

Title: Play of children living with HIV/Aids in a low resourced setting: Perspectives of caregivers

A short running title: Play of children living with HIV/Aids.

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Research Ethics

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Introduction

Play is a common childhood occupation (Cordier, Bundy, Hocking, & Einfeld, 2009) and is frequently used in occupational therapy as a medium for intervention with children. Play is fun and using it as a medium for interventions is likely to make them more enjoyable. Children have the ability to turn any activity into play and occupational therapists have leveraged on this to use play as a means to cultivate general skills needed to perform functional activities (Lynch & Moore, 2016). Play has thus been used in occupational therapy for children, especially those with chronic health conditions and disabilities (Dender & Stagnitti, 2015).

Play is defined as ‘a transaction with the environment that is intrinsically motivated, internally controlled and free from the constraints of reality’ (Skard & Bundy, 2008, p. 70). Although children have a propensity to play, at times they fail to engage and participate due to factors such as illness and environmental deprivation, which often limit opportunities. Restricted opportunities to engage in play are likely to affect the child’s development, with long-term effects likely noticed only in adulthood. The conceptualisation of play in occupational therapy thus ceases to be narrowed down to the child, but also considers the environment and the possibilities of enabling play occupations in context (Cordier et al., 2009). The need to promote play is integral to holistic occupation-based occupational therapy practice involving children.

Play, HIV/Aids and the impact of contextual factors

Children with HIV/Aids are at a higher risk of having developmental delays (Hutchings & Potterton, 2014). These children were also observed to have neuro-cognitive impairments (Mlambo, Jelsma, Rusakaniko, Dale, & Chingono, 2017), which are likely to affect engagement and participation in play. Although the studies mentioned here point to potential limitations in the play of children with HIV/Aids, no research has sought to understand the play of children with HIV/Aids living in low resourced settings, especially from caregivers’ perspectives. A recent systematic review conducted by Munambah, Cordier, Speyer, Toto, and Ramugondo (2020) revealed paucity of research on play for children with special healthcare needs such as HIV/Aids. This is of concern especially in Sub-Saharan Africa where approximately 90% of the 1.8 million children infected with HIV/Aids globally, reside (Joint United Nations Programme on, 2015).

Apart from illness, there are many factors that compete with play (Ramugondo, 2012) or restrict children's ability to participate in it. Play is often challenged by contextual factors such as stigma, neighbourhood violence and limited resources available for children living in poverty (Milteer, Ginsburg, & Mulligan, 2012). Rapid social change in certain parts of the world has resulted in play as understood by families and whole communities and across generations, being eroded (Ramugondo, 2012). Furthermore, increased use of electronic media, pressured lifestyles of adults and the growing emphasis on academic preparation are some of the factors that are contributing to the diminished opportunities for play (Moore & Lynch, 2018).

The terms environment and context have been used to mean more or less the same thing in occupational therapy. In this paper, these terms will be used interchangeably. Occupational therapy has extended its individualistic approach in understanding occupation by acknowledging how the broader context influences engagement and participation in occupations (Kuo, 2011). Occupation provides a medium through which humans transact with their contexts (Cutchin & Dickie, 2013). Context includes the physical, social, cultural and political aspects (Cutchin, Aldrich, Bailliard, & Coppola, 2008; Hocking, 2020) that affect the day to day functioning of individuals and collectives (Fogelberg & Frauwirth, 2010; Ramugondo & Kronenberg, 2015).

Occupational therapists have unique expertise to understand persons and their occupations in context, as well as how to enable occupational performance and participation (Rodger, Ashburner, Cartmill, & Bourke-Taylor, 2010). However, Hammell and Iwama (2012) pointed out that most models and theories that inform practice have been developed in the West. This could be problematic when such models are applied blindly to African contexts. Lately, occupational therapists are increasingly becoming aware of the significance of culture and ways in which cultural behaviours and beliefs shape everyday doing. There is therefore a growing need to develop context-based conceptual models that promote play in children. For effective interventions to be developed there is a need to understand context and how engagement and participation in play by children with HIV/Aids is shaped, especially in low resourced settings. This study aims to explore and describe the play of children with HIV/Aids from caregivers' perspectives. The research question that was asked was; what are the perspectives of caregivers on the play of children with HIV/Aids living in low resourced settings?

