would have been referred to by their parents. In most of the cases, these people were *sahwiras* or close acquittances of their parents. The *Sahwiras* would then play the role that would normally be played by the *tete* in the traditional family set up. The adolescents added that in some cases their single parents played the role that the *tete* is supposed to play. Three of the adolescents staying with their single parents mentioned that their parents had encouraged them to research on the internet for advice regarding their transition into adulthood.

Among all the adolescents, the *WhatsApp* platform was an important means for strengthening their one-on-one friendships. The adolescents revealed that a close friend or *sahwira* was the most important and frequently contacted person on their WhatsApp. The adolescents shared that they were in the habit of sharing concerns and messages in their inboxes with those other adolescents they considered to be their *sahwiras*. outside the WhatsApp group. The adolescents staying in households headed by the elderly also narrated that strengthening of existing friendship relationships was not only confined to themselves but also involved their guardians who often requested them to send WhatsApp messages to their close friends or *sahwiras*.

8.4 Social Media Social Networking and development of Social Capital

As discussed in chapter two the linkages between cyber-based social networking and the development of social capital have been debated among social scientist. Social networking on cyber platforms that include on *WhatsApp* has often been described as lacking the tenacity to create robust forms of social capital (see for example Lin and Erikson 2008). However, evidence from the study in Chitungwiza and Seke has shown that cyber-based social networking on *WhatsApp* functions to strengthen existing social ties. In this regard, social networking on this platform contributed to the creation of robust social capital that the adolescents could depend on. As noted by Lin (2008:51) social capital are the "resources that are embedded within one's social networks and these are accessed or mobilized through one's

ties in the network". In the case of the adolescents in Chitungwiza and Seke, the *WhatsApp* platform became an enabler or a means through which the social capital emanating from their existing relationships could be utilized.

As argued by Bourdieu (1983), Coleman (1990) and Lin (2001) social capital includes trust, mutual obligations and reciprocity which are all evident in the social relationships among the adolescents in the two communities. The lending and borrowing of material resources is evidence of the existence of trust among adolescents. It is however important to note that in the case of the adolescents in the study, the social media platform was not the primary means through which the social relations were formulated. The social media was a way of strengthening existing social ties which contributed to the generation of important social capital that the adolescents could rely on for receiving information, advice and mutual support (see paragraph above).

The existence of social capital among the adolescents was also confirmed by some guardians of the adolescents that participated in this study. One of the female guardians (Pride's grandmother) stated that her nephew was well supported by his friends that came around looking for him. She elaborated that;

> *"Since Pride became sick, he has received many visits from his friends. I see them here coming to see him, I don't know where he made those friends from but many of them, I guess are from this community".*

In the case above, the adolescents also mentioned that they had managed to link Pride and his family to individuals that had assisted him and his family. During the research period one of the adolescents, Tinashe, who was my research assistant, requested me to buy a ten kilograms bag of maize meal and some dried fish that he intended to pass on to Pride's family. I agreed to purchase the items on condition that the adolescent would not reveal my identity as I did not want to create an impression among my study participants that I was selectively rewarding some of them for participating in the study.

When I discussed with Tinashe after he had passed the food items to Pride's family the significance of gestures such as this for their social networking as adolescents living with HIV, he mentioned that their social network was a valuable resource that members of their

network could utilize in times of need. Tinashe added that mentioned that the gesture of giving to Pride and his family was based on information that Pride had passed onto them through *WhatsApp*. He had raised a concern that his sisters and grandmother were ill-treating him. According to Tinashe the visit to Pride's home was also a means of finding out more about his concerns with a view of taking up the case with authorities if the abuse was serious. The social media platform is therefore a means though which trust built from other social networking relationships is reinforced.

To get an in-depth understanding of the social capital resulting from interactions on *WhatsApp,* I took time to revisit Pride to get his understanding of this gesture from his other adolescents that he interacted with in the Rising Stars *WhatsApp* group. During those interactions with Pride, he stated that the *WhatsApp* group was an important platform to share information about the on-goings in his household with other group members. He said that he had faced problems with members of his household particularly his sisters whom he accused of harassing him. He also added that he had stopped adhering to his treatment schedule as no one from his household was willing to assist him to go to the Department of Social Services to renew his AMTO. Pride highlighted it was because of the intervention of his friends from the Rising Stars *WhatsApp* group that his grandmother had initiated the process of having his AMTO renewed. He stated his relationship with other adolescents had become more important than that he had with members of his household. He stated that:

> *"Sezvamunoziuva mukoma, pane tsumo iya yekuti husahwira hunokunda hukama, ndo nyaya yangu chaiyo. Vana Sahwira vangu veku group redu re WhatsApp ndohama dzangu chaidzo idzo". (As you know my brother, there is a traditional adage that says friendship is more important than blood relations, that is my real situation, these friends of mine from Rising Stars have become my real relatives, even better than my sisters here).*

The discussion above has demonstrated the importance of using the *WhatsApp* social networking platform as a way of building strong social relations among the adolescents. The strong social relations have become an important resource that the adolescents depend on for activities that support their adherence efforts in many ways. In the section below I delve into the details of the implications of social media social networking for ART adherence among the adolescents.

8.5 WhatsApp Social Networking and Implications for Adherence

In this section, I focus on how social networking on WhatsApp plays a significant role in shaping adherence behaviours amongst adolescents living with HIV. The findings in this section consist of the adolescent's collective reflections, their submissions and views from the LESO staff. According to the LESO staff members, there was no concrete evidence that social networking on *WhatsApp* was playing a significant role in aiding ART adherence among adolescents living with HIV. However, the staff members all agreed that the use of the *WhatsApp* platform for information sharing was one of the ways through which they encouraged people living with HIV to adhere to their ART treatment schedules. The staff members commenting specifically on their *WhatsApp* group expressed confidence that the adoption and use of mobile phone social media platforms constituted an important element of sharing information that encouraged their clients to adhere to their ART treatment.

The adolescents, however, had a different perspective from that of the LESO staff members on the effectiveness of the LESO *WhatsApp* platform in promoting ART adherence. In my interactions with the adolescents, they conveyed that whilst they were members of the LESO *WhatsApp* group, sometimes they did not read all the messages shared on the group. They highlighted that reading messages sent on the group was dependent on many factors such as where they are and whom they are with at the time the message is shared. For example, the adolescents mentioned that they would not open messages from LESO in the presence of people they suspected of stigmatising them. Adolescents that attended the emerging charismatic churches highlighted that they would not open messages from the LESO *WhatsApp* group when they are in the company of church members as this would be viewed as a sign of lack of faith in the healing powers of the church leaders.

Theresa, the adolescent who later got married and infected her husband, shared that she never opened her messages from LESO in the presence of her boyfriend because she feared that her boyfriend (to whom she had not disclosed her HIV status) would dump her on suspicion that she was HIV positive because of her association with LESO. Given all the reflections above, the adolescents believed social networking on the LESO *WhatsApp* group played a much lesser significant role in shaping their adherence to ART treatment behaviours. These views by the adolescents raise very important lessons on how organisations that have adopted social media platforms as a way of shaping positive health behaviours can improve on the

modalities of making these platforms more effective. This will be discussed more in the conclusion section of this chapter.

