

**SOCIAL INTEGRATION AND QUALITY OF SCHOOL LIFE:
EXPERIENCES FROM HIV-BORN ADOLESCENTS
LIVING IN HIV HOME IN MYANMAR**

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**A THESIS SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS (HEALTH SOCIAL SCIENCE)
FACULTY OF GRADUATE STUDIES
MAHIDOL UNIVERSITY
2016**

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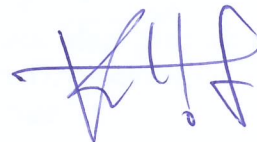
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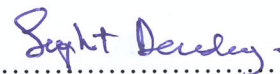
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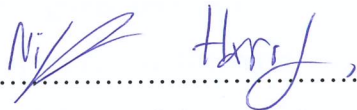
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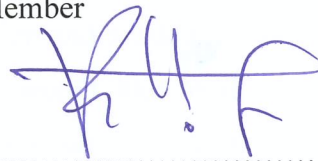
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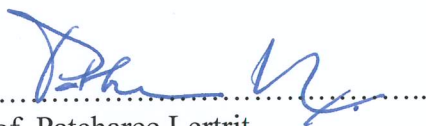
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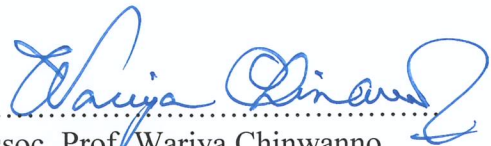
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SOCIAL INTEGRATION AND QUALITY OF SCHOOL LIFE: EXPERIENCES FROM HIV-BORN ADOLESCENTS LIVING IN HIV HOME IN MYANMAR

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ABSTRACT

This study explored the school experience of HIV-born adolescents in Myanmar. The theory of social integration and the concept of Quality of School Life was employed to discover the linkages between the conflicting social demands at institutional and interpersonal levels experienced by the HIV-born adolescents when they attended school and their satisfaction in their school life. Nine respondents who were HIV-born adolescents living in Thukha Yeik Myon Home; and four key informants including the director and two home staff, and a representative teacher at one of the schools that received the HIV-born adolescents were interviewed.

It was found that the predisposing institutional and societal contexts as well as individual HIV-related health status were the main barriers to the HIV-born adolescents' social integration at their schools. At institutional level, the conflicts of prioritization occurred between the home, health providers and schools. At interpersonal level, the HIV-born adolescents perceived strong HIV-related stigma, which was induced by limited knowledge of people both within and outside the school. The discrimination against HIV-born adolescents that general students observed from how the school teachers and parents treated the HIV-borns may reproduce and sustain the stigmatization. Likewise, the embedded own stigma of HIV-born adolescents acquired from socialization appeared to contribute to their loose or lack of social ties. In terms of quality of school life, the HIV-born adolescents were concerned about their study outcomes due to their frequent absence. Interestingly, most respondents indicated that they had good academic performance and motivations. Nevertheless, their unique abilities and achievements at school were hardly recognized by the teachers and the home staff.

The findings call for the promotion of HIV/AIDS-related literacy for not only the people in schools but also the people in the community to reduce HIV stigma. The schools that accept the HIV-born adolescents should be flexible in rules and regulations, and raise the understanding of the HIV-infected students' needs among teachers. The home should renew the social environment, where the individual is valued and belongs, by skilling up the social competence of the staff. Collaboration between the home and school is strongly recommended. And, at the policy level, national and international authorities should conduct joint activities to administer special policies about inclusive education for HIV-born adolescents. HIV/AIDS awareness should be promoted, layer by layer, from individuals in schools to the community outside schools for supporting the educational attainment and future opportunities for the HIV-born adolescents.

KEY WORDS: HIV-BORN ADOLESCENT/ STIGMA/ SOCIAL INTEGRATION/ QUALITY OF SCHOOL LIFE/ MYANMAR

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AZG	Artsen Zonder Grenzen
BEHS	Basic Education High School
BEPPS	Basic Education Post Primary School
CD4	Cluster of Differentiation 4
CPR	Comprehensive Personal Record
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
IRB	Institutional Review Board
MU-SSIRB	Mahidol University-Social Sciences Institutional Review Board
NAP	National AIDS Program
PLH	People Living with HIV
PMCT	Prevention of Mother to Child Transmission
QoL	Quality of Life
QoSL	Quality of School Life
SDT	Self-Determination Theory
SHM	Specialist Hospital, Mingalar Don
SHT	Specialist Hospital, Tharkayta
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCCT	Volunteer Counseling and Confirmation Test
WHO	World Health Organization

CHAPTER I

INTRODUCTION

Despite continuous global decline in overall HIV/AIDS incidence, the rate of infection is still high in the reproductive age of both men and women. Women occupy half portion of global HIV prevalence (UNAIDS, 2011). In 2013, about two thirds (67%, range 62%- 73%) of all pregnant women living with HIV are in low and middle-income countries (including Myanmar) (WHO, 2014). HIV can be transmitted through sexual contact, injecting drug use, occupational exposure, blood transfusion or organ transplants, and pregnancy, child birth and breast feeding. Among these modes of transmission, 20% to 45% of babies born to HIV-positive mothers will become infected if there is no intervention (WHO, 2010). Without any treatment, half of all infants infected with HIV will die before their second birthday (WHO, 2010).

The length of the lives of children living with HIV increases due to the introduction of highly active antiretroviral therapy (HAART). Due to the widespread availability of pediatric HAART, the survival rate of children living with HIV for six years can be extended from 76% to 91% when compared with 1990s and 2000s (Kapogiannis et al., 2011). This results in children who were born with HIV living longer, healthier lives and attending school (Kamau, 2012).

However, the infected children are socially stigmatized in their school environment (Despa, 2013). Especially, since adolescents mostly spend their time in educational activities and extracurricular activities with their peers in school, HIV-born adolescents experience day-to-day discrimination and stigmatization by their teachers and peers in the school institutions (Kamau, 2012). As a result, adolescents with perinatal HIV have fear of peers knowing about their HIV status in case of rejection and the fear of losing supportive friends (Kamau, 2012). The internalized and perceived stigma is a distinguished barrier to fix social relations into the school society resulting in self-isolation, depression, withdrawal and fear to stigmatization. The isolation or exclusion is in relation with the school performances of the learners (Ryabov, 2011).

1.1 Background and Justification

1.1.1 Current HIV/AIDS Situation in Myanmar

While HIV/ AIDS epidemic eludes control, it continues to inflict avoidable suffering and death (Bonita et al., 2006) especially upon a growing proportion of the national population (Takahashi et al., 1997). In 2013, there were 35 million (33.2 million–37.2 million) people living with HIV (PLH) all over the world (WHO, 2014). UNICEF (2014) reported that 2.1 million adolescents were living with HIV in 2013. Estimated 210 000 children were infected HIV in the Asia Pacific Region in 2012. The vast majority of children acquires HIV through vertical transmission (UNAIDS, 2013).

Myanmar HIV position is ranked top sixth prioritization among 12 countries with highest HIV burden trends in Asia Pacific region (UNAIDS, 2013).

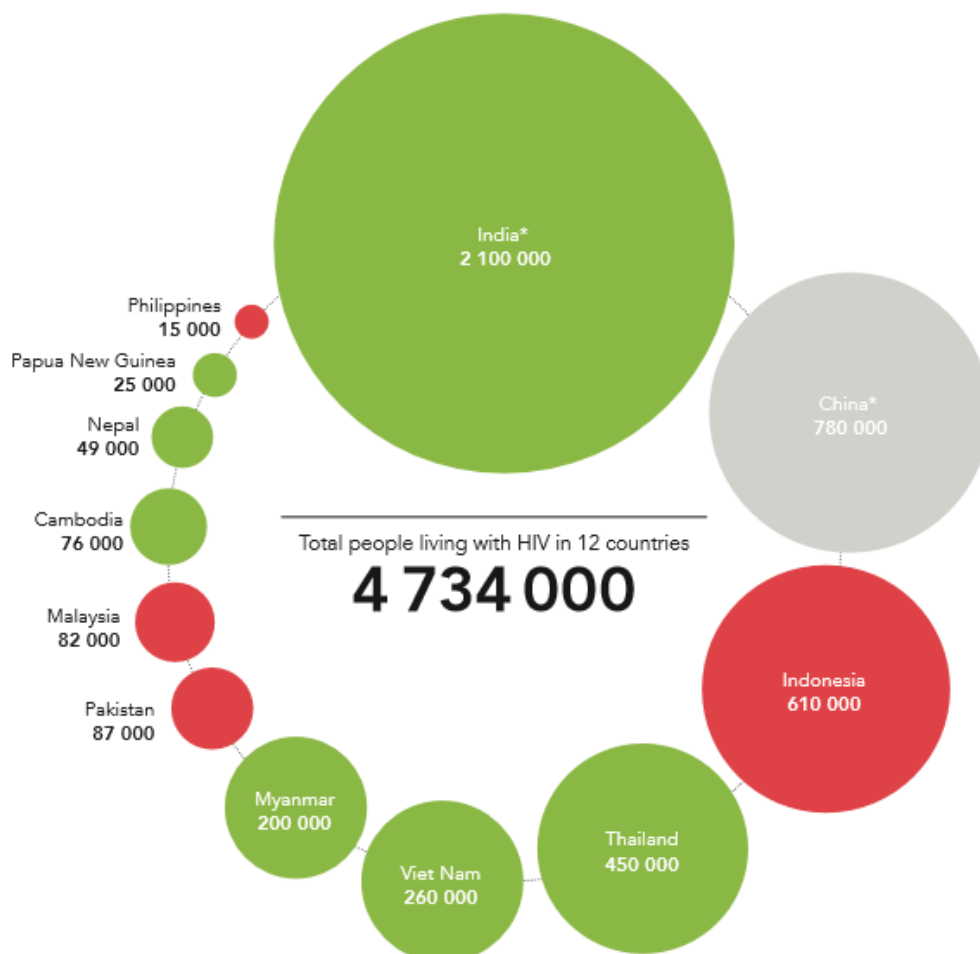


Figure 1.1 Twelve countries with highest HIV burden trends in Asia Pacific Region (UNAIDS, 2013)

Trends in new HIV infections

- Increasing
- Decreasing
- No recent trend

Source: UNAIDS HIV estimates 2012.

*Estimates for China and India are based on 2011 national data

Figure1.1 Twelve countries with highest HIV burden trends in Asia Pacific Region (UNAIDS, 2013) (Cont.)

The above figure represents the total number of PLH in each top prioritized country. Nonetheless, the following table describes the HIV prevalence rates among the top six countries in the Asia Pacific region.

Table1.1 HIV prevalent rate among top prioritized six countries in Asia Pacific region

No	Country	Total population	No of PLH	Year	No of PLH/100,000 people
1	Thailand	66.79 million	450,000	2012	673.75
2	Myanmar	52.8 million	200,000	2012	378.79
3	Vietnam	88.77 million	260,000	2012	292.89
4	Indonesia	246.9 million	610,000	2012	247.06
5	India	1.221 billion	2,100,000	2011	171
6	China	1.334 billion	780,000	2011	58.47

(Source: UNAIDS HIV estimation 2012 and World Bank population estimation 2011 and 2012)

Likewise, WHO (2013) reports that the HIV prevalence rate in Myanmar, 371 per 100,000, was double of the rate of the South East Asia Region, 185 per 100,000, in 2012.

Serious consequences of the HIV epidemic can be seen as demographic changes: falling life expectancy, changing population structures, growing numbers of parentless children (Greener, 2002). In addition, AIDS seriously weakens population withholding tax consequence in reduction of public expenditures (Greener, 2002). The

World Bank estimated the cost of care per person with HIV/AIDS was roughly 2.7 times per capita GDP for all countries (World Bank, 1997). The epidemic has definitely had an adverse impact on the Myanmar economy and will continue to do so at a household, community and state level. HIV affected families in Myanmar have socio-economic difficulties from HIV/AIDS on account of medical expenses or loss of the bread winner in some families (Mon et al., 2011). Many HIV-affected families encounter hardships in struggling even for family’s daily expenses. By looking at the situation, HIV pushes those families into poverty deeper and deeper (Mon et al., 2011).

Socially, PLH are highly stigmatized in Myanmar. UNAIDS (2013) investigated the degree of HIV stigmatization in Myanmar using HIV Stigma Index Surveys. The following figure clearly shows that PLH in Myanmar encounter high external stigmatization with the position of fourth and first stigma index respectively in Asia Pacific region. PLH were excluded by rejecting accessibility to health care in terms of dental health and sexual reproductive health owing to their HIV status in Myanmar society.

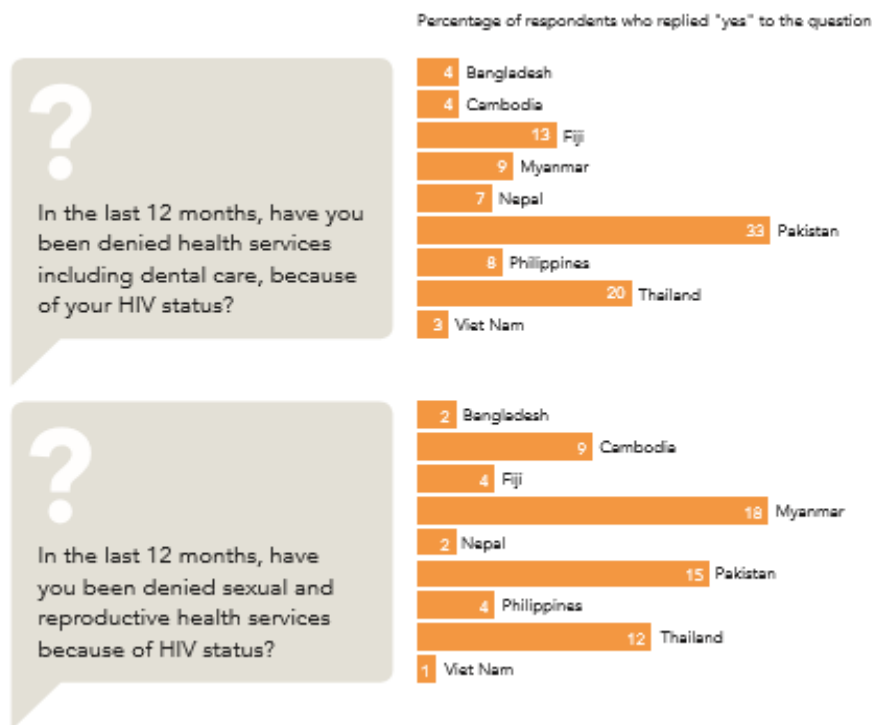


Figure 1.2 Result from the PLH external stigma index surveys, 2008-2012 (UNAIDS, 2013)

The ubiquitous use of HAART, PLH live healthy like normal people. However, the HIV epidemic still makes them vulnerable. Their own internal stigma is distinguished barrier of their social life. The following figure represents that Myanmar was the eighth and fifth position in Asia Pacific region where PLH suffered internalized stigma such as felt shame and felt suicidal owing to their HIV status.

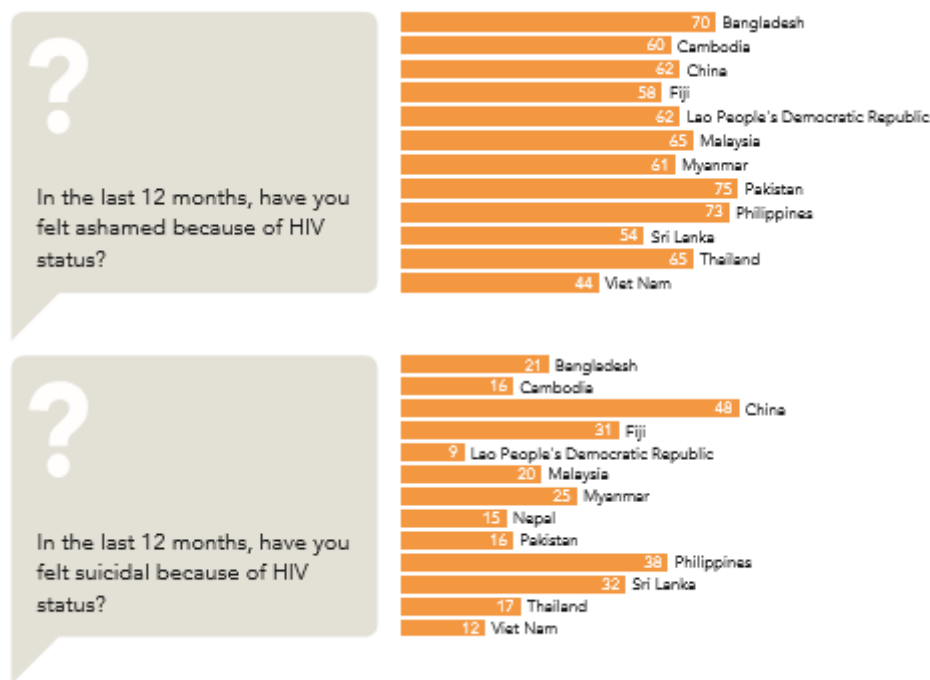


Figure 1.3 Result from the PLH internalized stigma index surveys, 2008-2012 (UNAIDS, 2013)

1.1.2 HIV/AIDS Care, Treatment and Support in Myanmar

The number of persons receiving HAART at the end of 2014 was 85 626, representing 40% of all persons estimated to be living with HIV. Of the number of persons receiving HAART, 18 947 newly initiated treatments during that year. The estimated number of those eligible for treatment in 2014 was 122,860 according to national treatment guideline of treatment for people with ≤ 350 CD count, 6341 of whom are below 15 years old (National AIDS Programme, 2015).

Overall, 27678 adults and children were newly enrolled in HIV care in 2014, 15 843 males and 11 833 females. The number of children aged below 15 years enrolled in HIV care was 2056 (National AIDS Programme, 2015).

NGO sector signifying an increasing shift in ART services from private to public sector. The number of patients estimated to be on ART by the end of 2016 is 144 437 (National AIDS Programme, 2015).

Overall, HAART services have expanded throughout the country. At the end of 2014, 184 health facilities were providing HAART countrywide, an increase in the number of health centers offering HAART by 37 sites, compared to 2013. The sites were distributed between the public and private sectors 136 to 48, respectively, and provided wider geographical coverage. Of the 184 sites, 108 were providing pediatric HAART (National AIDS Programme, 2015).

1.1.3 Prevention of Mother to Child Transmission (PMCT) in Myanmar

In Myanmar, the National AIDS Program (NAP) started PMCT service in 2001. It has been gradually scaled up to cover 183 sites by 2008. Of these, 38 are hospital based and 145 are community based. The service was HIV testing with pre-test and post-test counseling to the women accessing antenatal care service (National AIDS Programme, 2010).

In 2009, antiretroviral prophylaxis was introduced to prevent mother to child transmission (MTCT) in Myanmar. 1,697 mother-baby pairs received a complete course. Only 280 pregnant women were already on HAART when they delivered their babies (National AIDS Programme, 2010). With specific interventions in non-breastfeeding populations, the risk of MTCT can be reduced to less than 2%, and to 5% or less in breastfeeding populations (WHO, 2010). However, according to the WHO (2009) report, 45% of the estimated HIV-infected pregnant women in low- and middle-income countries received at least some antiretroviral drugs to prevent HIV transmission to their child. An estimated 430 000 children were newly infected with HIV in 2008, over 90% of them through mother-to-child transmission (MTCT). UNFPA (2009) reported that only 50% of known HIV-positive pregnant women, and mothers and their newborn babies, received antiretroviral prophylaxis in Myanmar. Without intervention, the risk of MTCT ranges from 20% to 45%.

1.1.4 Supports for HIV-born Children

With no treatment, about half of these infected children will die before their second birthday. The majority of those died by 5 years of age (WHO, 2010). Access to pediatric HAART have expanded globally since 2004. A study with 364 HIV-born children describes a six-year survival rate for the children born during the 1980s, 1990s, and the 2000s were 57%, 76%, and 91%, respectively. Children who receive HAART during the first six months of life had a six-year survival rate of 94% (Kapogiannis et al., 2011). The results showed a substantial decline in mortality in HIV infected children (Lowenthal, Larru, & Eby, 2014).

Children born from HIV-infected parents have been infected, and affected because most of them lost parents and became orphans (USAID, 2008). The international donors and the public HIV health care providers provided those children in Myanmar. The supports are nutrition, care and treatment, and psychosocial counseling through the HIV care and treatment centers. 7633 children in 2010 and 7011 children in 2011 received the support. The supports had been decreasing after 2010 and stopped in 2012.

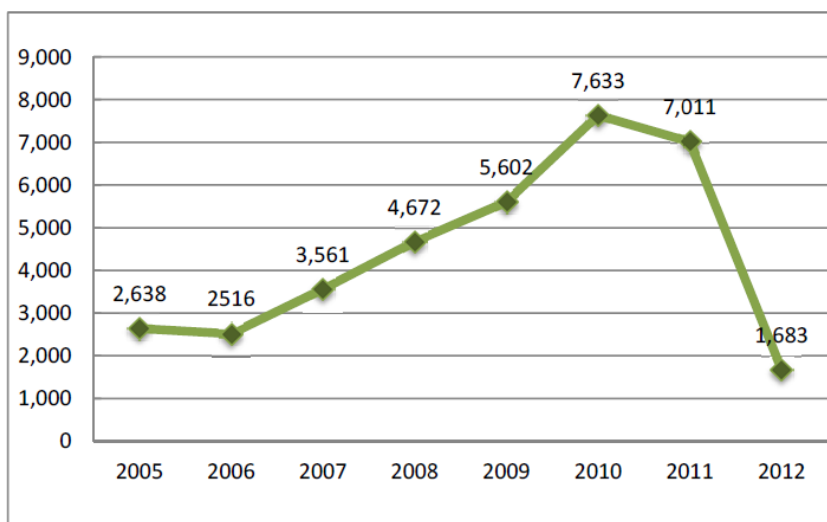


Figure 1.4 HIV infected orphans who received support from 2005 to 2012

(Source: National progress report, NAP Myanmar, 2014)

Furthermore, there is no governmental service for HIV-born orphans except medication. There is only one not-for-profit orphanage that provides shelters for HIV-infected children in the country however, not many people know its existence.

Thukha Yeik Myon Home has accepted 114 HIV-born orphans. The children receive regular health check-up and are attending school when they are ready. The home supports the children's education until they complete secondary level schooling.

1.1.5 HIV-born Adolescents

Advances in HIV treatment have increased the life expectancy of perinatal infected infants into adolescence and adulthood (Kapogiannis et al., 2011).

UNICEF defines adolescence as the developmental stage between the ages of 10 to 19 (UNICEF, 2011). The stages of adolescence can be separated into three: early (10-13 years of age), middle (14-16 years of age) and late (17-19 years of age). In early adolescence, physical changes include physical and sexual maturation. These changes continue through middle adolescence into the late stage (where they usually are completed), and over time, adolescents are thought to be less concerned with their body image than they are during early adolescence. **Cognitively**, adolescents in the early stage develop concrete thinking abilities, while in middle and late adolescence, the young person moves to thinking abstractly and can develop reasoning skills. **Emotionally**, adolescents in the early stage are beginning to explore decision-making opportunities, while in the middle stage, they begin to develop a sense of identity, established more fully in late adolescence (UNICEF, 2006).

Socially, during this stage, peers become a bigger influence and sexual interest usually begins. During the middle stage of adolescence, peers continue to hold influence, and sexual interest develops further. Finally, in the late stage, transitions to work and further schooling take place (UNICEF, 2006). **Behaviorally**, early adolescents begin to experiment with new ways of behaving, while middle adolescence is considered a time of risk-taking, ending in late stage adolescence, during which assessment of one's own risk taking occurs (ReCAPP, 2003). As such, adolescence is the period of developmental transition between childhood and adulthood. During adolescence, teens often struggle with their body changes, mood swings and social issues. It involves changes in personality, as well as in physical, intellectual and social development. During this time of change, teens were faced with many issues and decisions (Silbereisen, 2000).

For the HIV-born adolescents, growth and development is often deficient physically, socially and intellectually (Arpadi, 2005). Physically, the HIV-born adolescents lag behind peers who are going through periods of rapid growth and pubertal development (Mbwile, 2012). Performance of early adolescents in the school is below age expectations. HIV-born adolescents score poorly on measures of language functioning (Brackis-Cott, Kang, Dolezal, Abrams, & Mellins, 2009). Large numbers of adolescents are academically retained and placed in special education classes. The stressors of living with a chronic stigmatized illness coupled with a sense of educational failure place adolescents with HIV at further risk for behavioral and health problems, that is, poor language skills might limit their ability to understand their illness, and compromise their ability to adhere to challenging medication regimens (Peretti-Watel, Spire, Lert, & Obadia, 2006). Furthermore, lower intelligence might be a risk factor to protect against early unsafe sexual activity during adolescence (Halpern-Felsher, Ozer, Millstein, & et al., 2000).

