

Enhancing social capital in communities to manage HIV and AIDS: The role of social workers in the Johannesburg and Ekurhuleni Metropolitan Municipalities

by

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Abstract

Enhancing social capital in communities to manage HIV and Aids: The role of social workers in the Johannesburg and Ekurhuleni Metropolitan Municipalities.

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The goal of this study was to explore and describe roles of social workers in enhancing social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities. In order to achieve this goal, a qualitative research approach was adopted to explore and describe the views of social workers and community members. The research deals with the roles of social workers in enhancing social capital in the communities of Johannesburg and Ekurhuleni Metropolitan Municipalities in order to manage HIV and Aids.

To this end, the collective case study design guided the study. Focus group interviews were used as the data collection method for this study, and two distinct interview schedules developed and utilised for social workers and community members, respectively. From the raw data, the researcher implemented the qualitative data analysis process of Creswell (1998) to extrapolate themes and sub-themes through thematic analysis. The trustworthiness of the data interpretation was confirmed through reflexivity, voluntary participation and the guarantee of anonymity.

An analysis of three different sources of data, namely the literature review and focus group interviews with social workers and community members was undertaken to answer the following two research questions, namely: (1) Based on the views of social workers, what are the roles of social workers in enhancing social capital in the communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities?; and (2) Based on the views of community members, what are the roles of social workers in enhancing social capital in the communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities?

The key finding of the study was that, social workers have various roles to play in enhancing the social capital of communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities. More specifically, it was found that: (1) Social workers provide critical services in the identification and assessment of situations in which relationships between people and social institutions need to be initiated, enhanced, restored, protected and terminated; (2) Social workers promote social change, problem solving in human relationships, and the empowerment and liberation of people to enhance their well-being; (3) Social workers provide essential leadership and support in mobilising community response to HIV and Aids; (4) Social workers strengthen bonding, bridging or linking relationships that are critical for building family and community capacity, connecting families to services and supports, improving safety nets for prevention and early intervention, and for empowering family and community members; (5) Social workers develop special kinds of local communities that promote people's health and well-being and, at the same time, contribute to sustainable, integrated social and economic development; and finally, Social workers play a critical role in combating stigma related to HIV and Aids through education and raising awareness.

In strengthening the roles of social workers to enhance social capital in the communities, in order to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan, the following recommendations are made: to ensure that relevant international, regional, national, provincial and district level policies, guidelines and other relevant statutes are part of social workers' workplace orientation programme and continuous professional training; to emphasise the social capital concept in the tertiary education curriculum of social workers; to ensure that social workers are urgently and continuously strengthened and sustained during HIV prevention efforts; to ensure that social workers transition from their work in needs orientation to human rights affirmation; to encourage the NGO sector to include a developmental social work focus in their HIV and Aids work with communities; and to ensure that social workers work on coordination and open discussions of interpersonal networks between the government and NGOs. These recommendations are consolidated into a document entitled 'Guidelines for social workers to building social capital in communities towards the management of HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities'.

Future research could focus on the following: (1) Extending the research study to other Metropolitan Municipalities in the Gauteng province in order to compare if social workers in other municipalities identifies with the findings of the current study and to expand the recommendations originating from this study on a provincial level; (2) Investigating social capital as a community development tool for social work in the context of HIV prevention and management in the South African context further; (3) Guiding social workers on the role they could play in the efforts to

prevent and manage HIV infection at community level; and (4) Implementing the guidelines originating from this study in practice and determining their strengths and limitations.

Keywords:

HIV

Aids

Role

Social workers

Social capital

Johannesburg and Ekurhuleni Metropolitan Municipalities

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Chapter 1

General Introduction

1.1 Introduction and contextualisation

HIV and Aids continues to ravage many parts of sub-Saharan Africa. The disease brings untold suffering to millions of people and threatens the realisation of social development on the continent (Patel, 2005:176; Whiteside, 2008:6). The burden of HIV and Aids is not borne equally, as people who are considered deprived and powerless are most likely to be infected and affected with the pandemic (Whiteside, 2008:ii). Karim and Karim (2010:51) argue that HIV and Aids is a pandemic which impact on societies with rates unprecedented in recorded human history. Several authors (cf. Karim & Karim, 2010:51; Mueni, 2004:283) agree that there is no segment of society that can claim to have escaped its effect. HIV and Aids is devastating families and communities, overwhelming health care services and depleting schools.

The *Joint United Nations Programme on HIV/Aids* (UNAIDS, 2009:9) indicates that South Africa has the highest number of HIV-infected people globally. In 2011 it was estimated that around 5.6 million South Africans are infected with HIV. The HIV prevalence rate in Gauteng is 28.79% compared to the overall HIV prevalence rate of approximately 29.5% in South Africa (Department of Health, 2011:14). The HIV prevalence rate in Johannesburg and Ekurhuleni Metropolitan Municipalities is 28.9% and 30.1% respectively (Department of Health, 2011:29).

These data indicate that services to people living with HIV became, and remain, vital and override all consideration. In an attempt to deal with this devastating situations, millions of South African rands have been poured into programmes concerned with HIV awareness, behaviour change, condom use, Sexually Transmitted Infections (STI) treatment, Voluntary Counselling and Testing (VCT) and, most recently, anti-retroviral therapy (ART) (Van der Walt, Bowman, Frank & Langa, 2007:207).

Most interventions have been biomedical or behavioural in orientation, imposed on communities by outside experts with little reference to the worldviews of beneficiaries, and with tokenistic community participation. Notwithstanding all these efforts, Campbell, Nair and Maimane (2007:347) highlight that, to date, little hard scientific evidence exists that these interventions have sustained positive impacts. This situation is even more troublesome, as the most programmes, as described above, target communities as merely passive recipients of services and treatments

rather than active participants who are working in partnership with service providers to improve their bio-psychosocial health (Campbell & Cornish, 2010:1570). Therefore, within this context, there is a growing need to include the views of the target communities in programme planning, implementation and research (Nair & Campbell, 2008:45).

Barnett and Whiteside (2002:43) and Campbell and Murray (2004:189) agree that more and more empirical studies highlight the failure of current interventions to take into account the way in which local community relations may support or hinder the possibility of HIV and Aids programme success. At the level of rhetoric, it is increasingly common to hear of the need to build health-enabling community contexts. However, much work remains to be done in developing conceptualisations of what would constitute such environments, and practical strategies for promoting them. There are also efforts by Non-Government Organisations (NGOs) to develop Aids-competent communities, through community systems strengthening intervention in South Africa (Campbell et al., 2007:348).

Several authors, such as Kelly and Van Donk (2009:15) and Rooy (2001:128), agree that bonds within communities may help to prevent the large-scale Aids epidemic and to mitigate the impact of HIV and Aids in areas of high prevalence. There is some evidence that societies with high social capital and social cohesion may have better overall population health (Kawachi, 2001:33). Pronyk (2002:107) has suggested that strengthening the stock of social capital in South African communities could mitigate the transmission and impact of HIV. There is an agreement among several authors (Campbell et al., 2007:348; Lamboray & Skevington, 2001:514; Roos & Temane, 2007:283; SAT, 2008:15; Van Wyk, Strebel, Peltzer & Skinner, 2006:70) that HIV and Aids competent community is where there is strong social capital. The *Organisation for Economic Cooperation and Development* (OECD) (2001) defines social capital as “networks together with shared norms, values, and understandings that facilitate co-operation within or among groups”. The World Bank (2003) considers social capital to be a major factor affecting the sustainability of its world HIV and Aids, and poverty eradication programmes.

Engelbrecht (2008:167) and Kwok (2006:7) argue that the social work profession has long been concerned with enhancing community, building social capital, and effecting change in people’s social conditions or quality of life, but such involvement has not been given due recognition when the state plays the dominant role in providing care. Patel (2005:102) also states that in reality social workers devote a great deal of time to conveying information and providing social education to community members. Informal social community education is usually process driven, and as such, is situation specific, culturally relevant, responsive to local needs, and implies horizontal, rather than top-down learning, where the social worker works in partnership with the community (Engelbrecht, 2008:167).

Social workers may help diffuse HIV and Aids information, to shape community norms and showcase positive role-modelling behaviours, as well as to provide members with material, emotional and social support (Pronyk, 2002:111). Therefore, the researcher deemed it necessary to study the role of social workers in enhancing social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities particularly. It was alluded to earlier in this introduction that HIV negatively affects the general wellbeing of residents in Johannesburg and Ekurhuleni Metropolitan Municipalities. Furthermore, in light of the fact that HIV and Aids services are predominantly a top-down approach, the researcher is of the opinion that, in order to lend a voice to the community members who are involved in HIV and Aids work, this study explored and described the views of people at grassroots about what they perceive as the role that social workers should play in enhancing social capital to mitigate the impact of HIV and Aids.

The research findings resulted in valuable recommendations that will direct the improvement and/or development of roles of social workers in enhancing community social capital to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities. Based on the findings of the research study, the researcher developed guidelines of how social workers can be involved in enhancing community social capital to manage HIV and Aids.

1.2 Problem statement

The *United Nations Development Programme* (UNDP) (2008:5) and UNAIDS (2009:3) perceive HIV and Aids as the most formidable public health problem facing South Africa today. The social and economic impact of HIV and Aids on individuals, families and communities are enormous, the pandemic constitutes a human tragedy that is immeasurable. HIV and Aids may also undermine community social cohesion by straining households, kinship ties and various community structures (United Nations Office of the Special Adviser on Africa [OSAA], 2003).