The adolescents concurred that their own administered *WhatsApp* group had resulted in assisting their peers to adhere to treatment. One important issue highlighted by the adolescents was that the *WhatsApp* group has assisted them to keep connected and check on each other's adherence trends. The adolescents mentioned that sharing experiences of their monthly visits to the health facilities was a useful way of encouraging each other to adhere to the monthly clinical appointments. According to the adolescents, another important aspect of the adolescent *WhatsApp* group was that it was a useful way to follow up on their colleagues that were no longer adhering to treatment. For example, they highlighted that if they had not formed the group, one of their colleagues would already have been lost to follow up. The adolescents mentioned that when a person living with HIV is declared as being "lost to follow up" it meant that he or she would have stopped adhering to treatment and would have not picked up his or her drugs for a period exceeding three consecutive months.

The adolescents also shared that the sending of a reminder message encouraging each other to take "the seed of life" was an important way of enhancing adherence behaviours. Kudzai in argued that "the seed of life message" had assisted her to continuously take her medication at the prescribed times. She stated that;

> *"I now expect to receive the message, although I know that it is a monthly message, it also reminds me that my other friends are taking seriously their medicine. It gives me the courage to live, knowing that I am not alone but am among a group of my other peers with the same condition".*

The other adolescents added that their *WhatsApp* group had assisted them to evade social stigmatisation and building adherence behaviours. All the adolescents argued that unlike the LESO WhatsApp group they could read messages shared on their group as the group icon showing a soccer ball did not attract any attention from people that would otherwise stigmatise them. Shamiso highlighted that:

> *"I have the freedom to read my messages on the Rising Stars group, no one in my circles recognizes that this is a group for people living with HIV. In this way, I can evade stigmatisation that is rife here in Chitungwiza".*

The adolescents noted that family *WhatsApp* groups were also important in some cases for indirectly promoting treatment adherence. The adolescents contended that keeping connected to relatives had strengthened their social ties giving rise to useful social capital that facilitated the exchange of goods, including food items that are necessary for enhancing treatment adherence. Tinashe added that:

> *"The WhatsApp has assisted to keep connected daily to our relatives; this has assisted us to be very close to each other. These relatives as per our kinship expectations are obliged to send my grandmother some food and money to use here. The food is important to ensure I don't get sick after taking my ARVs. When we receive money, we buy food also which is important for my adherence".*

Adolescents staying with elderly heads of households argued that the involvement of their guardians on *WhatsApp* when they ask them to send greetings to their *sahwiras* had resulted in the strengthening of social relations between their grandparents and their *sahwiras*. According to the adolescents, the strengthening of friendship relationships involving their guardians or grandparents played an important role in their adherence to treatment. This according to the adolescents was because consolidation of such relationships resulted in the realisation of various forms of support that enhanced their treatment adherence. Kumbirai, a 19-year-old adolescent in Seke highlighted that;

> *"In some cases, getting money to go to the clinic can be difficult, however, my grandfather depends on his sahwiras here to sometimes get money for me to go to the clinic. Two months ago, when I wanted to go for my monthly clinic appointment, my grandfather had no money. He asked me to send a WhatsApp message to his sahwira requesting for some money. Within a short space of time, some money had been sent to my EcoCash (mobile money account). This assisted me to attend my monthly clinic appointment".*

A similar sentiment was also shared by adolescents that stayed in households that were headed by single parents. The adolescents testified that the participation of their single parents on their own *WhatsApp* spaces was bringing in benefits that assisted them to adhere to their treatment schedules. Adolescents living in female-headed households highlighted that their mothers' maintenance of social connections using WhatsApp assisted them to adhere as they often received solidarity messages from their mothers' friends and close relatives. Tapiwa in Seke said:

"I and my mother often receive messages of encouragement from my mother's friends whom she interacts with on WhatsApp. This is useful for me as my mother and myself are taking ARVs and we find a lot of support from these friends on WhatsApp". Some share their experiences of struggles with stigma with my mother; my mother then shares this with me, and it is so encouraging learning from other people".

It is interesting to note that the use of *WhatsApp* as a means of strengthening social relations among adolescents first; and secondly also among their heads of households and their relatives or *sahwiras* played a significant role in influencing adherence behaviours amongst the adolescents. The use of *WhatsApp* to strengthen existing social relations and network ties made the social connections an important resource that the adolescents could fall back on to support their adherence to ART in various ways as discussed above.

8.6 Conclusion

The discussion in this chapter has focused on the significance of adolescents' social networking on the *WhatsApp* social media platform and its importance in sustaining social relationships. *WhatsApp* has become so important that even community-based organisations like LESO are using it to try and influence adherence behaviours amongst people living with HIV and AIDS, including adolescents. The utilization of *WhatsApp* by community-based organisations that work with people living with HIV and AIDS has resulted in making it easier to share information between the organisation and its clients. The major advantage of using *WhatsApp* is its ability to relay information in real-time and this has been useful for organisations like LESO to mobilise its clients to attend emergency meetings.

Whilst the use of *WhatsApp* by community-based organisations like LESO has its advantages such as real-time information sharing, adolescents tended to abhor the strict controls applied by the organisation in managing the group. This is mostly because the adolescents regard *WhatsApp* as a social media platform where they can share jokes and exchange other humorous messages. Thus, the formalization of *WhatsApp* as a communication tool by community-based organisations like LESO tended to dissuade the participation of adolescents on organisation managed *WhatsApp* platform. Despite this, the adolescents continued to maintain their presence on the organisation managed social platform for them to access important updates and information on the emerging trends associated with HIV and AIDS.

The adolescents have innovative ways of going around the shortcomings of a formalized WhatsApp group and have formed their own *WhatsApp* group. The study has demonstrated that the *WhatsApp* platform is used by adolescents to strengthen existing social ties. Whilst literature on social media has sometimes pointed out that social media platforms are also effective in creating new social relations, findings in this chapter have shown that *WhatsApp* as a social media platform was mainly useful for the strengthening of existing offline social relationships. Instances, where *WhatsApp* was used to initiate new social relations, were far and few between, for example when a few male adolescents used the *WhatsApp* to try out possible girlfriends. Thus, the adolescents that were networking on the adolescent managed *WhatsApp* group already knew each other from their interactions at LESO organized activities.

The use of *WhatsApp* by both the organisation and adolescents for connecting was based on a shared understanding of some set rules and regulations. For the LESO managed group this is not surprising given the high incidences of social media abuse in Zimbabwe. However, for the adolescents managed group, the rules and regulations played a different role, and this was mostly to strengthen the adolescents' resolve not to disclose their HIV statuses to the general population. The application of strict controls on who was admitted into this group is a robust testimony of the adolescents' desire to keep their HIV status secret. On the other hand, the adolescent group was also an important platform for sharing important reminders for the social media group members to adhere to their treatment schedules.