1.1.6 HIV-born Adolescents and Social Integration

In the adolescence stage, teens spend more time in educational and extracurricular activities in school (Santrock, 1996). The experiences of adolescents in school society are likely to have a strong influence in such area as identity development, belief in one's competence, images of life and career possibilities, social relationships, standard of right and wrong, and conception of how as social system beyond the family functions. Adolescents in the secondary school have wider social field that is the school rather than the classroom. The adolescents socially interact with many different teachers and peers (Santrock, 1996). Childhood chronic illness often results in a disruption of normalcy because of an intrusion of the illness into activities of daily living, uncertainty, and disruption of the developmental tasks of peer relationships, communication, and disclosure (DeSantis et al., 2014). The wider social environment at school, the more HIV-born adolescents have got effects of social relations. Some people in the surrounds of the school believe that these inborn-HIV learners are a waste of resources as in the future because they would not be in a position to contribute to the wealth of the family (Kamau, 2012). The scholars in Italy noted that the students with inborn HIV experience psychosocial conditions such as

impaired social ability, school problems, and delinquent behavior (Bomba et al., 2010).

Besides, as HIV-positive adults, the HIV infected adolescents are stigmatized, and discriminated against by members of the society where they live. Although HIV-born adolescents are not concerned with sexual misconduct morality, people's discriminatory behaviors are due to ignorance about how HIV is contracted (Karamouzian et al., 2014). These people are often marginalized in the community school (Baxen & Haiping, 2014; Despa, 2013) because the parents of other children students fear HIV transmission to their own children (Klunklin & Greenwood, 2006). Teacher's breach of confidentiality divides the peer relationships as well as learning activities in group works (Kamau, 2012). Consequently, HIV-born adolescents behave self-isolation and withdrawal, insecurity, attention and recognition seeking behaviors, feelings of sadness (depression), embarrassment and shyness, clinging together, avoidance, fear of stigmatization (Kamau, 2012).

1.1.7 HIV-born Adolescents and Quality of School Life (QoSL)

Schools are physical, social and educational space that nurtures to improve relationships with peers and adults, are better adjusted emotionally, and to improve physical and mental health (World Bank and the International Rescue Committee, 2013).

School satisfaction is crucial for the young learners so that they have the right to feel good about themselves, and it is positively associated with the educational performance (Cock & Halvari, 1999). Positive achievement experiences are satisfying in themselves and can be expected to contribute to school satisfaction. While the students who do well in school tend to be more satisfied with school, high grades alone are not enough for school satisfaction (Epstein and McPartland, 1976). Cock and Halvari (1999) found a positive association between school satisfaction and educational performance. The level of school satisfaction concerns psychological well-being, school integration, absentee rate, drop-out and behavioral problems (Reyes & Jason, 1993).

HIV-born adolescents are in a transitional period going to productive adults (Choudhury, Blakemore, & Charman, 2006). The evaluation of teacher by self-

report in rural China indicate that vulnerable students due to HIV have disadvantages in school performances in comparison to their peers from the same community who have not HIV related experience in their family. HIV-born learners have the lowest academic marks based on the reports of both students and teachers. Those learners have also low educational expectation and more learning difficulties from teacher's perspective. This study suggest that a greater attention is needed to the school performance and behavior of learners affected by AIDS (Tu et al., 2009).

1.2 Implications of the Study

Generally, adolescents are vulnerable owing to facing many issues in their transitional stage. Adolescents with inborn HIV are double marginalized on the grounds that they encounter transition as well as suffering highly stigmatized chronic illness and its complications. The problems and its consequences of the adolescents infected perinatal HIV are obviously different from adult living with HIV since the adolescents are individuals under development, and they have different needs in various phases. Mostly, stigmatization is the barrier to socially integrate towards their school environment.

The researcher will focus in this study on how social integration of HIV-born adolescents related to their QoSL which has been never investigated in South East Asia. This study is intended to highlight the linkage between social integration and school satisfaction of HIV-born adolescents in their school society. The study findings would draw attention on the need of the policy and program to support HIV-born adolescents particularly for the development of their social lives and increasing qualified human resource as well in Myanmar.

1.3 Research Questions

- 1) What are the barriers of HIV-born adolescents to engage in the school?
- 2) How does social integration contribute to HIV-born adolescents' quality of school life?

1.4 Research Objectives

- 1) To investigate the barriers of HIV-born adolescents to engage in their school environment.
- 2) To explore the linkage between HIV-born adolescents' engagement in school and their quality of school life.

1.5 Definitions of Terms

Social integration refers to a sense of an individual as being a part of the society through the responsibilities and social obligations assigned by that society to which they are linked.

Quality of school life is the satisfaction of the students on their school experience which results from the social relation at school.

Adolescent is an individual within the developmental stage aged 10 to 19. There are three stages of adolescence: early adolescence aged 10 to 13, middle adolescence aged 14 to 16 and late adolescence aged 17 to 19.

HIV-born adolescent means the adolescent who has HIV transmitted from the HIV-positive mother during pregnancy, labor or breastfeeding.

External stigma is the experience of unequal treatment due to the HIV status by others.

Internalized stigma is the social product including which the internalization of shame, blame, hopelessness and guilt associate with being HIV positive.

Perceived stigma is the internalized negative perceptions that society holds about HIV infected people by accepting and internalizing the society's negative characterizations.

Felt stigma stands for the fear to potential discrimination owing to HIV status.

Pre-disposition is the existed condition towards social engagement of the student in school.

Engagement in school is active involvement of the students in school related tasks and activities.

CHAPTER II

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

This chapter is organized into two parts: literature review and conceptual framework. This chapter offers a review of different perspectives that can be considered for explaining the quality of school life (QoSL) in relation with social integration of HIV-born adolescents. Social integration theory is then selected as the main perspective to employ in this study.

2.1 Theory of Social Integration

2.1.1 Background

Primarily, Durkheim (1893, cited by Thompson, 2003) had initiated the term social integration in *The Division of Labor* to emphasize the nature of social ties which attach individuals to social group outside themselves. He believed that individual do not exist by themselves autonomously and are therefore not separate from society. According to Durkheim, social integration can be defined as the extent to which individual are linked to and feel allegiance for social groups to which they are attached. Social integration serves creating social duties, links of dependency and ties of social obligations, and a check against excessive social isolation and individualism. The imposing social duties and obligations within family, work and schooling institutions boost people into the wider society so as to increase their consistency of social linkage to group, expel personal isolation and social withdrawal (Thompson, 2003).

2.1.2 Social Bonds

According to Durkheim (1893), there are two kinds of bonds in the social division of labor namely links of dependency and bonds of obligation. Links of dependency determine social relations between individuals who carry out economic

and domestic tasks jointly and collectively, for instance, cooperation in business. Bonds of obligation regulate expectation and interchanges between individual from the same society. These social links and bonds between individuals based on custom, obligation and social duties that reflect a dependency on society.

2.1.3 Social Solidarity and Social Cohesion

Social solidarity serves as the system of social bonds, system of social relations and system of interchanges which ties individual to each other and to wider society. Social cohesion serves as social adhesive which generates attachment among individuals in the society. Two major types of social solidarity were identified, mechanical and organic.

Mechanical Solidarity and Organic Solidarity

According to Durkheim (1893, cited by Thompson, 2002), the types of social solidarity correlate with types of society. In a mechanical society, its cohesion and integration comes from the homogeneity or similarity of individuals, that is, people feel connected through similar work, educational and religious training, and lifestyle. Mechanical solidarity normally operates in traditional and small scale societies. In simpler societies, for example, tribal, solidarity is usually based on kinship ties of familial networks. Organic solidarity comes from the interdependence that arises from specialization of work and the complementarities between people. Although individuals perform different tasks and often have different values and interests, the order and very solidarity of society depends on their reliance on each other to perform their specified tasks. Organic is referring to the interdependence of the component parts. Thus, social solidarity is maintained in more complex societies through the interdependence of its component parts.

Furthermore, Durkheim argued, the organic solidarity of modern societies might have advantages over traditional mechanical solidarity. In traditional societies, people are self-sufficient, and therefore society has little need for cooperation and interdependence. Institutions that require cooperation and agreement must often resort to force and repression to keep society together. Traditional mechanical solidarity may tend, therefore, to be authoritarian and coercive. In modern societies, people are necessarily much more interdependent under organic solidarity. Specialization and the

division of labor require cooperation. Thus, solidarity and social integration are necessary for survival, and do not require the same sort of coercion as under mechanical solidarity.

2.1.4 Social Integration and Suicide

In the study of suicide, Durkheim used one of central concepts which is social integration (Poggi, 1978). Social integration plays a central role in the study of suicide. Hence, it is the key to understanding the connection between individual suicide and society. In the argument of Durkheim, individuals are attached to the wider society by the dynamic process of social integration. On the other hand, when integrative links tying individuals to the group are not sufficiently integrated at the point where the individual is contact with society, social bonds become weakening or absent. The breakdown of these social attachments makes the individual more rely on themselves and less on society (Durkheim, 1896, cited by Thompson, 2002). Consequently, individual extracts to the private ego, neglect their social obligations and retreat to themselves and to their private life. This not only leads to breakdown of their integrative mechanism in society, but it is also lead to the appearance of different social forms of suicide. Four types of suicide were distinguished by Durkheim.

Egoistic suicide reflects a prolonged sense of not belonging, of not being integrated in a community, an experience, of not having a tether: an absence that can give rise to meaninglessness, apathy, melancholy, and depression. It is the result of a weakening of the bonds that normally integrate individuals into the collectivity: in other word a breakdown or decrease of social integration. Durkheim refers to this type of suicide as the result of excessive individuation, meaning that the individual becomes increasingly detached from other members of his community. Those individuals who were not sufficiently bound to social groups were left with little social support or guidance, and therefore tended to commit suicide on an increased basis (Morrison, 2006).

Altruistic suicide is characterized by a sense of being overwhelmed by a group's goals and beliefs. It occurs in societies with high integration, where individual needs are seen as less important than the society's needs as a whole. They thus occur on the opposite integration scale as egoistic suicide. As individual interest would not

be considered important, Durkheim stated that in an altruistic society there would be little reason for people to commit suicide. He stated one exception, namely when the individual is expected to kill themselves on behalf of society (Poggi, 1978).

Anomic suicide reflects an individual's moral confusion and lack of social direction, which is related to dramatic social and economic upheaval. It is the product of moral deregulation and a lack of definition of legitimate aspirations through a restraining social ethic, which could impose meaning and order on the individual conscience. This is symptomatic of a failure of economic development and division of labor to produce Durkheim's organic solidarity. Durkheim explains that this is a state of moral disorder where man does not know the limits on his desires, and is constantly in a state of disappointment. This can occur when man goes through extreme changes in wealth; while this includes economic ruin, it can also include windfall gains. In both cases, previous expectations from life are brushed aside and new expectations are needed before he can judge his new situation in relation to the new limits (Morrison, 2006).

Fatalistic suicide occurs when a person is excessively regulated, when their futures are pitilessly blocked and passions violently choked by oppressive discipline. It is the opposite of Anomic suicide, and appears in overly oppressive societies, causing people to prefer to die than to carry on living within their society.

In brief, these four types of suicide are based on two social forces: integration and regulation. Since the individual loses his/her purpose for living outside the context of the larger society even prior to outcome of suicide, the immediate outcome will likely be psychological distress, including feelings of isolation feelings of worthlessness and self-blame resulting from the de-integration of society. The former research points out that a long-term effect on the risk of suicide is poor quality of life, and life dissatisfaction seems to be partly mediated through poor health behavior (Koivumaa-Honkanen et al., 2001).

Social Integration Theory explains the connection between individual and society through the process of social integration. This perspective is employed in this study to capture the process of how HIV-born adolescents interact with the others, develop social bonds and become a part of the school society, or, on the other hands, whether the process has been absent. There are also some competing perspectives that

could be used to explain school experience of HIV-born adolescents such as Self-Determination Theory, Symbolic Interaction, and Political Economy. The researcher had reviewed and compared the following perspectives before ended up with selecting the Social Integration Theory as the main perspective for this study.

2.2 Self Determination Theory

2.2.1 Background

Self-Determination Theory (SDT) was initially developed by Edward L. Deci and Richard M. Ryan, and has been elaborated and refined by scholars from many countries. SDT represents a broad framework for the study of human motivation and personality. SDT explains a meta-theory for framing motivational studies, a formal theory that defines intrinsic and varied extrinsic sources of motivation, and a description of the respective roles of intrinsic and types of extrinsic motivation in cognitive and social development and in individual differences. Intrinsic motivation refers to motivation that comes from inside an individual rather than from any external or outside rewards. Extrinsic motivation comes from outside an individual, such as rewards.

Perhaps more importantly SDT propositions also focus on how social and cultural factors facilitate, or undermine people's sense of volition and initiative, in addition to their well-being, and the quality of their performance. Conditions supporting the individual's experience of **autonomy, competence, and relatedness** are argued to foster the most volitional and high quality forms of motivation and engagement for activities, including enhanced performance, persistence, and creativity (Deci & Ryan, 2008; Ryan & Deci, 2000b).

2.2.2 Key Concepts

Autonomy stands for acting with freedom of choice. Deci (1971) revealed that offering people extrinsic rewards for behavior that is intrinsically motivated undermined the intrinsic motivation as they grow less interested in it. Initially, intrinsically motivated behavior becomes controlled by external rewards, which

undermines their autonomy (Deci, 1971). Further research found other external factors like deadlines, which restrict and control, also decrease intrinsic motivation (Amabile, DeJong, & Lepper, 1976). Studies looking at choice have found that increasing a participant's options and choices increases their intrinsic motivation (Deci, Vallerand, Pelletier, & Ryan, 1991).

Competence is a perceived self-belief in one's ability to perform well in an activity. Deci also found that giving people unexpected positive feedback on a task increases people's intrinsic motivation to do it, meaning that this was because the positive feedback was fulfilling people's need for competence. In fact, giving positive feedback on a task served only to increase people's intrinsic motivation and decreased extrinsic motivation for the task (Deci, 1971). Vallerand and Reid found negative feedback has the opposite effect, that is, decreasing intrinsic motivation by taking away from people's need for competence (Vallerand & Reid, 1984).

Relatedness is defined by a sense of shared experience and meaningful relationships. High levels of relatedness have been associated with overall well-being (Ryan & Deci, 2000a). Relatedness is linked to intrinsic motivation that intrinsic motivation will flourish if linked with a sense of security and relatedness (Grolnick & Ryan, 1989).

2.2.3 Application of SDT

According to self-determination theory, HIV-born adolescents require three basic psychological needs: need for competence to improve school performance, need for autonomy to control the course of their lives and need for relatedness to have a close relationship with people in the school environment so as to socially engage and satisfy in their functioning school environment. Many studies have shown that autonomy facilitates motivation. In China, parenting styles which granted high degrees of autonomy have been associated with students' social and school adjustment (Bao & Lam, 2008). Similarly, autonomy support from parents and teachers has been found to have positive association with the academic motivation of high school students in both the United States and Russia (Chirkov, Ryan, Kim, & Kaplan, 2003).

Likewise, affective teacher and student relationships is important for students' school adjustment. Two studies found substantial associations between

verbal and nonverbal immediacy of teachers' communication and students' perceived and affective learning (Allen, Witt, & Wheelless, 2006; Witt, Wheelless, & Allen, 2004). The quality of relationship between teacher and student has been shown significantly associated with students' social functioning (Ladd, Birch, & Buhs, 1999), behavior problems (Graziano, Reavis, Keane, & Calkins, 2007), engagement in learning activities (Skinner, Wellborn, & Connell, 1990), and academic achievement (Valiente, Lemery-Chalfant, Swanson, & Reiser, 2008).

SDT might contribute to HIV-born students are more intrinsically motivated and actively engaged in their learning when they experience competence when challenged and given prompt feedback; they experience autonomy when they feel supported to explore, take initiative and develop and implement solutions for their problems; and they experience relatedness when they perceive others listening and responding to them (Deci et al., 1991). On the other hand, SDT lacks to examine the large-scale factors such as economic factors, demographics, legal, and political conditions that influence on social integration and educational performance of students (Chirkov et al., 2003).

2.3 Symbolic Interactionism

2.3.1 Background

Symbolic interactionism is a sociological perspective on self and society based on the ideas of George H. Mead (1934), and Charles H. Cooley (1902). The central theme of symbolic interactionism is that human life is lived in the symbolic domain. In 1969, Herbert Blumer, a student and interpreter of Mead, coined the term "symbolic interactionism", and specified its three basic premises: (1) Humans act toward things on the basis of the meanings that things have for them; (2) the meanings of things derive from social interaction; and (3) these meanings are dependent on, and modified by, an interpretive process of the people who interact with one another. The focus is on meaning, which is defined in terms of action and its consequences. For example, the meaning of "grass" is food to a cow and shelter to a fox.

In addition to symbolic interaction, human develop and use symbols to communicate with each other, significant symbols lead to the development of language. People use symbols and language to communicate, give meaning to things or behavior. The capacity of thought; thinking and interaction; and making choices compose the basic principle of Symbolic Interactionism (Hutter, 1985; LaRossa & Reitzes, 1993).

Basic principles of Symbolic Interactionism has come into use as a label for a relatively distinctive approach to the study of human group life and human conduct (Blumer, 1986). The basic principles are: human have the capacity for thought; this capacity is shaped by social interaction; people interact by learning the meaning of things and symbols; meaning and symbols allow people to carry on human action and interaction; people are able to modify the meaning on the basic of their interpretation; people are able to interact with themselves, make choices and then choose one; and the intertwine patterns of action and interaction make up groups and society (Ritzer, 2008).

2.3.2 Key Concepts

The key concepts presented in Symbolic Interaction Perspective are those explaining the way human create meaning for the surroundings and the way they act towards things in the society. The concept includes Self, I and Me.

Every person has a self by Mead simply meant that the human being is an object to himself (Mead & Mind, 1934). The human being may perceived himself, have conceptions of himself (Snow, 2001). The idea of a looking-glass self can be divided into three parts. There are: we imagine how we appear to others; we imagine how they feel or think about our appearance; and we develop or judge ourselves, self-feeling and self-belief, as a result of our imaging others' judgement. The self is a social process. It is the ability of people to put themselves in the place of others, to act as they act and to see themselves as others see them. The ability to view oneself from the point of view of community is the organized group activities. Ritzer explains that the self has two components: the "I" and the "Me". The I is assumed unpredictable by actors, and the Me is a set of attitude of others (Ritzer, 2008).

2.3.3 Application of Symbolic Interactionism

The individual HIV illness, even if it is subjectively experienced as unique and isolating, always happens in the context of the HIV epidemic. The face of the HIV epidemic may look different from country to country or even between rural and urban areas. The study in the five African countries reveals that perceptions of self, social withdrawal and self-exclusion due to HIV are experienced by the person him-/herself in social engagement process of PLH. Perceptions of self is the negative evaluation of oneself based on one's HIV-positive status. Most of the perceptions about the self occurred before the community was aware of the PLH's status because they feared stigma. Self-blame and feelings of guilt, fear, sadness and futility were verbalized (Greeff et al., 2008).

Furthermore, social withdrawal is person withdrawing from sexual and/or loving relationships to protect themselves from discrimination. This specific behavior took place because the PLH made the choice to withdraw and not because the community isolated them. The PLH isolate and keep to themselves or deny others access to their homes. Likewise, self-exclusion refers to the process by which a person decides not to use services due to being HIV-positive and fearing discrimination or attend community activities. This behavior was seen in a social context by PLH not attending community activities but also excluding themselves from health services (Deacon, 2006).

Barriers to social engagement by the people around the PLH are examined as labelling, fearing contagion and neglecting. Labelling is attaching an identifying or negative term or sign to a PLH, linking cause of infection to behavior of PLH or blaming PLH for their behavior. Low morals were quite often mentioned, as well as labels assigned to the PLH to identify him/her, for example, hangers, stick animals, etc. Fearing contagion is behavior that shows a fear of close or direct contact with a PLH or things such as clothing he/she has used. Various forms of possible contagion were feared, for instance, coughing, using the same utensils, touching either the person or an item of the person, and playing with the affected children (Taylor, 2001).

In symbolic interaction, because symbols may be wrongly interpreted, its weakness does not develop the idea of socialization. It also does not answer questions about how/when/why the characteristics occurred. Furthermore, it ignores

socioeconomic categories and class structure. This study assumes that the HIV status of the adolescents is not disclosed to others. Therefore, the interpretation of symbols and interaction with others in regard to their status may not be easily concluded.

2.4 Political Economy

2.4.1 Background

Karl Marx (cited by Morrison, 2006) viewed that the capitalist system is owned and controlled by the capitalist class whose main aim is production for profit rather than production for need. This means that the social relations of production (ownership and control) prevent the full utilization of the highly developed forces of production which could be used to meet the real needs humanity but are instead used to increase the profits of the capitalist class at the expense of the class of wage-earners. Since the Proletariat are inevitably exploited under capitalism they do not receive a fair share of the goods and services produced via the forces of production. Capitalism results inevitably in periodic unemployment meaning that the factories and workers are often idle despite the obvious need for increased production so that, again the full potential of the forces of production is not being realized under capitalism because of the social relations of production which exist under capitalism. Capitalism results in alienation which means that the full potential of the workers cannot be realized under capitalism. Thus, according to Marx, the social relations of production under capitalism prevent the full development of the forces of production under capitalism and the contradictions between the forces of production and the social relations of production will result ultimately in the abolition of the capitalist mode of production (Baudrillard, 1981).

In economics and sociology, the means of production are physical, non-human inputs used in production, such as machinery, tools and factories, infrastructural capital and natural capital. The means of production has two broad categories of objects namely instruments of labor such as tools, factories, infrastructure, and subjects of labor such as natural resources and raw materials. If creating a good, people operate on the subjects of labor, using the instruments of labor,

to create a product; otherwise, labor acting on the means of production creates a good (Howard & King, 1988).

2.4.2 Key Concepts

These key concepts have been used to explain the social relations of production: ownership and control, prevent the full utilization to high developed forces of production in Political Economy Perspective. Power relation focuses on its relation to class domination in capitalist societies, and it is linked to class relations in economics, politics, and ideology (Marx, 1860s, cited by Morrison, 2006). Economic exploitation can be defined as using somebody's labor, but in return giving an unfair compensation, or taking unfair advantage of laborer (Corbett, 2005). Oppression is the exercise of authority or power in a burdensome, cruel, or unjust manner. It can also be defined as an act or instance of oppressing, the state of being oppressed, and the feeling of being heavily burdened, mentally or physically, by troubles, adverse conditions or people, and anxiety (Laclau, 1977).

2.4.3 Application of Political Economy

The studies (Black, Devereux, & Salvanes, 2005; Grotberg, 1995) speculated that external support structures such as school structure and function, and support from family are critical ingredients in the development of HIV-born students. However, teaching and supporting HIV-born learners at the secondary school where the study took place are viewed a waste of resources such as manpower, infrastructure, teaching material because they would not be in a position to contribute to the wealth of the family or the state. Discussions with teachers and parents whose children were on HAART also confirmed that result. Both groups questioned the benefits of teaching those students under HAART and also inquired the need for educational investment in children whose future was not guaranteed (Baxen & Haiping, 2014). Family members were the least supportive due to uncertain future productivity rather than external support from friends, and peers (Baxen & Haiping, 2014).

Political Economy perspective explains neglecting to support HIV-born students due to their unreliable outcomes in the future. It lacks to look at the social phenomenon of HIV-born adolescents in school setting where school authority was

already aware of having HIV infected students, and provide educational support for them. As such, political economy has the limited view on this problem.

Table 2.1 Applications of theoretical perspectives for “Social Integration and Quality of School Life: Experiences from HIV-born Adolescents Living in HIV Home in Myanmar”

Perspective	Benefit	Limitation
Social Integration Theory	Wide-ranging explanation for social phenomena Looking at wider society Contribution of useful concepts to the field Allow not only for stability but also for conflict, and social change	Cannot easily explain rapid social change or breakdown of societies
Self-Determination Theory	Usefulness to look at work on goal orientation	Incompatible concepts Proposed three psychological needs cannot cover the study problem Lack to view macro factors
Symbolic Interactionism	A subjective study of social phenomenon	Subjectivity Exclude outside influences of social structures Ignore socioeconomic categories and class structure
Political Economy	Macro level analysis	Lack to examine social phenomenon

2.5 School as a Social System

According to the social integration theory, school setting can be seen as a social system. The HIV-born adolescents at the HIV home are linked to the wider

school society. Social solidarity in terms of responsibility and social obligations, and the social cohesion such as involvement in the school activities, similarity, and dependency serves the HIV-born adolescents to integrate in the school social system. The outcome can be seen as the sense of belonging as a part of the school and close personal ties among those adolescents and the school members.

The school system is composed of many distinct sub-systems or parts, each with their own goals. Together, these parts make up a functioning whole. Each part is dependent on the other for smooth operation. If one part does not function well, the other parts are affected as well (Ballantine & Hammack, 2011; Jensen, 1997).

Therefore, a social system can be explained as an interconnected and organized activity which consist of parts that are interdepend to produce common results. Social systems are created by human beings and are strengthened by man's attitudes, perceptions, beliefs, habits and expectations. Social system has 2 main goals, namely, actualization of the goals and sustenance of goals. In a social system 2 or more people are constantly interacting and probably practice similar approaches, attitudes and social values (Blewitt, 2006).