Methodology

A qualitative descriptive study design was used to gain an understanding of the play of children with HIV/Aids in low resourced settings from caregivers' perspectives. This study design draws from naturalistic inquiry (Sandelowski, 2000), which entails presentation of the facts regarding the phenomenon under inquiry in everyday language. Qualitative descriptive study design was selected as there was need to gain information from those experiencing the phenomenon under study within the confines of limited time and resources (Bradshaw, Atkinson, & Doody, 2017). Fifteen caregivers of children diagnosed with HIV, whose children had been observed playing in the earlier phase of the study were purposively selected using maximum variation to participate in this study. Maximum variation involves selection of participants who cover the spectrum of positions and perspectives in relation to the phenomenon that one is studying (Patton, 1990). In this study, caregivers had different parental roles, varying numbers of children under their care, and their children were of different ages. For the purposes of this study, a caregiver is defined as an adult (above legal age of 18 years), primarily responsible for the care of the child and is able to give consent on behalf of the child. See table 1 below for the demographics of the caregivers.

<Insert table 1 here>

Ethical approval for the study was obtained from the University of Cape Town (HREC REF: 640/2017). In Zimbabwe where data was collected, ethical approvals were obtained from the Medical Research Council of Zimbabwe (MRCZ REF: A/2364) and Joint Research and Ethics Committee (JREC REF: 163/18). Written informed consent was obtained from all the participants prior to participation in the study. Privacy and confidentiality of the caregivers was maintained throughout the research process. Data collection was done using in-depth interviews with the caregivers. An interview guide developed from the study objectives and adjusted based on the findings from earlier phases of the study was used to guide the researcher. Before data collection, the interview guide was reviewed by three experts in occupational therapy and qualitative research. Thereafter the guide was piloted with two of the caregivers and their data was included in this study.

Two interviews were carried out with each of the caregivers. An appointment for the interviews was set with each of the caregivers at a convenient date, time and place. Also,

caregivers were free to choose the language they wanted the interviews to be conducted in and all chose to be interviewed in their native language (Shona). The estimated length of each interview was 45 minutes. Immediately after each interview, data was transcribed, translated to English and analysed before the next interview. Data was analysed thematically. During analysis, the researcher revisited the original transcripts in Shona to retain the original meaning of the data. Shona terms were used in the manuscript if their deeper meanings were lost when translated into English. An iterative and reflexive process was done throughout analysis with data continuously reviewed back and forth to confirm or discredit original findings (Sandelowski, 2000). A technique of member checking was also used to ascertain that the findings were a true reflection of what the caregivers said (Krefting, 1991).

Findings

The study was aimed at understanding the play of children with HIV/Aids living in a low resourced setting, from the perspectives of the caregivers. Four themes emerged from the data. Of these four themes, the first theme refers to play for children in general and the other two speak specifically to play of children with HIV/Aids. Table 2 below presents the themes and categories.

<Insert Table 2 here>

Ubuntu is no more

This theme draws from the caregivers' own childhood, juxtaposed against the current play experiences of their children, pointing to some of the contextual barriers to play. "*Ubuntu* is no more" reflects some of the changes in social and physical environments and how these have impacted on the play of children with HIV/Aids in this setting. *Ubuntu* refers to a shared ethical responsibility for humanity; how this is an ongoing process allowing for co-existence involving the individual and other people in a community (Ramugondo, 2015). Caregivers highlighted how in the past, through *Ubuntu*, elders would look after anyone's child without expecting any payment. For example, when children were playing in communal areas, elders (who are not caregivers of the children playing) would protect children from any potential danger. This has changed, with some elders now viewed as a threat instead.

"It's not safe to just let your child out, ...umm (swaying head sideways) people nowadays no longer have love for one another as in the old days," (Caregiver 1)

Ubuntu was significant for outdoor play, as most children prefer to play outdoors, often involving running around and playing with mud. Forced by circumstances, caregivers at times keep their children indoors, often against the child's will. Indoor play is often restricted due to limited space.

“We live in a single room which is just divided by a curtain to separate the bedroom, no space for kids to play.” (Caregiver 2)

The current study was carried out in Harare (capital city of Zimbabwe) and in the peri-urban locations. Most of the caregivers involved in this study were staying on rented property and had limited space for children to play indoors or outdoors in the yard. Often the landlords were not supportive of children playing on their premises. On asking about designated play areas, caregivers raised concerns about safety and lack of security in these play-spaces. In most communities where the study took place; there were no clearly designated play areas for children except for the playgrounds at school. Children would often go and play at open spaces whose purpose is not known. Caregivers reported that these open spaces were not safe for children.