The impact of social stigma on people living with HIV and AIDS and particularly for adolescents also shaped the social networking patterns and behaviours of adolescents on *WhatsApp*. The design of the group symbols for the adolescents' group and disguising it as a football team group or a football supporters' group is evidence of the adolescents' desire to escape the pervasive social stigma facing adolescents living with HIV and AIDS. The use of symbols and icons that are not normally associated with HIV and AIDS was an effective means for the adolescents to avoid stigmatisation by their communities, friends and close relatives whom they did not want to reveal their status to.

An important aspect of social networking on *WhatsApp* by adolescents is the fact that such social networking resulted in the development of important social capital. This means that the

social network relationships became an important resource on which the adolescents depended on to support their adherence behaviours. For the adolescents that were not adhering to their treatment schedules, the social capital was a means through which they could start to adhere to their treatment. Adolescents that were not adhering and could have been easily lost to follow up through the formal health systems were easily located through their existing presence on the *WhatsApp* social media platform.

The involvement of the adolescents together with their guardians or parents on the *WhatsApp* social media platform played a significant function in supporting adherence behaviours by the adolescents. As discussed above, the major advantage of the *WhatsApp* social media platform is its ability to transmit information in real-time. Added to this is also the affordability of *WhatsApp* that allowed adolescents and their parents or guardians to increase the frequency of their social interactions with their relatives. It was evident that the increase in social interactions between the adolescents, their parents or guardians and their close relatives resulted in the strengthening of their social ties. As highlighted by the adolescents, frequent communication with relatives is a traditional and social obligation that is expected of all people belonging to the same clan or for people that are closely related. The reinforcement of social ties was a means through which various forms of support could be directed towards adolescents living with HIV and their households. Such forms of support included psychosocial support and material support that aided the adolescents to adhere to treatment. In the same manner, *WhatsApp* was also an important tool to strengthen the traditional friendship/*ushwira* amongst the adolescents' parents and guardians.

CHAPTER 9: DISCUSSION OF FINDINGS AND CONCLUSIONS

9.1 Introduction

In this chapter, I undertake a discussion of the key findings of this research and I discuss identified knowledge gaps and proffer propositions for further academic research. I have a section that present key recommendations that can be taken up by national and regional policymakers, government institutions, academics, non-governmental organisations, adolescents and their families in the promotion of public health for young people in living Zimbabwe, Africa and the world at large. I conclude the chapter by discussing this thesis's contribution to knowledge and the important lessons learnt throughout the research process.

9.2 Discussion of Findings

This study has examined the significance of social networks on ART adherence behaviours among adolescents living with HIV in Zimbabwe with a focus on Chitungwiza and Seke. As a first step towards this, this study investigated the different forms of social networks that influence adolescent's adherence behaviours. The different social network ties include those entered by members of their households such as the kinship social ties, close friendship relations *(usahwira),* church-based social ties and social networks that involve community-based institutions. This study considered the social networks that the guardians or parents of the adolescents entered into and how these played a role in influencing treatment adherence. The most common types of social networks were those constructed around the traditional friendship concept of *usahwira* (strong friendships). As discussed in chapter five, the *usahwira* social networks played a critical role in influencing adolescents towards treatment adherence. The strong friendships for example were depended upon by guardians or parents to obtain various kinds of support from the close friends that enhanced adherence treatment.

For example, it was a common phenomenon to find guardians involved in the usahwira relationship lending each other money for use by adolescents to attend their monthly clinical appointments. Social networks that involved the guardians and parents in some instances ended up involving the adolescents. As shown in chapter five, one adolescent worked as an apprentice under the tutelage of his father's close friend *(sahwira).* From this apprentice, the adolescent was able to earn money that he used to fulfil his monthly clinical appointments and observe a balanced diet that was critical for his treatment adherence.

Another form of social networking that was common among guardians and parents of the adolescents was based on sharing a similar totem. Sharing similar totems resulted in close social ties that the guardians or parents would depend on in times of need. Just like the usahwira social ties, the social relations emanating from people sharing similar totems were also characterised by the exchange of gifts, lending each other money and sharing information. The sharing of information was one of the ways through which adolescents' treatment adherence was supported. Information pertaining to available opportunities for adolescents' support streamed in the social networks. An interesting aspect of the social ties based on sharing similar totems was that the people involved had a sense of obligation to assist each other just like blood relatives.

The discussion of *usahwira* closely ties in with the broader African philosophy of *Ubuntu* as demonstrated in the exchanges that occur within and between groups. However, it is quite dominant that the levels of mutual care exisiting within the adolescent groups follow the tenets of Ubuntu described by such authors as Mbaya and Shuttle in chapter three of this thesis.

The different social relations that heads of households and adolescents were involved in satisfied the arguments by authors like Lyon and Santo (2002) who highlighted reciprocity and social exchanges as the critical elements of social networking. There were exchanges of goods and information between household heads in rural areas and those in the urban areas. The flow of information from households in the rural areas was often reciprocated with the sharing of material goods by households in the urban areas (see the case of Devine on page 70). Sharing of information and material good also characterised the social relations among households in one physical setting. For example, among households in Seke, information and small grocery items were sometimes shared among households.

Social relations involving adolescents and health personnel did not only include exchanges and reciprocity by both parties, but also the building of trust in the social relations. The adolescents trusted the health personnel as sources of authentic information on health-related knowledge. The fact that some health personnel would go into the communities and provide medical support outside their line of duty including prescribing medicines was based on the trust that the adolescents would not divulge this to third parties. Evidence from this study

supports the assertions by Campbell and Cornish (see discussion on page 27) that social relationships between individuals and people from health providers provided an opportunity for positive health behaviours. Based on the social relationships with health personnel, adolescents were able to negotiate for flexibility in the times they could fulfil their clinical appointments. Adolescents for example would avoid going to the clinic on the designated day when people living with HIV go to pick up their monthly drug allocations. This allowed the adolescents to avoid stigmatisation that was associated with going to the clinic on the designated day for drug pick-ups and clinical appointments.

On the other hand, the health personnel that were involved in pilfering medical drugs from health facilities and using adolescent to market them on the black market banked on the trust that the adolescents would not report them to authorities. The pilferage of medical drugs from the formal health systems to the informal through the social networks involving adolescents and health personal brings to the fore the negative side of such relationships within the medical field as this has the potential to affect equitable distribution of drugs among those in need. This scenario brings to the fore the importance of the work by Campbell and Cornish (see page 27) who make reference to the concept of "institutionalized" relations involving individuals and people from community-based institutions that provide services and support to people living with HIV. While Campbell and Cornish do not extend their analysis to the effect of these social networks on the institutions from which these health personnel come from, evidence in this study has shown that there is potential for the health facilities to suffer drug shortages as well as inequitable drug distributions.

The social ties that involved the adolescents and staff members working for community-based HIV and AIDS service organisations included the building and maintenance of trust on the side of the adolescents and the LESO staff. The adolescents trusted the LESO staff not to divulge details about their HIV status. On the other hand, the LESO staff had an opportunity to ensure that the adolescents trusted the knowledge that they were giving to the adolescents and that they also used it to support their treatment adherence. The fact that the adolescents kept trusting the knowledge passed on to them by LESO staff members, even when they were exposed to claims of HIV miracle healing by the papas of the charismatic churches is evidence of the enduring trust that characterised their social networks with LESO staff. It is important to note that the trust between these two parties was built on the fact that the LESO

staff ably upheld the unwritten norms and rules that governed their social networking. For example, the LESO staff members were all clear that for their social networks with the adolescents to be functional, they needed to uphold the rule on *hatina kumboonana uye hatizivane* (we do not know each other). The observance of this rule was key to trust building among the parties involved. This discussion highlights how the fundamental elements of social capital discussed in the theories of Bourdieu, Coleman and Putnam came to life, particularly the elements of trust, social sanctions and social obligations.