Thus, a school can be said that is a social system with a clear border that separates it from the environment. Nonetheless, it is not a closed social system. It has a close relationship with the environment and they accomplish each other. The school prepares students with living skills, knowledge and expertise necessary for the society. The school is provided with resources, building and personnel (students and teachers) in order for it to function (Parsons, 1959).

As a social system, a school has a physical and social structure. The physical structure refers to the rules and functions, roles of the individual in hierarchy and school mission and vision. The social system relates to its social relationship that helps the organization to function. Its components are individuals irrespective of the hierarchical position in school. Social structures are more important than physical ones, for instance, informal student leaders are more influential than formal ones such as an executive committee member or monitor. Hence, the social structure is the key to effectiveness in the school structure (Parsons, 1959).

Each school has its own climate which refers to the school environment or atmosphere. This climate exists along its corridors, classrooms, among its students and

teachers. The school culture is part of the school climate. Culture refers to a group's shared beliefs, customs, and behavior. A school's culture includes the obvious elements of schedules, curriculum, demographics, and policies, as well as the social interactions that occur within those structures and give a school, its look and feel as friendly, elite, competitive, inclusive, and so on. School culture is important in instilling a feeling of loyalty among its members (Ballantine & Hammack, 2011; Parsons, 1959).

Socializing in school involves instilling values and standards of behavior. In other words, socializing involves efforts made by teachers to shape children's behavior, inculcate moral values, and cultural styles. Teachers will describe a student as well behaved if she conforms to the standards of conduct, good if she conducts herself well morally, and well-adjusted if she conforms to the school culture (Brookover, 1979).

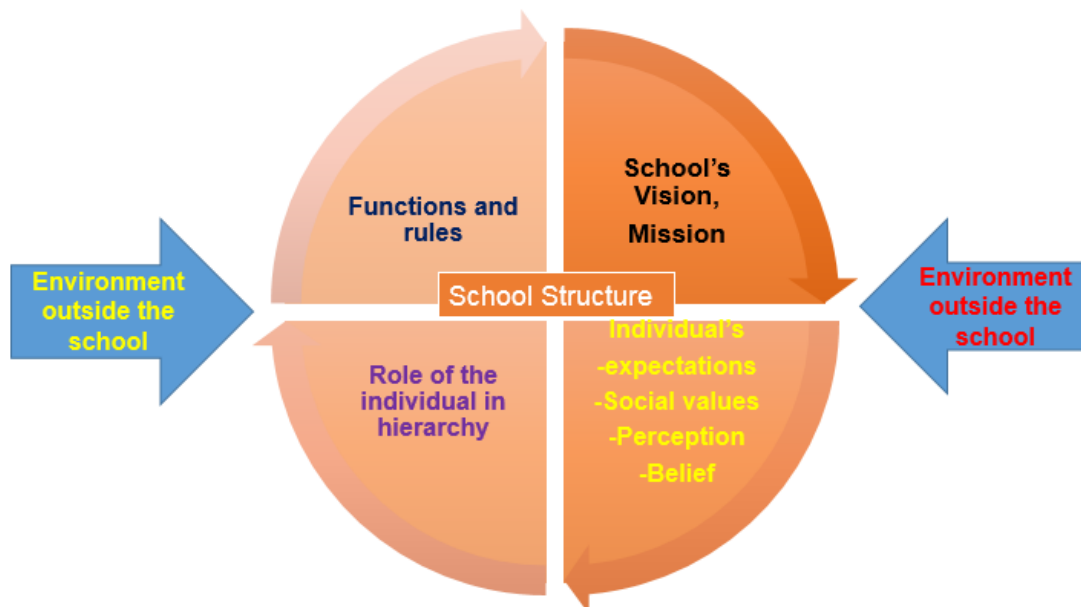


Figure 2.1 School as a social system

2.6 Engagement in School

Being engaged in school social system has a prominent effect on both students' subjective well-being (Creed, Muller, & Patton, 2003; Eccles, Vida, &

Barber, 2004) and their academic performance (Wang & Holcombe, 2010). Most students successfully engage in school activities throughout their student life; however, some students encounter serious problems. School engagement is important concerned with student motivation and friendliness, and prevent high dropout rates in urban area (National Research Council and Institute of Medicine, 2004). Enhancing or undermining factors towards school engagement were investigated as the crucial contexts interact with individual students (Skinner & Belmont, 1993; Skinner et al., 1990).

2.6.1 Barriers to School Engagement at Individual Level

Since the study views school as a social system, the barriers to school engagement can be understood at the individual-level and institutional-level points of view.

HIV Stigmatization in School

Stigmatization is a powerful form of social control where an individual exercises power over another because he/she possesses certain traits (Takahashi, 1997). Internalized stigma is defined as the product of the internalization of shame, blame, hopelessness and guilt associated with being HIV positive (Nyblade & MacQuarrie, 2006). Felt stigma is stated the fear of being discriminated against owing to his or her HIV status (USAID, 2006). Perceived stigma is also the internalized negative perceptions that society holds about HIV-born adolescent by accepting and internalizing the society's negative characterizations (Berger, Ferrans, & Lashley, 2001; Sandelowski, Lambe, & Barroso, 2004). Staggs (2007) had proved the fact that the mark of an illness did not need to be physically visible for someone to be stigmatized, and could occur to people with other health conditions. In particular, PLH might look completely healthy, but still be stigmatized. HIV-born adolescents in this study have been under antiretroviral drugs for several years; therefore, it might be difficult to detect their HIV status since they may physically appear healthy (Staggs, White, Schewe, Davis, & Dill, 2007).

HIV stigma in school is stated as negative treatment, perceived mistreatment, social isolation or exclusion and denied opportunities by teachers and peers because of the HIV-born adolescent's HIV positive status (Kamau, 2012). The

results of the study in Zambia show that many students hold negative attitudes toward people infected with HIV. Substantial proportions of respondents did not want to work with them, associate with them or let their children attend school with them, and many felt that no one should treat them (Mufune, Osei-Hwedie, & Mwansa, 1993).

The study in Kenyan Public Schools indicated that stigma and discrimination were visible in the school and negatively impacted the social interactions and learning of HIV infected children. Children with inborn HIV received limited support due to lack of empowerment and inadequate resources, and stigma and discrimination were poorly addressed. Most HIV-born children who internalize stigma encounter difficulties in socializing with members of the family and friends, which in turn further affects their psychological well-being (Wattradul & Sriyaporn, 2014). Most of the HIV positive children experienced stigma and discrimination by parents, teachers and peers, which impacted on their social interactions and learning.

School plays a major part in the psychosocial, intellectual, and vocational development of students. Notwithstanding advantages for students, teachers, curricula, school activities, school environment and school culture all structurally negative effect to the HIV-born adolescent to be socially marginalized.

Socioeconomic Status

Low socioeconomic status and its correlates, such as lower education, poverty, and poor health, ultimately affect the society as a whole, in particular. Many studies describe increasing evidence that supports the link between poor socioeconomic status and students' educational performance. Children from low socioeconomic families often begin kindergarten with significantly less linguistic knowledge (Purcell-Gates, McIntyre, & Freppon, 1995). Socioeconomic status appears to create achievement gaps for Black and Hispanic children, when compared to the achievement levels of White children (Duncan & Magnuson, 2005). Children from less-advantaged homes score at least 10% lower than the national average on national achievement scores in mathematics and reading (Hochschild, 2003). Children in impoverished settings are much more likely to be absent from school throughout their educational experiences (Zhang, 2005), further increasing the learning gap between them and their wealthier peers. While national high school dropout rates have steadily declined (National Center for Education Statistics, 2002), dropout rates for children

living in poverty have steadily increased. From 60% to 70% of students in low-income school districts fail to graduate from high school (Harris & Sass, 2011).

Context of low socioeconomic status negatively affects students' attitudes towards schooling (Thrupp, 1999; Willis, 1977). There were relationships between familial HIV/AIDS, poverty, child internalizing problems, gender and four educational outcomes: non-enrolment at school, non-attendance, deficit in grade progression and concentration. Although analyses reveal no direct associations between familial HIV/AIDS and any of the educational outcomes, being orphan owing to HIV, or caregiver taking care sick PLH in family impacted indirectly on educational performance via the poverty and internalizing problems that they occasioned (Orkin, Boyes, Cluver, & Zhang, 2014).

Teacher's Support

Wentz el (1997) found that students who perceived their teachers as caring and supportive were more likely than were students of less nurturing teachers to show greater academic effort and to express more prosocial goals. When students perceive that their teachers support them, students' attachment to school increases (Hallinan 2008). Teacher trust in students denotes the quality of school life of both students and teachers. Educational research increasingly acknowledges the significance of trust as indicator of positive teacher-student relationships producing favorable outcomes for student learning and teacher functioning (Bryk & Schneider, 2002; Goddard, Goddard, & Tschannen-Moran, 2007; Van Maele & Van Houtte, 2011).

By contrast, degrees of trust resulting from what HIV-born students perceived to be insensitivity amongst teachers shaped the decisions and actions by HIV-born adolescents. The result in turn adversely affected teacher-student relationships. First, lack of trust prevented HIV-born student from seeking help at school. One of the respondents made the point that teachers could not be trusted because they often breached confidentiality (Baxen & Haiping, 2014). When students do not experience trust from their teachers, they will be less likely to engage in learning processes (Ennis & McCauley, 2002; Tschannen-Moran & Barr, 2004).

2.6.2 Barriers to School Engagement at Institutional Level

School Function

One of the school functions is to produce educated students. Schools are responsible to trained future work force. They are to identify the most qualified person to fill the positions in society. Students are taught specific subjects in schools and later enrolled into programs at the college and university. Individuals that have the qualification and requirements are then channeled into future adult status in job market. HIV/AIDS have a direct negative impact on the infected learners in schools. Garvie et. al., 2014 found cognitive, adaptive, as well as behavioral delays in HIV-born adolescents compared to normative samples. The learning activities are continually interrupted by sickness, repeated occasions of grief and mourning in the community, widespread sense of insecurity and anxiety among HIV-born learners (Gakii, 2013). As such, HIV-born students deviate from the desire level of school towards students' performance what want them to be now and what expect them to be in the future.

Unwritten Rules in School

The school system attempts to mould the input in such a way as to enable the optimal assimilation of the knowledge and skills to take place during the learning process, and hence, maximise the quality of the output (Reeves-Ellington & Anderson, 1997). Each school has different undocumented own disciplines. In a previous study, both students and teacher were African American. The teacher assigned students to tables based on ability; the "better" students sat at a table closer to teacher, the "average" students sat at the next table, and the "weakest" students sat at the farthest table. The researcher discovered after monitoring the students through the year that the students closer to the teacher received the most attention and performed better. The farther from the teacher a student sat, the weaker that student performed (Rist, 1970). Clinical reports indicate that HIV-inborn adolescents present with significant learning problems affecting their academic performance, developmental milestones, and ability to function independently (De Santis, Garcia, Chaparro, & Beltran, 2014). As such, accepted instructions in a certain school push HIV- born student to the edge of school society and make them vulnerability.

Culture

One of the theories that explains cross-cultural differences in relation to general happiness is the Folklore theory (Veenhoven & Ehrhardt, 1995) where life satisfaction is the reflection of nationally-held notions which depend on tradition and culture rather than on the current circumstances of the country. Inglehart suggested that France, Italy and the US could be characterized as cultures of 'happiness', despite unfavorable living conditions for a relatively large part of the population. Individual school culture may also be responsible for cross-cultural differences (Inglehart, 1990). Dawson (1985) found that the levels of school satisfaction were very different across schools. These differences could be attributed to experiences of students as a result of the school environment and culture (Karatzias, Power, Flemming, Lennan, & Swanson, 2002).

2.7 Quality of School life (QoSL)

2.7.1 Quality of Life (QoL)

QoL is the general well-being of individuals and societies (Sen, 1993). QoL has a wide range of contexts, including the fields of international development, healthcare, politics and employment. Unlike measurement in financial terms, it is harder to make objective or long-term measurements of the QoL experienced by nations or other groups of people. Several studies provide support for the importance of QoL among peoples (Frisch, 2000). Perceived QoL reports have been shown to predict a variety of outcomes, including psychological disorders (e.g., depression, suicide), physical health (e.g., respiratory illness, cardiovascular disease), longevity, interpersonal problems (e.g., marital difficulties, peer rejection), job difficulties (job dissatisfaction, unemployment), and willingness to participate in health promotion programs.

According to Frisch, QoL focuses on excellence or goodness in aspects of life that go beyond mere subsistence, survival, and longevity (Frisch, 2000). Concise definition was offered by Renwick and Brown (1996, as cited in Zekovic & Renwick, 2003): QoL is the degree to which a person enjoys the important possibilities of his or

her life. In addition, the World Health Organization (WHO) has defined QoL as “individuals’ perceptions of their position in life in the context of the culture and the value systems in which they live and in relation to their goals, expectations, standards and concerns.” Coverage might be categorized within five dimensions: physical wellbeing, material wellbeing, social wellbeing and emotional wellbeing (Felce & Perry, 1995).

2.7.2 QoSL

Generally, the quality of life plays an important role in all aspects of human life, and it has a particular effect on students’ lives. The QoSL has been highlighted as an important aspect of schooling (Ainley, 1999; Ainley & Bourke, 1992; Delors, 1998). The purpose of schooling is more than the transfer of knowledge or the development of learning skills. Students learn in school the socially-acceptable language and behavior, the etiquette in relating to peers and adults, social norms, taboos, rules and regulations (Lee & Holland, 1995). As such, school satisfaction become a major aspect of learner’s quality of life. Furthermore, the level of school satisfaction is important because it affects psychological well-being, as well as school engagement, absentee rate, and drop-out, behavioral problems, and higher achievement according to one’s ability (Voelkl, 1995). Assessing students’ views of QoSL may highlight on the ways to promote and assure the quality of school education (Sun-Keung, 1999).

The QoSL is defined as a general sense of well-being resulting from student’s involvement in school life and their engagement in the school environment (A. Karatzias, Papadioti-Athanasiou, Power, & Swanson, 2001). QoSL has several dimensions tested in different schools in different countries. Epstein and Mcpartland (1976) carried out the earliest conceptualization and measurement of students’ perceptions of QoSL. In their research, the QoSL was defined in terms of three dimensions of student reactions: (1) satisfaction with the school in general, (2) commitment to schoolwork, and (3) attitudes towards teachers (Epstein, 1981; Epstein & McPartland, 1976). This scales of QoSL were tested in many countries such as the United States, Canada, Israel and West Germany.

In 1981, William and Batten extended the concepts of QoSL in Australia. They proposed a model of students' perception of QoSL that is distinguished into general feelings of well-being and feelings related to specific domains of life. The general domains of QoSL include: general satisfaction and negative affect. General satisfaction concerns general positive feelings about school. For instance, student perceived that school is a place where he or she has preference to go every day. Negative affect concerns general negative personal reactions to school such as feeling of student as a distressed place (Williams & Batten, 1981).

William and Batten (1981) also proposed five specific domains of student experience originated from a theory of schooling developed by Mitchell and Spady (1978). They were: teacher-student relation, social integration, opportunity, achievement and adventure. Teacher-student relation is the adequacy of interaction between teachers and students. For example, student has sense that school is a place where teachers help students to do the best. Social integration concerns the students' relationships with other people and classmates, that is, school is a place where other students accept as he or she is. In addition, opportunity relates to a belief in the relevance of schooling in which student believes school where the things he or she learn are important. Achievement concerns a sense of being successful in schoolwork. Student also needs a sense of self-motivation as an adventure that learning is enjoyable for its own sake.

Based on this framework, Ainley, Reed and Miller (1986) was developed a school-life questionnaire to reveal students' views of quality of school life in the Victorian government secondary schools (Ainley, Reed, & Miller, 1986). Next, school-life questionnaire for use in primary schools was developed by Ainley, Goldman and Reed in 1990. It was applied in both the Victorian and New South Wales school systems (J. Ainley & Bourke, 1992).

In a pathway model of QoSL (Mok, 2002), four determinants to the students' QoSL tested were developed and tested in 70 schools in New South Wales, Australia. The determinants are expressing interrelationships between students' background characteristics, their expectations of schools, the perceived quality of both the formal and the informal school curriculum, the classroom environment and students' quality of school life. Firstly, demographic background of the students

consists of gender of the student and home background characteristics. Secondly, academic motivation was measured by three scales: enjoyment in school, future employment and no choice except schooling.

The third variable is development expectations of schools by the student which scales are academic development expectation, personal development expectation, vocational development expectation, social development expectation, and religious development expectation. The fourth variable is the students' attitudes regarding the school curriculum and classroom environment which is measure by academic atmosphere, personal relations atmosphere and classroom discipline. The last variable is QoSL. It was measured by a Likert scale originally developed by Williams and Batten (1981). The questionnaire comprises 40 Likert items grouped into seven subscales, designed to measure two general dimensions and five specific domains. The seven subscales of this instrument are general affect, negative affect, status, identity, teachers, opportunity and achievement.

After reviewing the literature about the QoSL, it was tested in different countries in different ways for the general students. It has several dimensions measured quantitatively. However, in this study, the QoSL of HIV-born adolescents explored qualitatively. School satisfaction has become the major aspects. Its components are academic performance, educational expectation, opportunity, personality development expectation, academic motivation and achievement. They are defined as followed:

Academic performance refers to the academic grading. It is arranged according to the academic marks in the class examinations.

Educational expectation refers to a predicted career in the future based on education.

Opportunity refers to the sense of being satisfied, beneficial or relevant to acquiring knowledge through learning the subjects in school.

Personality development expectation refers to the predicted improvement in self-awareness, potential, or becoming self-leader or autonomy resulted by social interaction in school.

Academic motivation refers to the sense of arousing to go to school and to regularly study homework at the home.

Achievement refers to a sense of being successful in school lessons irrespective of the academic positions in the class.

2.8 Conceptual Framework

The researcher reviewed and analyzed the reachable and reliable literature. To fulfill the objectives of this study, a conceptual framework is designed to explore and analyze how Social Integration contributes to HIV-born adolescents' QoSL as follow. There are three main parts: pre-disposition, engagement in school and quality of school life.

In portion of pre-disposition, this research has explored the experiences of HIV-born adolescents at institutional and individual level in their social life in school. At institutional level, when school is viewed as a social system, the research has examined how school structure and functions including individual needs, beliefs, and a cognitive understanding of the job regardless of position, positions that are arranged in a hierarchy, school culture, traditions, unwritten rules, unspoken expectations, a proud heritage or past, and a sense of spirit, and environment outside the school have affected the social engagement of HIV-born students in school. At individual level, perceived stigma, internalized stigma and felt stigma are mainly explored as barriers of social engagement.

When the engagement of HIV-born adolescents is studied in school, they have to do responsibilities and social duties assigned by the school. Inclusion and participation in the school activities, and interdependency have become an opportunity of being a member of the school. Similarity also developed the feeling of part of the school society according to the social integration theory. Finally, the sense of belonging and close personal ties can be seen as the outcomes of social fixation of those adolescents at school.

In the part of QoSL, their academic grading as academic performance, a predicted career in the future based on education as educational expectation, the sense of being satisfied, beneficial or relevant to acquiring knowledge as an opportunity, the predicted improvement in self-awareness, potential, or becoming self-leader or

autonomy based on social integration as the personal development expectation, the sense of arousing to go to school and to do school activities as academic motivation, a sense of being successful in schoolwork as achievement are speculated to clarify the school satisfaction of HIV-born adolescent as an outcomes factor of school engagement to meet the specific objective which is to explore how social integration of HIV-born adolescents is related to their quality of school life.

Social Integration in School Society		
Pre-disposition	Engagement in School	Quality of School Life
<p>Institutional Level</p> <p>School structure</p> <ul style="list-style-type: none"> • Functions and rules • Vision and mission • Individuals • Roles of individuals in hierarchy <p>Environment outside the school</p> <p>Individual HIV-related conditions</p> <p>Physical Health</p> <p>Social health</p> <ul style="list-style-type: none"> • Internalized stigma • Felt stigma • Perceived stigma 	<p>Interpersonal Level</p> <ul style="list-style-type: none"> • Responsibilities • Social duties • Inclusion in the school activities • Participation • Interdependency • Similarity • Sense of belongingness • Close personal ties 	<p>School satisfaction</p> <ul style="list-style-type: none"> • Academic performance • Educational expectation • Opportunity • Personal development expectation • Academic Motivation • Achievement

Figure 2.2 Conceptual framework on “Social Integration and Quality of School Life: Experiences from HIV-born Adolescents Living in HIV Home in Myanmar”

CHAPTER III

RESEARCH METHODOLOGY

This study aims to explore the barriers to social integration of HIV-born adolescents in school, and contribution of social integration towards their quality of school life (QoSL). This chapter presents the selection of research site, research design, samplings, data collection methods, data analysis and ethical consideration for the study.

3.1 Research Site Selection

The study setting was Thukha Yeik Myon Home which was the only HIV home in Myanmar. It was located in East Dagon Township, Yangon.

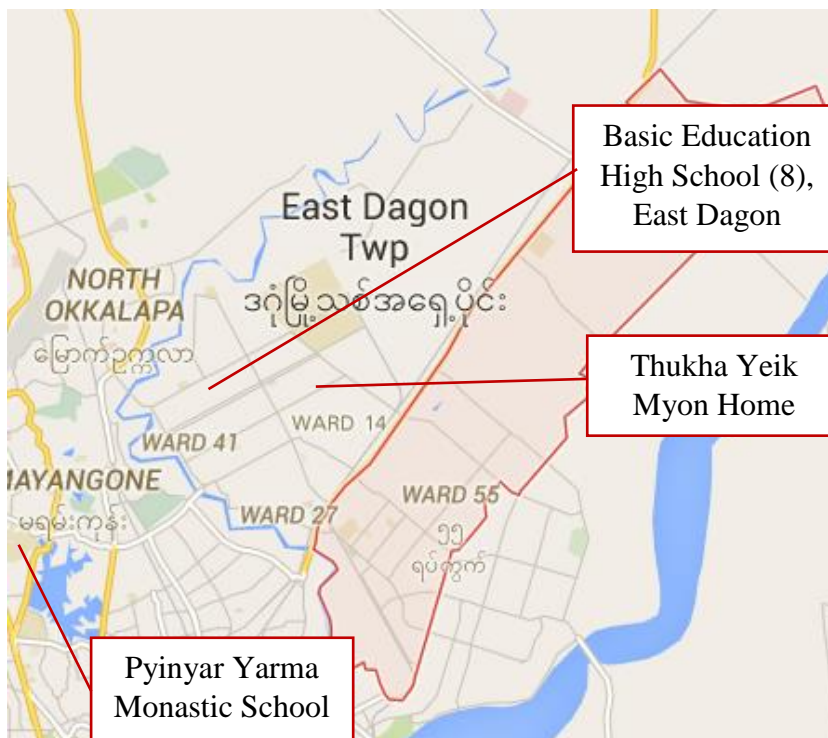


Figure 3.1 Location of Thukha Yeik Myon Home in East Dagon Township, and Basic Education High School (8) East Dagon, and Pyinyar Yarma Monastic School Yangon, Myanmar

There were 114 HIV-infected and HIV-affected children aged between 3 and 21 living in the home. The 35 staff were employed in the home which was operated by a director. The home accepted 18-months to 12-years-old HIV positive child with both or one parent deceased. Special consideration was given to non HIV infected children on case-by-case basis.

The children went to four anonymously named schools: Zayar Thiri Monastic School, Pyinyar Yarma Post Primary Monastic School, Basic Education High School No.8 (BEHS 8), East Dagon, and Basic Education Post Primary School No.8 (BEPPS 8), East Dagon. Three schools located near the home in East Dagon Township, and one school was in Mayangone Township.

The two health providers were Thazin clinic (Tharkayta), and Specialist Hospital, Mingalar Don (SHM). Thazin clinic (Tharkayta) is an anonymous clinic situated in Thakayta Township, and SHM is in Mingalar Don Township.

3.2 Research Design

This study is exploratory in nature as it aimed to explore the school life of HIV-born adolescents in terms of their social engagement and quality of school life. It is a qualitative study that seeks for the detailed information in regards to the contexts surrounding the HIV-born adolescents that might be the barriers to social integration through their own subjective view.

3.3 Sampling Methods, and Approach to Respondents and Key Informants

HIV-born adolescents who meet the study criteria were purposively recruited. As well, purposive sample of key informants were selected from the home and schools. Even though HIV-born adolescents were in the same setting, direct identification of the underage respondents by the researcher might be uncomfortable for them. Thus, snowball technique was rather than direct contact to the respondents.

The director of the home served as the entry point who identified the very first respondent. After that, each respondent was asked to refer to the next respondent.

3.3.1 Recruitment of Respondents

Nine respondents were interviewed. The researcher kept contact with them, and interviewed at least three times or until the data was saturated. The recruitment criteria include:

- 1) Adolescent who was born with HIV through mother-to-child transmission.
- 2) Aged between the ages of 14 to 19.
- 3) Living in the HIV home which is for HIV infected children.
- 4) Schooling secondary level from Grade 6 to Grade 11.