The adoption of the *White Paper for Social Welfare* in 1997 firmly mandated social workers to play a decisive role in human, social and economic development, through, amongst others, developmental community-based services, and to obtain a balance between remedial, protective, preventative and developmental strategies (Patel, 2005:73). Simultaneously, the *Integrated Service Delivery Model* (ISDM) (Department of Social Development, 2006a:14) states that the social work profession must promote social change, problem solving in human relationships, and the empowerment and liberation of people to enhance well-being. Within the context of HIV and Aids, Green (2008:180) postulates that this epidemic poses major challenges to all professions in South Africa and, in particular, to the social work profession.

Patel and Hochfeld (2008:207) argues that service delivery continues to reflect historical patterns of service types and funding in that the focus of service delivery is on residential care, statutory services and on children and older persons. Over the past decade the government of South Africa, especially the Department of Social Development, focused predominantly on social security, to the detriment of the other development social services for, amongst others, communities affected by HIV and Aids (Department of Social Development, 2006b:11). In addition, services in terms of HIV and Aids are characterised by a top-down approach where the knowledge and opinion of local communities are neglected (Campbell, Gibbs, Maimane, Nair, 2008:163).

Therefore, the researcher is of the opinion that social workers are capable, by virtue of their holistic perspective, to respond to the needs of people living with HIV and Aids, and mandated by current social welfare policy to build effective coalition through networking and strategic alliance, to help people gain more control over their lives, in partnership with them and addressing major political, social and economic issues on grass roots level. Inasmuch as there is a need to understand HIV epidemiology in more localised terms, there is a need to think further and more seriously about how to localise responses to the epidemic (Kelly & Van Donk, 2009:5).

The problem statement of this study can be synthesised by stating that, irrespective of social welfare policies mandating social workers to build social capital to, amongst others, mitigate the impact of HIV and Aids in communities, the specific roles and strategies that could be followed by social workers, are not yet clear. In addition, the views of grass root community members, involved in HIV and Aids work, about the roles that social worker could play in enhancing social capital to mitigate HIV and Aids, are also not yet described. From the data, it is clear that the Johannesburg and Ekurhuleni Metropolitan Municipalities is seriously affected by the HIV pandemic.

It was confirmed through the literature reviews and the South African Research Database (the SABINET) that no accredited article exists and that no individual or organisation have conducted a similar study. Therefore, this study was considered timeous and proposed guidelines of how social workers can be involved in enhancing community social capital to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities, based on research findings obtained from social workers practising in the field of HIV and Aids, and community members involved in HIV and Aids projects.

1.3 Theoretical frameworks

The study was guided by two theories, i.e. social capital theory and social development theory.

1.3.1 Social capital theory

The tenet of the social capital theory is that social relationships among people can be productive resources and that social capital facilitates coordination and cooperation for mutual benefit (Putman, 2000:42). Social capital theory suggests that, social networks and the set of resources embedded within them, strongly influences the extent to which interpersonal knowledge sharing occurs (Chiu, Hsu & Wang, 2006:1873). According to social capital theory, community sentiment and involvement partially represent the resident's degree of community attachment.

Theoretically, the stronger the individual's attachment to their community the more likely they are to work together toward the common good of the community (Miller, 2001:476). Through a qualitative study, the researcher drew on social capital theory to inform her analysis of data obtained through focus group interviews on how social capital "glue" can involve communities in ways that enhance the outcomes of social programmes (Awio, Northcott, Lawrence, 2011:66), specifically with regards to the management and mitigation of HIV and Aids.

1.3.2 Social development theory¹

Midgley (1995:25), a world leader in social development studies, defines social development as "a process and planned social change designed to promote the well-being of the population as a whole in conjunction with the dynamic process of economic development". Social development proclaims that purposeful intervention from both the state and non-state actors, the creation of organisational and institutional arrangements at national level to harmonise economic and social policies within a comprehensive commitment to people-centred development, and social service interventions that are to be locally relevant and sustainable promote people's human, social and economic development (Midgley & Tang, 2001:246). The focus of social development in line with its theoretical roots, is on interventions targeting the poor and socially excluded groups, such as people affected and infected with HIV, and views service providers and beneficiaries as active participants (thus proclaiming a bottom-up approach) in the development of society (Patel, 2005:33).

The researcher, in line with a social development theoretical orientation, explored how both social workers and community members articulate, and foresee, the role of social workers in enhancing

¹ Sometimes referred to as the developmental approach in the text.

community's social capital to manage HIV and Aids. More detail on this theoretical frameworks follow in Chapter 2, paragraph 2.6.

1.4 Goal and objectives of the research study

The **goal** of the study was to explore and describe the roles of social workers in enhancing social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities.

The **objectives** of the study were as follows:

- To determine the role of social workers in enhancing social capital to manage HIV and Aids according to international, regional and national policy.
- To explore the views of social workers about the roles they play, or could perform, in enhancing social capital in the communities of Johannesburg and Ekurhuleni Metropolitan Municipalities to manage HIV and Aids.
- To explore the views of community members involved in HIV and Aids work about the role social workers play, or could perform, in enhancing social capital in the communities of Johannesburg and Ekurhuleni Metropolitan Municipalities to manage HIV and Aids.
- Based on the outcomes of the study, to draft guidelines for building social capital in communities towards the management of HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities. Furthermore, recommendations for further social work research will be made.

1.5 Research question

The research study was guided by two research questions namely:

1. Based on the views of social workers, what are the roles of social workers in enhancing social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities?
2. Based on the views of community members, what are the roles of social workers in enhancing social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities?

1.6 Overview of research methodology

This study was rooted in constructivism as research paradigm in order to explore and describe the roles that social workers play, or should play, in enhancing social capital in communities to manage HIV and Aids from the frame of reference of both social workers involved in practice and affected community members (Ponterotto & Casas, 2002:402). The constructivism paradigm was used because it states that people construct their own understanding and knowledge of the world, through experiencing things and reflecting on those experiences (Linda, 2004:233).

As the aim of this study was to explore and describe the roles of social workers in enhancing social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities, a qualitative research approach was considered the most relevant and appropriate approach to guide the study, since the study focused on the experiences, views and opinions of the participants (cf. Fouchè & Delport, 2002:77). The study pursued an exploratory purpose to gain insight into the subject area (Neuman, 2011:38).

Since the study was qualitative in nature, the collective case study was considered the most adequate research design for this study as the researcher is interested to obtain answers to the research questions, not only based on the opinion of one or two isolated cases, but rather the collective view of two groups of participants, i.e., social workers and community members (Nieuwenhuis, 2010b:70).

The data collection procedure for this study was focus group interviews. Focus group interviews, based on two distinct interview schedules, enabled the researcher to collect the collective views of a group of participants, instead of individuals, and as such it effectively links with the collective case study research design adopted for the study (Greeff, 2005:300; Neuman, 2011:459).

The researcher used reflexivity and voluntary participation and guarantee of anonymity as strategies at different stages of research process to ensure trustworthiness of the data. In accordance to Horsburgh's (2003:308) strategy on reflexivity, the researcher conducted a process of introspection regarding her viewpoint and experience as a social worker working in the HIV and Aids field in order to produce valid and accurate research findings. The process of introspection was followed by a self-reflection process in order to ascertain if there was the possibility of being biased in the way research data will be analysed. In addition, the researcher took notes, during the interviews and also recorded the interviews conducted with social workers and those conducted with community members. The interviews were recorded so as to allow the researcher to review and verify during data analysis to avoid the influence of the researcher's predetermined knowledge and experience.

In line with Li's (2004:303) strategy on voluntary participation and guarantee of anonymity, the researcher ensured that information provided by the participants is kept confidential; this process was enforced by signing of confidentiality agreement by the researcher and research assistant. To ensure anonymity participants included in the research were not called by names but were assigned codes so that they are protected from identification.

From the raw data, the data analysis was conducted using Creswell's (1998) qualitative data analysis process (Nieuwenhuis, 2010a:103) with the view to specifically undertake thematic analysis.

Before the empirical study was undertaken, its feasibility was ensured through, among others, ethical clearance from the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria (see Appendix A). For a more detailed discussion of the research methodology and ethical considerations applicable to this study, see Chapter 3, Section 1.

The next section will highlight the limitations of the study.

1.7 Limitations

Due to the qualitative nature of the nature, the following limitations must be taken into considerations when reading this mini-dissertation.

- The study took place in only two out of five Metropolitan Municipalities, and the results could therefore not be generalised to the whole population of social workers in the Gauteng Province or whole country. The two metros are Johannesburg and Ekurhuleni Metropolitan Municipalities
- Social workers who participated in the study were from the non-governmental (NGO) sector, and their opinions are not representative of the whole population of other social workers working in other sectors, such as government and private practice.
- Out of the 10 social workers who were targeted for the focus group interview, only nine were available on the day of the interview.

1.8 Definition of key concepts

The key concepts relevant to this study are presented below.

1.8.1 HIV

Watstein and Jovanovic (2003) define HIV (Human Immunodeficiency Virus) as the virus that causes Aids. This virus causes a specific disease affecting the immune system by attacking the T cells, which are part of the defence mechanism that copes with infection.