This thesis also sought to understand the factors that determine the nature of social networking relations among adolescents. As argued by sociologists like Mararike (see chapter two) HIV and AIDS take place within a socio-cultural context and as such findings in this thesis point to the effect that the immediate socio-cultural environment determines the nature and form of social networks. In the two study sites, the prevalence of high levels of stigma shaped the way adolescents behaved in social networks. The subject of HIV related stigma has been tackled by various authors (see for example the works of Campbell and Deacon (2005), Deacon and Stephney (2007) and Deacon (2005). Deacon (2005) identified three types of stigma that affect people living with HIV, these are: self-stigma, anticipated stigma, and enacted stigma. Of these three, anticipated stigma seems to be the most relevant to the situation of adolescents in this study.

According to Deacon (2005:33) anticipated which is also refered to as perceived stigma is a negative response people living with HIV expect to receive from their families and communities in the event that their positive HIV status becomes known. Fear of what will happen to them if their status is known. The adolescents reactions to the fear of their HIV statuses being known publicly is a clear manifestation of anticipated stigma. The rules and norms guiding the intercations of the adolescents with staff at LESO, staff members working in institutions that provide HIV and AIDS service and the upholding of the values of secrecy are all put up in reaction to anticipated stigma. The non-HIV status disclosure stand by the adolescents is also a clear example of of the adolescents suffering anticipated stigma.

Evidence from this study has shown that the social networks that involved adolescents worked effectively in avoiding HIV and AIDS-related social stigma. The need to avoid the anticpated societal stigma by the adolescents gave rise to norms and values that governed

social networking by adolescents. The norms discussed in chapter five such as the *"hatina kumboonana"* (we have never met and we do not know each other) were employed by the adolescents to mask their HIV statuses and attempted evasion of the anticpated stigma. This evidence corroborates the observations by Campbell et al (2013:2) highlighted in chapter two on how social networks provided useful platforms where people living with HIV negotiated their way around social stigma and harmful societal norms.

The fear of HIV related social stigma and discrimination played a significant role in shaping the norms and rules that governed social networking among adolescents. As demonstrated in chapter six, as a result of the high levels of social stigma and discrimination against people living with HIV, a very strong culture of secrecy evolved. The culture of secrecy and exclusive nature of the adolescents social networks can be pointers to what Deacon (2005:31) HIV self-stigmatisation. Stigmatised people may suffer disadvantage without experiencing and direct discrimination by avoiding situations that they think will be discriminatory. Self-stigmatisation is a response to stigma and should be mistaken for a type of stigma. The adopted norms and rules governing social networking among adolescents, their parents and guardians resulted in a culture of non-disclosure of HIV status and social exclusion of those whom the adolescents regarded as not being part of them. As argued by Deacon (2005) HIV self-stigmatisation takes place when an individual internalises feelings of shame or blame due to hie or her negative social perception or judgement of his or her HIV status.

Not all response to stigmatisation are maladaptive (page 32), avoidance coping startegies such as non-disclosure. The copying mechanism does not constitute denial of HIV status but an attempt to reject its stigmatisinf connotations (Deacon 32). Stein (1996) argues that non-disclousure of HIV status maybe functional to the individual's privacy and peace of mind. The culture of secrecy with regards to one's HIV status transcends the adolescents' social network ties with institutional staff members to also include some of their relatives that did not want the HIV statuses of their kinsmen known. To show the impact of social stigma in determining social networking behaviours adolescents' social networking even on social media platforms conformed to the norms and rules mutually agreed by the adolescents in keeping their HIV statuses a secret. The norms and rules practised by adolescents to evade the social stigma provide illuminating evidence that people living with HIV can develop and sustain robust forms of social networks. This evidence tends to contradict findings of authors

like Webel et al (see chapter two, page 26) that people living with HIV are likely to have weak social network links.

As discussed in chapter two, authors such as Campbell et al (2013) have highlighted the importance of social networks in influencing adherence behaviour outcomes. Whilst scholars like Campbell et al focused on how the social networks promoted positive health outcomes amongst different people living with HIV, evidence in this study has also brought to the fore the negative influence of social networks in inhibiting adherence. For example, the three adolescents that had close-knit social relations had experimented with traditional medicines as alternatives to ARVs. The social networking by these adolescents had resulted in the adolescents abdicating on their ART treatment schedules.

The adolescents' social networks also played an important role in preserving the value of scientific knowledge that the youths obtained from formal institutions such as local health facilities and community-based HIV and AIDS service organisations like LESO. For example, whilst the adolescents had social networks with people in charismatic churches (these churches claim to perform miracle healings including for HIV and AIDS infected people), they still held in high esteem the view that HIV and AIDS did not have a cure. This view was strengthened in the social networking that occurred on social media platforms as evidenced by the youths' resolve to circulate weekly reminders on taking their ART medications. The values of such health-related knowledge systems and information to which the adolescents were exposed continued to be given prominence in the adolescents' social networks. This made such knowledge and information to influence adherence patterns amongst adolescents. For example, the supremacy of scientific knowledge obtained from formal institutions that provide HIV and AIDS services compared to spiritual healing proclamations by church leaders is demonstrated when adolescents that are not adhering make decisions to restart adhering to their treatment schedules. This scenario is in sync with the postulations by Perry and Pescosolido (see chapter two, page 20) on their concept of health-related social capital which is often activated by people in a social network discussing and sharing knowledge on health issues.

It is important to note that while social networking had positive implications on treatment adherence there were instances where this was not the case. For example, there were instances where some adolescents temporarily stopped adhering to their ART schedules as a

result of pressure from their guardians that were members of charismatic churches and had strong beliefs in miracle healing. This revelation from the study confirms theoretical positions by authors like Lyons and Santo and Myroniuk (see chapter two, page 25) that some religious-based social ties resulted in negative adherence outcomes for people on ART treatment.

The emergence of charismatic churches in Zimbabwe has seen social networking taking place in these spaces as well. Church-based social networking involved both parents or guardians and adolescents. Critical evidence from the study has shown that the charismatic churches ran partnership schemes that became strong platforms where both parents/guardians and adolescents established social networking relations. The fact that the partnership schemes operated at community level meant that the church-based social networks had numerous benefits for both the parents/guardians involved. As evidenced in the study adolescents could access financial assistance which came in the form of loans from the partnership schemes. The adolescents used the money from the schemes to initiate income-generating activities that benefited their household members. It is also important to note that the benefits from the income-generating projects had implications for treatment adherence. For example, the adolescent who ran a poultry project used the proceeds to purchase food items needed for maintaining a balanced diet.