Table 3.1 Sampling methods and recruitment criteria

Sample Population		Sampling Method	No. of respondent	Criteria
Respondents	HIV-born adolescent	Purposive	9	1) Aged between 14 and 19, and 2) Schooling secondary level from Grade 6 to Grade 11
Key Informants	Director of HIV home		1	1) Responsible for Management of the home
	Staff		2	1) Working at the home for at least one year, and 2) Taking closely care of the HIV-born adolescents
	Representative teacher		1	1) The teacher of Pyinyar Yarma Monastic School

3.3.2 Recruitment of Key Informants

The following three different categories of key informants must have first-hand knowledge about the school experience of HIV-born adolescents. Their different background may offer diverse sets of views for the total understanding of the investigated problem. The key informants include:

- The director who manages Thukha Yeik Myon Home.
- Two home staff who closely take care of HIV-born adolescents for at least one year.
- A representative teacher of Pyinyar Yarma Monastic School that received HIV-born adolescents.

3.3.3 Data Collection Procedure

Before entering the field sites, the researcher contacted in person the executive committee of Thukha Yeik Myon Home in December 2014 to conduct research there. The home committee had permitted to do research HIV-born adolescents who were under care of the home. The researcher discussed for the data needed for research through entry points into the research field where were HIV home and school. In addition, the executive committee had allowed the researcher to work as a volunteer for those children until the end of data collection. In addition, the committee had agreed to introduce the data point at the school who was the principal of BEHS 8, East Dagon.

When entering the field, the researcher approached the director of HIV home who managed the home as an entry point. She arranged the researcher to work as a volunteer private teacher for students of Grade 6 and 7 at the home, and referred to the most senior home staff who were taking close care of HIV-born adolescents. The researcher made clear all people in the home that she had planned to do research for HIV-born adolescents in the home, at the same time, she had been working as a volunteer teacher.

During working, the researcher tried to be familiar with the staff and the children especially adolescents, simultaneously, she observed almost all related to the HIV-born adolescents at the home as much as she could. The researcher had pretested the interview guidelines bit by bit before her volunteer working hours. After working

as a volunteer teacher for two and half months, the researcher had noticed that some elder children had started asking her about HIV related matters, and they openly talked their personal in school and the problem in the home each other in front of her. As such, she had decided to start collecting data from a HIV-born adolescent according to the referral of the staff, information by the children and the observation of the researcher. Next respondent was referred by the first interviewee. If the researcher cannot assess the in-depth data from the respondent, she stepped back to the second last data point. The second last respondent referred next new respondents who was desirable to participate with reliable and valid data in the process of collecting data. Afterward, data collection was done in order: the HIV-born adolescents, home staff and the director of the home. The senior staff of the home had allowed to copy what they documented of all children.

Unfortunately, the principal of BEHS 8, East Dagon who is the only key informant represents the school passed away. She was the only teacher who was disclosed the HIV status of the children in the higher school. The researcher had discussed two times with the home committee to replace that key informant. Finally, the committee referred the researcher to the representative teacher of the Pyinyar Yarma Monastic School.

Next, the approach to the representative teacher of the monastic school was introduced by the director of HIV home. The researcher kept contact with all participants starting from entering field site until getting completed research, and interviews at least three times including follow up interviews them to get saturated data.

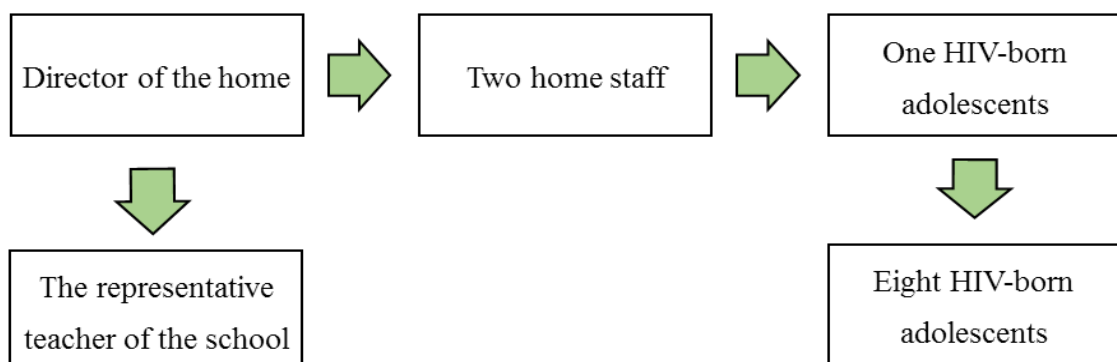


Figure 3.2 Diagram of approach to participants

3.4 Data Collection Method and Tools

3.4.1 In-depth Interview

In this study, semi-structured in-depth interviews were performed with respondents to achieve in depth understanding of HIV-born learners' social engagement in the school in which how social ties link those learners to school society, how predispositions in institutional and individual level influence on the social integration matter of HIV- born adolescents and correlation of social integration and their QoSL. The same objectives of In-depth interview are set for both respondents and key informants to achieve sufficed data from the diverse views.

The method of the in-depth interview is an important part in this study to achieve intense information for the study objectives. The appropriateness of this method is that there is time for the respondent, and it encourages answering from an individual point of views - without being influenced by the opinions of other respondents (Dundon & Ryan, 2009).

3.4.2 Research Instrument

The research instruments were:

- 1) in-depth interview guidelines (Appendix A and B),
- 2) voice recorder, and
- 3) field notes,

3.5 Data Processing and Analysis

To be systematic, disciplined, and able to be seen, and described, data processing and data analysis should be done along with the data collection. Data are collected primarily through in-depth interviews. Open-ended questions are used. Probing questions are used to explore the participant's specific comments rather than to a preexisting theory. Data processing and data analysis are done after each in-depth interview.

There are 13 primary document files transcribed from the interviews. Data analysis started with reading all data repeatedly to obtain a sense of the whole. The

data then were read word by word, and coding was done. In the coding process, the researcher had done the color coding with three different colors for three main themes. Then, the notes were made in the margin. The coded notes were exposed into another Microsoft word sheet by using “view macros” command. Afterward, the coded data we rearranged according to the main themes. The researcher analyzes the findings whether they fulfill the research objective or not. If not, the researcher notes to ask in the follow up interview.

Next, all of the main and sub themes were examined each in detail, and consider its relevance. If not, the researcher returned to the original transcripts, and conducted re-coding. Then, they are exposed into the Microsoft excel sheet according to the main contents in columns such as the predisposition, school engagement and the quality of school life. The respondents are arranged in rows from the eldest to the youngest. After that, the researcher conducts single case analysis column by column, and cross case analysis row by row. When data interpretation and entry are completed in the process of translation, all recordings and jotted notes are destroyed for the confidentiality and privacy of respondents.

3.6 Data Quality

3.6.1 Trust Building

The target population of this research is marginalized and silent, that is, they are under the age 18, and under lifelong care and treatment to treat the chronic stigmatized inborn syndrome. Those adolescents tend to be inferior and isolated owing to experienced stigmatization and do not trust on unfamiliar people. Therefore, trust between the researcher and the respondents are the most essential task. It was not only for smooth operation of research, but also to provide the true, valid and reliable data from the participants.

The researcher introduces herself that she is currently a student of Mahidol University and explains clearly them the reason coming here. The researcher makes sure that she conducts a research about them, and she works as a volunteer worker during this period. In addition, the researcher makes sure the purpose of the

research and why she was meeting with them. She takes time to build trust and rapport by going along with them and help them when they go to school or HIV clinic. The researcher was a staff nurse of HIV clinics for almost seven years. Her experiences are far supportive for HIV-born adolescents.

The researcher treats them friendly. When they are unclear in school lessons, the researcher explains and assists them. By the time the HIV-born students start sharing their feelings and difficulties to the researcher, the researcher supposes that she has got their trust and starts collecting data. The interviews are conducted starting with informal conversation. Their story is listened to with sympathy in her mind, and polite and kind regards are important throughout the process in pursuing and sustaining trust from them. The researcher pays attention without any interruption during conversation and respect their ideas and concept and their behavior without making judgment on it.

3.6.2 Inter-subjectivity and the Researcher's Identity

When doing qualitative research, the researcher must be aware the subjectivity is different between the researcher and her respondents. These differences can influence the researcher's understanding and interpretation. Hence, so as to reveal the social phenomenon of HIV-born adolescents in school society, the researcher needs to understand them from the own perspective of HIV-born students in the school context in which they are schooling, and avoids judgment and influences from her own subjectivity. The researcher maintains this idea in her mind throughout the preparation phase of research to the publication phase of research.

At the same time, the identity of the researcher is very important, and can affect the outcome of the research. The researcher has multiple identities such as nursing professional, students in the Mahidol University, volunteer teacher in current in the home, or researcher. However, the researcher makes sure her identity to be health social scientist cum researcher. With an attitude of respect and accepting them, the researcher tries to understand their social illness, sorrow, anxiety, burden, difficulties, and enjoyment and perceived from the insider point of view. By keeping a warm-heart, the researcher paid attention without any interruption during conversation

and respect their ideas and concept and their behavior without making judgment on it to avoid unequal power relation between professional and lay people.

3.6.3 Reflexivity

The researcher consciously keeps being aware of her own bias which might effect on the process of data collection and interaction with respondents, and outcomes of research when she establishes strong relationships with her respondents in order to delve deeply into the social integration matter. The bias may arise from her background, including educational status, personal status, previous knowledge and experiences, and it makes the researcher still remaining outside of the subject matter. However, researcher tried to separate her feelings to avoid the view from outside, and keep the view herself from the insider point to the school life of HIV-born adolescents.

3.7 Ethical Consideration

Ethical practices are crucial and essential in conducting social research. This research is accomplished through the participation of HIV-born adolescent living in HIV home. Throughout the preparation phase of research to the publication phase of research, the researcher committed not to break physical, mental and social wellbeing of the respondents. The researcher treats the respondents with respect, and obeys not to insult their dignity, safety and right to participate and drop out in this research.

The researcher also has been recognized understanding on the research ethics with the certificate by the Institutional Review Board (IRB) of Mahidol University, and it was submitted to the IRB for conducting the research before going to the field. This research is conducted after getting the approval from the IRB of Mahidol University. Moreover, the researcher also discusses details in the meeting of the board of directors of HIV home about additional protections for them in order to convince that they will be comfortable and safe to be in the research regarding to ethical consideration of the research.

3.7.1 Privacy

The researcher respects for privacy of respondents with the aim of protecting individuals against unwanted interference and exposure during both in-depth interview and observation process. The place for the interview is chosen carefully according to the desire of participants to ensure that they are comfortable, speak openly and discuss or share their private opinions deeply and safely. Researcher always emphasizes the right of participants, and allow them to stop in data collection procedure at any time when they want to end.

3.7.2 Confidentiality

Preventing from being harmed and feeling of wellbeing of participants was important in conducting qualitative research. At first, the researcher guarantees the respondents that all information they provide about their private lives will be treated confidentially. The researcher prevents the use and dissemination of information that could harm the respondents by using pseudonyms. Every information and experience shared by participants was kept secret. All research materials used in the study are anonymized and kept under safety. After data entry and proper data analysis, all notes, and recording are destroyed. In addition, the approval of the utilization and publication of their provided information in direct quotations in the report were asked.

3.7.3 Informed Consent

All data collection procedures in this research are only conducted after respondents are fully informed of, and understand the nature, purpose and implications of the research. For the subgroup of sample, HIV-born adolescents, they are under 18-years-old and all are under care of Thukha Yeik Myon Home. The director of the home is the guardian for those adolescents. She is therefore informed and explained the clarification of research objectives and interview procedures paper written in Myanmar Language before conducting the interview the adolescents. Then, the HIV-born adolescents are individually informed until they understand. The researcher gains assent, verbal consent, with voluntary involvement. After that, she collects the written consents of the home director as the responsible person of the adolescents.

CHAPTER IV

RESEARCH FINDINGS

This chapter presents the contextualization of the HIV-born children in the HIV home, HIV care and treatment and the school settings. The presentation of the study findings is categorized according to the three linked components underlined in the study's conceptual framework: (1) HIV-born adolescents' pre-disposition to school engagement at individual and institutional levels, (2) their social engagement within the school setting which is considered in this study as the interpersonal-level phenomena and (3) their perceived quality of school life.

4.1 The Study Context

4.1.1 Thukha Yeik Myon Home

Thukha Yeik Myon is the only home which takes care of the children who suffered lifelong negative impacts of HIV in Myanmar. The name, Thukha Yeik Myon, stands for the place of happiness or bliss where people are able to take a rest and seek protection along the Samsara: cycle of rebirth. It was started with nine HIV-born children in Tanyin, Southern Yangon in 2005. Afterward, it was moved to South Dagon, and finally it was established in East Dagon Township in the easternmost part of Yangon until the present. Initial fund was provided by the volunteer committee members. The ongoing fund for home operating cost depends on the donors. The major organizers for fundraising are well-known writers and medical doctors cum writers.

Majority of the children in the home were those infected and affected by HIV, that is, children with perinatal HIV, and became orphaned due to the loss of either or both parents on account of HIV or had been abandoned by the parents living with HIV who could not afford to bring up their children. Out of 114 children in the

home, 111 children were infected orphans and three were non-infected but parentless due to HIV.

Table 4.1 Children in Thukha Yeik Myon

Age	Male	Female	Total
0 to 5	4	2	6
6 to 10	16	19	35
11 to 15	27	28	55
16 to 20	7	10	17
Above 20	0	1	1
Total	54	60	114

There were 54 boys and 60 girls living in the Thukha Yeik Myon Home. The youngest one was 3-year-old boy and the eldest was 20 years and 6 month-old-girl. Seventy-five children were in adolescence aged from 10 to 19, and 28 children were at their middle and late adolescence aged between 14 and 19 (Table 4.1).

Distinct channels of the children to Thukha Yeik Myon Home were via homes, monasteries, and nunneries. Fifty children got into Thukha Yeik Myon before their fifth birthday, and 18 children were sent there prior to the age of two. Forty-two children arrived there at ages from 6 to 10-years-old. Although one of the criteria accepting the children by the home was aged between 1.5 and 12, seven children aged above 12-years-old, and six children aged below 18-months-old were accepted and taken care based on conditions.

The Home Staff

There were 35 staff at the home. Senior staff and general staff were working under the director's supervision. The director did not directly manage all home staff and the children, but supervised the home operation by having meetings monthly. Two senior staff acted as assistants of the director in managing both children and the staff at the home. Senior staff were from Yangon. Later recruited staff were from the villages of Irrawaddy delta area. They came from their village in groups. The groups were recruited at the same time. When they resigned, they were in groups.

Almost all staff did not complete lower secondary level education, but a senior staff was a Degree holder. Figure 4.1 illustrates the organization chart of the Thuka Yeik Myon Home.

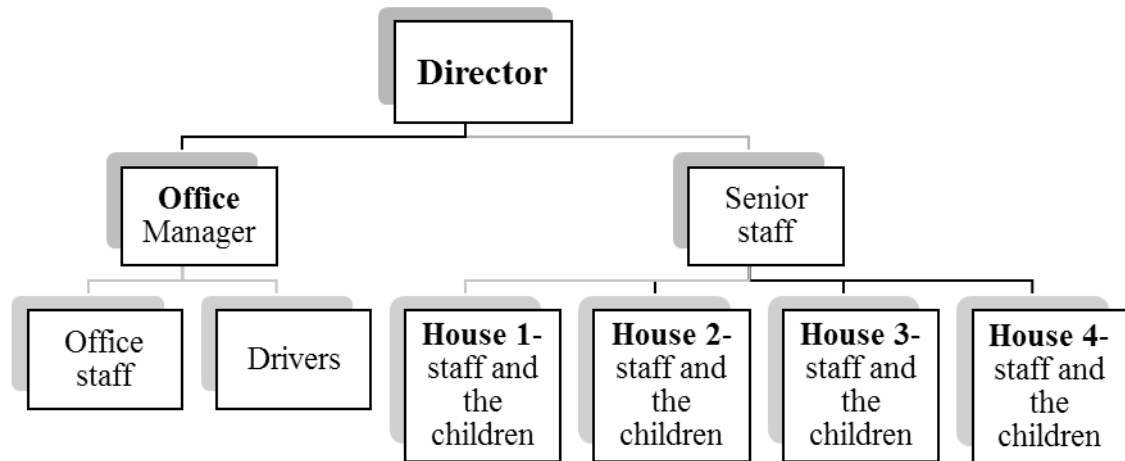


Figure 4.1 Organogram of the home

Role and Responsibility of the Home Staff

The staff had played role of care givers. The responsibilities were everything about the HIV-born children. Generally, the senior staff who were under direct management of the director had to take the duties to contact with the schools, and the home smooth running. The responsible staff of respective house had to arrange clinic follow-up and go along with the children, prepare HAART and other drugs at the exact time, be an attendant of hospitalized child and provide basic patient care at the home such as wound dressing, sponging for child with fever. The remaining staff were responsible for meal preparation, taking a bath to the younger children and some elder children, sending to and picking children up from the schools, going along with Grade 1 and 2 students to Zayar Thiri Monastic School and prepared to take HAART at 8:00 a.m. on school days and washing and ironing the clothes of the children. The tasks were not fixed. If there was staff shortage, they had to replace in the necessary place.

The staff lived together and slept with the children in the same room; they closely took care of the children. The children called them “mom” in order to replace

children's mother. The staff were prohibited to make physical punishment if a child behaved improperly whereas they could verbally warn.

4.1.2 HIV Care Facilities

HIV-born children needed to seek health care providers to access continuous critical medical and non-medical service.

Eligibility to start HAART or the readiness of the children living with HIV was decided by the health care providers based on the prescribed guidelines of WHO and National AIDS Program, Myanmar. After initiating HAART, regular appointment was still essential to see their health care providers to monitor the short term and long term side effects of HAART, adherence to HAART, and the drug failure. After all, the continuous medical services for HIV-born children with the particular health professionals from the initial visit to lifelong affordability and accessibility was essential.

Thazin Clinic (Tharkayta)

In Myanmar, there were 21 anonymous clinics which were named "Thazin clinic". They were private clinics managed by staff of Médecins Sans Frontières, Holland (MSF-H). The clinics had mainly provided reproductive tract infection diagnoses and treatment, volunteer counseling and confirmation test (VCCT), and prevention of mother to child transmission (PMCT) and HIV/AIDS care. All services were free of charge.

In Yangon, five Thazin clinics were operating. Thazin clinic (Tharkayta) was one of them. It stood as a major health provider of the children from Thukha Yeik Myon. Most home children received regular HIV care and treatment there. The clinic opened from 8:30 a.m. to 5:00 p.m. on weekdays. Yet, the children had to go before 8:30 a.m. to get early priority. At the Thazin clinic, HIV-born children had to see same medical doctor, same counselor and same nurse in every follow-up.

The doctor scheduled the next appointment for the children every three months, or HAART could be refill for maximum three months. If the child had any health problem such as signs of drug failure, side effects of HAART or loosen adherence to HAART, he or she would be appointed closely.

Specialist Hospital, Mingalar Don (SHM)

If the HIV-born children of Thazin Clinic needed emergency medical care on weekends, they could access emergency medical services at Specialist Hospital, Mingalar Don (SHM) and Specialist Hospital, Tharkayta (SHT). The home staff usually arranged to hospitalize such children to nearer SHM in Mingalar Don Township.

SHM in Mingalar Don Township was a government major health facility to treat the AIDS patients. It had both outpatient department and inpatient department. Outpatient department opened weekdays. It provided HIV health care and treatment to the stable patients. Inpatient department was for severe AIDS patients who needed close monitor, or the patients who required the hospital procedures. Being a 100-bed hospital, HIV/AIDS specialist doctors for PLH and pediatricians for HIV-born children were available.

SHM had been supporting essential HAART, and health services for about one-third of the children at the home. When the HIV-born children needed close medical care, they were hospitalized at SHM. The appointment with the pediatricians at the hospital was bimonthly for the HIV-born children with normal conditions. If any specific investigations were needed, the children were ordered to do the test a week before the appointment date. If the children had monthly exam, they could see the medical doctors prior to the follow up date. However, HAART could be refilled solely on the appointed date. No extra HAART package was supplied.

Both health facilities were crowded with the appointed HIV-infected patients. The children had to go early in the morning to get early priority in the waiting queue to see the doctors. Nevertheless, it usually took almost a whole day so that the children had to skip the school.

4.1.3 Education and Schooling

In Myanmar, Ministry of Education was the focal education provider. There were two main sectors in the education system: the basic education sector and higher education sector. In basic education, there were three types of schools in Myanmar, namely, State-operated schools, private schools and religious-operated schools. State-operated schools were generally divided into Primary, Middle and High

Schools which were implemented by the department of Basic Education. Primary schools were obtainable from Grade 1 to 5 whereas Middle Schools and High schools were accessible from Grade 1 to 9 and Grade 1 to 11 respectively.

In 2011, the promulgation of Private School Law encouraged the private participation in education sector. Small number of private schools had been approved to open by the Ministry of Education.

In addition, religious-operated schools had a significant role in Myanmar education system. They offered free education and especially target orphans or children from poor families who could not afford to pursue formal education. The monastic schools were usually kind of the homes. They followed the official primary curriculum of basic education. The Buddhist abbot supervised these schools.

At the beginning of the home, children lived in the compound. The gates were closed to be safe. They played with their HIV peers, and lived together. Going outside was absolutely banned. After Ms. Nyo who was a medical doctor took over the home management from the previous director, she viewed the children had been isolated. She was also aware that the longer life span of the HIV-born children depended on the medication. She had weighed the longer life of the children and the acceptability of the home. Besides, even if the children entered adulthood, they were likely to move out. Thus, she had decided to arrange schooling as preparation for their future.

When HIV-born children were decided to schooling, the director had mainly considered health condition of the children and the acceptance of people in the school. She had found the nunnery education school, namely, Vithar Kha to pick for. The nuns knew the home committee members. The children in the home were enrolled in the nunnery school, but they were taught by the recruited teachers in the home. They did not attend the classes at the school to prevent them from getting new opportunistic infection. The final examination was sat at the nunnery school.

Nonetheless, the committee had come to notice the ineffective outcomes and its reasons. There were three main reasons. First, although the curriculum was taken from nunnery education school, the teachers were not the school teachers. As such, their teaching was a bit different to the school teaching. Secondly, the teachers were as care givers. As such, the children were not frightened and obedient them.

Lastly, the children were not stressed and taught because they were infected the serious deadly disease.

The home committee sought another way to school education. They had three challenges to choose the government schools. Primarily, the home regardless of being HIV infected was viewed degrading in East Dagon Township. Prior to settle down Thukha Yeik Myon in East Dagon, the small homes encountered difficulties in school enrolment of orphans. Schools looked down them as loosen admonished children.

In addition, there were HIV-born children who lived with parents in the community. HIV status of their family was spread through neighbors until the school teachers in the same community. The school near their home did not want to receive those children. When they were inevitably received, the children faced discrimination because of being HIV positive. Hence, the parents did not choose the school near their home.

Likewise, different educational backgrounds of the children were a challenge to school enrolment. They were identified when they arrived to the home as the children who were too young to attend the school; who were still schooling; the children whose education were interrupted by different causes; and the children who had no opportunity to attend school. The home staff asked the children whether they wanted to attend the school. If the child wanted to attend the school, they would find the way how to fit the age and educational level of the children with that required at the mainstream schools. If the child did not want to attend school, they were considered to learn vocational courses.

Like the above underlying situations, there were resent status that most children were over aged, enrolment of 40 or 50 children was significant and the government schools had limited space to accept large number of children at once. Therefore, the home committee had assumed that the government schools were not appropriate for the first enrolment to basic education school. At that time, the director presented the difficulty of the children to access education in a child-network training. The representative teacher of Pyinyar Yarma Monastic School committed that she could assisted the children. Then, the monastic school became the entry point to basic education.

Currently, 93 children were attending in two monastic schools and two government schools. Grade 1 and 2 children were enrolled at a monastic primary school near the home. Sixty children were attending at a monastic middle school in Mayan Gone Township from Grade 3 to 8. Inevitably after Grade 8, children were moved to a public high school in East Dagon where the home was situated in. In addition, two HIV-born children were schooling at another public post primary school in East Dagon. Table 4.2 presents the grades and schools for students from Thukha Yeik Myon.

Table 4.2 Students of Thukha Yeik Myon in four different schools

Name of School	G 1	G 2	G 3	G 4	G 5	G 6	G 7	G 8	G 9	G 10	G 11	Total
Zayar Thiri monastic School	8	12										20
Pyinyar Yarma Monastic School			16	14	12	7	5	6				60
BEPPS 8, East Dagon						1	1					2
BEHS 8, East Dagon							1		6	1	3	11
Total	8	12	16	14	12	8	7	6	6	1	3	93

Structure of Basic Education School

Basic Education in Myanmar consisted of five years for primary level, four years for lower secondary level, and two years for upper secondary level. Primary education was compulsory and free for the students. To continue onto secondary school, students must pass a comprehensive examination of basic subjects held by the Board of Examination at township level. Upper secondary level students chose one of two tracks upon entering high school: science or arts. All studied Myanmar, English and mathematics. Arts students studied geography, history and economics, while science students concentrated on chemistry, physics and biology instead. At the end of secondary level education, students had sat the matriculation examination annually administered by the Myanmar Board of Examinations in March to continue the University education.