The Department of Health (2007) defines HIV as follows: "Human Immunodeficiency Virus is a lot like other viruses, including those that cause the "flu" or the common cold. But there is an important difference over time; the immune system can clear most viruses out of the body. That is not the case with HIV; the human immune system can't seem to get rid of it. HIV can hide for long periods of time in the cells of the body and that it attacks a key part of the immune system the T-cells or CD4 cells. The body has to have these cells to fight infections and disease, but HIV invades them, uses them to make more copies of itself, and then destroys them."

The researcher defined HIV as a condition in humans that leads to the progressive failure of the immune system and results in life-threatening opportunistic infections. HIV is contracted through human body fluids, such as blood, semen, pre-seminal fluid, breast milk, vaginal fluids and rectal (anal) mucous.

1.8.2 Aids

Cichocki (2009) defines Aids (Acquired Immunodeficiency Syndrome or Acquired Immune Deficiency Syndrome, sometimes written Aids) as a human disease characterised by progressive destruction of the body's immune system. It is widely accepted that Aids results from infection with HIV (Human Immunodeficiency Virus), although this hypothesis is not without controversy. Aids is currently considered incurable.

Van Dyk (2001) explains Aids as the acronym for Acquired Immune Deficiency Syndrome. It is caused by a virus (the Human Immunodeficiency Virus or HIV), which enters the body from outside. Aids is diagnosed when a person infected with HIV has a CD4 count less than 200 cells/mm³ or has an Aids-defining condition.

The researcher defines Aids as a syndrome characteristic of a person where the HIV infection has badly damaged the immune system over a period of time, it is also a final and terminal stage (phase) of HIV infection.

1.8.3 Role

Role is defined as “a function or position that somebody has or is expected to have in an organisation, in society or in a relationship” (*Oxford Advanced Learners Dictionary*, 2005:1268).

The *New Social Work Dictionary* (1995:54) defines the term role as “the expected or prescribed working method of a social worker in specified situations which develops during social work intervention.”

The researcher defines role as the expected function and position of the social worker in working with communities to enhancing their social capital to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities.

1.8.4 Social workers

A social worker is “a person who is registered and authorized, in accordance with the Social Act 1978 (Act 110 of 1978), to practice social work” (*New Social Work Dictionary*, 1995:54).

De Vos, Schulze and Patel (2005:17) define social workers as “well-trained professional[s] with theoretical knowledge base of methods and techniques for participating in wider social action and policy making.”

The researcher defined social workers as a trained professional whose role is helping people obtain basic human need services; counselling with individuals, families and groups; helping communities/groups provide or improve social and health services; and participating in relevant legislative and social policy processes.

1.8.5 Social capital

The World Bank (2003) defines social capital as “institutions, relationships, and norms that shape the quality and quantity of a society's social interactions. Social capital is not just the sum of the institutions which underpin a society – it is the glue that holds them together.”

The Organisation for Economic Co-operation and Development (OECD) (2001:41) defines social capital as “networks together with shared norms, values and understandings that facilitate co-operation within or among groups.”

In this study, the researcher defined ‘social capital’ as the community spirit, social bonds, community networks, extended friendships, community life, social resources, informal and formal networks and good neighbourliness.

1.8.6 Johannesburg and Ekurhuleni Metropolitan Municipalities

In this study Kintu's (2010) definition of **Ekurhuleni Metropolitan Municipality** will be adopted, namely "a metropolitan municipality that forms the local government of the East Rand region of Gauteng, South Africa. The name *Ekurhuleni* means *place of peace* in Tsonga. Ekurhuleni is one of the 6 metropolitan municipalities of South Africa. Population: 2,724,227 Area: 1,925 km² (743.2 sq mi)"

In this study, Kintu's (2010) definition of the **Johannesburg Metropolitan Municipality** will be adopted, namely "is a metropolitan municipality that manages the local governance of Johannesburg, South Africa. It is divided into several branches and departments in order to expedite services for the city. Population: 3,888,180. Area: 1,645 km² (635.1 sq mi)"

1.9 Contents of the research report

The remainder of this research report is structured as follows.

Chapter 2: HIV and Aids in communities of Johannesburg and Ekurhuleni Metropolitan Municipalities: The role of social workers according to policy.

Chapter two, amongst others, provides an overview on the prevalence of HIV and Aids and its impact on communities in the Johannesburg and Ekurhuleni Metropolitan Municipalities. Furthermore, it determines and describes the mandate of social workers to mitigate HIV and Aids in communities through, amongst others, social capital formation as outlined in provincial, national and international policies.

Chapter 3: Research methodology, research findings and interpretation

Chapter three focuses on an overview of the research methodology followed in the study, and provides the research findings and offers an interpretation thereof.

Chapter 4: Conclusion and recommendations

Chapter four highlights the key findings of the study and forward recommendation for how social workers can build social capital of HIV and Aids affected communities in the Johannesburg and Ekurhuleni Metropolitan Municipalities.

Chapter 2

HIV and Aids in the communities of Johannesburg and Ekurhuleni Metropolitan Municipalities: The role of social workers according to policy

2.1 Introduction

Statistics for the end of 2010 indicate that around 34 million people are living with HIV globally, the virus that causes Aids. Each year around 2.7 million more people become infected with HIV and 1.8 million die of Aids related diseases (Joint United Nations Programme on HIV and Aids [UNAIDS], 2011: 2).

UNAIDS (2011:3) states that although HIV and Aids is found in all parts of the world, some areas are more afflicted than others. The worst affected region is sub-Saharan Africa, where in a several countries more than one in five adults is infected with HIV. The pandemic is spreading most rapidly in Eastern Europe and Central Asia, where the number of people living with HIV increased by 250% between 2001 and 2010.

South Africa is one of the countries hardest hit by the pandemic. South Africa's HIV and Aids prevalence rate (the percent of people living with the disease) is much higher than that of the sub-Saharan African region overall (Health Economics and HIV/AIDS Research Division [HEARD], 2003:3). The epidemic has already profoundly impacted many aspects of South African society, and is projected to affect the country's economic, education, and health sectors if more is not done to stem its tide (Whiteside & Sunter, 2004:36).

Heinsen cited in Chetty (2002:16) purports that South Africa's HIV infection thrives in conditions of socio-economic vulnerability and inequity, and its impact is most severe in communities that lack access to life-sustaining resources. In turn, HIV and Aids impact on the sustainability of communities and their development conditions.

HIV and Aids is a global pandemic that affects individuals, families, and entire communities around the world and has profound social and economic implications. The demographics behind HIV and Aids are as diverse as the world in which we live and work, calling for a range of responses from the social work profession. The eradication of HIV and Aids represents one of humanity's greatest challenges, one that requires cooperation and comprehensive collaboration between scientific

disciplines, governments, social institutions, the media, the social work profession and health care professions, and the general public (National Association of Social Work [NASW], 2005). According to the International Federation of Social Work [IFSW], 2012:1) social workers, by virtue of their training, their commitment to human rights, and the fact that they are uniquely placed within a wide variety of health and welfare settings can play a very effective role in the global effort to address the HIV and Aids epidemic.

The focus of the next section will be on the concept of HIV and Aids as a social problem, impact of HIV and Aids at the international, regional, national and municipal levels, and on policies guiding social workers in building of social capital in communities of Johannesburg and Ekurhuleni Metropolitan Municipalities. Social capital as a strategy, and social development as a theory, which could be used by social workers, will be discussed extensively in this chapter and the discussion will be in the context of HIV and Aids in local communities.

2.2 HIV and Aids as a social problem

Barker (2003:107) defines social problems as “conditions among people leading to behaviours that violates people’s value and norms and causes emotional or economic suffering”. The author gives examples of social problems, such as crime, social inequality, poverty, racism, drug abuse, HIV and Aids, dysfunctional families and mal-distribution of limited resources.

The enormous Aids burden in South Africa suggests that Aids is perceived as a unique social problem, most closely associated with crime and violence; the social problems that represent leading causes of death among young people (Kalichman & Simbayi, 2003:33). Most communities in Southern Africa are discussing issues arising from HIV and Aids and include them in the analysis of their particular poverty situation along with other problems, such as the lack of water, absence of economic and basic social services and infrastructure, the lack of credit, or the lack of opportunity for education.

According to Mawar, Seema, Sahay and Mahajan (2005:471) HIV and Aids is increasingly being recognised as not merely a medical problem, but a social problem as well. Aids does not occur in isolation of other serious social problems. HIV infections are most prevalent in urban areas, particularly in socially and economically impoverished communities (Nelson Mandela/ The Human Sciences Research Council (HSRC) Study of HIV and Aids, 2002). HIV infection is linked to poverty because of poor health care infrastructure, greater social density, social isolation leading to closed sexual networks, alcohol and drug abuse, and engaging in sex in exchange for survival resources (Kalichman, Simbayi, Kagee, Toefy, Jooste, Cain & Cherry, 2006:1641). HIV and Aids is

clearly not the direct result of hunger and impoverished living conditions (Booyesen, 2004:58), but it is likely that poverty creates a social and environmental context that promotes the spread of HIV.

One of the major factors that play a role in the dynamics of HIV infection is the level of empowerment. The low level of education, especially in women; and the patriarchal systems which place women in a subservient position. Consequently, women have lesser control over their own bodies and lack negotiating skills for their protection (Moore & Williamson, 2003:616). Also, sex and sexual behaviour were hitherto tabooed subjects for discussion between parents and children and even in a formal set-up between teachers and college youth. Thus, children and youth are likely to have more misconceptions and be misinformed, and in the long run, pose risk for HIV and Aids.