Social networking by adolescents within the charismatic church spaces also provides further evidence of the durability of existing social networks involving adolescents. The adolescents that were already members of the social networks originated at LESO continued to observe the norms and rules that governed their social networking outside the church. Of importance is to note that the adolescents believed that churches were not free from social stigma for those living with HIV. The existing social ties such as those based on the youths attending sessions at LESO superseded the importance of the social ties that the adolescents developed with church leaders or their representatives. This was different from the social ties that their parents or guardians had with the church leadership or their representatives. In all the cases none of the adolescents were paying the twenty dollars affiliation to the partnership schemes as their parents or guardians would normally pay on behalf of the youths.

This scenario points to the differences in the importance placed on the church-based social networks by the parents/guardians and adolescents. This difference was to some extent due to

the fact that the adolescents believed in the supremacy of the knowledge given to by staff members at community-based institutions such as LESO and the personnel at health facilities. On the other hand, the parents or guardians believed in faith healing and in some cases were afraid of the backlash from the church leaders in the case that members of their households showed signs of doubting the healing powers of the *papas*. There were some contradictions within the ranks of the adolescents as some adolescents stopped adhering. However, the fact that these adolescents would return to adhere indicates their belief and trust in the knowledge they obtained from their social networking relations with staff members from health service providers.

Another important exploration in this study focused on the importance of social media platforms in nurturing social networks that promote or hinder treatment adherence. Whilst writers like Lin (1999) had questioned the role played by cyber-social networks in supporting social relations that can be depended on by individuals in times of need, the critical evidence from the study participants point to the effect that social ties nurtured on social media platforms tend to reinforce existing social network ties and thus play an important role as a resource that can be depended on. Evidence from the study has also highlighted that cyber-based social ties reinforced the norms and rules that governed social networking in other spaces. The upholding of the norms and rules in the social media platforms like *WhatsApp* is evidence of the existence of the fundamental characteristics of social networks such as building trust and social sanctioning espoused in the writings of Bourdieu, Putnam and Coleman (see chapter three, page 32). As discussed above, the norms and rules adopted by adolescents discouraged disclosure of HIV statuses and thus becomes a problem in sustaining long term ART adherence.

The cohesion witnessed in the *Whatsapp* groups and the continued adherence to the norms and rules governing social interactions among the adolescents has provided greater substantiation of the views of Putnam (2000) on social networks and their bonding effects. Naseri (2017:16) also agrees with Putnam and adds that social media interactions are likely to improve bonding and strengthen social communication between individuals as shared messages are motivating and sometimes rich in content which encourages future interactions.

While cyber-based social networking was common among the adolescents, there is evidence that guardians and parents living with the youths also made use of social media platforms for real-time communication with people in their social networks including their kith and kins

and *sahwiras*. The evidence from the study points to the effect that the involvement of the adolescent's parents and guardians in cyber-social networking resulted in strengthened social relations as communication became more frequent and regular among people in the same network.

9.3 Propositions for future research

This study proposes the following specific issues for further exploration:

Long Term ART adherence – The incidences of early pregnancies among female adolescents living with HIV points to the fact that long term adherence is a huge challenge amongst adolescents born with HIV. A longitudinal study approach that focuses on the same cohort of adolescents could bring out critical information that answers the question of long-term adherence among adolescents living with HIV.

Social stigma and discrimination – The pervasive nature of social stigma and discrimination targeted at people living with HIV is a complex one. There is social stigma that relates to members of staff working for community-based organisations providing HIV and AIDS services. Stigmatisation does not end with the staff members of these organisations but also extends to the institutions themselves. In addition to this, individuals that associate themselves with these institutions are also stigmatised. This aspect of institutional stigmatisation and its impact on ART adherence needs further academic enquiry. The enquiries should also be extended to those other health institutions such as local clinics, district, provincial and national health facilities that have a mandate to assist people living with HIV. Based on these studies, there should be consideration of pragmatic approaches towards reducing HIV and AIDS-related social stigma and discrimination for individuals living with HIV and institutions providing HIV and AIDS services.

Widening the scope to include youths aged 10-24– According to official statistics (see the National HIV Report of 2017), the 15-24 age group in Zimbabwe is experiencing a rise in the rate of new HIV infections. With a treatment coverage rate of above 80 % at national level (National HIV Report of 2017), an in-depth assessment of the factors and issues affecting adherence for the 15-24 age group must be undertaken. Thus, whilst there is a good national coverage in terms of HIV and AIDS treatment services, this should also be supported by

evidence of high adherence levels in order for the country to sustain the gains of its fight against HIV and AIDS and meet the set international benchmarks (the 90-90-90 targets).

Institutional Effectiveness and national referral systems - The nexus between social networking involving adolescents and personnel working in public health facilities at community level needs further academic exploration given the evidence in this study that such social relationships are giving rise to drug pilferage from these institutions. The impact of such pilferage and the inequality that is created in terms of access to life saving drugs by people living with HIV is an area that needs further interrogation. Given the high levels of corruption and poor economic performance in Zimbabwe the impact of these acts could be having devasting effects on those people that are not involved in social networking with people at public health institutions.

Social Media and adherence – The role played by social media platforms such as *WhatsApp* in influencing adherence behaviours amongst young people has been well explained in this study. There is a need to explore the large-scale use of different social media platforms such as *Facebook, Twitter* and *Instagram* in influencing adherence behaviours across various age groups given the evidence that elder persons are also getting hooked onto social media. There is a need to produce tangible evidence on the potential of social media based social networking in building robust social capital that can be depended on.

9.4 Implications for Health and Development Policy

There are various health and development policy implications that emanate from the conclusions of this study. These are presented in this section to help inform public health and national HIV and AIDS policies in Zimbabwe.

The contradictions between the modern medical approach to treating HIV and spiritual healing as the alternative being offered by the emerging charismatic churches need serious policy guidance. Whilst the Zimbabwe National AIDS Council is very clear about the management of HIV and AIDS as a public health issue and emphasises that HIV has no cure, the policy does not clearly pronounce on any measures that will be taken against those individuals and institutions (including traditional and religious) that claim to cure HIV. This

lack of clarity in the policy has left people living with HIV and institutions providing HIV and AIDS services fighting the narratives from these emerging churches on their own.

The study has focused on adolescents and their adherence to ART treatment. This is an opportunity for policy makers to reflect on the other health and reproductive health needs of adolescents in Zimbabwe. For a very long time, the country has been grappling with the development of an adolescent sexual and reproductive health policy. Since the policy was developed in 2016, its implementation has stagnated. The conclusions in this study and the challenges that adolescents face including those emanating from social stigma can inform the revision of the policy and the strategies for implementing the National Adolescents Sexual and Reproductive Health policy. The impetus for this can be derived from the fact that evidence from this study has shown that adolescents are active agents who can devise their own strategies to challenge social stigma in the communities they live in.

The active agency demonstrated by adolescents that are heads of households and the process of their 'adultification' (see chapter 5 on page 92) presents an interesting scenario for development practitioners. It implies that adolescents can map their own development agenda and should only be supported by external institutions including NGOs, government and churches for those initiatives to actualise. In order to do so effectively, these institutions should take time to analyse and understand the various social networks that the individual adolescents are involved in; and the different strengths of these. As demonstrated in the study, the strength of a particular social network is dependent on the knowledge that the individual adolescent obtains from the social interactions in such social networks and their personal decisions as to which social network they value most.