Table 4.3 Duration and prescribed ages for the children in basic education

Level		No. of Years	Age	Grade
Lower	Primary	3	5+ to 7+	1 to 3
Upper		2	8+ to 9+	4 to 5
Lower	Secondary	4	10+ to 13+	6 to 9
Upper		2	14+ to 15+	10 to 11

Source: Department of Education Planning and Training, MOE (Myanmar)

Alternative Pathway to Education for Over-Aged Children

With the aim of access to primary education for over-aged children, a special program was being implemented at basic education schools. The program enabled children who were of aged 7+ or 8+ to complete primary education in three years and for those who were 9+ to complete primary education two years. Specially designed prescribed texts and teachers' manual had been introduced to instruct the over-aged children. The lessons were extracted and taught by summarizing to conform to the time available but this in no way lessens the achievement.

The over-aged children were taught together in Grade 1 with regular students. Afterward, they were instructed separately by using the multi-grade teaching method. To promote them to another grade, the Child Centered Approach (CCA) and continuous assessment system were used. Oral questions and answers were utilized for Grade 1 and 2, and chapter end tests were used for Grade 3, 4 and 5. After completion of upper primary education, they will gain access to lower secondary level education.

4.1.4 Life at School

Majority of HIV-born adolescents experienced the situation of over-aged for primary education enrolment. Teachers in the monastic school admitted them. The teachers adopted the alternative pathway or non-formal education instead of the normal way as the children who started schooling from Grade 1 with the aged 5. They applied a curriculum which combined curriculums of Grade 1, 2 and 3 to teach them, and held chapter end tests to those children. After completed the course, the teachers allowed to start attending the HIV-born children in the formal education Grade 4.

Fortunately, they fixed in non-failure education system which resulted in to continue their schooling.

The respondents in this study were attending in two different school: Pyinyar Yarma Monastic School and BEHS 8, East Dagon. All students in the monastic school were learning from 12:00 noon to 5:00 p.m. The school time for BEHS 8 was divided into two times: from 6:45 a.m. to 12:00 noon, and 12:00 noon to 5:00 p.m. Students from Grade 9 to 11 in BEHS 8 had to attend the morning school.

They were schooling and getting higher grades. After Grade 8, they transferred to the public high school. The teachers of monastic school had known they had HIV. Currently, majority of infected children were schooling there. The teacher had decided that the non-infected students were necessary separation from the infected students not to be contagious. The last rows in the class were for the students with HIV. A room was arranged to have lunch. The teachers' arrangement to learn together with HIV-negative students had come the discrimination specific to HIV. Existed social stigmatization also comes along with it to such children. HIV-associated stigmatization was more advanced at school. School teachers mainly stigmatized HIV infected students. Despite outstanding, infected students were supposed they did not deserve to be chosen as school representatives in the public or in multi schools' activities owing to being HIV infected.

The parents of non-infected students fueled the stigmatization at school. Because parent had known that HIV-infected children were schooling in their community schools, they avoided enrolment of their children. They believed that HIV infected students was source of incurable infection to their children. Some parents strictly banned their children not to play with the infected students at school. Mothers of HIV negative students looked at their children from outside the school compound. The teachers also watched the infected children during school hours. As a consequence, HIV-infected students isolated among HIV negative counterparts in the school.

In addition, students who were not HIV imitated as their parents and teachers perceived HIV. They treated HIV-infected students in stigmatized ways. They called HIV-infected student as "guy who had 4 digits disease" or "guy bitted by A" even though they did not know HIV exactly. The negative treatment of the students

marked embedded fear to the HIV-born students' mind. Even though the home had fully supported them, the treatment of people in the schools depending on the HIV status adversely affected on the school life of HIV-born adolescents.

4.2 The Respondents

In this study, nine respondents participated in the in-depth interviews. Five girls and four boys from two different schools shared their experiences.

Table 4.4 Characteristics of respondents

No.	Name	Age	Gender	Religion	Grade	School	HAART	Arrived age to the home
1	Ms. Ayechan	19	F	Buddhist	9	BEHS 8	1 st Line	12 years, 6 months
2	Ms. Theingi	17	F	Buddhist	9	BEHS 8	1 st Line	9 years
3	Ms. Ei	16	F	Buddhist	9	BEHS 8	1 st Line	10 years
4	Mr. Ye	16	M	Buddhist	9	BEHS 8	1 st Line	5 years, 6 months
5	Mr. Nyi	15	M	Buddhist	8	Pyinyar Yarma Monastic School	2 nd Line	11 years
6	Mr. Shine Lin	15	M	Buddhist/ Christian	8	Pyinyar Yarma Monastic School	1 st Line	12 years
7	Ms. Thandar	14	F	Buddhist	6	Pyinyar Yarma Monastic School	2 nd Line	11 years
8	Ms. Kyizar	14	F	Buddhist	10	BEHS 8	1 st Line	12 years
9	Mr. Naing	14	M	Buddhist	6	Pyinyar Yarma Monastic School	1 st Line	11 years

Five HIV-born adolescents were from BEHS 8, East Dagon, and four adolescents were schooling at Pyinyar Yarma Post Primary Monastic School. The oldest respondent was 19-years-old, and the youngest was 14-years-old. All were under HAART, and two HIV-born students were taking second line HAART. Seven respondents were sent to Thukha Yeik Myon Home at the age after 10. A boy arrived the home at the aged 5 years and 6 months old. Both parents of all respondents passed away. (See table 4.4) Their profiles are described in the following.

Ms. Ayechan

She was 19-years-old girl who was schooling in Grade 9 at Basic Education High School No.8, East Dagon. Her ethnicity was Bamar and she is a Buddhist.

When she was young, her father sold heroin to earn for the family. Both of her parents were HIV-infected. Owing to suffering from AIDS, financial status of the family was tight even for the daily expense. Her father had come to have lesser wife. Afterward, he passed away. Ayechan just attended Grade 1. She dropped out in the Grade 1 because of lack of money even for the family standing. Her mother became vendor with three children. Either her brother worked. Later, her mother could do nothing. She had both AIDS and Tuberculosis (TB) and later passed away. Ayechan had to take care of her younger sister, and saw the doctor in the clinic. Her younger sister also had inborn-HIV. The eldest brother who had no HIV worked.

When she was 12-years-old, the staff of Thazin clinic in Hlaing Tharyar Township arranged and sent her and her younger sister to the Thukha Yeik Myon Home. Then, a kindergarten teacher taught her from Grade 1 school lessons. After that, she was enrolled at Pyinyar Yarma Monastic School from Grade 4. She attended from Grade 4 to Grade 8 at the Monastic school, and she moved to BEHS 8 in East Dagon Township.

HAART was started after getting the home. She and her younger sister regularly see the doctor, and get regular supply of HAART at Thazin Clinic. She is taking first line HAART at 8:00 p.m. every day.

Ms. Theingi

She was 17-years-old girl, and she believes in Buddhism. She was schooling in Grade 9 at BEHS 8, East Dagon.

She attended the school when she was at her home. However, she had poor education performance. Since she could not follow the school lessons, she always got a punishment by having her palms beaten at school. She could not stand it. Therefore, she dropped out the school in Grade 3. That was also because of poor health status. At the aged over 10 years in 2006, her relatives sent her to the Thukha Yeik Myon Home. She restarted schooling there. At first, the home staff taught her literacy at the home. Afterward, she was enrolled at the Pyinyar Yarma Post Primary Monastic School from Grade 4. From Grade 4 to Grade 8, she attends at the monastic school in Mayan Gone Township. After Grade 8, she transferred to BEHS 8, East Dagon.

When she lived with her aunts in Hlaing Tharyar Township, she did not take the drug regularly. It had to be taken at 9:00 a.m., or sometime at 10:00 a.m. As she did not speak much, her aunt suspected that she had a small portion of brain impairment. She was not allowed to go outside. If the guest came, she was not allowed to meet with them. There was no child to play with her. Her aunts did not let her go outside. In addition, she had to assist her aunts the house chores. She lived there up to 10-years-old. After getting to the home, no one had come and meet her in spite of having three siblings and relatives. She and her siblings were divided and adopted by the relatives after her mother passed away with AIDS. She did not receive any news of her siblings since she was at her aunties' home.

She had been under first line HAART for seven years. Her treatment regimen had to be taken at 8:00 a.m. and 8:00 p.m. every day. Her health care provider was Thazin Clinic (Tharkayta). She believed that the responsible teacher for Grade 9C and Geography teacher knew she had HIV.

Ms. Ei

She was 16-years-old, and was attending Grade 9C at BEHS 8 in East Dagon Township. She was Bamar in ethnicity, and she believes in Buddhism.

She was from Pa Koke Ku town which was in the middle part of Myanmar. She passed Grade 5 in her home town. Although she had school transfer letter, the teachers of Pyinyar Yarma Monastic School supposed that she had not

digested Grade 5 lessons. Thus, she restarted schooling from Grade 4 in the monastic school.

In her home town, since both parents passed away due to AIDS, she lived with her grandfather at first. She was the only child. When her grandfather died, she was sent to the Christian nunnery in Pa Koke Ku Town. At the age 10 in 2009, the Christian nuns arranged and sent her to Thukha Yeik Myon Home.

HAART was initiated after getting the home. She had been under HAART since 2009. She had taken first line HAART twice a day: 8:00 a.m. and 8:00 p.m. Her health provider was Thazin Clinic (Tharkayta). Her responsible teacher of Grade 9C knew that she had HIV.

Mr. Ye

He was 16-years-old boy attending in the Grade 9C of BEHS 8 in East Dagon Township. He was Bamar and Buddhist. From Grade 4 to Grade 8, he attended at the Pyinyar Yarma Monastic School.

When he got to the home, he was 5-years-old in 2005. Either his elder HIV-born brother was sent together with him to the home. They involved in first nine children of Thukha Yeik Myon's beginning. Now, his brother was under care of a local organization for vocational training. After sending them to the home, their mother visited and met with them. Sometime, she did not come to them. Later, she passed away with AIDS.

Thazin clinic was supporting him first line HAART and medical services. He had been taking HAART for three years. HAART taking time was 8:00 a.m. and 8:00 p.m.

Mr. Nyi

He was 15-years-old student of Grade 8 in Pyinyar Yarma Monastic School. He was Bamar in ethnicity and Buddhist.

When he was young, he lived in Thailand. After his parents died, he was back from Thailand with his elder brother. Afterward, he lived in a monastery for six years. He had not to learn school education. He just learnt Buddhist course in the monastery, and prepared for the examination held to test knowledge of Buddhist scriptures. However, he had not sat the exam due to be hospitalized.

By the time he was in monastery, he frequently had fever, and admitted at the Yangon General Hospital. Next, he was transferred to the Specialist Hospital, Waibargi. Anti-TB drug was given. Almost at the same time, he was sent to the home and initiated HAART at his age of 10. His treatment was changed to second line after two years' duration of first line regimen. At the home, he was taught school education in the home first, and he started schooling from the Grade 4 at Pyinyar Yarma Monastic School in 2000-2001 academic year.

Currently, he had got the drugs from SHM. He had been taking HAART for almost five years. He had to take HAART twice a day: 7:00 a.m. and 7:00 p.m.

Mr. Shine

He was 15-years-old school boy who was attending in Grade 8 of Pyinyar Yarma Monastic School. His ethnicity was Kachin, and he believed in both Christianity and Buddhism.

He was from Phar Kant in Kachin State. He attended Grade 1 to 6 in the government primary school in his hometown. His mother was strict in relation with education. In his Grade 4, his mother died. After four or five months, his father passed away. He lived with his grandmother in Phar Kant in Kachin State after his parents passed away with HIV. School was near his home. Starting from Grade 5, he played truant, played the TV games, and went here and there. As a result, he failed the final exam of Grade 5. He repeated the Grade 5, and he passed. Afterward, he continued Grade 6. Again, he failed Grade 6 final exam. As such, he was decided not to enroll anymore in the school in Phar Kant. He was sent to Thukha Yeik Myon Home when he was 12-years-old. He had been attending at Pyinyar Yarma Monastic School starting from Grade 6 in 2012-2013 academic year.

HAART was initiated in his Grade 4 when he was at his home. Thazin Clinic was near his home. He had been taking HAART for almost four years. Drug taking time was 8:00 a.m. and 8:00 p.m. every day. He had known his HIV status since he was 10-years-old. He was supported HAART by Thazin Clinic (Tharkayta).

Ms. Thandar

She was 14-years-old girl attending Grade 6 of Pyinyar Yarma Monastic School. She was Bamar and Buddhist. Her mother passed away when she was in Grade 2. She was the only child.

When she was young, her schooling was frequently interrupted because of her mother chronic illness and hospitalization. In addition, she was hospitalized on account of the opportunistic infections as a result of the noncompliance upon the strict treatment regimen. Consequently, her school-absent days were long and frequent. She had indigested lessons and repeated grades. She had repeated Grade 2 for one time and Grade 3 for two times. At present, she was in Grade 5 instead of attending in Grade 8.

At the age of 7, her grandmother told her that she had HIV. At the beginning, first line HAART was initiated. Nonetheless, she had drug failure because of poor adherence to HAART. Consequently, she suffered TB, and became bed-ridden. Second line HAART was changed when she was in Grade 3 and in her home. Her drug taking time was 7:30 a.m. and 7:30 p.m. Health care provider was SHM. After that, she was sent to the home in 2012. She had started schooling at Pyinyar Yarma Monastic School from Grade 4 in 2012-2013 academic year.

Ms. Kyizar

She was 14-years-old student of Grade 10 in BEHS 8, East Dagon. She was Bamar in ethnicity and Buddhist.

When she was young, she always won 1 to 5 academic position up to Grade 6. She attended at BEHS 6, North Dagon until Grade 10. After that, she transferred to the current school to attend Grade 10. People in the school were not aware she had HIV. Even the responsible teacher of Grade 10C did not know about it, but the teachers just knew she lived in the home.

Her mother died with TB or other diseases when she was young. Her cause of death was unknown. She had one elder sister and one elder brother. She was the only HIV-born child among her siblings. Her elder aunt adopted her and her siblings. Both her elders got married. In March 2013, she got into the HIV home. Her adoptive mother gave hope that she could go back to her home after Grade 11.

When she was initiated HAART at her home, the time was adjusted with the school time. It was daily taken at 6:30 a.m. and 6:30 p.m. She had been taking HAART for over two years. She had gone to SHM every two months to see the doctor and refill HAART.

Mr. Naing

He was 14-years-old student of Grade 6 in Pyinyar Yarma Monastic School. He was Bamar and Buddhist.

He lived with his grandmother in Meik Htilar town before living in the home. He passed Grade 3 in his hometown. Afterward, his aunt brought him to Yangon to live with them. He restarted schooling from Grade 1 in Yangon because of having no school transferred letter. After few months, he ran away from the home because the husband of his aunt tortured him. A monk saw him in the pagoda near Bayint Naung Bridge in Hlaing Tharyar in the evening, and brought him to a monastery in Pale new town. In the monastery, he became a novice, and continued schooling.

When he lived in the monastery, he had known he had HIV. He met and saw Dr. Nyo at Thukha clinic to treat winter-sweatfungi. She said that he has HIV. She said him, and the monk there was a home for the children who had HIV. In 2012, he had got into Thukha Yeik Myon Home. The staff of the home arranged him to see the medical doctors at SHM. After arriving the home for two weeks, he was started HAART at the aged 11. HAART taking time was 8:00 a.m. and 8:00 p.m. every day.

Schooling at the monastic school was started from Grade 4. At the monastic school, he was out of the school for one year as soon as he began Grade 4. He was hospitalized three times in that year. Later, health status become better and better. He did not need to be absent long.

4.3 The Key Informants

There were four key informants: two home staff, the director of the home and the representative teacher of the Pyinyar Yarma Monastic School gave the

interview. All key informants indicated that they had close relationship with the HIV-born adolescents.

Table 4.5 Characteristics of key informants

No.	Name	Age	Gender	Religion	Marital Status	Job Title	Working period
1.	Ms. Nyo	52	F	Atheist	Single	Director of the home	10 Years
2.	Ms. Ni	47	F	Buddhist	Single	Representative teacher, Pyinyar Yarma Monastic School	25 years
3.	Ms. Yin	42	F	Buddhist	Single	The home staff	10 years
4.	Ms. Marlar	30	F	Buddhist	Single	The home staff	6 years

The two staff from the Thukha Yeik Myon Home lived together with the children for a long time. They were very close to the children. They involved in daily life of the children. As they understood HIV-born children's challenges both at the home and the school, they have been trying to find the ways to overcome the challenges with the children together.

In addition, the director of the home was the medical doctor of the children for minor illness and on contact of emergencies. As she was the decision maker of the home, she was the explorer to fix HIV-born adolescents into school. She also acknowledged that social integration in school and quality of school life of HIV-born adolescents were current major challenges for the home.

Lastly, the representative teacher of the Pyinyar Yarma Monastic School was essential at the monastic school where HIV-born children were accepted. She had experienced for 5-years-school life of HIV-born children. She encountered the most of the challenges regarding HIV-born children at the school.

4.4 Research Findings

This study assumed that the social integration of HIV-born adolescents might be related to the existed surrounding conditions within and outside the physical school space. Those conditions could be considered as barriers to their engagement in school. The predisposing contexts found in this study, are presented at two levels: (1) institutional context and (2) individual HIV-related conditions. Institutional context consisted of the interactions between the HIV-born adolescents and their schools, HIV home and health care facilities. Individual HIV related conditions involved health status and stigma. Then, the interpersonal relationship between the HIV-born adolescents and the home staff, teachers, classmates and classmates' parents were reported to reflect how well (or how poor) the HIV-born adolescents could be engaged in the school environment. Finally, the respondents' perception on their quality of school life was presented.

4.4.1 Institutional Context

(a) School

School Enrolment Procedure

Generally, the official primary school entrance age was eligible at five. The school accepted the children according to the standard procedure. Generally, new enrolment for Grade 1 required the birth certificate for admission. However, many children from Thukha Yeik Myon Home knew neither name of the parents nor their birth date. Some HIV-born children were admitted around at the age 10 to 13-years-old at the Monastic School.

Among total nine HIV-born adolescents interviewed, 8 adolescents did not match with prescribed age in the Primary Education. A school girl mentioned that she restarted her basic education after getting into the home. At first, the home staff taught her. After that, she schooled at the age 10.

“I am 17-years-old. I restarted schooling when I got here. The age was over 10 years. I was taught the school lessons here at first. Then, I was enrolled at the Pyinyar Yarma Monastic School.” (Ms. Theingi, 17-years-old, Grade 9 student, BEHS 8, East Dagon)

Prescribed Age for Basic Education

While the monastic school teachers were flexible to join to formal school education, they were still the oldest students in the class along schooling. When they transferred to BEHS 8, their age was noticeable in the class. An oldest respondent felt worried since her responsible teacher of Grade 9C asked about her age. She was not confident because she had known that she was the oldest in the class, and she physically grew more than others.

“I am older than my grade. The responsible teacher called me and told whether I had known my birth year. I replied that I knew. When I sat down in my place, the teacher looked at me and said something to a teacher next to her.” (Ms. Ayechan, 19-years-old, Grade 9 student, BEHS 8, East Dagon)

That student therefore wanted to make the friends who was as same physical growth as her in the class. She hoped that way could help to easily mixed with other students in the teacher’s view. Besides, she planned to work at the home after Grade 9 before end of basic education.

Class Arrangement

In the Pyinyar Yarma Monastic School, the school had placed HIV-infected children separately from other students in the class. At the beginning, the last rows were left for HIV-born students with the reason of visible wounds in the skin. Later, it became a usual placement for the next comers from Thukha although their health condition was better. This kind of placement could also be seen in the Zayar Thiri Monastic School. The teachers usually assigned class activities by row. The placement limited their chance to develop relationship with other students.

“All Thukhas are in the last rows. The teacher arranged for placement. If we read out the lessons, we went to the teacher row by row.” (Mr. Naing, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

At BEHS 8, Grade 9C was for poor academic performers such as repeaters, new students who transfer from other schools and the lowest academic position in the grade of last academic year. After Grade 8, HIV-born children had to move to BEHS 8. HIV-born adolescents were placed Grade 9C because they were new students. Grade 9 Thukha group had good academic record in the former monastic

school. Although there were new students in Grade 9C, teachers still generalized and recognized as the worst notorious classroom. From the student's view, Thukha students wanted teachers to recognize, understand, and respect their unique abilities. Whenever teachers scolded the whole classroom, they felt sad being in 9C.

“If I can, I wanna learn in classroom A. The bad thing of C room is that the teachers roughly say all students class C is the worst. As such, it likes telling me I am the worst even though I follow the teachers' instructions. The teachers also suppose classroom C students have poor academic performance.” (Mr. Ye, 16-years-old, Grade 9 student, BEHS 8, East Dagon)

In brief, HIV-born adolescents in the last rows received unequal academic benefits due to get less emphasis of the teachers as well as limited chance to develop social relationships. In addition, placement in the worst classroom C induced feeling of ignorance and lack of recognition which discourage those adolescents' school satisfaction.

School Time

Each academic year begins in June and ends in March. The basic education schools operated on a five weekdays rotating fixed schedule for the whole academic year. Normally, school time was from 9:00 a.m. to 3:15 p.m. including lunch time between 12:00 noon to 1:00 p.m. However, school time was divided into two times in in big cities and crowded towns: morning school and afternoon school owing to limited classrooms and increasing number of students. Morning school was between 6:45 a.m. and 12:00 noon. Afternoon school was from 12:00 noon to 5:15 p.m. There were six sections in fixed schedule, and each took 45 minutes. Break time started from 9:30 a.m. in morning school, and 2:45 p.m. in the afternoon school, and it lasted 15 minutes. All students in Pyinyar Yarma Monastic School were attending the afternoon school. However, Grade 9, 10 and 11 students in BEHS 8 had to attend the morning school.

School time for higher grade students was not convenient, but there was no other choice for those children in the home. They had to wake up at 5:30 a.m. in the morning, and prepare to go to school. They departed from the home at 6:30 a.m. if it

was not their team duty day. A student experienced absence the class because the school time was too early to wake up the students.

“I was absent the school for one day because I was late to wake up. It’s not good going to school in the morning or in the afternoon. It would be better if the school time is 10:00 a.m. to 3:00 p.m. Drug time won’t overlap the school time. I also won’t be absent due to wake up late.” (Mr. Ye, 16-years-old, Grade 9 student, BEHS 8, East Dagon)

School Time, Disciplinary measure and Strict Regimen

All respondents in this study were under recommended strict therapy, which referred to HAART. Strict adherence to HAART was key to sustained HIV suppression, reduced risk of drug resistance, improved overall health, and survival, as well as decreased risk of HIV transmission. Conversely, poor adherence was the major cause of therapeutic failure. Persistent adherence to HAART was a critical determinant of long-term outcome in HIV infected patients. In BEHS 8, HAART taking time overlapped the school hours. It was inevitable that they had to take the drug in the class.

The Most HIV-born adolescents were aware their surviving depends on HAART and strict compliance on it. A respondent’s drug time was 8:00 a.m. and 8:00 p.m. At 8:00 a.m. on every school day, he was trapped in the class. He took HAART not knowing by others in the class.

“School time is 6:45 a.m. to 12:00 noon. Drug is taken at 8:00 a.m. and 8:00 p.m. every day. I take the morning drug at school. When I take the drug, I hide and take it. The time cannot be shifted. If I don’t take at exact time, I will die.” (Mr. Ye, 16-years-old, Grade 9 student, BEHS 8, East Dagon)

When they took the drug in the class daily, they hid and took it since they were afraid to get a trace their health conditions to friends and teachers. A friend of HIV-born adolescents who was sitting next to her had come to notice, and asked her about the drugs. She dared not let her know the real situation. She lied and answered her friend.

“When the teacher explained the lessons, I pretended that I nodded down or sought anything behind the desk, and took the drug at once. I didn’t

take the drug with water. Then, I continued learning. My friend who is next to me asked what drug I was taking. I lied drugs for eyes.” (Ms. Theingi, 17-years-old, Grade 9 student, BEHS 8, East Dagon)

Moreover, there were strict disciplines prescribed by the teachers. Geography teacher did not allow eating any food or drink in her lecture. The adolescents had to take the drug in her teaching time every school day. Once the teacher had noticed a school girl taking the drug. She scolded as a disobedient student in the class. However, the HIV-born school girl could not explain her real situation to the teacher. She was not convenient in the class.

“The teacher doesn’t like speaking, drinking water and having snacks during her time. One day in last month, she saw I took drug. She scolded that I hadn’t obeyed her. I hadn’t followed what she said. This is not disobedient. I have my condition. Inconvenient in the classroom.” (Ms. Ei, 16-years-old, Grade 9 student, BEHS 8, East Dagon)

As this conflict situation disturbed subjective well-being of the adolescents, it gradually destroyed their physical health. HIV-born students at BEHS 8 got loosen adherence to HAART.