The spread of HIV is attributed to a wide range of factors, which include behavioural factors, the quality and access to services and programmes aimed at prevention, care, social support and the mitigation of impact, as well as social and economic factors (Kürschner, 2002:7).

According to UNAIDS (2006:7) from the very outset the HIV and Aids epidemic has manifest social characteristics connected with a transformation of the social and demographic structure of the societies as well as with a transformation of basic social institutions, such as public health, civil society, church, education, social work and others. HIV has also had an impact mostly on the young generation; that is the most reproductive and able to work age, as a result the labour market was impacted as a result of decrease in segment of those in the population capable of working and reducing the productivity of labour.

As an international public health issue, HIV and Aids is proving severely disruptive to families, entire communities, and social structures worldwide (IFSW, 2012:1). Aids affects the entire household, with family members losing their most productive years, resulting in permanent poverty as the illness reduces the ability to work, increased medical costs, as well as funeral expenses. Young people continue to be at the growing centre of the pandemic. For example, in Africa, nearly one million African students are deprived of a teacher annually because of the impact of HIV and Aids (Summers & Murphy, 2002:6). Worldwide, there is insufficient programming and support services for family members/caregivers and orphans. Children, orphaned due to Aids-related deaths of parents or caregivers, face an unpredictable future that is often compounded by the same stigma, discrimination, and social isolation faced by their parents/caregivers (NASW, 2003).

Women suffer doubly when HIV and Aids enters the home, due to the burden of enduring the infection while also caring for family members who are ill. A woman's vulnerabilities are "further compounded if she is single or widowed; with discriminatory access to inheritance, shelter and other care facilities" (Mehta & Gupta, 2006:3). The impact of HIV and Aids on the lives of women is

one of the most critical reproductive health concerns of our time. In sub-Saharan Africa, where the epidemic has spread to the general population mainly through sexual contact, women make up 59 percent of adults living with HIV (UNAIDS, 2006:15).

Perhaps more important, powerlessness, dependence, and poverty tend to diminish women's ability to protect themselves from unsafe sex. In this sense, different dimensions of human development determine the transmission of HIV and its impacts, implying that it is "not simply a function of sexual behaviour" (United Nations Development Programme [UNDP], 2003: 24).

Stillwaggon (2002:17-18) purports that the HIV and Aids epidemic is not an isolated phenomenon. It is a predictable outcome of an environment of poverty, worsening nutrition, chronic parasite infection, and limited access to medical care. In such circumstances, people are more susceptible to all infectious diseases, however they are transmitted. Just as tuberculosis, diarrheal diseases, and respiratory infections are more prevalent and more quickly fatal among poor people, so too, HIV is a disease of poverty in the African context. Prevalence of HIV in Africa is not a special case, but an indicator of the nutritional, infectious, and parasitic diseases that have afflicted African people all along and a precursor of higher rates among similarly marginalised populations in the rest of the world.

2.3 Impact of HIV and Aids

The Aids pandemic is one of the most destructive health crises of modern times, ravaging families and communities throughout the world. We are living in an 'international' society, and HIV has become the first truly 'international' epidemic, easily crossing oceans and borders. The impact of HIV and Aids at the international, regional (i.e. African), national and municipal levels will be discussed in the next section.

2.3.1 International

HIV is recognised as a global threat. According to UNAIDS/The Henry J. Kaiser Foundation (2009:9) donor governments, low-income and middle-income country governments, the private sector, and individuals have contributed to the substantial increase in HIV and Aids funding from the 1990s into the new millennium. In 2008, an estimated US\$15.6 billion was spent on HIV and Aids compared to US\$300 million in 1996 (UNAIDS, 2006:5). However, the global economic recession (2007 - 2011) has led to declining financial commitment (UNAIDS, 2009:3). Moreover, the availability of treatment is being outpaced by the rate of new infections; two people are infected with HIV for every one put on treatment (United Nations, 2011:6). Much has been achieved but the

momentum must be maintained or the hard-won achievements of the past two decades risk being reversed.

The UNAIDS (2010:6) states that when Aids first started, no one could have predicted how the epidemic would spread across the world and how many millions of lives it would change. There was no real idea what caused it and consequently no real idea how to protect people against it. Now it is known from experience that HIV is the cause of Aids and that it can devastate families, communities and whole countries. The epidemic removed decades off countries' national development, widens the gulf between rich and poor nations and push already stigmatised groups closer to the margins of society.

According to the United Nations (UN) (2011:2) more than 30 million people around the world have died of Aids-related diseases. In 2010, 2.7 million people were newly infected with HIV, and 1.8 million men, women and children died of Aids-related causes. 34 million people around the world are now living with HIV (UNAIDS, 2011:2). In 2011, according to the UN (2011:2), world leaders gathered to restate their commitment to ending the HIV and Aids epidemic worldwide. In the Political Declaration (UN, 2011:2), they stated:

HIV and Aids constitute a global emergency, pose one of the most formidable challenges to the development, progress and stability of our respective societies and the world at large and require an exceptional and comprehensive global response.

The global leaders, in committing themselves through this declaration, agreed to work together with a view to guiding and intensifying the global response to HIV and Aids by promoting continued political commitment and engagement of leaders in a comprehensive response at the community, local, national, regional and international levels to halt and reverse the HIV epidemic and mitigate its impact. The leaders also recognised that although HIV and Aids are affecting every region of the world, each country's epidemic is distinctive in terms of drivers, vulnerabilities, aggravating factors and the populations that are affected, and therefore the responses from both the international community and the countries themselves must be uniquely tailored to each particular situation taking into account the epidemiological and social context of each country concerned (UN, 2011:2).

2.3.2 Regional

According to the World Health Organization [WHO] (2013:16) sub-Saharan Africa remains the region most heavily affected by HIV. In 2010, about 68% of all people living with HIV resided in sub-Saharan Africa, a region with only 12% of the global population. Sub-Saharan Africa also accounted for 70% of new HIV-infections in 2011, although there was a notable decline in the

regional rate of new infections. Almost half of the deaths from Aids-related illnesses in 2011 occurred in southern Africa. Aids have claimed at least one million lives annually in sub-Saharan Africa since 1998. Since then, however, Aids-related deaths have steadily decreased, as free antiretroviral therapy has become more widely available in the region.

While the HIV epidemic is reaching a plateau and even declining in some parts of sub-Saharan Africa, trends show southern Africa continues to bear the largest burden of HIV globally (UNAIDS, 2010). Southern Africa accounts for 34% of the global burden of HIV, 31% of new infections in the world, and 34% of all HIV and Aids related deaths (UNAIDS, 2010).

The Southern African Development Community (SADC) (2008:3) postulates that the region has the highest levels of HIV infection to be found globally. The majority of Member States (MS), such as South Africa, Swaziland and Zimbabwe have experienced adult infection levels in excess of 15%, and several have been tackling epidemics where 20% or more of adults are infected. In contrast, the global average is just 1%. Many MS are now grappling with the escalating impact of mature epidemics of HIV and Aids, as well as HIV and Tuberculosis (TB) co-infection. Eleven SADC MS are among the 27 countries that are estimated to account for 80% of all children living with HIV worldwide. To date up to an estimated 530,000 children are infected annually, mainly through mother-to-child transmission (MTCT). More than 1 million children under the age of 15 are infected with HIV accounting for 8% of people living with HIV in the region. The HIV and Aids as well as TB/HIV epidemic are eroding hard-won development gains of previous decades and have a particularly heavy impact on women and children.

The SADC (2008:4) states that the HIV and Aids epidemic in the region is fuelled by a multiplicity of factors such as poverty, cultural practices, migrant labour within and between countries, separation of spouses for economic reasons, gender imbalances, intergenerational sex, sexual violence against women, illiteracy, stigma and discrimination, population mobility, alcohol abuse, and emergency situations such as civil conflict, war and displacement. Women are disproportionately at risk, accounting for 59% of all people living with HIV in the region.

Twenty percent of the entire adult population aged 15-49 is currently infected in the nine southern African countries of Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe (UNAIDS, 2004). This is close to 16 million people.

It is also estimated that as of 2005, 15.2 million children under 18 lost one or both parents to Aids, and that millions more are at risk of experiencing poverty, homelessness, school drop-out, discrimination, loss of opportunities and death due to HIV related illnesses (Unite for Children, Unite Against Aids). Nearly 90% of all HIV-positive children live in sub-Saharan Africa (UNAIDS, 2007).

2.3.3 South Africa

Statistics South Africa (2013:2) purports that the estimated overall HIV prevalence rate is approximately 10%. The total number of people living with HIV is estimated at approximately 5,26 million in 2013. For adults aged 15–49 years, an estimated 15,9% of the population is HIV positive.

Gow and Desmond (2008:3) argue that the HIV and Aids epidemic has had many negative implications for South African society, which stem from the illness and eventual death resulting from HIV and Aids. The poor people in South Africa are the most adversely affected by HIV and Aids, the public health service is struggling to satisfy the medical needs of Aids-sick patients, support to Aids-affected households is limited and available government grants are not getting through. But there are more profound longer term ramifications of the HIV epidemic, deepening poverty among the already poor and disruption and premature termination of schooling for children, especially girls, increasing early childhood malnutrition and increasing strain on extended family networks (Steinberg, Johnson, Schierhout & Ndegwa, 2002: iii).