“People are now cruel. Children are now being targeted by criminals. Even us the adults! It used to be very safe back then, there is no longer anything called safe place these days.” (Caregiver 6)

Ubuntu as a communal ethic for a shared humanity means one must view another's child as their own.

Family migration in some instances could have also played a role in bringing about the sense that ‘*Ubuntu* is no more’, as most families no longer live together. Often grandparents, aunts and uncles are not available to play with the children. A number of caregivers reported that they decided to stay away from extended family members and would not allow their children to visit relatives due to fear that their HIV status may be exposed.

In the Shona culture, there is an expectation that the father should be shown respect in particular ways. A child has a specific way of talking to the father that shows respect, in ways that are restrictive. More freedom is accorded to children as they interact with grandparents, aunts and uncles. One caregiver narrated how culture restricted him, as a father, from playing with his daughter.

“Ummm...but as a father we play to a certain level. Yes! ...but you should also leave room for respect, you should not play like an uncle and niece but I should play with her to a level that I would be able to be granted my respect as a father. because a child should feel free to say anything that she likes to her grandfather, ...unfortunately the grandparents are in the rural areas, far away from us.” (Caregiver 2)

This has also led to the disappearance of indigenous play forms. Some caregivers held a belief that adults should not play with children, instead children should play with their own peers.

Survival is primary (*chikuru kurarama*)

The theme ‘Survival is primary’ emerges from the lived experience accounts of caregivers of children HIV/Aids in this study. Until recently, HIV/Aids was experienced as a fatal condition in Zimbabwe, and much of Sub-Saharan Africa. With the advent of antiretroviral medication, this terminal illness changed to become a chronic condition. In the context of poverty, which is unfortunately reality in this study setting, the primary focus of caregivers is on things presumed to be linked to survival. Survival however in the context of HIV/Aids is not only about food per se, but that also the ability to remain compliant with taking medication. Anti-retroviral drugs on an empty stomach are a significant risk for children with HIV/Aids. Caregivers were thus mostly preoccupied with meeting basic needs for survival to the extent that not much focus was given to play. The phrase ‘*chikuru kurarama*’, literally meaning ‘better to be alive’, was echoed by many caregivers who said that children’s play was secondary as they focus on survival from one day to the other.

Caregivers reported that medication, which is mostly antiretroviral therapy, is of paramount importance when taking care of a child with HIV. Thus, caregivers prioritised giving medication above all responsibilities, because the survival of a child with HIV was viewed as tied to correctly complying with medication intake.

“Medication should be given on time and (one has to) manage that time, if you say you will give your child his or her medication at 8 let it be 8 and maintain that time.”
(Caregiver 11)

The health team was also influential in making sure that parents adhere to the appropriate administration of medications. Counselling at the hospital is centred on complying with medication and proper nutritional intake. This notion was further accentuated by many

parents having experienced their child's health deteriorating when they failed to give medication appropriately.

“I have seen with other parents (that) they do not give their children proper medication, the end result is you will face many challenges as that will affect the growth of your child.” (Caregiver 10)

Some of the effects of not taking medication included stunted growth, with some children presenting with opportunistic infections. Caregivers agreed that if medications are taken appropriately, then children's health improved, which is a prerequisite for children to engage in play.

“As parents, we should just encourage and support them (our children) in taking their medication so that a difference will not be noticed when he/she is playing with others unless they have been told so.” (Caregiver 5)

In the struggle to survive, caregivers prioritised food provision for the children. Caregivers highlighted some challenges they face in providing food and taking care of children with HIV.

“The biggest challenge is the food issue; it is very hard for us to get food to an extent that we had to have delayed breakfast so as to coincide with lunch. We now only have tea here (at the clinic).” (Caregiver 15)

Although food is a basic need for all people, caregivers reported that it is different for children who are on antiretroviral medication as they require more food compared to other typically developing children. The struggle to provide food is complicated because children with HIV/Aids do not require just any food but they need to be given healthy food. Also, the food had to be well prepared and given at appropriate times. Caregivers narrated how at times it was difficult to find the right food that aids in boosting their children's immune system.

Caregivers reported that, once the children are fed, they looked happy and played for longer hours either by themselves or with other children. Pursuant to the above, some caregivers said that play should be accompanied by food.