“Sometime I was late to take the drug because I had to follow and note down what the teacher read out.” (Ms. Theingi, 17-years-old, Grade 9 student, BEHS 8, East Dagon)

Attendance Expectation

Excused leaves were prescribed for the students on condition that chronic or acute sickness, prearrange appointment, religion, and unexpected or emergency circumstances emerged. The guardian needed to contact and requests with leave form to the responsible teacher to differentiate excused or unexcused absence. Minimally, schools allowed the students who met 75% attendance annually to sit the final. However, students were expected to be in school on every school day because it was obvious that absences limit academic potential.

Students with inborn-HIV were unavoidable regular absentees in the school for prearranged clinic follow-ups, or unforeseen health situations. HIV-born students who had got health care and HAART from SHM had to be absent at least four days for every six months.

“I have to go the Mingalar Don Specialist Hospital bimonthly to see the doctor. My next appointment is in October. I have to absent for one day when I go to the hospital.” (Mr. Ye, Grade 6 student, Pyinyar Yarma Monastic School)

Moreover, Thazin Clinic (Tharkayta) regularly appointed the children under HAART minimum three times per six months in the office days. Some children who had signs of drug failure or side effects of HAART were frequently appointed. A school boy whose CD4 dropped explained about his clinic appointments.

“I am regularly absent schooling every three months to refill drugs. Blood investigation is every two months. At first, I had to go frequently for blood testing. I had frequently to take leave for it. It’s because of CD4 drop.” (Mr. Shine Lin, 15-years-old, Grade 8 student, Pyinyar Yarma Monastic School)

Moreover, absent schooling induced stress upon the student with inborn-HIV who must catch-up missed work. Some were not willing to go to the clinic owing to delay of the study.

“I don’t like going to the clinic because I am late in school lessons.” (Mr. Nyi, 15-years-old, Grade 8 student, Pyinyar Yarma Monastic School)

In schools, as there were standardized and prescribed rules to maintain school functions, so also are there the *undocumented rules* based on the situation of the students in order to achieve school expectations. Undocumented rules were usually set to improve school reputation or to prevent it.

The final exams of Grade 5, Grade 9 and Grade 11 which were held by Board of Examination determined students to promote higher grade or not. Likewise, the percentage of passed students which was calculated based on number of exam candidates decides academic position of the school. It is the academic performance of the school. Thus, school wanted to reduce the exam candidates who had poor academic record.

BEHS 8, East Dagon did not allow the students sitting year-end exam for promoting the grade if he or she failed three subjects and above in chapter-end tests for three times continuously. However, it allowed to continue attending the class. The

teacher notified the students after the first chapter-end test of Grade 9. An HIV-born adolescent worried for this school rule, and her friend said:

“Theingi failed three subjects for two months continuously. If she fails in this month again.....She is sure not to sit the final exam.” (Ms. Ayechan, 19-years-old, Grade 9 student, BEHS 8, East Dagon)

School Mission and Vision

Ministry of Education, Myanmar was functioning with the vision “to create an education system that will generate a learning society capable of facing the challenges of the Knowledge Age”. Basic Education sub-sector had been conducting to produce all-round developed citizens according to the Thirty Year Long-term Education Development Plan (2001-2002 FY to 2030-2031FY). In addition, the mission of the basic schools upon students could be seen in the Comprehensive Personal Record (CPR) which record student participation in the activities listed for secondary level students.

- 1) Having 75% school attendance
- 2) Sitting regularly the chapter-end tests
- 3) Abiding by school rules and not indulging in social crimes
- 4) Fulfilling obligations to school, teachers, parents and the community and the taking care of the younger students
- 5) Growing trees, plants and making the school environ verdant and green
- 6) Participating in sports and physical activities
- 7) Giving assistance in parent’s livelihood
- 8) Keeping oneself neat and tidy
- 9) Participating in Aesthetic education such as involvement in literary activities, music, singing, dancing and painting
- 10) Participating in development tasks of the local community and the and the State
- 11) Offering voluntary service for community work
- 12) Participating in the activities of team, clubs and association of the school and the social activities such as the Red Cross, etc. (Ministry of Education, 2004)

Although students were expected widely, the teachers, parents and the students mainly focus on the school lessons and the exams. The representative teacher in the Pyinyar Yarma Monastic School clearly described the school expectation upon the students as:

“Our only expectation on all students is to pass the exam with high academic marks. This is also the way to keep our school’s prestige, and the existence of our school to keep on.” (Ms. Ni, Representative teacher, Pyinyar Yarma Monastic School)

Existed Stigma at School

Even though people in school did not know about the HIV-born adolescents, HIV associated stigma have existed in the school. The experience of stigmatization worsened in the school where people knew the health status of the HIV-born adolescents. In this study, HIV-born adolescents had experienced the double stigmatization regarding being HIV infected as well as being orphan. Before presenting the social stigmatization at school, ways of HIV status dissemination would be introduced at first.

1) Disseminating HIV status in the school

When HIV-born children enrolled in Pyinyar Yarma Monastic School, the director disclosed the representative teacher in regard to the health status of the children upon necessary. Children were accepted in the Monastic School. As schooling was longer at the monastic school, HIV status of the children was later exposed. It was disseminated to the schools’ environment through the teachers, the HIV-born children themselves, and the home.

HIV-born children in the home have been schooling in the monastic school for five years, and HIV status of the children has disseminated and become known. All people in Pyinyar Yarma, some parents of students, and snack shoppers in front of the monastery had known HIV infected children were attending in the monastic school.

“All people in school have known we have this disease. People have known what Thukha Yeik Mon Home is. All are aware if someone is from this home. Parents also know.” (Mr. Naing, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

Another way of dissemination was also through the younger children from Thukha Yeik Myon to their classmates. An older school girl shared her feelings as:

“The bad thing is younger students from Thukha said everything at school in terms of what happen in Thukha, the drugs they are taking and the disease they suffer.” (Ms. Ei, 16-years-old, Grade 9 student, BEHS 8, East Dagon)

A Grade 8 school boy had disclosed his HIV status to his close friend. However, his friend had known his health status. He said the closeness allowed to know the private things. In addition, people in the Monastic school had matched Thukha Yeik Myon and HIV.

“When I disclosed my friend, he told me that he had known. He knew by himself. At first, people there didn’t know. Later, familiarity let people know the personal as well as having the disease. If the name ‘Thukha Yeik Myon’ is heard, they knew it together with this disease.” (Mr. Nyi, 15-years-old, Grade 8 student, Pyinyar Yarma Monastic School)

In addition, the home is financially depending on the funders. If the funders come, they knew about the children via the home palm flat. Some teachers in BEHS 8, East Dagon knew that students from Thukha Yeik Myon were infected with HIV. Since the school was near the home, they had been and donated the home children. However, almost students in BEHS 8 were not aware both HIV status of those adolescents.

“Home depends on the donors. The teachers of BEHS 8 had been here and donated two to three times. They asked us about the children. We just gave the pamphlets which present brief explanation about the home.” (Ms. Yin, Staff of the home)

To conclude, confidentiality was not really protectable. In some schools, the status was exposed as “Thukha Yeik Myon equals to HIV” whereas some school was not, that is, the teachers knew the status, but not the students.

2) Existed stigma associated HIV

People in the school kept the view about HIV that it was deadly disease, no cure, hopeless. A teacher of BEHS 8 explained HIV/AIDS lessons to the students as she perceived about HIV. She compared with other hopeless diseases to survive. In

addition, she highlighted that HIV carriers were difficult to avoid because they were as similar as healthy people.

“The teacher said in the class that HIV-infected and non-infected people cannot be differentiated. HIV involves in the kind of diseases which have no prevention, no cure as cancer.” (Ms. Kyizar, 14-years-old, Grade 10 student, BEHS 8, East Dagon)

This made some students did not want to be friend with a person who had HIV. They gossiped because of having HIV.

“Some students who don’t get along with us said about us behind us. They said not to make friends with us because we have this disease. Some friends said me back.” (Mr. Naing, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

Furthermore, HIV-born adolescents had verbally harassed specific to HIV. A school girl of BEHS 8 annoyed because the HIV-negative students cautiously responded each other even her sneezing when she was at the monastic school.

“When I was at Pyinyar Yarma, I sneezed. One student behind me told her friend, “Hae! Hae! She sneezes! She sneezes! HIV! HIV!” I felt annoyed.” (Ms. Theingi, 17-years-old, Grade 9 student, BEHS 8, East Dagon)

Seven out of 52 students in Grade 6 were Thukha students. Other students in the class told each among them not to be close to Thukha group when they suspected that a person from Thukha group was sick.

“When we were ill, they told that we (Thukha) have disease, stay away with us (Thukha), they (you) will be infected. Once, we felt cold, and we wore warm clothes. They told not to stay near her, not to come close Thukha.” (Ms. Thandar, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

People in the Monastic School scared no matter what happened in small group of Thukha students. Consequently, the HIV-born adolescents skipped schooling on condition they had any kind of wounds, minor illness, fever, and cough with or without blood-stain.

3) Existed stigma associated with being orphans at school

HIV-born students were double stigmatized at school based on being HIV positive and being orphans. A respondent said that students who had no HIV behaved as they had superiority owing to have parents. They degraded being parentless of HIV-born adolescents as a weak point.

“It would be better if others don’t know we are living here. Some asked me whether I have mom and dad. I nodded that I have. Yeah! If I answer I haven’t, they dispraise me. They have parents, but we don’t have. They censured that we are different with them. When we have a quarrel, they told that they have parents; we are parentless.” (Ms. Thandar, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

Likewise, the teacher negatively assumed that they were from the place of weak or lack discipline.

“The place where Thukha children are from, is not strict in discipline, and less admonishment.” (Ms. Ni, Representative teacher, Pyinyar Yarma Monastic School)

4) Solution of the home to stigmatization

Since the children were stigmatized at school, the director had decided not to disclose the status of the children in next enrolment in higher school.

“When we disclose like this at first, it isn’t convenient both for the children and school enrolment. We can’t do anymore. It’s not we lie or we hide or we keep as a secret about the children’s status. It is just that we don’t say about it. We don’t say this child is that. Then, we enrolled him/her like this.” (Ms. Nyo, Director of the home)

(b) HIV Home

Permissions to Engage in Social Activities

The home was totally responsible for all HIV-born orphans. If there is any special activity in the school, the children had to request the permission of the home to join it.

The monastic school usually arranged the school excursion. The students who got academic position from 1 to 10 in each grade were eligible to join the activity. Some HIV-born adolescents qualified for the excursion. However, the home did not allow them.

“For the excursion, the teachers called only the best students grading 1 to 10 of the respective class. In Grade 8, I got seventh position. They went to the Kan Daw Gyi Garden, and amusement park. I didn’t go along with them because moms didn’t allow me. I don’t know why.” (Mr. Ye, 16-years-old, Grade 9 student, BEHS 8, East Dagon)

In addition, the home did not allow playing games with teams such as football or volleyball which enhanced joint activities. Playboys needed appointments with opponent team which were usually different teams in the class, different grades or different schools. Those games were strictly prohibited to prevent fighting.

“Making appointment and playing football with friends are banned here, in case we have a quarrel.” (Mr. Nyi, 15-years-old, Grade 8 student, Pyinyar Yarma Monastic School)

Rules, Regulations and Requirements in the Basic Education Schools

Commonly, each and every test or exam was accepted and focused as the most important for all students. By contrast, the home staff said that health matter was the very first prioritization for those children regardless of any other issues including the exam. They had the view that HIV-born students enabled to sit the exam as long as they were healthy.

“Follow-up for blood investigation, the date and time are fixed, and number of patients are limited. We take leave on that day anyhow. The exam can be sit again. Their health is more important than education. Their education will become to a certain level in a certain time. That’s why we decided to be absent the exam if necessary. We have to choose one.” (Ms. Marlar, Staff of the home)

Lack of Resource

When the children started schooling at Pyinyar Yarma Monastic School, transportation was not adequately arranged because of insufficient funding. In first

academic year, the children were divided into two groups in respective grade. They were arranged to attend the school on alternate days. Group 1 attended Monday, Wednesday and Friday. Group 2 went to school Tuesday and Thursday. In next week, group 1 attended for two days, and group 2 attended for three days. Two teachers were recruited for two groups. The teachers also learnt the course to teach the students group who had not to attend the school.

“Let’s say there are five lessons for five weekdays. They attended only for three days. They missed two lessons. If those missing two lessons were connected with the three lessons they learnt, the students lost the link. As a result, they lag behind other students in the class.” (Ms. Ni, Representative teacher, Pyinyar Yarma Monastic School)

The teacher said attending school on alternate day was inconsistent for the children. It decreased their academic motivation. They were unable to follow the teachers’ instructions. On the other hand, most staff who closely manage the home did not have even lower secondary level educational qualification in order to understand it and take care of the HIV-born students.

“The staff hasn’t passed even the Grade 9. Just a Degree holder here.” (Ms. Ayechan, 19-years-old, Grade 9 student, BEHS 8, East Dagon)

Fortunately, basic education schools practiced non-failure education system. They passed the final exam and upgraded to higher grade. The children attended the school in that pattern for two years. Later, the monastic school did not allow it any more. When the home bought bigger car, they had been schooling every day.

(c) Health Care Facilities

Inflexible appointments of health facilities pushed an HIV born adolescents to be an absentee of the chapter-end test. The subject which he was absent to sit was his most interested subject, History. He usually got the highest academic marks in History. In that monthly test, his academic position got lower than last month.

“On the day to test History, I had to go hospital for blood investigation. Actually, Thursday, Friday and Saturday, three days for six subjects.

Being two reading subjects on Saturday, the teacher moved history test to Monday. The teacher let's know on Saturday. On that day, second line HAART takers were appointed. The day to refill the drugs can't be changed. It disturbed my mind. Because of that, I forgot all I read.” (Mr. Nyi, 15-years-old, Grade 8 student, Pyinyar Yarma Monastic School)

4.4.2 Individual's HIV-related Conditions

(a) Physical Health Status

HIV infected status determined friendship in school. If classmates knew that a student had HIV, they did not come close him or her. A respondent of the monastic school had noticed a school girl had HIV. However, the students did not know her that she had HIV. They befriended with the girl. In addition, they made friend with students who had other diseases such as diabetes and asthma. It was obvious that HIV status negatively influence on close friendship with friends.

“Classmates come near and stay with the students who have diabetes and asthma. Likewise, they come close to the student with HIV not from Thukha because nobody knows her HIV status.” (Ms. Thandar, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

The next respondent supported that her HIV status disturbed her close friendship with her friends at school. She cried and said:

“If the friends who are not from the Home know about me, I cannot absolutely get along with them.” (Ms. Ayechan, 19-years-old, Grade 9 student, BEHS 8, East Dagon)

(b) Social Health Status

Even though HIV-born adolescents looked as healthy as their counterparts, they had stigma associated HIV. Their HIV associated stigma was revealed as own resistance of HIV-born adolescents who linked to the school society.

Internalized Stigma

HIV-born adolescents had internalized fear having HIV which came through socializing with people. People undesirably treated them because of fear to

transmit HIV. HIV-born adolescents were afraid to deal with those people. They felt hopeless and insecure because of no complete cure, and people's unwilling conduct.

"I am afraid that. This disease cannot be cured. People think if this is infected, the infected person will die. They are frightened lest they are infected this incurable virus. Some friends who are living with their parents don't want to make friend who has this disease." (Ms. Theingi, 17-years-old, Grade 9 student, BEHS 8, East Dagon)

HIV-born adolescents seemed as fit as their uninfected peers. Internalized stigma settled in their mind. When coincidence occurs, their internalized feeling appeared.

"Two guys bore a whole in their ears each other in the class. The teacher said, "Be careful guys!! You will get HIV. You will be bitten by A." I had goose-flesh at once. It was as she intends to me. Then, she said, "Be aware!! You will get AIDS. The teacher doesn't know about us." (Ms. Ayechan, 19-years-old, Grade 9 student, BEHS 8, East Dagon)

Felt Stigma

HIV-born adolescents had experienced social stigma and discrimination in the monastic school. Consequently, they were frightened of being stigmatized again at BEHS 8. If their HIV status was uncovered, they worried that they could not make friend with their classmates. They believed that their classmates would discredit and dispraise them.

"I am afraid that I can't get along with others. If so, I am afraid lest he or she degrades and says me. This is because I have weaknesses. Although they don't know me, I know myself I have this disease." (Ms. Kyizar, 14-years-old, Grade 10 student, BEHS 8, East Dagon)

They were afraid that close contact was stopped by friends.

"Classmates don't know I have this disease. But, if they know, they will stay away with me. They won't lend their note book. It doesn't happen yet. But, I am afraid that." (Ms. Theingi, 17-years-old, Grade 9 student, BEHS 8, East Dagon)

Likewise, HIV-born adolescents in the Monastic school had concerns to face social stigmatization by the time they transfer to the higher school.

“By the time we move to Government School, I think I don’t tell others that I have this disease. I worry that no one stays with me in outside school (High school). I am afraid I will face again the same situation at Pyinyar Yarma.” (Mr. Naing, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

Perceived Stigma

HIV-born adolescents accepted that people viewed HIV as negative characterizations. Negative self-acceptance became barrier to be socially cohesive with students who had no HIV. It was found in an HIV-born adolescent starting from the way going to school.

An HIV-born school girl said that people on the way to school expressed their dispraise when they saw the Thukha Yeik Myon name stuck on the car. She though that people on the road had known Thukha Yeik Myon was the home for HIV children. Thus, they behaved like that.

“When we went to school, people looked at on the street. (crying) Blue car has Thukha Yeik Myon sticker on the front glass. At the traffic point, I found many school buses. People in the buss make a wry face. (crying) Some people on the street have known Thukha Yeik Myon is what kind of home. They pointed with their index finger and grimace. I felt very very something. Their chin is up.” (Ms. Ayechan, 19-years-old, Grade 9 student, BEHS 8, East Dagon)

A respondent did not trust her classmates. She believed that they would distribute about her HIV status if they knew it. Because of her concern, she lived separately with her classmates.

“Friends from outside don’t exactly know about me. I am afraid they will pass over about me to others if they knew about me. Some girls’ tongue cannot be trusted even though they are friends. Thus, I dare not mix with others.” (Ms. Theingi, 17-years-old, Grade 9 student, BEHS 8, East Dagon)

4.5 School Engagement at Interpersonal Context

At school, HIV born students mainly interacted with the teachers, and students who had no HIV. Parents of other students and the home staff had indirectly influenced on their school engagement.

4.5.1 Responsibility

In basic education schools, students had to share tasks for classroom tidiness as well as the study obligations. Students were divided and assigned fixed classroom duties according to five teams in five school days. School girls had to sweep the classroom, clean the cups to drink water and change flowers to offer Buddha. School boys had to arrange benches to sweep the room easily, and fill drinking water. HIV-born adolescents had to go school early in their duty day.

“My team duty is on every Monday. Thukha students always arrive the school early. I sweep and clean the teacher’s table. I am the only girl among boys who arrives early. I do all classroom cleansing alone. Mr. Naing (Thukha) arranges the seats to sweep all dust. He cleans the cups to drink water. Late comers have to clean the toilets.” (Ms. Thandar, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

Respective team members had to work together in regarding duty day. Mr. He took the suitable assign and usually did his duty after the class.

“On my team day, I cannot go to school early. They do the team duty in the morning. I do it in the afternoon. I don’t adjust with other team members. I do by myself. Other team members don’t say me owing to be late. Five team boys do the duty in the morning, and four team boys do it in the afternoon.” (Mr. Ye, 16-years-old, Grade 9 student, BEHS 8, East Dagon)

The two HIV-born school boys were assigned as team leaders. They were Mr. Shine Lin and Mr. Nyi.

“I’m team leader. The teacher assigned to do the team leader. There are three girls and four boys in our team.” (Mr. Nyi, 15-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

4.5.2 Social Duties

Social duty can be seen as considering proper conduct and behavior around people in school to have a pleasant learning environment.

Teachers

A teacher's responsibility involved more than lecturing. In fact, the actual teaching component is part of the job. Teachers were expected to ensure smooth running of the school and all students receive a quality education. As they had multiple roles, so also they had multiple responsibilities.

One of the teachers' responsibilities is to allow students learning in safety. HIV-born children were assumed source of unhealthy environment for other students. The teacher said her experience as:

"I faced a difficulty when they were friends with their classmates. An infected school girl there took her blood with compass, and punched her classmate's hand. It was like tattooing, but the pattern was not the tattoo image. She took her blood, and punched two to three times the skin of the school girl." (Ms. Ni, Representative teacher, Pyinyar Yarma Monastic School)

The teachers kept the HIV-born students in their view to prevent any risk of HIV transmission during playing in the school.

"Thukha students have been kept in the sight of teachers. All students can safely learn together with infected children." (Ms. Ni, representative teacher, Pyinyar Yarma Monastic School)

In addition, the teacher of the monastic school changed the school time from 9:00 a.m. to 3:15 p.m. to evening school from 12:00 noon to 5:00 p.m. to reduce playing time. The teachers were assigned to be with the students.

"One or two teachers are always with the students. There is no place and time to play here. Fixed school time is a way of prevention. If they have extra time to play, they may have any kind of injury." (Ms. Ni, Representative teacher, Pyinyar Yarma Monastic School)

In addition, Grade 5 teacher said the students with no HIV not to be close to the HIV-born students if an accident happens. She said when HIV-born students were outside the classroom.

“The teacher instructed other students not to come near us. The teacher in charge of Grade 5 said, “You don’t go near them if they have bleeding.” Pyae Pyae heard it near the door.” (Mr. Naing, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

After all, the teachers’ protection from HIV transmission limited the HIV-born students to extend friends, to exchange the social values, to play the games which encouraged the team spirit and way to express their identity. Schooling was solely for learning the school lessons and to pass the examination for HIV-born students.

Students

HIV-born adolescents performed social duties as a form of sharing workload from teachers as much as they can.

“If the teacher asked me to do something, I do. As I found unwashed plates in front of me, I had to wash them.” (Mr. Nyi, 15-years-old, Grade 8 student, Pyinyar Yarma Monastic School)

Similarly, Mr. Shine Lin assisted the teachers in his way.

“I help the teachers by carrying the things. Other girls also assist the teachers. But, I am very fast. I bring the teacher’s things. If they are ahead of me, they bring the teacher’s things.” (Mr. Shine, 15-years-old, Grade 8 student, Pyinyar Yarma Monastic School)

However, most respondents did not share the snacks with their classmates because of HIV.

“They don’t ask for the snacks from us because if we are from Thukha, we have this disease.” (Mr. Naing, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

Both HIV-infected and non-infected students did not tend to practice sociable behavior in school.

“I don’t help others’ team. They also don’t help us. The teacher told that we have to do for our team.” (Ms. Thandar, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

4.5.3 Inclusion and Participation

All member of the school society should have equal access to all school activities. Individuals in the school were responsible to involve all school members in both curricular and extracurricular activities. Equal opportunity enhanced individual's participation in the school. In the contrary, HIV-born adolescents experienced exclusion by the people in the school.

Exclusion by the Teacher

Even though some HIV-born adolescents were eligible in the criteria of school excursion, they were casually neglected by the teacher to involve in it.

“When there was a school excursion, they don't participate in it. The criterion is outstanding students who won 1 to 10 academic position. They won't get within that positions. Hence, they are autonomically excluded.”
(Ms. Ni, Representative teacher, Pyinyar Yarma Monastic School)

Moreover, a respondent of the monastic school experienced conditional exclusion respective of being orphan. He won the first position in reciting poem. However, he was not chosen as the school representative to compete with other schools.

“If we have any school activity, students have to compete at the school first. Afterward, we had to compete with other schools. I had competed the reciting poem in the class. I recited the poem. I won. But I didn't become a school selection. I didn't compete with students from other schools. I don't know why.” (Mr. Shine, 15-years-old, Grade 8 student, Pyinyar Yarma Monastic School)

The teacher of the monastic school explained that they carefully picked for representative students of the school to show in the public. Negative prejudgment of the teacher associated being orphans prohibited to choose the HIV-borns as students who represented the school.

“When the international organizations invited us, the most obedient children are selected for presentation. To do this, our school is impressive and reliable in the public. If the child is not compliant, or... he or she will escape from the control...Immm...We are blamed something due to the

orphans.” (Ms. Ni, Representative teacher, Pyinyar Yarma Monastic School)

Exclusion Indirectly Affected by Concerns of Home Staff

The home staff were the closest responsible people to take closely care. They supposed that school excursion was unnecessary. They did not focus about the importance of participation in the school activities. They prioritized the workload of the staff and the children’s safety.

“Dr. Nyo doesn’t allow the children to go excursion of school. Since the places are not where the children haven’t been, I didn’t let them go. If they go there, the staff also has to go along with them. There will be no one in case an accident happens.” (Ms. Yin, Staff of the home)

HIV-born adolescents were physical safety by that kind of strict protection. The negative conduct was immature, late to learn environment outside the school, still remained dependence on the staff of the home, unable to make decision for himself or herself without consulting with the care givers, and later failure to make friend.

Exclusion from Daily School Life by Stigmatization

The students in the monastic school had known that all Thukha students had HIV. They thought that they would be transmitted HIV even through touch the skin or sharing cup to drink water. Besides, they passed over their concerns to others. A respondent shared his experience.