HIV and Aids have had a serious impact on mortality and other demographic variables in South Africa. Falling life expectancy has been one of the most visible impacts of HIV and Aids on human development. The United States Agency for International Development [USAID], 2010:1) purport that South Africa is among the countries most severely affected by the Aids epidemic, with the largest number of HIV-infections in the world.

2.3.3.1 Impact on families and communities

Lyons (2008:1) postulates that HIV has found a wealth of opportunities to thrive among tragic human conditions fuelled by poverty, abuse, violence, prejudice and ignorance. Social and economic circumstances contribute to vulnerability to HIV infection and intensify its impact, while HIV and Aids generates and amplifies the very conditions that enable the epidemic to thrive. Just as the virus depletes the human body of its natural defences, it can also deplete families and communities of the assets and social structures necessary for successful prevention and provision of care and treatment for persons living with HIV and Aids. The impact of HIV and Aids extends beyond those living with the virus, as each infection produces consequences which affect the lives of the family, friends and communities surrounding an infected person (International Community of Women Living with HIV and Aids [ICW], 2007:8). The overall impact of the epidemic encompasses effects on the lives of multiples of the millions of people living with HIV and Aids or of those who have died.

The Department of Provincial and Local Government [DPLG], 2007:6) states that in communities that are very cohesive, but also economically weak, the dependence of especially vulnerable

households on social networks mean that HIV and Aids can deplete the resources of the entire community. Over time, this may result in decreasing ability and willingness amongst community members to assist and support those who are highly vulnerable. The prevalence of HIV and Aids in Johannesburg is marginally higher than in the Gauteng Province and significantly higher than in the rest of South Africa (Tomlinson, 2006:12).

2.3.3.2 Gauteng Province

According to Statistics SA (2011:3), the Gauteng Province comprises the largest share of the South African population. Approximately 11.3 million people (22.4%) live in this province. The province mainly comprises the three urban areas of Pretoria, Johannesburg/Soweto and the southern Vereeniging-Vanderbijlpark industrial complex. Gauteng contains three of the six metros in South Africa, these being the City of Johannesburg (CoJ), the City of Tshwane (CoT) and Ekurhuleni.

Mokonyane (2012:1) is of a view that for a small province such as Gauteng, the situation is exacerbated by numerous social factors such as in-migration, unemployment, poverty and substance abuse that contribute and drive the increase in HIV incidence. Moreover, the inequalities prevalent in the society turn women and young girls into objects of abuse, violation and exploitation by those who abuse them. The number of orphans and vulnerable children left to fend for themselves is rising. Increasingly, many young women and men are driven to transactional sex as a means to survival (Mokonyane, 2012:2).

The Human Sciences Research Council (2008) states that the proportion of people with HIV and Aids in Gauteng increased from 2001 to 2004 before slowing down in 2005. HIV and Aids infections for Gauteng declined to 11.7% and 10.7% in 2008 from 13.1% and 11.7% respectively in 2004. The province registered the first negative prevalence growth rate for people with HIV and Aids of -0.5% in 2005, deteriorating to -2% in 2008. The war against the pandemic is not yet won but expenditure was increased in the financial year 2005/06, creating a comprehensive prevention and treatment programme. According to IHS Global Insight (2009:13), HIV and Aids deaths contributed to approximately a quarter of total deaths in the province.

2.3.3.3 Impact of HIV and Aids on Municipalities (Local Governments)

The DPLG (2007:i) is of a view that municipalities are expected to be active role-players in all efforts to prevent the spread of HIV and to mitigate the negative consequences of Aids for communities. Municipalities also need to consider the ways in which HIV and Aids impact on their ability to govern and deliver services effectively.

It is well documented how the social fibre of the society and the economy have been negatively affected by the pandemic; hence, the development of the *Framework for an Integrated Local Government Response to HIV and Aids* in 2007 (DLPL, 2008:4). The Framework serves to guide municipalities and provincial government on how they can respond in partnership with other stakeholders using the Integrated Development Plan/Planning IDPs as tools for planning, integration and coordination between and across all spheres of government (DPLG, 2007:ii).

The *Centre for Actuarial Research*, (2006:3) estimates that the prevalence of HIV and Aids at municipal level is one of the challenges government is facing, particularly as there is a high correlation between HIV and Aids and poverty. Municipalities are used as direct channels of communication by the state to deliver awareness messages to communities. The HIV and Aids pandemic presents a challenge because it threatens to reverse the development gains that have been achieved since the transition to democracy in 1994 and the birth of developmental local governance in South Africa (DPLG, 2007:ii).

Mathoho (2008:3) postulates that HIV and Aids increasingly poses potentially serious political and economic threats to local governments as more and more local communities and poor families bear the brunt of the pandemic. Because local government is the sphere of government closest to the people, it is required to be actively involved, not only in the fight against the spread of HIV and Aids, but also to ensure the participation of local communities and citizens in such processes. Unless the intended beneficiaries are involved in this battle against HIV and Aids (including the formulation and implementation stages of policy) efforts to combat the pandemic will have limited impact and success.

The pandemic has a profound impact on municipalities, constraining their capacity to effectively promote and advance a developmental agenda. The effect of HIV and Aids is such that many people in municipalities are either infected or affected. As a result, no one, including councillors and council officials, is immune to the HIV and Aids (Mathoho, 2008:7). Indeed, it is feared that the impact of the pandemic will undermine the capacity of municipalities to effectively and efficiently deliver services to local communities. In general, the HIV and Aids pandemic is increasingly impacting on the services that municipalities are delivering to local communities and it is likely that the situation will deteriorate unless bold steps are taken.

The next sub-sections will be focusing on the impact of HIV and Aids on two metropolises, namely, Ekurhuleni and Johannesburg Metropolitan Municipalities as the two focus areas of the research study.

❖ **Ekurhuleni Metropolitan Municipality**

According to Gauteng Online (2011:1) statistics reveal that Ekurhuleni has the highest number of people infected with the HI Virus in the Gauteng Province. Ekurhuleni is the second most populous municipality in Gauteng and had the second highest density at 128 followed by the City of Tshwane at 68 people per square kilometre in 2008. Nearly a third of the approximately 2.5 million people living in Ekurhuleni live in poverty (Ekurhuleni Growth & Development Strategy 2025, 2005: 25). Currently unemployment is estimated at 40%. Many people are forced to resort to desperate measures, such as prostitution and child labour, while others were now eating poisonous roots and wild fruits in order to merely survive. The majority of the people below the poverty line, i.e. less than R7.00 per day, live on the urban periphery far from mainstream job opportunities and urban amenities, and in informal settlements without basic services. In total, approximately 98% of all the people in Ekurhuleni that live below the poverty line are Africans (Ekurhuleni Metropolitan Municipality, 2005:25).

According to Mathoho (2006:10) Ekurhuleni has the largest contingent of migrant workers from the rural villages of South Africa, as well as one of the largest populations in informal settlements, in the country. There is evidence that the overall HIV prevalence in Gauteng province has remained level from 2007 to 2009. The highest HIV prevalence of 34.0% was recorded in Ekurhuleni (Department of Health, 2010: 42). In responding to the HIV and Aids pandemic, the Ekurhuleni metro has adopted its own local guidelines and initiated programmes to combat the pandemic (Mathoho, 2006:11).

RSA (2007:4) states that the high prevalence of HIV and Aids in South Africa in general and the Ekurhuleni metropolitan council in particular, has significant governance and developmental challenges for the country and council. While some policies and programmes are in place, a lot more needs to be done, especially by the metropolitan government, to limit the impact of the pandemic on its service delivery capacity (Mathoho, 2006:14).

❖ **Johannesburg Metropolitan Municipality**

Statistics South Africa (2011:10) indicates that the Johannesburg is South Africa's largest city, with an estimated population in 2011 of 4,434,827 million persons. Johannesburg is located in Gauteng province and immediately abuts two other metros, Ekurhuleni and Tshwane. They effectively constitute one large conurbation with a population in 2011 of 6 million persons. The population growth of the three metros has considerably exceeded that of other large cities.

The City of Johannesburg had the largest population of all the municipalities and Metsweding the smallest. City of Johannesburg, the most populous municipality, recorded the highest population

density of 1,945 per square kilometre in 2001, increasing to 2,122 per square kilometre by 2008 (Gauteng City Region Observatory, 2009:1). This shows an increase of 178 people per square kilometre.

Lerutla (2003:7) states that HIV and Aids is a critical factor in increasing the pressures for social and economic disintegration in South Africa's cities such as Johannesburg. It has a disproportionate impact on the black urban poor, vastly increasing poverty when combined with high unemployment, low household incomes, breakdown of traditional support systems and lower access to services. The HIV and Aids epidemic constitutes an enormous threat to the City of Johannesburg's development into a World Class City. It will be a major obstacle to reducing poverty and illnesses and may reverse many gains made (Gauteng, 2005:16). The focus of this chapter now shifts to HIV and Aids policies.

2.4 HIV and Aids policies

Social workers in working with communities to manage the impact of HIV and Aids, are guided by international, regional and national policies, frameworks and guidelines on how to effectively perform their roles. These policies will be discussed in the next section. In the following subsection the researcher will focus on international, regional and national standards as well as the policies, frameworks and guidelines that regulate the services provided by social workers to various clients.