“I think the playing aspect should be accompanied by food if possible as it helps a lot even to suppress stress on the child.” (Caregiver 14)

Caregivers involved in this study came from low resourced settings and most did not have financial resources to meet basic needs for survival. Poverty was primarily due to lack of employment or other alternative means of income. The situation was exacerbated by the prevailing economic hardships in Zimbabwe, where most industries are functioning below capacity. The most common source of income in Zimbabwe is informal trade, especially of goods sourced in neighbouring countries. Other people are involved in small projects like gardening, chicken rearing and doing some short-term jobs (though erratic) for survival. Due to poverty, some caregivers either failed to enrol their children into school, or to pay fees for their children. Yet the school environment offers space and opportunities for children to play with their peers.

More is required for this child

All the caregivers involved in this study reported that more is required in the care of their children. They also indicated that such care was foundational to enabling play. Compared with typically developing children, caregivers narrated some of the things they see children with HIV/Aids incapacitated to do and gave solutions to some of the problems they faced. Caregivers reported that some of their children with HIV/Aids had physical, behavioural and emotional problems. Some of the children were reported to be generally weak and some would fatigue easily during play.

“I have realized that he is not physically fit. One can notice it when they are playing. If he is slightly pushed he falls or when they are playing soccer, if he misses a kick he falls down.” (Caregiver 7)

Behavioural and emotional challenges highlighted by caregivers included being short tempered, signs of depression and problems in social skills. Caregivers also noted that children living with HIV had various challenges in both verbal and non-verbal communication. Some of the deficits in communication were visible during play.

“She is very short tempered.... I always think that her temper is caused by her condition. She ends up playing alone” (Caregiver 2)

Most of the children involved in this study had not been screened for other impairments such as hearing, eye problems and behavioural problems. Caregivers were not aware of services they could access for their children apart from HIV medication. One caregiver was quick to

blame herself saying that maybe she had spoiled the child. The lack of knowledge on some of these behavioural problems and possible interventions pose some challenges in parenting. Some caregivers reported how they would discipline the child without seeing much change from it.

“My child is very stubborn to an extent that even if you discipline him, he doesn’t change and I have since given up.” (Caregiver 9)

Apart from difficulties in play posed by developmental delays and behavioural problems noted in children with HIV/Aids, caregivers reported that their children also needed to be protected against stigma. One of the caregivers shared her experience of how her child was stigmatised at school as a result of her HIV status. This means that children with HIV/Aids in this context also often barriers to schooling. Most of the caregivers had resorted to not disclosing their children’s status for fear of the child being stigmatised.

“The problem in our communities is stigmatization (paused); it is a matter of concern to us, so you will try by all means to be very secretive” (Caregiver 5)

Although some caregivers attested to not having personal experiences of being stigmatised, they remained afraid of stigma. Much of the fear stemmed from the fact that if the child’s status is disclosed, this would imply an HIV positive status for the mother. Some thought that once other people knew the status of the child, other children may refuse to play with him or her.

Apart from the fear that other children will isolate the child during play, caregivers were also afraid of how adults would also treat the child. Caregivers, whose children know their own HIV status, have also told their children not to disclose their status to other children or people in the community. As a way of protecting the child from stigma and other adversities, caregivers tend to also control the play of the children. Some caregivers reported that they dictate the times at which the child should play, whom they play with and where they play. In controlling the children, caregivers often beat, blame or shout at the children.

“We just make sure she is playing close by us ... if she is going beyond our approval, I normally give her a talking eye... and she will simply correct herself from the bad group or from the unwanted play.” (Caregiver 2)

Caregivers felt that they could do more to promote play for their children. One of the things they mentioned was that children with HIV should be given more time to play. Play was viewed as a medium to get close to the child and promote bonding with the child. In that respect, caregivers felt they needed to be more involved in their children's play and expressed a desire for coaching in this regard, to be equipped with knowledge on how to promote play. Many of the caregivers highlighted that they had not had any session to discuss benefits of play and how they could promote play for their children, reporting that most of the counselling sessions they had at the hospital were centred on compliance with medication. Caregivers' interest in knowing more about play could have grown out from experiencing their children being observed playing at the clinic and at their home, as participants in a previous phase of the broader study.

“You should teach us how to play with them, in the same way we receive counselling at hospital. Tell us about these things. We need our children to do better.” (Caregiver 13)

Play affirms that my child is still like other children

Caregivers narrated some of their joys experienced when they observed their children play against all odds. Play in many ways disrupted the ‘HIV is death’ narrative. One grandmother narrated how her daughter passed away and she had to take care of a sickly baby (her granddaughter) when everyone else refused to take custody of the baby.