“Once, a girl said to next girl near me not to drink water with a cup that I drunk. She said it was disgusting, and the disease would be got through the cup.” (Mr. Naing, Grade 6 student, Pyinyar Yarma Monastic School)

Another respondent said:

“If others know about us, they dare not touch the skin. Here....they have to touch the skin like this. They are afraid to get this disease if they touch my blood.” (Mr. Shine Lin, 15-years-old, Grade 8 student, Pyinyar Yarma Monastic School)

A school girl of Grade 6 described her experience in the school that students who were not infected HIV treated the Thukha students as disgusting people.

“I have met with a school boy. That boy looked disgusting us. When we went near and touch him, he shook off and cleaned his skin with his hand. He behaved only Thukha when we sat next to him.” (Ms. Thandar, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

HIV-negative students did not want to sit the infected students. The teachers arranged the students in the class that four students had to sit in one row. Some HIV-born students had to share the row with HIV-negative students. HIV-negative students sit in the row only in the teaching time.

“Students have to sit in the place where the teacher arranged although they don’t want to sit in the teaching time. Some students are haughty, and they don’t wanna sit with us. There are two to three students in the class.” (Mr. Naing, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

Indirect Exclusion Caused by Concerns of Classmates’ Parents

Parents had accepted and practiced the obligations for their children to arrange everything to protect from potential harms. The parents of the HIV-born students’ classmates had known the infected children were schooling in the Pyinyar Yarma Monastic School. A respondent responded that the parent of their classmates discouraged their children making friends or playing with them in the school because they wanted to prevent HIV transmission from the HIV-born students to their children. Another three informants supported with same answer.

“Some students’ parents don’t like us playing with their children.” (Ms. Thandar, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

The representative teacher was complained by the parents about HIV-infected children.

“If they play with the students from outside, their parents don’t like. Some parents worried. And they sometime complained Teacher Ni.” (Ms. Ayechan, 19-years-old, Grade 9 student, BEHS 8, East Dagon)

In summary, HIV-born students could not participate in any school activities if they were sanctioned no matter what they tried hard to fix in the school activities. Exclusion in the school activities permanently extracted HIV-born adolescents from the school prior to end of expected education.

4.5.4 Interdependency

Interdependence was situations in which students needed reciprocal assistance each other. One's contribution was necessary for the success of another. As such, students rely each other to do well. However, mutual support between HIV-born adolescents both in BEHS 8 and the monastic school and their friends was rarely found. It was usually found among HIV-born peers in terms of explaining undigested lessons or borrowing notebook to the absentee.

A respondent said that she did not borrow the note books from her HIV-negative classmates. Reciprocally, either her classmates did.

“If I take leave, I usually rent books form Thukha friends, not from other friends. If they don't attend the class, they don't copy the lessons from friends. They don't borrow the books from both us and no others.” (Ms. Ayechan, 19-years-old, Grade 9 student, BEHS 8, East Dagon)

When all HIV-born students were absent due to be out of order of vehicle, exceptional dependence on the classmates was found, but not being reciprocal.

“If all Thukha students are absent, I borrow from the students who live outside. They also lent. But when they were absent the school, they didn't borrow the books from me. They borrowed the books among them.” (Mr. Naing, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

Solely, Mr. Nyi mutually relied on his friends who were HIV negative.

“I have friend. I borrowed the notes from him. I can also borrow note books from other friends. They also copied my notes. I gave them it. They asked me the writing notes, but Mathematics. I showed History notes and questions.” (Mr. Nyi, 15-years-old, Grade 8 student, Pyinyar Yarma Monastic School)

4.5.5 Similarity

Close friendship usually acquired through the basis of resemblance in qualities, characteristics, or appearance. As being HIV positive separated them to view difference by others, they had accepted they differed from others. Despite several same situations among all students in schools, a sense of dissimilarity associated with HIV hid them.

“I’m different from friends in the school, I think. I am a person who has this disease. But, they don’t have this disease.” (Mr. Naing, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

Conversely, HIV-born adolescents compared HIV peers and HIV-negative students. They concluded that their HIV peers understood among them. As a result, they stuck together with their HIV-born peers in school. An HIV-born school girl of BEHS 8 had a sense of similarity to friends from the home.

“Friends from Thukha and friends from outside are not the same. Thukha friends knew about me. Here I have HIV, and she also have HIV. We are peers, same life. Because of this, I am close and familiar with them. I am friendly only with my peers.” (Ms. Kyizar, 14-years-old, Grade 10 student, BEHS 8, East Dagon)

4.5.6 Sense of Belongingness

HIV-born adolescents required a sense of being a member of a school which led to the experience of positive emotions such as happiness, joy and high motivation in learning. Nonetheless, it was rarely found.

The two school boys at the monastic school presented that sense. Mr. Shine Lin said that he had many friends in the school. He was proud of having many friends. He preferred to be with big friend group. He and Mr. Nyi had a group with five friends: four Thukha school boys and one school boy who had no HIV.

“We are familiar. Very close between us. Our group is in accord and united.” (Mr. Nyi, 15-years-old, Grade 8 student, Pyinyar Yarma Monastic School)

In addition, Mr. Shine Lin described about his friends as:

“When I was absent the class, my friends who are from outside also didn’t go to school. When I borrowed their notebook, they told me that they also hadn’t it. If I was absent the class, they had to attend. But, they didn’t.” (Mr. Shine, 15-years-old, Grade 8 student, Pyinyar Yarma Monastic School)

The remaining respondents both at BEHS 8 and the monastic school were not found a sense of the member of the school society. They presented that they

belonged to their peer from the home. An informant believed that she and her HIV peers had same situations in terms of having HIV. Even though they said her weakness, it did not hurt her because they had same life.

“.....Even we have a quarrel, friend outside said you have HIV....., and friend here said you have HIV..... Different!!! Here I have HIV, and she also has HIV. We are peers, same life. I don't need to hurt what she says. Because of this, I am friendly only with my peers. I don't wanna mixed with others.” (Ms. Kyizar, 14-years-old, Grade 10 student, BEHS 8, East Dagon)

From the view of the representative teacher, she did not recognize the HIV-born children as her own students. Along the interview, she differentiated as “my children” for students with no HIV and “their children” as students from Thukha Yeik Myon.

“Our children mind is good. No discrimination to their children.” (Ms. Ni, Representative teacher, Pyinyar Yarma Monastic School)

4.5.7 Close Personal Ties

Mostly, HIV-born adolescents spent time together with their HIV peers both at the home and the school. They had more time to strengthen personal bond through sharing interests, mutual practices, closeness, and expressive attach. Otherwise, they had limited time to build close friendship with the friends in the school.

“I feel friendlier with the friends here. We sleep together. In the early morning, we wash our face together. All the time, we are together. However, I am with friends from school from 6:45 am to 12 noon. The remaining time I spend with my friends here.” (Ms. Kyizar, 14-years-old, Grade 10 student, BEHS 8, East Dagon)

They supposed that their HIV peers understood how they felt. Because of this, they chose their close friends among HIV peers. An HIV-born school girl said that she and her friend interconnected in mind.

“She is Yadanar. If I feel something, she feels something in her mind also. If anything she happens, I also feel something. Our minds look connected.”

When we meet, we share our feelings. She keeps what we said.” (Ms. Kyizar, 14-years-old, Grade 10 student, BEHS 8, East Dagon)

A school boy of Grade 6 said that Thukha students made friends among them. Thukha group was enough for him. He did not require any new friends more.

“I befriend only Thukha group. If I feel something, I can tell or outburst in this group. They don't share others what I said. We are five, the most familiar. I, Phyo wai, Thandar, Wai Wai and Pyae Pyae.” (Mr. Naing, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

4.6 Quality of School Life (QoSL)

The QoSL is a general sense of satisfaction on schooling. It results from their engagement with the school society. School satisfaction of HIV-born learners was investigated from six different aspects.

4.6.1 Academic Performance

Academic positions of HIV-born adolescents in the class demonstrated that they possessed good or acceptable educational performance except few students.

A student of Grade 8 presented his academic marks and position in the monthly exam as:

“I passed all monthly exams. Myanmar: 18, English: 18, Mathematics: 16, Geography: 22, History: 10 I got. I got 20th academic position in the first monthly exam, and 23rd position in the last month exam. There are 32 students in Grade 8.” (Mr. Nyi, 15-years-old, Grade 8 student, Pyinyar Yarma Monastic School)

A Grade 6 student answered that she got 6th academic position in the monthly exam. It decreased from 3rd position in last month.

“In the first monthly exam, I got 3rd position. In this month, I got 6th position.” (Ms. Thandar, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

Table 4.6 Academic performance and expectation of the respondents

No	Name	Academic Performance in July-2015	Academic Performance in August-2015	Educational expectation
1.	Ms. Ayechan	21 st / 78 position of Grade 9C	17 th / 78 position of Grade 9C	Staff at the home Teacher
2.	Ms. Theingi	38 th / 78 position of Grade 9C	39 th / 78 position of Grade 9C	(Preschool) / Work in the beauty salon
3.	Ms. Ei	19 th / 78 position of Grade 9C	15 th / 78 position of Grade 9C	Teacher (Basic education)
4.	Mr. Ye	25 th / 78 position of Grade 9C	14 th / 78 position of Grade 9C	Medical doctor
5.	Mr. Nyi	20 th / 39 position of Grade 8	23 rd / 39 position of Grade 8	Electrical engineer
6.	Mr. Shine Lin	21 st / 39 position of Grade 8	29 th / 39 position of Grade 8	Electrical engineer
7.	Ms. Thandar	3 rd / 52 position of Grade 6	6 th / 52 position of Grade 6	Teacher (Basic education)
8.	Ms. Kyizar	25 th / 70 position of Grade 10C	25 th / 70 position of Grade 10C	Business man
9.	Mr. Naing	30 th / 52 students of Grade 6	23 rd / 52 students of Grade 6	Actor

A school boy of BEHS 8 said that his position was 14th among 15 passed students.

“There are 78 students in the class. Only 15 students passed in this month. I got 14th position.” (Mr. Ye, 16-years-old, Grade 9 student, BEHS 8, East Dagon)

However, the teacher viewed HIV-born students that they delayed in memorizing the lessons. She thought that it might be because of the drugs they were taking.

“As I said in the former, have the drugs damaged their intelligence? They can’t study the lessons within half an hour by the time their classmate study within 30 minutes. They have a weakness like this.” (Ms. Ni, Representative teacher, Pyinyar Yarma Monastic School)

4.6.2 Educational Expectation

Education expectation was answered that the majority of respondents expected academic related occupation, namely, school teacher, electrical engineer, medical doctor and business woman. Notwithstanding Myanmar school education, staff of the beauty salon, actor and the home staff were also anticipated by three respondents. (See table 4.6) Their educational expectation was influenced by educational qualification, and expectation of the people who closely interacted with the HIV-born adolescents.

In addition, although a school girl of Grade 9 wanted to be a school teacher, she was not certain that she would complete the current grade. She also anticipated to work in a beauty salon. She said the latter did not need any educational qualification.

“To be a school teacher, I have to pass the Grade 11. My destiny can’t be said. I don’t have like I must pass the Grade 11 or I must be a graduate. That is how much I reach. I will open the beauty salon. I don’t need school education to open the beauty salon.” (Ms. Theingi, 17-years-old, Grade 9 student, BEHS)

Another situation was that the HIV-born adolescents understood future job was available at the home after schooling. They would be recruited if they wanted to work at the home. An eldest respondent had planned to work at the home after Grade 9. She supposed that schooling was unnecessary because most home staff were working at the home even though they did not complete basic education. She said that she had more academic qualification than the home staff.

“To work here doesn’t need educational qualification. I’m in Grade 9. The staff didn’t pass even the Grade 9. I am going to work here. After Grade 9, I will attend the nurse aid training in this Summer. Moms here also attended nurse aid training.” (Ms. Ayechan, 19-years-old, Grade 9 student, BEHS 8, East Dagon)

The most senior staff of the home shared her view upon the educational expectation related to their health status. They were not assured to stand by themselves because of their health status.

“Their standing on their feet depends on their health. If they stand by themselves, to what extend can they stand? They are supported school education as much as they can.” (Ms. Yin, Staff of the home)

Likewise, the director wisely responded poor guarantee of Myanmar education for readiness of future career.

“Their educational level we supported and their life career...Immm....I cannot say by looking at.....Other childrenThere are many children who cannot stand by their education. Graduated Mohn Hin Khar (Myanmar traditional food) seller is near here. There is graduated dry goods (for the kitchen) seller in the market. By looking at today’s education, I cannot say that.” (Ms. Nyo, Director of the home)

She explained that she did not expect on the children in this way since expectation might not sometime come. She assessed the need of the individual children, and fulfilled them.

From the view of school teacher, she said that the expectation on the HIV-born adolescents were not sure. Although the adolescents were intelligent, she pointed out that they still need to be healthy and parental or guardian support to succeed. The teacher of the monastic school said that HIV-born adolescents could not be expected as their healthy counterparts.

“My children (students who haven’t HIV) are a kind of students to whom we can expect as clever as they are. But, we can’t expect much on their children (Thukha student) in spite of to what outstanding they are. It totally depends on their health and supporter.” (Ms. Ni, Representative teacher, Pyinyar Yarma Monastic School)

In short, diverse views of respondents unpacked uncertainty of educational expectations towards HIV-born adolescents whether the adolescents anticipated career associated school education or not.

4.6.3 Opportunity

The opportunity of HIV-born adolescents was explored as sense of being beneficial or relevant to acquiring knowledge in the school. HIV-born adolescents had decided relevance of the subjects they were learning based on their career expectation. Most HIV-born adolescents were likely to satisfy what they were taught and learnt in the school on the grounds that they set expected career related Myanmar school education. On the other hand, the respondents who did not expect academic related career did not think they got much benefited from schooling.

A respondent whose dream was a performer stated that schooling was just opportunity to express her performance in terms of dancing in the ceremony of school.

“My dream in the future is a performer. My mom was a performer, a dancer. Schooling is not supportive for my dream. An opportunity at school is that I have danced in the Prize-giving ceremony.” (Ms. Ayechan, 19-years-old, Grade 9 student, BEHS 8, East Dagon)

A school boy expected his future career as an actor. He clearly answered that school education did not support his expected future career.

“School education and what I want to be in the future are not related.” (Mr. Naing, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

A school girl who wanted to be a teacher expressed that the subjects she learnt at school would be taught to the students by the time she is a teacher.

“I think the subjects I learnt are totally supportive for my future career. If I become a teacher, I have to teach all subjects to students.” (Ms. Thandar, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

4.6.4 Personality Development Expectation

It was commonly expected that schooling empowered students to develop their personality. Personal development expectation was predicted progress in self-awareness, potential or becoming self-led or autonomy.

The teacher of the monastic school generally expected personality development of HIV-born adolescents as usual students. She said that the higher grade they reached, the more awareness increased. Thinking skill of Grade 8 student was likely to be different from a Grade-5-student. If the education transferred from the school teachers added to the knowledge acquired through socializing with friends, more and more knowledge would grow as long as they got higher grade year by year. Specific answer for HIV-born adolescents was not offered.

“The personality could acquire as long as the grade was higher. Behavior changes are like that. They have changed their mind also.” (Ms. Ni, representative teacher of Pyinyar Yarma Monastic School)

A staff of the home had supported the above answer. HIV-born adolescents were likely to expect their personality development rather than living at home. The teachers would admonish and guide them in school. However, she explained it was depended on how much they perceived.

“Some children are aware other’s wish. There is a child who said there are garbage, and collected them. Otherwise, there are some children. When they are asked to do, they do. Some avoid lest they are tired.” (Ms. Yin, Staff of the home)

From the point of HIV-born adolescents, the response of a respondent reflected self-awareness regarding with schooling. A respondent of monastic school was aware that education was the only gateway to her future career. Whenever she was absent schooling to go to the hospital, she has concerns her education outcomes not only in the present school but also in the higher school.

“Leave can be taken as we want. Thukha students are allowed to go to hospital. Whenever I was absent, I lag behind others in the lessons. I don’t like it because I don’t understand the lessons. In addition, age is getting older and older. We may pass the exams in this school. But, I might fail in

the higher school.” (Ms. Thandar, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

However, other respondents answered no other expectation apart from school lessons, or not related about it.

“I don’t want any more from the school besides the school lessons.” (Mr. Nyi, 15-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

4.6.5 Academic Motivation

Students’ persistent willingness to do academic activities was investigated as academic motivation. All HIV-born adolescents had to study regularly. The home set discipline to do homework from 6:30 p.m. to 8:00 p.m. daily. The adolescents had to sit in the round tables whether they had homework or not. Apparently, they studied every day. In addition, the home staff strictly checked the child who wanted to take excused absence schooling. They decided to send school, take a rest at the home or to see the doctor.

However, a home staff said a Grade 10 girl was back from the school twice due to being late. She said the gate of the school was closed. She also did not attend the private tutoring class. At first, she was not noticed by the staff because she was the only student of Grade 10. When she was interviewed, she said she had no friends in the class because she was the new student at the current school. She enjoyed accompany. Nevertheless, classmates sitting in the same row did not involve her in the daily school life. They sometime skipped her to go together to the snack shops, to eat snacks together or to play. She said that she felt downhearted as a result of making friends with classmates in inferior situation.

“In school, I am friendly with them in a situation of inferiority. I don’t wanna degrade and make friend like this. I am not happy. I don’t want to go to school.” (Ms. Kyizar, 14-years-old, Grade 10 student, BEHS 8, East Dagon)

In addition, she was not convenient at the home. The senior home staff hold negative view her. The staff frequently blamed her because the staff was invited by the teacher to discuss her education owing to fail three subjects last year. In addition, she committed group theft at the home. She was moved to the house of

youngest children where was closest place of the senior staff, that is, she was recognized as a problem child.

“Here also, if I was scolded again when my feeling is not good, the tear comes spontaneously around my eyes. I cannot control my mind. I feel I wanna cry even a small thing. I resent I am bad too much as they said. To what extend do they want to oppress me. Sometime I feel angry mom Yin and mom Hla. Sometimes I want to response them what they blamed me.”
(Ms. Kyizar, 14-years-old, Grade 10 student, BEHS 8, East Dagon)

Another HIV-born girl had perseverance to study. The care giver said she studied up to midnight every day. By contrast, she said she could not concentrate what the teacher taught.

“Sometime I miss the lessons that the teachers explained. I can’t concentrate all the time. Sometimes, I understood. Sometimes, I didn’t. Sometime I forgot all. I cannot recall all. My mind is a blur, and flee away when the teacher explained.” (Ms. Theingi, 17-years-old, Grade 9 student, BEHS 8, East Dagon)

She explained that she was not happy both at the home and the school. It was related with the event at the home. The 6 HIV-born elder girls committed theft. All HIV-born girls were seriously investigated.

“Three lakhs money of the care giver of our house was stolen. We were accused “thief-bint,” “thief-bint”. They said cruelly. I could not speak out like them. I could not be tolerant. We are said that children here broke morality. Poor moral. As such, our group cried at school. Ayechan run away for the whole day. It happened during the exam days. That’s why Grade 11 student girls were sent back their home. The remaining thieves were moved to different houses.” (Ms. Theingi, 17-years-old, Grade 9 student, BEHS 8, East Dagon)

4.6.6 Achievement

A sense of being successful in schooling was viewed as achievement of HIV-born adolescents regardless of academic grading. First of all, a school girl

weighed her current grade and her age. She said that she had to be in higher grade at the current age. Thus, she did not think that she was successful schooling.

“I don’t think I’m successful. Actually, I have not to be in Grade 9 when I compared with my age. Nineteen-years-old girl has to be a University student.” (Ms. Ayechan, 19-years-old, Grade 9 student, BEHS 8, East Dagon)

Furthermore, the two respondents said they did not achieve in school work since they failed final exam in the previous grades. They did not satisfy their failure.

“I am not successful in education because I hadn’t tried hard in the previous grades. I failed Grade 5 exam, and repeated Grade 5. Zayar is in Grade 7. I’m still in Grade 6.” (Mr. Naing, 14-years-old, Grade 6 student, Pyinyar Yarma Monastic School)

“I don’t feel success because I failed the grade 9 exam. And I had to sit the supplementary exam for that.” (Ms. Kyizar, 14-years-old, Grade 10 student, BEHS 8, East Dagon)

CHAPTER V

SUMMARY, DISCUSSION AND RECOMMENDATION

This chapter had provided summary of the findings, discussion points, and recommendations to tackle the study problem.

5.1 Summary of the Study

This study explored the barriers of HIV-born adolescents to their social engagement in school and the quality of school life (QoSL) in relation with school integration. This research had been conducted at the only one HIV orphan home in Myanmar: Thukha Yeik Myon. The researcher interviewed nine HIV-born adolescents aged between 14 to 19 and four key informants including the HIV home and school representative.

5.1.1 Barriers to Social Integration

The findings showed that HIV-related health and social conditions influenced the adolescents' dynamic process of social integration. HIV-associated stigmatization appeared to be the strongest barrier to social integration in school. Such barriers have been manifested at institutional, interpersonal and individual levels as follows:

At institutional level, HIV-related conditions directly and indirectly contradicted against both school social and physical structures (e.g. school rules, regulations, and expectations). Firstly, because chronic illness interrupted education during their childhood, the time of the respondents started schooling was usually later than the prescribed age of Myanmar basic education structure. The HIV-born adolescents were older thus, their physical and mental conditions had been more matured than their classmates. As a consequence, they felt uncomfortable to stay in the same level as other younger students and felt that their current grade was not for them.

Furthermore, the adherence to HIV medication during schooling hours could be considered as a violation of class rules because in general, food and drink are not allowed in class. In addition, HIV-born adolescents had fear that others might know their HIV status. This made them unable to concentrate on school lessons at the time to take HAART. Moreover, the respondents reported that HIV disclosure led to discrimination in classroom. They were asked to skip schooling when they showed just minor illness like cough or wearing warm clothes. Besides, the teachers supposed that HIV-born adolescents were source of unhealthy environment for general students. Thus, HIV-born students were usually seated at the last rows. In addition, being HIV positive coupled with being orphan discouraged teachers to select as a school representative to the public irrespective of their competency.

Besides, conflicts of prioritization occurred among the home, health providers and schools. The HIV care providers require the adolescents to receive regular clinic follow-up. The follow-up schedule was not flexible enough so that the children had to be absent from school on the clinic days. On the other hand, school expects its students attend every school day because absence cut off the link between school chapters resulting in lessened learning. When clinic follow-up overlapped the monthly exam, the home prioritized towards health matter, not the schooling. The home maintained the view that there was nothing important, but the health of the children. By doing this, the HIV-born adolescents had to be absent from school frequently.

Likewise, the contradicted view and practice were found between the school and the home whether to keep or disclose the HIV status. The health status was silently spread among people both in the school and outside environment of the school despite the facts that the HIV-born students seemed healthy. People passed over it to be cautious new infection among the non-infected people. The spread of information started from the home, and the younger HIV-born students. The home depends on the donors. When the donors came, the home was responsible to explain about the children. However, the home wanted to conceal the HIV status of the children as much as it could avoid the stigmatization. In addition, the younger children talked about them to their friends at the school. Spread of their health status was really difficult to

prevent, but the home as well as the HIV-born adolescents were still desirable to keep it.

At interpersonal level, HIV-born adolescents were often separated from other students when doing school activities. They usually shared the class duties and the social obligations assigned by the school with other students, but participation in school events was limited. They were less likely to engage in school activities in terms of the school field trip, reciting poem contest, and joint activities with other schools or organizations. While they were eligible, school casually cut off the opportunity to participate. Similarly, the home did not allow school field trip to prevent unexpected situation such as an accident that might be spread HIV. Moreover, although similarity determines friendship, the HIV-born learners are not able to develop it since they have different situations with other students which is HIV “have” and “have not”. Consequently, reciprocal assistance between the HIV-born students and other general students was not found. Even though they perform the duties they were assigned, they did not have any reward to participate at school. The situation does not develop satisfaction of HIV-born being a member of the school society. The school teachers also did not treat them as equal as the non-infected students. Even though they were eligible to the school activities (school excursion, reciting poem contest), the teachers did not allow them.

Once they shared the school tasks or participate in any activity, they were together with other students at school. Afterward, they might develop the close personal tie. However, HIV-born adolescents might not develop it on account of the stigma. On the other hand, other students discriminated, and did not want to tie them. The parents of their classmates prohibited their children to make friends with them and the teacher cautioned other students not to get close to them when they got injured (i.e. bleeding). While they were assigned to share the classroom tasks, they could participate in only few activities. They felt that they were still in school as other students. It could not be summarized they socially integrated in the school society because close personal ties did not develop.

At individual level, physical health status and social health status of HIV-born adolescents were other barriers to their engagement at the school. Their self-stigma with regard to the illness differentiate them from other students. As their

friends did not come close to them, they lacked daily social activities with their friends. The respondents pointed out that they could not develop personal links to other students. Their internalized stigma obstructed it.

In terms of social health status, undesirable treatment induced perceived and self-stigma among HIV-born adolescents such as hopelessness, lack of dignity and insecure in dealing with people in school. An experience of stigmatization and discrimination in the previous school formed the fear to be stigmatized when they were transferred to the new school. They had lack of trust on the people at school even though people did not know their HIV status. It was because they perceived that people viewed them with negative attributes. That altered close social relation with people at school. As the fear of being discriminated against HIV status made them reluctant to start friendship, their internalized negative perception about people's view enclosed them from HIV negative counterparts at school.