9.5 Contribution of study to knowledge and literature

In this section I reflect on the conclusions made above and highlight my contribution to the body of knowledge on adolescents' health, ART adherence and social networking. I also discuss the important lessons learnt from this study and how these can be applied to further deepen research and understanding of adolescents' health issues within sociological theory and the sociological discourse in general. This thesis has contributed to the knowledge and literature that seek to undertake an in-depth understanding of how social networks mould the behaviours of adolescents that are living with HIV.

9.5.1 Adolescents HIV status and Social Stigma

Through the adoption of the qualitative method of enquiry and my attempt to use the same to portray the lifeworld of the adolescents, I have learnt that the lifeworld of the adolescents living with HIV is dominated by the perceived stigma that surrounds their condition of HIV positivity. This provides the motivation for their overriding concern to hide their HIV status as discussed in chapter 5 (page 136). The enduring social stigma that characterises the adolescents' life world became the normative basis of their social networks as this was used to come up with norms, social obligations and behaviours that supported non-disclosure avoiding certain days at the clinic (see page 146). The use of the qualitative approach and engagement with guardians of the adolescents led me to discover that the fear of social stigma extends beyond the adolescents and affects their friends, parents, guardians and other relatives. The pervasive nature of social stigma in the study sites tended to permeate all social circles including those based on religion (see page 195). As highlighted above the existence of social stigma was largely responsible for determining how the adolescents behaved within their different social networks.

9.5.2 Local culture and social networks

Social networking among adolescents occurs within the existing cultural realms. The construction of social network relations and their reference to the cultural concepts of traditional forms of social relations such as *usahwira* is an important indicator of how the local culture and traditions help shape and moderate adolescents' social networking behaviours (see chapter 5). This is further signified by the reference to totems by both the adolescents and their parents and or guardians as a means through which social relations are generated or strengthened. My intent to gain an in-depth understanding of the adolescents social networking behaviours led me to the conclusion that the use of norms and rules that are derived from cultural idioms of expression such as *"kusafugura hapwa"* (see page 111) is further evidence of how the local culture plays a vital role in shaping the way adolescents behave in their social networks. *Kusafugura hapwa* is an expression that supports and finds value in people who do not divulge any secrets.

The religious beliefs regarding faith healing also shape the way adolescents behave in social networks that were based on religion. The belief in faith healing has shaped the way adolescents and their parents and guardians' network within church circles either in

anticipation of a miracle healing or potential material benefits that emanate from maintaining robust social relations with other members of the church.

9.5.3 Social networks and social capital

The discourse on social networks and social capital has continued to evolve within the social science discourse over the years. The evidence generated from this study pertaining to the dependency on social networks as a resource to support ART adherence by adolescents has generated knowledge that highlight the intricate linkages between social networking and positive and negative health outcomes. This study focus area has been of interest to many scholars since the time of Bourdieu. Whilst contributing to the same strand of knowledge, this study has brought out the complexities arising from the social configuration of social networking. This is particularly when analysis of the norms, values and rules that govern adolescents social networking are brought to the fore. The emergence of social capital from the social networking process is not a unidirectional process. It is complicated by the development of unwritten rules of the game and social sanctions that are enforced by the adolescents themselves, thereby giving rise to specific forms of behaviours such as reinforcement of non-disclosure of one's HIV status.

9.5.4 Implications for Social Science Research Methods

This study took a qualitative approach to bring out an in depth understanding of the circumstances that adolescents born with HIV encounter daily. The adoption of this study approach contributes to the social science research methods discourse as it illuminates the great advantages of using qualitative approaches to gain an in-depth view of the circumstances that shape human behaviours and in this case the behaviours of adolescents that are born and living with HIV. This study has brought to the fore how qualitative information obtained from different sources such as focus groups, key informant interviews and informal discussions (for example, the ones I had with my research assistants) can be triangulated in order to obtain an authentic view of adolescents' life experiences. This is also evidenced from the triangulation of information with data obtained from my own interactions with the adolescents, my interactions with community-based support group staff members, and key informant interviews with church representatives. Listening to the parents' and or guardians' narratives provided an opportunity to triangulate and validate information that provided a comprehensive picture of how the adolescent's life world looks like in reality.

This was backed up by my approach to include some of the adolescents as research assistants as this proved to be a very useful way of getting to know more about the complex ways which adolescents interacted with each other, particularly in the smaller group social networks. In the detailed methodology chapter, the emphasis on the above cross referencing and evidencing from multiple sources highlights the need to pay attention to detail as well as giving enough time to study participants to express themselves when use of the qualitative approach is adopted for social science studies.

9.5.5 Digital social networks

This study has generated new knowledge on how the current permeation of electronic social media has impacted adolescents' behaviour. This is an emerging area for many scholars from across the social science field. Many scholars have identified adolescents as having the highest uptake of communication technologies that are collectively referred to as social media platforms. This aspect becomes even more interesting in the academic discourse given the evidence from this study that adults are also joining the social media bandwagon. The effect of social media in sustaining traditional social relations such as the *usahwira* type of social relationships is an area that could interest many academics studying social networks.

9.6 Key Lessons

The following key lessons were learnt during the study process and their implications for the academic discourse are also highlighted below:

9.6.1 Working with adolescents as Research Assistants

The inclusion of community-based research assistants helped me gain community acceptance during the initial stages of the study. This was also important in getting acceptance from a group of adolescents that is usually suspicious of new people in a society that is heavily affected by HIV stigma. The three research assistants I worked with helped with initiating my relationships with the target group and also maintaining the relationship throughout the research process. As members of the community in which the research process was taking place and also as part of the study sample, the assistants became important sources of knowledge on the beliefs, norms and values that helped influence the behaviour of the adolescents. The assistants also shared their knowledge of the community with me and this helped me to gain a deeper understanding of the study sites and the people's ways of life. The

critical lesson here is that in order for researchers to generate useful and in-depth narratives considerations should be made towards engaging with local research assistants.

9.6.2 Research and Ethics

An important lesson emanating from this study on research ethics is the need for researchers to attend to the pressing needs of their research participants. This involves in some instances linking research participants with existing referral systems such as linking adolescents living with HIV to local institutions that provide health related services for people living with HIV. This is important in cases where study participants do not have information about the existence of such services and their accessibility.

9.7 Conclusion

This chapter has presented a discussion of the findings highlighting the different types of social networks that significantly influence ART treatment adherence among adherence, as well as the aspect of community social stigma and how this shapes norms and rules that determine social networking among adolescents. This chapter has also presented thoughts regarding the thesis's contribution to knowledge and its implications for academic discourse. The lessons learnt during the study process have also been highlighted and how these might have wide applications for the future use of qualitative research to generate in-depth narratives on understanding human behaviours.

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Zimbabwe Republic Ministry of Health and Child Welfare (MOHCW) .2009. National HIV and AIDS estimates, Government Printers, Harare.