“The child was very small and very pale, to be honest there was no sign of life... (Paused) There was nothing I could do because I am her only grandmother. I took the child with grief in my heart... umm ... it was difficult. But thank God she has fully recovered.” (Caregiver 14)

The ability of a child to engage in play brought relief to the caregivers. Even when they are not feeling well, they try to engage in play.

“Even when he is not well, he gives himself time to play. Ah!! Sleeping! You would be shocked, because he will be gone!! The moment he sees his friends, he goes out to play.” (Caregiver 13)

Caregivers used play as a yardstick for constantly comparing the play of their children to typically developing children and were delighted when they saw little or no differences. Apart from seeking to nullify differences in play between children with HIV and those without HIV, caregivers also stated some of the physical, emotional and cognitive benefits of play. Caregivers also reported that their children learn new things through play and also learnt soft skills which caregivers thought was important in their development.

All caregivers involved agreed that play was more fun with others. Although caregivers were secretive about the status of their children, they were of the view that children with HIV should play with other typically developing children. Engaging in play with typically developing children was seen as a way of reducing stigma targeted at children with HIV/Aids.

“These children should not be separated, they should mix with other kids who are negative to reduce stigmatization and stress from the HIV affected children.”

(Caregiver 6)

Some caregivers reported that they also engage in play with their children or have seen other adults playing with their children. However, caregiver involvement in play was generally centred on creating an environment that promotes play and providing things for the children to play with. For example, some caregivers described taking their children out to a family fun show as play. Some caregivers felt that provision of toys, creating time to play and allowing children to go out to play as some of the ways of getting involved in children’s play.

Sentiment among caregivers was that if more toys could be provided, their children could play more. Most children were reported not to have toys. Caregivers however, mentioned how most of the children make their own toys from a variety of things. This creativity in making toys could have been necessitated by the fact that most of them do not have specifically designed toys, as families could not afford to buy toys from shops. Some caregivers also attested to making low cost toys from locally available materials. Some of the materials included seeds from a variety of grains, empty jars and old clothes.

“One can improvise by using peanut butter containers. You can take material from clothes that you want to dispose of and sew nice dolls for your child.” (Caregiver 11)

Discussion

This study is one of the few studies that have explored the play of children with HIV/Aids from the perspectives of caregivers. Findings revealed that the context in which play occurred for these children shaped their engagements. The condition of being HIV positive coupled with poverty and cultural beliefs, influenced how caregivers prioritised play. However, despite contextual barriers, play opened possibilities for children with HIV/Aids. A significant finding of the study is that play seemed to mitigate stigma, disrupting the “HIV is death narrative”. The findings also provide important insights on the play of children with HIV/Aids living in low resourced contexts, identifying factors that either limit or promote engagement and participation in play occupations.

Similar to Potterton et al. (2009), the current study found that children with HIV/Aids experienced physical, behavioural, emotional and communication deficits which impacted on their engagement and participation in play. Thus, there is need for early assessment and intervention for children with HIV/Aids to address these deficits. Of note in the current study, was that caregivers could identify some of these deficits but were not aware of the impact of these deficits on the development and wellbeing of their children and the services that they could benefit from. Positive strides of reducing mortality gained through the provision of antiretroviral therapy (Hutchings & Potterton, 2014) need to be complimented by improving the quality of life for these children.

Apart from deficits in the child as a result of HIV/Aids, a critical look at the context and how it promotes or hinders play in children is of significant importance (Dickie, Cutchin, & Humphry, 2006). In the current study, caregivers reported that there were often no safe places for children to play. Play was often restricted to either indoors or somewhere close to the caregivers. Similarly, a study in an impoverished setting with typically developing children by Kimbro and Schachter (2011) also reported concerns of safety as one of the major reasons for limited outdoor play. Outdoor play offers various benefits on development and wellbeing. Children play when the environment is safe and supportive of play (Cordier et al., 2009), thus unsupportive environments can deprive children of play opportunities.