5.1.2 QoSL

In general, HIV-born adolescents reflected their school satisfaction. Firstly, their academic performance could be seen the academic positions in the monthly exam. They had acceptable academic grading except a few respondents. Some had good academic performance. Secondly, some respondents expected their future career such as school teacher, electrical engineer, business man and medical doctor whereas other respondents anticipated to be an actor or a home staff at Thukha Yeik Myon. Thirdly, the opportunity of schooling relied on their career expectation. Most HIV-born adolescents satisfied the subjects they were learning in the school. Their expected careers required the high school graduation and the continuation to higher education. Otherwise, some respondents who presumed non-academic related career had not sense of being beneficial because educational qualification was not necessary.

In terms of the personality development expectation from schooling, almost all respondents reflected no other expectation apart from school lessons, or not related about it. Furthermore, high motivation on towards education was visible among most respondents. They studied regularly in the evening and actively prepared to go to the school. However, some respondents admitted that they could not concentrate

during the lecture. In achievement irrespective of academic position in the class, majority of the respondents did not demonstrate the sense of success in school lessons.

5.2 Discussion

This study reveals that more or less HIV-born adolescents do not integrate well with the school society. The theory of social integration describes HIV stigmatization in multi-level conditions significantly influence their social integration at school. The implications from the study findings in relation to their quality of school life are discussed as follows:

5.2.1 HIV stigma and discrimination is most obvious in school.

The study found that the HIV-born adolescents faced with social stigma that existed not only within the school boundary but also outside the school. Within school, the HIV-born adolescents were discriminated against by teachers and their classmates and that resulted in their lack of opportunities to interact with the others. This phenomenon is, in fact, not specific to the Myanmar society as found in this study. An earlier research conducted in Kenyan Public Schools indicated that stigma and discrimination were visible in the school and negatively impacted the social interactions and learning of secondary level students living with HIV (Kamau, 2012). In this study context, social stigma is structural in society and can create barriers for persons with a disease socially perceived to be infectious, fatal or harmful to the others. HIV-related stigma is embedded and reproduced in the school system where all members – teachers, classmates and parents of students have been interacting with each other. Such stigma creates inferiority and may result in unequal opportunity for HIV-born adolescents to participate in social activities through which the students in general develop the ties among them.

As the stigma comes with the ‘HIV status’ itself, not the visible ‘health status’, lack of HIV confidentiality has limited the HIV-born students’ interaction with the others. At interpersonal level, ‘unequal’ treatment or discrimination occurs once the others know one has HIV. In particular, HIV-born adolescents who looked completely healthy, were still stigmatized. It is consistent with the previous finding

that states the mark of an illness did not need to be physically visible for someone to be stigmatized, and could occur to people with other health conditions (Staggs, White, Schewe, Davis, & Dill, 2007).

In addition, the non-infected students learnt and memorized what they had been told at school and home. The discrimination against HIV-born adolescents that the general students observed from how the school teachers, parents treated the HIV-borns reproduces, and sustains the HIV stigmatization. When an HIV-born student is stigmatized at school, such experience might negatively affect their own self-stigma not only within the school life but also their whole life.

HIV-born adolescents had received product of social stigmatization as internalized stigma through dealing with people at school. The internalized stigma replicates into another forms of stigma which are felt stigma and perceived stigma. Those work as barriers to be less or absent personal bonds among HIV infected and non-infected students. Besides, the HIV-born adolescents are pushed to HIV peers so that social cohesion develops solely among them. This creates a separated world between infected and non-infected individuals, even though they have been sharing the same physical space.

Furthermore, the overall school structure, especially school rules and regulations are not compatible with HIV-infected students' health needs. In addition, the schools usually focus on meeting the state's performance requirements and thus sometimes try not to show the students with poor academic records. The HIV-born students were placed in a 'hidden' zone once more when they performed poorly. This creates the loss of self when the HIV-born students were not recognized as a part of the school society.

As mentioned previously, HIV stigmatization at school was formed by the fear to incurable fatal infection even through the casual contact to the skin. It is a result of limited HIV/AIDS knowledge of people in school and outside the school. There were also other gaps in knowledge and misconceptions about infection through casual contact (Sallar, 2009). Therefore, when social integration at school is studied, the out-of-school environment should be considered.

5.2.2 The attitudes against HIV among the school members is a product of social perception.

The attitudes against HIV among the school members is a product of social perception which limits the opportunities of the HIV-born adolescents to develop social bonds with other school members. It was also found in a study in Zambia. It showed that many students hold negative attitudes toward HIV-infected persons. They did not want to work with them or associate with them at the school, and many felt that no one should treat them (Mufune, Osei-Hwedie, & Mwansa, 1993).

Considering the institutional-level context of the HIV-born adolescents' school life, Parsons (1959) explained that school itself is a social system. Despite having transparent border, it cannot be said a close social system. The individuals with different backgrounds brought different traditions, social norms, attitudes, beliefs, views and expectations to the school. In this study, individuals irrespective of hierarchical positions are working and schooling in the school. The social norms, values and attitudes towards HIV in the society outside the school come together with those individuals into the school, and the school has to comply them. The attitudes against HIV of the school members can be considered as the product of how the wider society perceive about HIV. Although the school institution itself tries to accept and provide education opportunity for the students with HIV, it also has to be responsive to the concerns from the outer environment (e.g., parents). As such, the school and the teachers have to act accordingly by preventing possible transmission and that leads to insensitive (or even mis-) treatments on the HIV-born adolescents.

5.2.3 The outer environment plays a vital role on how HIV-born adolescents spend their school life.

The study findings imply that HIV-born adolescents' enjoyment of school life is shaped by the social context outside the school. Actually, school life is a part of the HIV-born adolescents' daily life. At the same time, another important part is in the HIV home where they live. Close caregivers' interaction with no value and low expectation on their future suppress the internal motivation of the adolescents. Likewise, availability of future job at the home fuels those adolescents who have tendency to expel from the school. It also makes them to feel education is unnecessary

for future. Therefore, social context outside the school has become the central concern of the successful school life of the children.

Besides, the home itself was found in this study to be the place which mediates growing social stigmatization which may lead to difficulty in socializing with other people outside the home. Previous studies explained that the orphans placed in institutions (homes) have increased risk of socio-emotional disorders and personality dysfunctions. There is also a greater likelihood that they grow up disconnected from their culture, extended families, and communities. Countries with long-term experience have seen the problems that emerge as children grow into young adults and have difficulty reintegrating into society (Richter, Foster, & Sherr, 2006). In this study context, living the place in the organization emerges sense of difference from their HIV-negative peers. The strict disciplines and over protection of the home generate final outcomes of isolated lives. The home staff focus on the health matter of the adolescents, but not the social aspects. In taking care of those adolescents, a lot of considerations are necessary. According to the research findings, the home staff have lower education. Besides, they have not been trained especially in taking care of HIV children in terms of both health and social competency. By looking at this, the home might not be prompt to deal with the holistic aspects of taking care of HIV-infected children.

5.2.4 Conflicts of prioritization among surrounding institutions discourage students' learning.

The contrasting practice of the home and the school was found to compromise the social wellbeing of the HIV-born adolescents, for instance, the home concealed the HIV status, but the school distributed about it. The result of home-school prioritized conflict pointed out a negative contribution in students' academic achievement and sense of well-being in school (Vasquez-Salgado, Greenfield, & Burgos-Cienfuegos, 2014). In the schools where HIV-born adolescents attend, concerns of the people in the school to prevent new HIV transmission imply lack of social obligation to keep students' personal information.

In addition, although the home staff tried to keep the children's HIV status confidential, the home's financial demand inevitably allows visitors and donors to

know it without a verbal explanation. It enhances the sense of secret to people as well as silent spread of the information. Keeping confidentiality may also result in temporary avoidance from HIV associated stigmatization, but it cannot mitigate the stigmatization. The adolescents have stress to hide their HIV status as a secret for their whole life. The most importance is that makes unseen by other people who can support them. Thus, the attention of the responsible personnel is called to take actions whether the home faces the HIV associated stigmatization rather than running away from it.

Moreover, the home and the school have not noticed the barriers for HIV-born adolescents to engage in the school society that they have created. Hence, they did not cooperate to tackle the HIV associated stigmatization. Finally, the HIV-born adolescents do not feel they belong to their own school and might discourage them to continue and complete their basic education.

Furthermore, lack of integrated functions of institutions intrudes their learning as well as their physical health. The development of HIV-born adolescents requires a collaborative management from diverse institutions: the school; the health care facilities, and the home. Instead of the collective activities as a whole, independent functions with respective different goals are found in the findings. The objectives of health providers push HIV-born adolescents from school, simultaneously, the home supports to follow the health providers. The school also expects its students focuses on school lessons and the examination. Such ambiguous prioritization makes HIV-born adolescents confused whether their emphasis is on the school lessons or the health.

5.2.5 School engagement is embedded in the concept of quality of school life.

Difficulty to integrate in school led to low expectation of academic potentials. Tu and colleagues (2009) revealed that the HIV-born learners presented poor school performances in comparison to their HIV-negative peers in the same community. They also had the lowest academic marks based on the reports of both students and teachers. On the contrary, in this study, the HIV-born students' academic records indicated good performance among all students and most of them had good motivations. They got into school later than the prescribed age, thus they might be

more matured comparing to the younger students and could eventually do better in the class. In this sense, better grades might not imply that the HIV-born adolescents were having good academic performance.

The study found that HIV-born adolescents had limited opportunity to share hope and dream with general students which come from the feeling of elite, high self-esteem and competitive being in the friendly school social context. They do not have much chance to learn about the society and life opportunities that might make them have lower life aims. The finding of this study supports the conclusions of Epstein and McPartland (1976) in which while children who did well in school tended to be more satisfied with school, high grades alone are not enough for school satisfaction.

Cock and Halvari (1999) found a positive association between school satisfaction and educational performance. By contrast in this study, despite the fact that good or acceptable academic grading proves the children's academic performance, it could not be concluded that they are satisfied with their life at school. HIV-born adolescents with lower life aims are difficult to imagine that achievement of schooling is important. This is because their unique abilities and achievements at school were hardly recognized by the teachers and the home staff. Because of no more expectation apart from school lessons, school has no special meaning rather than the place to study school lessons for the HIV-born adolescents. Therefore, their school satisfaction relied on the social well-beings in the school.

To conclude, lack of integration has been linked with the loss in social attachment and ultimately suicide, as proposed by Durkheim (1893). This study may not be directly related to suicide, but the reflection of the loss of social integration. Thus, it aims to point out the structural barriers to school engagement among HIV-born adolescents which are assumed to result in weakened social bonds, exclusion from the school activities, lack of sense of belonging, and lack of personal ties. These states are all related to egoistic suicide in Durkheim's perspective. He stated that prior to the suicide, the breakdown of social attachments makes the individual more rely on themselves and less on society. The experience of HIV-born adolescents reflects sense of not belonging, and of not being integrated. It is the result of a weakened personal bonds that normally integrate individuals into the collectivity: in other words, a

breakdown or decline of social integration. They become increasingly detached from the school society where they had been attached and lost their satisfaction in school life and even motivation for their own future.

5.3 Recommendation

From the implication of the findings, this study offers the recommendations to the schools, the home, education and health authorities, and policy stakeholders as follows:

5.3.1 The Schools

Since the HIV-born adolescents are eligible to enroll in the mainstream schools, the schools should be least restrictive and student-friendly environment regardless of any characteristics. In addition, it should be the place where students have opportunity to be different from others in terms of religion, ethnicity, gender, physical or social attributes and so on. All students should have benefit from school how to deal with diversity and to respect it besides learning prescribed school lessons.

Likewise, the flexible school structure instead of the standardized school structure is recommended for the school which received the HIV-born adolescents. Raise understanding is essential among teachers for being willing to listen to students' concerns which effect on learning. School should create time for teachers to meet with parents or guardians giving constructive feedback of their children's educational attainment and implementation of new practices to improve. Regular meeting schedule should be set between the responsible teacher and the students' guardians. In addition, the school should arrange gathering of students' guardians in order to raise the guardians' involvement to meet the school expectation.

In addition, multi-grade student union should be formed to initiate schoolwide positive behavior support and self-discipline approaches. The union will facilitate the inclusion and development of students in all school extracurricular activities.

5.3.2 The Home

Since the over protection of the home enhances the social stigmatization, the actions to deal with HIV stigmatization should start from the home. The home should reduce additional disciplines and practices that separates children from the outside world. It would be better if the home has transparent boundary in which people can see the normal life of the children as well as the children can learn the wider society. The children ought to be allowed the social exposure to not only at school but also the environment outside the home. It is the way that encourages the HIV-born adolescents to face the HIV related social, psychological and physical impacts. Assertive standing of the home upon the benefits and unexpected drawbacks that come from disclosure is essential for the children. When the donors and visitors come, the staff should naturally explain the reliable information of the children.

Furthermore, the home should renew social environment where individual is valued and belongs by building the capacity of the staff in terms of specific knowledge and general literacy related to child development and social aspects of HIV. In order to be sensitive to social health issues of the children, the staff need technical support to improve interpersonal skills. Psychosocial counselling training is recommended for the staff who closely take care of those children.

In addition, social skill building can be provided at the home, particularly when the acceptance of HIV-infected individuals is low in the community they are living in. Moreover, the children should be fully clear that their capability in learning cannot be disturbed by the disease they suffer, and they can expect their education outcomes like other students. In addition, they should be imposed the reminder that there are students who still desire to befriend with them even though some do not want.

In addition, the home should work collaboratively with school to mitigate HIV stigmatization. The home staff should keep contact with the respective school teachers and discuss about the challenges for the children's learning to address the problems in a timely manner.

5.3.3 Education Authority

Ministry of Education may consider renovating standardized school structure into flexible school structure that supports individualized education programs. As the issues of HIV-infected and affected children are even more complex due to the importance of their growth and development, there is the need for multi-level collaboration among Ministry of Education, the Ministry of Health and UNICEF revise or create a policy that enhance an inclusive education for HIV-born adolescents. The policy should fulfill the fundamental human right to education.

5.3.4 Health Authority

Ministry of Health should widely alleviate HIV stigmatization through joint activities with community based organizations, non-governmental organizations and Ministry of Education.

HIV/AIDS awareness should be promoted layer by layer from individuals in schools to the community outside schools. Since the reproduction of HIV stigmatization is mainly influenced by the members of the communities outside the school, the public involvement is crucial for the activities. When the awareness raises, peer to peer education is strongly recommended. In distributing the HIV knowledge, people should be clear transmittable ways and non-transmittable ways of HIV.

Furthermore, the HIV-born adolescents should be received quality social counseling with trained pediatric counsellors in HIV care and treatment settings. Adequate number of counsellors are also essential to qualify social counseling with updated information and education materials. In addition, HIV peer gathering helps HIV-born adolescents to share feelings and difficulties, and learn from the experiences from their peer of different townships. Moreover, the findings of this study highlight that the young learners did not notice the stigmatization. It is noticeable among the middle and late adolescents living with HIV. The counsellors should focus and prepare to encounter it before entering those adolescence stages. Likewise, participation of same care giver is essential for those psychosocial preparation. The responsible counsellor should emphasize voluntarily involvement of the care giver.

5.4 Study Limitation and Direction for Future Research

There are several limitations that should be taken into consideration. Firstly, the data collection period was limited to four months, which the researcher found not really enough to collect all the required information from enough number of study respondents. This was due to the nature of children with highly stigmatized conditions like HIV/AIDS and orphanhood. It took time to get familiar and build rapport with the respondents. During the first month, the researcher obtained very little information from the interview. Among 12 children who agreed to participate in the interview, only nine respondents provided in-depth information that can be reported in the findings. Therefore, inclusion of more study sample and longer data collection period is encouraged.

Secondly, the data in this study were obtained only through the in-depth interviews when the respondents were at the home. The observation at school was not possible due to the issue of HIV confidentiality. The information obtained are, thus, solely from the perceptions of the respondents. Although the researcher also interviewed the key informants, the concrete picture of HIV-born students' engagement in school activities (e.g. how they behaved at school, how well they got along with other classmates, how they performed the class activities and how they interacted with the others) have not been observed.

Thirdly, the concept of quality of school life (QoSL) has been proposed in quantitative studies, while this study explored it in qualitative ways. Using the concretely defined components of QoSL might hamper the deeper understanding of how the HIV-born adolescents reflect their satisfaction in school in their own subjective meaning. It might be interesting to study about how HIV-born adolescent value and give the meaning to their school life.

Lastly, an investigation of QoSL in HIV-infected students with more consideration of social aspect in a larger sample would contribute to the HIV and adolescent literature. As this study found possible linkage between social integration and quality of school life in a specific population group, it can be used as the guidance for the development of the measurement of quality of school life specific to students with highly stigmatized conditions.

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APPENDICES

APPENDIX A

IN-DEPTH INTERVIEW GUIDELINES FOR RESPONDENTS

Guidelines for interview play the most crucial role to guide the researcher to achieve saturated information for the study. As such, additional “probing questions” will be asked to clarify the experiences of the respondents upon necessary.

A. Background Information

To achieve the background information of HIV-born respondents:

1. Name: I am.....Nice to meet you, and may I know your name, please?
2. Age: If you don't mind, how old are you?
3. Gender: I will write down your gender here, sis/brother. Right? (According to the physical appearance, voice and body movement)
4. Grade: You look mature, in which grade are you attending?
5. Religious: Which religious do you prey?
6. Ethnic group: Please tell me your ethnic group.
7. HIV status: When and how did you know that you have HIV?
8. Disclosure status: If you don't mind, please share me about your disclosure status.
9. HAART: How long have you been taking HAART? When/where/how do you take it?

B. In-depth Interview Guideline

- 1. To explore experiences of HIV-born adolescents in school life.**
 - a. Do you like going to school? What do you like or dislike about going to school?

- b. How much do you expect from what you receive from school?
- c. How well do you think you can get along with your friends and teachers?
- d. Have you ever experienced any discomfort feelings when you stay with others in school? What do you think the cause of such discomfort?
- e. Do you have any discomfort experience not because of your friends or teachers? What made you inconvenient and how?

2. To analyze the barriers of HIV-born adolescents to engage in their school environment.

- a. Do you think people in school know your health status? Can you say your current concerns about your health status among your friends and teachers?
- b. Have you ever felt inferiority in dealing with people in school who are not from the Home? Why do you feel like this?
- c. How do you think people's treatment in the school on you based on your health status despite not disclosing all?
- d. How different do you think yourself compared to your friends or classmates who are not from the Home?

3. To understand how well adolescents with perinatal HIV socially engage in their school.

- a. Could you describe to me about your social life in school, and how have you been beneficial by doing like this in your school life and learning?
 - 1) Your sharing tasks of classroom for cleanness and tightness
 - 2) Your assistance to your friends and teacher irrespective of tasks
 - 3) Being included in all school activities in terms of group work for school lessons, religion, sport, students' gathering occasion, cultural events
 - 4) Your participation in joint activities in classroom, the whole school or with other schools
- b. What kind of friends do you want to make new friends or close friends? Why?
- c. How many close friends do you have? Why are your close friends? How do you contact with them outside school?

- d. With who do you usually share your personal feeling each other? When, where and how do you share your feelings?
- e. Do you have any special skill among friends? How do you think that your friends like you or not because of these skills?

4. To explore how social integration of HIV-born adolescents is related to their quality of school life.

- a. How do you usually do when you have unclear lessons? Have you ever joined the academic competitions? Why?
- b. How do you set your carrier inspiration?
- c. What are expectations from school aside from education?
- d. How do you usually prepare your homework and to go to school?
- e. How are the subjects what you learn in school beneficial for you?
- f. How do you think whether you can well perform in school activities or not? Why?

APPENDIX B

IN-DEPTH INTERVIEW GUIDELINES FOR KEY INFORMANTS

A. Background Information of Key Informants

To achieve the background information of key informants:

1. Name: I am.....Nice to meet you, and may I know your name, please?
2. Age: If you don't mind, how old are you?
3. Gender: According to the physical appearance, voice and body movement
4. Occupation: Could you tell me your responsible position here?
5. Working duration for those HIV-born adolescents: How long have you worked for and known about HIV-born adolescents?
6. Responsibilities for HIV-born adolescents/students: Could you share me more about your main tasks for HIV-born adolescents/ students?

B. Interview Guidelines for the Home Staff

1. How do you think that the adolescents from the home enjoy to go to school?
What make them to enjoy or not to enjoy school?
2. To what extent can they well fix with the school's rules and regulation?
3. How well do they get along with their teachers and friends who are not from home?
4. Have you ever noticed any discomfort feelings of the adolescents in school?
What do you think the cause of such discomfort?
5. If you were aware of any discomfort of children in school apart from people in school, please share your view? What made them inconvenient and how?
6. How different are the adolescents compared with their friends or classmates who are not from the Home?
7. How do these differences disturb their social life in school?

8. When you picked up the adolescents from school, with whom they talk and come outside school together? Why do you think that?
9. Can they reduce their own discomforts and socially engage with their friends and teachers with the followings? How do you think?
 - a) Sharing tasks for cleanness and tightness of classroom
 - b) Assistance to their friends and teacher irrespective of tasks
 - c) Being included in all school activities in terms of group work for school lessons, religion, sport, students' gathering occasion, cultural events
 - d) Participation in joint activities in classroom, the whole school or with other schools
10. What kind of friends are easy to make new friends or more fixed with them? Why?
11. Have you noticed their contact with friends who are not from the Home? How do they usually contact outside school? Is it frequent or rare? Why?
12. Have you noticed their close friends? Are they from the Home or not? How is your view?
13. Are you aware special skills of individual adolescent? Do the competent adolescents more socialize or not? Why?
14. How the adolescents from the Home do if there are unclear lessons or academic competition? Why?
15. How do you think expected future carrier of individual adolescent in Home?
16. How does schooling develops the personality of these adolescents? How are their progress in terms of self-awareness, potentials or self-leading or not?
17. Please share your opinion academic motivation of these adolescents?
18. How are school activities relevant for these adolescents?
19. How do you view the achievement of HIV-born adolescents in school?

C. Interview Guidelines for the Representative Teacher of the School that Received the HIV-born Adolescents

1. What were your challenges on the HIV-born students' admission to school?

2. How much have you considered for the admission from different aspects?
3. Have you had any encounters for those students in recent? In what ways are you adjusting it?
4. Can you explain the HIV stigmatization for those students in school? How have school and Home tried to mitigate it?
5. How did you disclose the HIV status of the children to school administrators and teachers?
6. With the followings, can the students with perinatal HIV mitigate their own stigma and socially engage with their friends and teachers? How do you think?
 - a) Sharing tasks for cleanness and tightness of classroom
 - b) Assistance to their friends and teacher irrespective of tasks
 - c) Being included in school activities in terms of group work for school lessons, religion, sport, students' gathering occasion, cultural events
 - d) Participation in joint activities in the classroom, the whole school or with other schools
7. In which situations ease them to have new friends or more and more socially fixed with them? Why?
8. Have you noticed whether the students from the Home live with their peers or others who are not from the Home? How do you think about it?
9. Are you aware any outstanding students from the Home? How is their social interaction in school compared with others who are also from Home?
10. How have you heard general expected future carrier of the students with inborn HIV from their classroom teachers? How is your opinion on their expectation?
11. In what ways schooling can develop the personality of the adolescents with inborn HIV? How do you think about it?
12. If you don't mind, how have academic motivation of HIV-born adolescents been view in general by the teachers? How is your opinion?
13. Why do school activities are relevant for those students? How?
14. How is the achievement of HIV-born adolescents in school viewed from teachers' perspectives? How do you think about it?

D. Interview Guidelines for the Director of the Home

1. Let me know your experiences the children's enrollment in school?
2. Could you please explain how much you considered to choose school for these adolescents?
3. Have you had any encounters for those students in recent? What are they? In which ways are you fixing it?
4. How do you view the HIV stigmatization for these adolescents in school? How have responsible personnel of school and Home mitigated it?
5. With the followings, can they reduce their own stigma and can socially engage with their friends and teachers? How do you think?
 - a) Sharing tasks for cleanness and tightness of classroom
 - b) Assistance to their friends and teacher irrespective of tasks
 - c) Being included in all school activities in terms of group work for school lessons, religion, sport, students' gathering occasion, cultural events
 - d) Participation in school joint activities in the classroom, the whole school or with other schools
6. Do the adolescents from the Home usually live with their peers or others who are not from the Home in the school? How do you think about it?
7. In which situations ease them to have new friends or make more socially fixed with their friends? Why?
8. Are there any outstanding students in the Home? How is their social dealing in school compared with others who are also from Home?
9. How have the Home support unclear lessons or academic competition in school? Why?
10. How do you think their expected future carrier?
11. How does schooling develops the personality of the adolescents in Home in terms of self-awareness, potentials or self-leading or not? Why or why not?
12. Please share your opinion academic motivation of these adolescents?
13. How are school activities relevant for these adolescents? Why or why not?
14. How do you view the achievement of HIV-born adolescents?

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