APPENDICES

APPENDIX 1. UNISA ETHICAL CLEARANCE LETTER

UNISA university of south africa

Department of Sociology
College of Human Sciences
15 April 2014

Proposed Title: *A study of the impact of social networks on adolescent antiretroviral therapy adherence in Zimbabwe*

Principal investigator: M John Marondo (Student number: 50887092)

Reviewed and processed as: Class approval (see paragraph 10.7 of the Unisa Guidelines for Ethics Review).

Approval status recommended by reviewers: Approved

The Higher Degrees Committee of the Department of Sociology in the College of Human Sciences at the University of South Africa has reviewed the proposal and considers the methodological, technical and ethical aspects of the proposal to be appropriate to the tasks proposed. Approval is hereby granted for the candidate to proceed with the study in strict accordance with the approved proposal and the ethics policy of the University of South Africa.

In addition, the candidate should heed the following guidelines,

- To complete and sign a Supervisor-Student Agreement form, which is a code of conduct guiding the research process,
- To start the research study only after obtaining the necessary Informed Consent,
- To carry out your research according to good research practices and in an ethical manner,
- To maintain the confidentiality of all data collected from or about research participants, and maintain safe procedures for the protection of privacy and when storing such data,
- To work in close collaboration with the assigned Supervisor and to ensure the way in which the ethical guidelines as suggested in the reviewed proposal has been implemented in your research,
- To notify the Committee immediately in writing if any change/s is proposed to the study and await approval before proceeding with the proposed change,
- To immediately notify the Committee in writing if any adverse event occurs.

REGARDS,

Dr. Chris Thomas
Chair: Department of Sociology
Tel: 0027 (0)12 429 6301

APPENDIX 2: ASSENT FORM FOR PARTCITPANTS

Introduction: You are requested to take part in a research study which seeks to understand the ART amongst young people. The researcher is John Marondo, a student with the University of South Africa. Please read this form carefully and ask any questions you may have before agreeing to take part in the study.

What I will ask you to do: If you agree to be in this study, I will conduct an interview with you. The interview will include questions about your health life history. The interview will take about 30 minutes, though there will be other follow up sessions which can be scheduled with your agreement. With your agreement, I would also like to tape-record some of the sessions of the interview.

Risks and benefits: There is the risk that you may find some of the questions about your adherence to be sensitive. There is however no physical harm that are likely to happen to you as a result of participating in this study. There are no benefits to you, however from time to time during the interview sessions the researcher may supply some refreshments.

Your answers will be confidential. The records of this study will be kept private. In any sort of report, we make public we will not include any information that will make it possible to identify you. Research records will be kept in a locked file. If we tape-record the interview, we will destroy the tape after it has been transcribed.

You should know that:

- You do not have to be in this study if you do not want to.
- You may stop being in the study at any time.
- Your parent(s)/guardian(s) were asked if it is OK for you to be in this study. Even if they say it's OK, it is still your choice whether or not to take part.
- You can ask any questions you have, now or later. If you think of a question later, you or your parents can contact me at at marondoj@yahoo.co.uk, or 263-773 065203.

Your Signature _____ Date _____

Full Name_____

Name of Parent(s) or Legal Guardian(s)

_____

Signature of Researcher _____ Date _____

Full Name _____

APPENDIX 3: CONSENT FORM FOR KEY INFORMANTS

Introduction: You are requested to take part in a research study which seeks to understand ART amongst young people. The researcher is John Marondo, a student with the University of South Africa. Please read this form carefully and ask any questions you may have before agreeing to take part in the study.

What I will ask you to do: If you agree to be in this study, I will conduct an interview with you. The interview will include questions about your understanding of community values, beliefs, adolescents' adherence behaviours among other issues. The interview will take about 45 minutes, though there will be other follow up sessions which can be scheduled if you agree. With your permission, we may tape-record the interviews.

Risks and benefits: There is the risk that you may find some of the questions about adherence of your close relatives or other young adults that are close to you. There is however no physical harm that is likely to happen to you as a result of participating in this study.

Your answers will be confidential. The records of this study will be kept private. No identifying information about you will be placed in any written documents. The research records, including tape-recorded interviews, will be kept in a locked file cabinet. This will be destroyed after the completion of the study.

Taking part is voluntary: Taking part in this study is completely voluntary. You may skip any questions that you do not want to answer. If you decide to take part, you are free to withdraw at any time.

If you have questions: The researcher conducting this study is John Marondo. You are welcome to ask any questions now or at a later stage. You may also contact me at marondoj@yahoo.co.uk, or 263-773 065203.

Statement of Consent: I have read the above information, and have received answers to any questions I asked. I consent to take part in the study.

Your Signature _____Date _____

Full Name_____

Signature of Researcher _____ Date _____

Full Name _____

APPENDIX 4: PARENT ASSENT FORM FOR PARTCITPANTS 15 – 17 YEARS

Introduction: You are requested to grant permission for your child/dependent to take part in a research study which seeks to understand the ART amongst young people. The researcher is John Marondo, a student with the University of South Africa.

Interview Process: The researcher will interview your child about his/her health life history. The interview will take about 45 minutes, though there will be other follow up sessions which can be scheduled with your agreement. Part of the interview sessions may be tape-recorded some of the sessions of the interview.

Risks and benefits: There is no anticipated physical harm that is likely to happen to your child as a result of participating in this study. There are no benefits to child for participating in the study, though during the interview sessions the researcher may supply some refreshments.

Confidentiality: Information collected during the will be kept private. If we tape-record the interview, we will destroy the tape after it has been transcribed.

Consent Statement: The study has been explained to me and I fully understand its objectives. I agree that my child participates in the study.

Your Signature _____ Date _____

Full Name_____

Signature of person obtaining consent _____ Date _____

Full Name _____

If you think of a question later, you can contact me at marondoj@yahoo.co.uk, or 263-773 065203.

APPENDIX 5: TRANSLATED CONSENT FORMS – SHONA

Introduction: Ini zita rangu ndinonzi John Marondo, ndiri mudzidzi pachikoro Che University of South Africa. Sechikamu chezvidzidzo izvi, ndiri kuita tsvagiridzo pamusoro pevana vanorarama nehutachiwana hwe HIV ne chirwere che AIDS. Ndinokumbirawo mvumo yako kuti unge uri vamwe vevanhu vandichabvunza mibvunzo mutsvagiridzo yangu. Ndichakupa nguva yekuverenga gwaro rino pamwe nekubvunza zvimwe zvaungada kuziva usati wazvipira kuva mumwe wevandichabvunza.

Zvatichakurukura: Kana ukabvuma kuva mumwe wevanhu wandichataura navo ndichazobvunza mibvunzo yakati wandei inoenderana nehupenyu hwako nehutano hwako. Mibvunzo yangu inowanzo tora maminitsi angaita makumi matatu, uyezve ndinozodzoka zvakare kuti tikurukure zvakadzama nenguva dzatinenge tatenderana. Apo nepapo ndichazokumbirawo kuti ndi recodhe ne tape recorder zvimwe zvatinenge tichikurukura kuti ndizozvishandisa pakunyora gwaro rangu.