2.4.1 International

According to Kuper (2005:2) there is no global international treaty on HIV and Aids, but there are elements of other treaties that lay down the rights to life, health, medical treatment and non-discrimination. However, on an international level this is mainly policy, which is not legally binding. A key issue is to identify the relevant international frameworks and knowledge about how to use it, and here the work of social workers, NGOs and other professional is particularly useful.

❖ International law of human rights and HIV and Aids

The World Health Organization (2002:965) identified the *International law of human rights and HIV and Aids* as a comprehensive framework to which public health practitioners could anchor responsibility for addressing the underlying causes of HIV and Aids, trauma and other threats to health. Human rights are a set of universal entitlements that individuals enjoy irrespective of their gender, nationality, religion, culture or other status, that are inherent to human beings and that are proclaimed and protected by international law. Human rights have major relevance for shaping appropriate responses to the HIV epidemic and other global health challenges, including offering

system-wide public health responses and identifying deficiencies in public health research agendas.

Social work is based on respect for the inherent worth and dignity of all people as expressed in the United Nations Universal Declaration of Human Rights (1948) and other related UN declarations on rights and the conventions derived from those declarations.

The *International law of human rights and HIV and Aids* applies a “rights-based approach” to public health in general, and HIV and Aids in particular, supports sound public health practice by providing additional tools to motivate governments to act to achieve public health goals. It also sets concrete, time-bound targets for the introduction of national legislation and other measures to ensure the respect of rights in regard to education, inheritance, employment, health care, social and health services, prevention, support, treatment, information and legal protection (WHO, 2002:975).

The WHO (2002:976) argues that *International human rights law and HIV and Aids*, as reflected in the International Guidelines on HIV and Aids and Human Rights, does not provide, or claim to provide, a moral code for living with HIV and Aids. It says nothing, for example, about the personal moral responsibility to care for affected people, although it addresses states’ obligations in these areas.

❖ **International Federation of Social Work (IFSW) Policy: Social work manifesto on HIV and Aids**

The IFSW (2012) recognises that HIV and Aids is a serious threat to the health and development of the world and that commitment to tackle the consequences is needed from every sector within society. The IFSW acknowledges that partnerships at global, national and local level are vital to tackle the epidemic and recognises that education is a key strategy in tackling the epidemic. Consequently, the IFSW acknowledges that social workers should support the development and implementation of programmes that include educational and prevention strategies that meet the needs of diverse population segments of society. Access to formal education promotes economic sustainability and supports efforts to ensure that all children have academic and /or vocational education opportunities.

This IFSW policy acknowledges that HIV and Aids is both a social and a health issue, and it is also an issue regarding human rights and social justice. Social workers, by virtue of their training, their commitment to human rights, and the fact that they are uniquely placed within a wide variety of health and welfare settings, can play an effective role in strengthening social capital of communities to address the HIV and Aids epidemic (IFSW, 2012).

In its policy statement on HIV and Aids, the IFSW (2003) underscores the catastrophic nature of the HIV and Aids crisis in many parts of the world. Since the publication of this statement, little improvement has occurred in the global picture. Women's voices continue to be largely absent from the social work literature.

2.4.2 Regional

The SADC secretariat is the key policy coordinating body in the region (Giuffrida & Müller-Glodde, 2008:8). SADC has broad policy and programmatic functions. Most of the countries, other than Tanzania, are within the SADC region, and subscribe to the SADC protocols, including *the SADC HIV and Aids Strategic Framework* (2009-2015) and the accompanying documentation.

❖ SADC HIV and Aids Strategic Framework (2009-2015)

This Strategic Framework is a multidimensional response to HIV and Aids by the SADC. It is aimed at intensifying measures and actions to address the devastating and pervasive impact of the HIV and Aids pandemic in a comprehensive and complementary way. The focus of the response is on the prevention of HIV and Aids, care and support and the mitigation of the impact of the epidemic in order to ensure sustainable human development in the SADC region (SADC, 2003:2).

The Strategic Framework includes a strong priority on harmonisation of cross-border health policies and practices and specific focus on HIV positive migrants and mobile workers as a particularly vulnerable group (International Organisation for Migration (IOM), 2010:34).

Help Age International (2009:16) argues that the SADC HIV and Aids Strategic Framework (2009-2015), on responses to the impact of HIV and Aids in Africa did not acknowledge and support actions to achieve universal access to prevention, care, support and treatment for older people. According to the US-based Centers for Disease Control and Prevention (CDC) (2002:2) age accelerates the progress of HIV to Aids and blunts CD4 cell response to antiretroviral therapy. Age-related conditions, such as osteoporosis, increase the risk of severe complications.

2.4.3 National: Republic of South Africa

According to the Department of Social Development (DSD) (2009:ii) the Government of South Africa has recognised HIV and Aids as one of the main health and development challenges facing the country.

❖ **The Constitution of the Republic of South Africa, 1996**

The Constitution is the supreme law of South Africa. Chapter 2 of the Constitution sets out the fundamental rights and freedoms of all persons. Laws and conduct that conflict with the Constitution are invalid. The Bill of Rights guarantees every person - including people affected by HIV and Aids - the right to equality and to protection from unfair discrimination (section 9).

❖ **HIV & Aids and STI Strategic Plans for South Africa**

The South African government has therefore introduced two important policies on HIV and Aids since 2000 to ensure that there is a multisectoral response to HIV and Aids. (1) *The HIV, Aids and STD Strategic Plan for South Africa* (2000) which set the basis for South Africa's response to the growing challenge of HIV infection; (2) the *Comprehensive HIV and Aids Prevention, Care, Management and Treatment Plan for South Africa*, (RSA, 2003) and (3) the *National Strategic Plan of HIV and Aids* (2012-2016), which get updated and revised every four years.

The HSRC (2007:21) postulates that to date various partnerships have been coordinated among government, civil society and business in response to the HIV and Aids epidemic, particularly in the areas of funding and delivery of HIV and Aids education campaigns and treatment programmes as stipulated in the above mentioned plans. At the policy level, it is clear that considerable progress has been made towards the achievement of the stated goal(s) of coordinating interdepartmental and inter-sectoral responses to the HIV and Aids epidemic.

Notwithstanding this apparent progress at the national policy level, available evidence suggests that HIV and Aids activities at the municipal level are still characterised by a lack of coordination between government agencies (i.e., Departments of Health [DoH], Social Development [DoSD] and Education [DoE], civil society and business. This is in spite of the fact that the proportion of the national health budget that is devoted to HIV and Aids has been increasing over the last several years (HSRC, 2007:21).

❖ **The White Papers for Social Welfare**

The *White Paper for Social Welfare* (RSA, Ministry for Social Welfare and Population Development, 1997) provide the overarching policy framework for the DSD, and its stakeholders, and states that social welfare services and programmes must be based on the respect for human rights and fundamental freedoms as articulated in the Constitution of the country. The social development approach, as prescribed by the *White Paper for Social Welfare*, is relevant as it embraces human rights values and ensures socio-economic development. It is therefore of immense importance for the social work profession to incorporate the new approach into its professional interventions.

The White Paper is at pains to point out that social welfare interventions led by social development departments are only a small part of the package of interventions required from government to care for vulnerable individuals and that social welfare services and programmes will promote non-discrimination, tolerance, mutual respect, diversity, and the inclusion of all groups in society, such as women, children, the physically and mentally disabled, offenders, people with HIV and Aids. The social welfare interventions must also be complemented by interventions led by other government departments in the form of health, nutrition, education, housing, employment-creation, rural and urban development and land reform programmes.

❖ **Integrated Service Delivery Model for Social Services (ISDM)**

The DSD (2005) through its ISDM proposes services through the three broad programmes: Social Security, Social Welfare and Community Development. These programmes should be integrated and enable the target groups to deal effectively with all social issues, such as psychological stress, chronic poverty, food insecurity and other adverse social conditions, such as HIV and Aids. A developmental approach to service delivery is an approach that is based on the strengths of the individual, group or community, and that recognises their capacity for growth and development (DSD, 2005:5).

The major goal of the ISDM is therefore to provide a comprehensive national framework that clearly sets out the nature, scope, extent and level of social services, and which will form the basis for the development of appropriate norms and standards for service delivery (RSA, 2004b:2).

The ISDM does not include broader sustainable-livelihood approaches, which essentially foresees to capitalise on the income base provided by the Social Grants Programme with a view towards engaging recipients in additional income supporting programme (DSD, 2008:3). These approaches should have been imported to the vast majority of social services beneficiaries, owing in part to limited resources. To overcome this and other limitations, the DSD have extended its reach by deepening partnerships with civil society, the religious sector, the private sector and international development co-operation partners.

❖ **Social Development Plan on HIV and Aids**

The DSD is an active partner in the fight against HIV and Aids in South Africa. It has very strong role in addressing the social development and welfare needs of the population of the country. Services are informed by the HIV and Aids, and STD Strategic Plan for South Africa, and the Social Development HIV and Aids Strategic Plan (Erasmus & Nkai, 2009:41).

The main aim of the DSD plan is to achieve a decline in the prevalence of HIV and Aids through targeted preventative interventions to manage the impact of Aids on social security; develop affordable community-based care and support models; formalise strategic alliances; and develop appropriate policy.