Poverty shaped the everyday occupations of caregivers and children involved in this study such that their everyday doing was centred on securing basic necessities for survival. Thus, children’s play was often not a priority. Poverty in Zimbabwe has been worsened in recent years by the crippling macro socio-economic situation which has resulted in high unemployment rates, forcing most people to survive on informal jobs (Manjengwa, Matema,

& Tirivanhu, 2016). As a result of poverty, caregivers often face challenges in providing a healthy diet to their children with HIV/Aids. The worst scenario of being deprived of basic necessities to life is that it may lead to illness and mortality (Leadley & Hocking, 2017). Lack of a healthy diet has implications on the general growth of children, affecting play and overall child health.

Apart from poverty, the depreciation of humanity expressed in the current study as *Ubuntu* is no more, also played a role in limiting the play of children with HIV/Aids. Caregivers in this study also feared HIV-related stigma from both adults and children; and as a way of protecting their children from stigma, they often controlled their play. This control of children's play by the caregivers can best be explained through a transactional view of human occupation, which draws on Dewey's action theory and highlights societal constraints on human aspirations, reflected in what they do every day (Cutchin et al., 2008, p. 159). As a result of stigma and consequent limited opportunities for play, caregivers could have inadvertently contributed to their children's occupational deprivation. Occupational deprivation has been defined as "social exclusion by restricting a population in diverse contexts from participating in occupations that would promote their health and well-being" (Whiteford, 2000, p. 201). However, further research to explore occupational deprivation among children with HIV/Aids is needed.

Play is shaped and influenced by parental beliefs and values (Lynch & Moore, 2016), as such an understanding of children's play from the perspectives of caregivers is important. Some caregivers involved in the current study believed that adults should not actively participate in play but should limit their role to providing resources for play; adult-child play was viewed as the reserve of grandparents, aunts and uncles. The configuration of family beyond parents/caregivers but involving 'extended' family members is often missed in most research studies done with a western conceptualisation of family. As theorisation in occupational therapy moves beyond a narrow western perspective of occupation (Ramugondo, Galvaan, & Duncan, 2015), there is a need to continuously consider contextual factors that inform parental beliefs and value systems that impact on play as an occupation.

Children, like any another human being have an innate need for relations with others (Ramugondo & Kronenberg, 2015). Caregivers in this study reported that their children were happy when playing with their peers. As children engage in play with their peers, they imitate

social actions and learn to interact with others (Cordier et al., 2009). Of interest in this study was that caregivers also reported how opportunities of play for children with HIV/Aids involving typically developing children can serve to fight stigma. Adopting the view of play as a collective occupation (Ramugondo & Kronenberg, 2015) offers a lens to view all the multiple actors involved and how they shape play occupations.

Findings from the current study support the notion that occupation is linked to health and wellbeing (Wilcock, 2007). Caregivers highlighted how through play, their children's health had improved. Engagement in play is one of childhood occupations that allow children to learn and develop fundamental motor, cognitive and socio-emotional skills (Lynch & Moore, 2016). In the current study, caregivers showed willingness to do more to promote play for their children, demonstrated some resourcefulness' in this regard, and a desire to be coached on how best to promote play.

Limitations of the study

The caregivers who participated in this study were recruited from caregivers of children with HIV/Aids whose children had participated in the earlier phase of the broader study which involved observing the child playing with a playmate at the clinic and home [Reference removed for blinding]. All participants were recruited from outpatient clinics at two central hospitals. Therefore, the perspectives of caregivers of children with HIV/Aids who do not receive medical services from these hospitals were not captured. However, maximum variation was used to make sure participants with varied experienced were included in the study. Through in-depth interviews the study generated rich data that are important in understanding the play of children with HIV/Aids from the perspectives of caregivers.

Conclusion

Being HIV positive, along with contextual factors such as poverty, and limiting cultural beliefs and values are barriers to engagement in play. Play however, is a useful resource for children with HIV/Aids as it has the potential to reduce the effects of stigma and generate new meaning in life to both the child and the caregiver. Occupational therapists in paediatric practice need to be constantly aware of contextual factors that affect engagement and participation in play of children with HIV/Aids. This study affirms the role of occupational therapy in promoting play in collaboration with caregivers of children with HIV/Aids in a

low resourced setting. Further studies on contextually based interventions to promote play occupations of children with HIV/Aids need to be conducted.

Key Findings from the study.

- Play, like any other human occupation is contextually situated.
- Children with HIV/Aids will benefit from occupational therapy.

What has the study added?

The study informs readers about play for children with HIV in low-resourced settings from caregivers' perspectives, highlighting the contextually situated nature of human occupation and practice.

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