Tarisiro Mutsvagirodzo ino: Handina tarisiro yokuti pane zvingazokukanganisa nekuvepo kwako mutsvagirodzo iyi, uyezve handivimbisi kuti pane zvandichazokupa kunze kwokuti apo nepapo ndingazongo kutengerawo zvekudya tichitaura.

Chengetedzo yezvatichakurukura: zvese zvatichakurukura ndichazvichengeta zvakahwanda uyezve zita rako harizoshandiswi muchinyorwa changu. Mapepa ose andichashandisa ndichaachengetedza akavharirwa paasinga onekwi kana naani zvake, uyezve zvandicha rekodha ndichazozvidzima ndangopedza kuzvishandisa.

Zvaungada kuziva usati wazvipira kupinda mutsvagiridzo iyi:

- **Kana uchinzwa usingadi kupinda mutsvagiridzo iyi haumanikidzwe.**
- **Kuyange tatanga kukurukura wakasununguka kuramba kuenderera mberi netsvagiridzo iyi.**
- **Vabereki wako vaudzwa nezve tsvagiridzo iyi, asi iwe ndiwe unozvisarudzira kupinda mutsvagiridzo iyi kana kuti kwete.**
- **Pari zvino unokwanisa kubvunza mibvunzo yaunayo kana kuti unozogona kubvunza chero ipi nguva zvayo yaunenge wakasununguka. Unogona kundifonera panumber dzangu dzinoti 263-773 065203; kana kundinyorera pa marondoj@yahoo.co.uk.**

Ndatsanangurirwa zvizere pamusoro pe tsvagiridzo iyi, uye ndazvipira kupinda mutsvagiridzo iyi pasina kumanikidzwa.

Signature _____ Date _____

Zita Rizere_____

Zita Romubereki wako (Name of Parent(s) or Legal Guardian(s)

_____

Signature of Researcher _____ Date _____

Full Name _____

APPENDIX 6: TRANSLATED CONSENT FORM - SiNDEBELE

ISIGABA SAKUQALA: UKWAMUKELA UKUBA YINGXENYE YESIFUNDO LESI EMUNTWINI OLEMINYAKA 15 KUSIYA KU17 - SiDEBELE

ISINGENISO: Uyacelwa ukuphathisa esifundweni lesi esidinga ukuzwisisa ngokunathwa kwemithi yama A.R.V's kubatsha. Isifundo lesi siyenziwa nguJohn Marondo, isifundi sase University of South Africa. Bala iphepha leli uzwisise njalo ubuze imibuzo ongaba layo ungakazinikeli ukuba yingxenye yesifundo lesi.

IMIBUZO ONGAYIKHANGELELA: Uma ungamukela ukuba yingxenye yesifundo lesi ngizakubuza imibuzo engahlanganisela imbali yempila kahle yakho. Inkulumo leyi ingathatha imizuzu engamatshumi amathathu. Kungenzeka sibe lezinye izigaba zenkulumo esingaziyenza umauvhumelana lakho. Njalo ngingafisa uku TAPE RECORDER ezinye inkulumo esingaziyenza uma uvhumelana lakho.

ONGAKUKHANGELELA: Kungenzeka ukuthi ngibuze imibuzo engathinta imizwa yakho kodwa akula kuhlukuluzwa ongahlangana lakho ngenxa yokuba yingxenye yesifundo lesi. Akula lutho engithembisa ukukunika khona ngaphandle kokuthi ngezinye izikhathi nginga letha okuncane okokudla.

IMPENDULO ZAKHO ZIZABA YIMFIHLAKALO: Ngizagcina njengemfihlo konke esizakukhuluma ngesikhathi sesifundo sethu. Uma nginga sebenzisa okunye kwezinto ozikhulumileyo asisoze sibhale okungatshengisa isikhulumi sendaba leyi. Ubufakazi bonke sizabugcina endaweni efihlakeleyo njalo siza bhidliza ubufakazi obukumaTAPE ngemva kokusebenzisa esikuswelayo.

OKUQHAKATHEKILEYO UKWAZI:

- **Awubanjwa ngamandla ukuba yingxenye yesifundo lesi.**
- **Uyavhunyelwa ukuma ukuba yingxenye yesifundo lesi loba yisiphi isikhathi.**
- **Lanxa abazali bakho bevhumile ukuthi siyenze isifundo lawe kulilungelo lakho ukuvhuma kumbe ukwala.**
- **Ungabuza loma yiphi imibuzo ongaba layo khathesi loba ngemuvha kwesifundo lesi. Wena kumbe abazali bakho lingangithinta ku marondoj@yahoo.co.uk loba kunombolo ezithi+ 263773065203.**

Signature _____ Date _____

Ibizo lakho_____

Ibizo lomuzali_____

Signature of researcher_____ Date_____

Ibizo_____

APPENDIX 7: INTERVIEW GUIDE

PERSONAL INFORMATION

Pseudonym:	
Date of Birth:	
Sex:	
Parent/Guardian Employment Status:	
Parent/Guardian Level of Education:	
Province/Town/City:	

GENERAL PERSONAL INFORMATION

HOUSEHOLD INFORMATION **How many people live with you in your home?** **What is your relationship to the household head? And with the other household members?** **Are both of your parents alive? If not in the same household, where do they live?**
SCHOOL ATTENDANCE **Are you currently attending school?** **If yes, which grade/form are you currently in?** **If not in school, what is the reason/s for currently being out of school?** **When and at what level did you drop out of school?** **If other children in household, are all school going children in your household currently enrolled in school?** **If not, what are the reasons for being out of school?**

SOCIAL ACTIVITIES

Are you involved in any social group activities in this community/school/church?

What social group activities are common in this community? eg church groups, youth associations and or clubs.

What do you think is the role played by social group activities in this community?

Do you have access to the social internet based medias e.g. *facebook, watsup,yourtube?*

What do you think is the role played by these forms of media in shaping your social networks?

GENERAL INFORMATION ON ART

Do you think HIV and AIDS is a problem in this community?

Who is affected by HIV and AIDS in this community?

Since when did you know what your HIV status is?

Do you feel that placement of people with HIV and AIDS on treatment is beneficial to the community and or the individual?

What are some of the problems faced by people who are currently taking ART?

In your view, are children and young adults in this community living with HIV and AIDS being afforded enough support by the community?

PERSONAL INFORMATION ON ART

When did you start on ART?

Do you think that it is important to always take ART at prescribed times. Do you agree with this? Why do you say this?

Have you ever experienced problems taking your pills? What are the general problems that you have had taking your pills?

In the last month, how many times have you had challenges taking your pills? How did you resolve the challenges?

If you have had no problems taking your pills, how have you managed to keep up to your schedule?

Have you disclosed your status to anyone? If yes: Tell me about that process. If no: Why did you choose not to disclose your status?

If you have not discussed your status with anyone, what coping strategies have you put in place to ensure that you adhere to your treatment schedule?

If you have disclosed your status to someone, what has been the role of the following in your life since you learnt of your status? Family members, school, church, youth associations, community clubs, non-governmental organisations?

Are there any support systems for people living with HIV and AIDS in this community? If yes, what are the forms of support available in this community?