Following the Plan on HIV and Aids the Department developed a Plan of Action, identifying critical outputs related to HIV and Aids, namely;

- Develop a model to understand the social impact of HIV and Aids, and identify a national pilot project;
- Develop an appropriate social welfare infrastructure to deal effectively with HIV and Aids;
- Development of a population and development information service specifically focusing on HIV and Aids as a national population concern;
- Development of the government-wide human resource development strategy on planning for the impact of HIV and Aids;
- Collaborated with the Department of Health to develop appropriate models of home/community-based care (DSD, 2009).

The DSD HIV and Aids Plan was only ever mentioned in the Social Development document towards a 10-year review of the population policy implementation in South Africa (1998-2008) as part of the Government response to HIV and Aids (Erasmus & Nkau, 2009:40). The researcher is of the view that the South African Government or Department of Social Development missed a great opportunity by not stating the objectives of the key strategic themes of the plan, including social cohesion will be achieved by the Department.

❖ **The Policy on Financial Awards to Service Providers (PFASP)**

The PFASP is aimed at guiding the country's response to the financing of service providers in the social development sector, to facilitate transformation and redirection of services and resources, and to ensure effective and efficient services to the poor and vulnerable sectors of society (DSD, 2011:4). The policy strives to facilitate the achievement of the mission of the Department, which is "to enable the poor, the vulnerable and the excluded within the South African society to secure a better life for themselves, in partnership with them and with those who are committed to building a caring society" (DSD, 2011:4).

This policy is intended to facilitate the achievement of strategic priorities of the DSD through services that are integrated and developmental in nature, and to ensure the care and support of poor and vulnerable groups, and those with special needs such as children, youth, older persons,

persons with disabilities, women, victims and survivors of violence and abuse, persons affected by substance abuse and those infected and affected by HIV and Aids (DSD, 2011:5).

The National Coalition for Social Services (NACOSS) and the National Welfare, Social Service and Development Forum's position is that the PFASP fails to provide for an efficient distribution of resources. It places unrealistic expectations on the NPO sector, which is already severely overstretched in trying to meet the demands from extremely vulnerable individuals, families and communities. In short, it is not providing the amount and kind of support that is essential for NPOs to meet the enormous social welfare needs of the South African population (National Welfare Social Services & Development Forum, 2008:1).

According to NASW (2002:8) in practice, social workers apply generalist social work perspectives, skills and principles to make changes in laws, rules, budgets, and policies and in the bodies that create those policies, whether they be local, or national agencies or other decision-making bodies, in the pursuit of the social work mission of social and economic justice. Social work utilises a variety of skills, techniques and activities consistent with its holistic focus on persons and their environments. Social work interventions range from primarily person-focused psychosocial processes to involvement in social policy, planning and development Hare (2004:419 – 420). The skills, knowledge and principles will be discussed in the next section.

2.5 Knowledge, skills, attitude, roles and guiding values and principles for social work with communities affected by HIV and Aids

Payne (2006:32) purports that social work's mission of serving both people and the social environment is ambitious. To fulfil that mission, social workers must possess a broad range of knowledge about the functioning of people and social institutions, as well as have a variety of skills for facilitating change in how individuals, organisations, and other social structures operate.

2.5.1 Social work knowledge and skills

Social work is practiced within a range of settings and is increasingly undertaken as part of integrated service delivery systems. This diversity occurs partly because utilisation of knowledge and skills is a contested activity in social work that enables different interpretations and values stances to be adopted. The following are social workers key knowledge and skills as purported by Islam (2011:1).

❖ **Observation**

Before, during, and after a social worker asked a single question during interactions with the client, they should use their senses to observe and record not only the client's verbal responses but also his or her nonverbal communication (Islam, 2011:1).

❖ **Self-awareness**

A social worker's efficacy hinges on his/her level of self-awareness. As a social worker, the reliance on use of self within the context of the therapeutic relationship requires the development and refinement of awareness of motivations, assumptions, expectations, and biases. Competence in observing, exploring, and articulating how thoughts and feelings impact on behaviour and how behaviour impacts others is a prerequisite for the conscious development and direction of a helping relationship to facilitate change. A high degree of self-awareness facilitates a social worker's ability to identify transference and counter-transference issues and utilise this information to assess quality of treatment interventions.

❖ **Critical thinking**

How a social worker interprets data obtained not only through observation, interviews, and case file/document review but also clinical supervision, research, and consultation influences the client's assessment, diagnosis, treatment, evaluation, and termination. Critical thinking asks the social worker to consider how his motivations, assumptions, expectations, and biases (self-awareness) shape the lens through which he analyses and draws conclusions from the available data.

❖ **Verbal communication**

Verbal communication involves actively listening to understand and speaking to be understood by an audience. As a result, a social worker may alter his/her communication style multiple times during a single workday to maximise effectiveness with clients, colleagues, supervisors, or community members. Social workers rely on the strength of their verbal communication skills in settings as diverse as advocating for a client.

❖ **Written communication**

"If it isn't documented, it never happened" is one of the first lessons learned in almost any social work employment, particularly if programmes are accountable to public or private funders. Social workers gain legitimacy with their supervisors and colleagues by writing clear and concise progress notes, correspondence, and reports. As a service provider, social workers are better placed than an external grant writer to articulate a case for financial support to sustain a

programme. Proposal writing skills, including the ability to write programme evaluation plans and reports, are highly desirable to potential employers.

2.5.2 Social worker's attitudes

Among social workers, personal attitudes and opinions that influence professional behaviour are tempered and shaped by the norms, values, and ethics acquired through the process of professional socialisation (Hantman, Mosek, Ben-Oz, Cohen, Doron & Farchi, 2006:79). Ginsberg (2001:17) states that social workers should maintain the following when providing services to individual, families and communities:

- Non judgemental attitude
- Avoid quick decisions about people
- Maintain confidentiality
- Clients come first
- Separate personal and professional lives and values
- Be a loyal employee
- Maintain a private personal life
- Establish emotional privacy
- Identify with the profession

Linsk (2011: 219) said social workers like everyone else, were unprepared, knew little, and had to approach these events through the lenses of their own experience working with clients, be they in health care or in other fields of practice. The social work response initially emerged as workers attempted to assist those with this new, often mysterious deadly syndrome. Social workers at the beginning of the epidemic had to be dedicated and innovative, be committed and put in practice values to help to guide action (British Association of Social Workers [BASW], 2002:2).

2.5.3 Social work roles and HIV and Aids

According to Payne (2006:31) social work is the most comprehensive of human service occupations and, through time, has become recognised as the profession that centers its attention on helping people improve their social functioning. Hick (2004:2) postulates that in doing their day-to-day work, a social worker is expected to be knowledgeable and skilful in a variety of roles. The role that is selected and used should ideally be the role that is most effective with a particular client, in the particular circumstances.

In pursuing their professional mission in working with HIV and Aids in communities, social workers generally perform the following roles.

❖ **Educator**

The educator role involves providing clients with new information on HIV and Aids, and at times role modelling new behaviours. To be an effective educator, the social worker must first be knowledgeable on HIV and Aids. Additionally, the social worker must be a good communicator so that information is conveyed clearly and is understood by the client or macro system at all times (Zastrow & Kirst-Ashman, 1997).

❖ **Enabler**

Social workers perform the “enabler” role by enhancing the coping and problem-solving capabilities of clients.

❖ **Mediator**

Social workers perform the role of “mediator” when they help resolve disputes between the client and other people or organisations.

❖ **Advocate**

Rowan, Furman, Jones and Edward (2008:142) argue that providing services to people living with HIV can be daunting to even a seasoned social worker simply because of the sheer magnitude and scope of services needed. Furman and Negi (2007:108) said that people living with HIV are an extremely vulnerable population and thus are often in need of advocacy services from social workers. The functions of an advocate include interventions on both a micro and macro level. Social workers providing services can help clients by assisting them with the disability determination process for example.

❖ **Lobbyist**

Macro level social workers can affect change by lobbying for increased funding from varied sources to assist in the treatment of clients with HIV and Aids and prevention efforts (Krisberg, 2006:3).

❖ **Service broker**

HIV case management involves linkage with other services and systems and requires that social workers take on the role of a service broker (Rowan et al., 2008:143). The most common overlapping systems that clients and social workers interface with are the governmental, medical, and legal systems. Individuals, households and communities that are empowered, cohesive and

have access to life sustaining goods and infrastructure are in a stronger position to minimise the spread of HIV and mitigate the impacts of Aids (RSA, 2007:ii).

2.5.4 Guiding values and principles: Social work with communities affected by HIV and Aids

According to Whitaker, Weismiller and Clark (2006:5) globally, social workers are proactively providing critical services to individuals, families, and communities affected by HIV and Aids. Social workers are employed in a wide range of community settings, including public, non-profit, and for-profit organisations. Therefore, working with a diverse and changing population in supportive, clinical, and administrative roles requires that social workers be capable of providing up to date expertise on research, policy, and evidence-based clinical approaches. Even social workers not directly serving persons living with and /or affected by HIV and Aids should have an understanding of their complex and unique challenges, as HIV is correlated with both substance use and other mental health concerns.

Medical advances alone, no matter how effective in reducing the number of Aids-related death, cannot decrease the number of new infections nor can they support the needs of the many HIV-positive people now regaining health and lost roles as a result of ARTs. People of ART are doing so with guarded optimism about how long this medication will be effective and feel limited in their ability to live life fully (Spies, 2007:144).

2.5.4.1 Values and ethical principles of Social Work

Social workers are to uphold and foster the Ethics of Social Work as set out in the International Declaration of Ethical Principles of Social Work and in the International Ethical Standards for Social Workers (IASSW), and to apply them rigorously in the context of HIV and Aids (Banks, 2001:5).

Social work is based on respect for the inherent worth and dignity of all people as expressed in the United Nations Universal Declaration of Human Rights (1948) and other related UN declarations on rights and the conventions derived from those declarations.

The values are then articulated into a single sentence: Social work practice should both promote respect for human dignity and pursue social justice, through services to humanity, integrity and competence (BASW, 2002:2).

❖ **Social work values**

Framing social work's commitment to respect for the dignity and worth all people and the profession's quest for social justice, the core values of social work also set the standards for what is desirable in practice. The South African Council for Social Services Professions (SACSSP) Code of Ethics describes the professional values that guide social work practice:

- Service: helping people in need and solving social problems.
- Social justice: addressing injustices of all forms.
- Dignity and worth of the person: respecting inherent dignity
- Importance of human relationships: recognising the importance of belongingness
- Integrity: being trustworthy
- Competence: practicing within their abilities and work to enhance their professional expertise

Suppes and Cressy Wells (2003:1) postulate that social workers may be involved in a few or all of these roles depending on the nature of their job, and the approach to practice that they use. In order to undertake the roles described, and support people to fulfil their potential and achieve their chosen outcomes, social workers perform a variety of tasks. Not all of them are exclusive to social work, but social workers carry them out as an integral part of enabling people to achieve the outcomes they want.

Strug, Grube and Beckerman (2002:7) postulate that social workers will increasingly become involved in primary prevention efforts due to the fact that medical intervention alone is insufficient to prevent new infections. Infected persons will need a wide variety of medical and psychosocial support services for long periods of time, since HIV and Aids becomes a chronic conditions for persons living with the disease.

❖ **Social work principles**

According to DuBois and Miley (2010:5) social workers should work according to the following principles in helping individuals, families and communities.

i. A commitment to social betterment

Belief in the fundamental importance of improving the quality of social interaction for all people, that is, social betterment, is a central value of the social worker. The social work profession has taken the position that all people should have the opportunity for assistance in meeting their social needs. Social work has maintained idealism about the ability and responsibility of the society to

provide opportunities and resources that allow each person to lead a full and rewarding life. It has been particularly concerned with the underdog, the most vulnerable people in the society.

ii. A goal to enhance social functioning

Social workers take the position that social betterment involves more than addressing problems, it also involves assisting those who want to improve some aspect of their lives, even though it may not be considered “a problem.” Social work, then, is concerned with helping people enhance their social functioning, that is, the manner in which they interact with people and social institutions.

iii. An action orientation

Social work is a profession of doers. Social workers are not satisfied just to examine social issues. Rather, they take action to prevent problems from developing, attack problematic situations that can be changed, and help people deal with troublesome situations that cannot be changed. To do this, social workers provide services that include such activities as individual counselling, family and group therapy, linking people to the network of services in a community, fund raising, and even social action.

iv. An appreciation for human diversity

To deal effectively with the wide range of change to which social work is committed, it has become a profession characterised by diversity, diversity of clientele, diversity of knowledge and skills, and diversity of services provided. In addition, social workers themselves come in all shapes, colours, ages, and descriptions. Social workers should view diversity as positive. They should consider human difference desirable and appreciate the richness that can be offered to a society through the culture, language, and traditions of various ethnic, racial, and cultural groups. What’s more, social workers should view their own diversity as an enriching quality that has created a dynamic profession that can respond to human needs in an ever-changing world.

v. A versatile practice perspective

The wide range of human conditions with which social workers deal, the variety of settings in which they are employed, the extensive scope of services they provide, and the diverse populations they serve make it unrealistic to expect that a single practice approach could adequately support social work. The social worker must have a comprehensive repertoire of knowledge and techniques that can be used to meet the unique needs of individual clients and client groups. The versatile social worker, then, must have a solid foundation of knowledge about the behaviour of people and social institutions in order to understand clients’ situations. He or she also needs to understand that differing beliefs may affect the way people will interpret and react to those situations and, finally,

the social worker must have mastered a number of helping techniques from which he or she can imaginatively select to help individuals, families, groups, organisations, and communities improve their social functioning.

Loeffler et al., (2004:22) state that social workers' commitment to social justice requires that they embrace, understand, and use the level of strength and trust inherent to the social relationships (social capital) formed by individuals, families, communities to help overcome the widening inequitable social distribution of resources that continues to exclude many individuals, families, communities, and even nations from accessing opportunities and resources.

To be effective, social workers must understand to what extent social exchanges augment or deplete social capital to promote socio-economic mobility for individuals living with HIV and communities that have historically been excluded from access to valuable social and economic resources (Domingues & Watkins, 2003:113; Miller-Cribbs & Farber, 2008:49).

The role of social capital in mitigating the impact of HIV and Aids in communities will be the focus of the next section.

2.6 Social capital development in the mitigation of HIV and Aids

According to Emler (2006:302) the HIV and Aids epidemic is having a major impact at all levels of society, from the individual to the macro-economic. At the micro-level the impact is particularly devastating, not only for the individual who is infected, but also for his or her family and the wider community. Traditional methods of care and support are put under tremendous pressure as families lose their capacity to cope. Social workers are at the forefront of the battle to provide effective care, counselling and support to those affected, and to develop new interventions to prevent the spread of infection (IFSW, 2012:1).

Social capital has elicited a great deal of interest because of its potential as a means for better understanding community mechanisms underlying health and HIV and Aids. In recent health literature, social capital has been linked to improved child development and adolescent well-being, increased mental health, lower violent crime rates and youth delinquency, reduced mortality, reduced HIV incidence, less mental health problems, less substance use, and higher perceptions of well-being and self-rated health (Szreter & Woolcock, 2004: 652).

The value of understanding social capital, then, as a mechanism to better utilise community resources for health promotion purposes is widely recognised as sufficient reason to refine the term (Campbell & Mzaidume, 2001:1979). South Africa is one of the most HIV affected countries in the world, and many attribute the high prevalence rates, in some part, to the country's historical

response to the disease. Grootaert (2004:3) states that research has found significant associations among social capital, HIV infection, and risk behaviours among young adults. Mansuri and Rao (2004:7) indicate that other literature confirms that group membership, as well as makeup of group and level of participation within the group, affect an individual's perceived social capital. Another study by Campbell and Williams (2002:46) investigating the effectiveness of an HIV peer-education programme in rural South Africa reported that social capital was strongly related to better health behaviours.

The next sub-section will explore further social capital as a concept and a strategy to be used by social workers in working with communities to mitigate the impact of HIV and Aids. Social development occurs when social relationships change such that: less people are poor; less people are (or feel) systematically excluded from the benefits that their societies deliver to others; and there is reductions in poverty and exclusion, and enhancements in self-fulfilment, become more durable (Bebbington, 2002:7).

2.6.1 What is social capital?

The concept of social capital has been applied in disciplines ranging from sociology to economics to psychology to public health (DeFilippis, 2001:787; Leonard, 2004:928; Lin, 2001; Mukherjee, 2007:210). Social capital, however, has been used less often in social work, either as a research variable, a practice tool or to inform policy development (Loeffler et al., 2004:26; Mukherjee, 2007:210).

The *Encyclopedia of Social Work* (2008:34) defines social capital as “a feature of empowering interventions in neighbourhoods and community development, as is collective efficacy, which is a measure of working trust that exists among residents.” Social capital is defined as the internal social and cultural coherence of society, the norms and values that govern interactions among people and the institutions in which people and their norms are embedded to coordinate action to achieve desired goals (World Bank, 2003:1). Thus, the researcher has chosen to adapt and operationalise the definition put forth by Lin (2001:17), whereby social capital is defined as the by-product of social interactions that are embedded in and accessed via formal and informal social relationships with individuals, communities and institutions. This definition rejects the claim that social capital is a solely community resource (Lochner, Kawachi, and Kennedy, 1999:259) and builds on Lin's (2001) multidimensional framing of social capital as ‘resources embedded in one's network or associations accessible through direct and indirect ties’ (Lin, 2001:17). Social capital is the glue that holds individuals, communities and societies together.

The next section will be discussing social capital theory and the work of other key theorist who contributed to the body of knowledge on social capital.

2.6.2 Social capital theory

The tenet of the social capital theory is that social relationships among people can be productive resources (Coleman, 1988). Putnam (1995) suggested that social capital facilitates coordination and cooperation for mutual benefit. This section will focus the interpretation of the concept of social capital by two theorists, Putman and Lin.

❖ Putnam's theory of social capital

Putman's central thesis is social capital has three components: a) moral obligations and norms, b) social values (particularly trust) and c) social networks (especially the membership of voluntary associations) (Siisiainen, 2000:4). These forms of social capital are central to the promotion of civil communities and civil society in general. According to Putnam, the productive activity of social capital is manifest in its capacity to "facilitate coordination and cooperation for mutual benefit" (Putnam, 1995: 2). The threat to this productive capacity comes from changing social trends which appear to indicate that such 'coordination and cooperation' is on the decline.

Putnam makes a direct link between levels of civic engagement and a community's capacity to tackle social and economic problems such as unemployment, poverty, educational nonparticipation, and crime. Putnam (1995:2) claims that: "networks of organised reciprocity and civic solidarity, far from being an epiphenomenon of socio-economic modernisation [are] a precondition for it." Taking Putnam's position is that social capital constitutes positive social control. It is the family's and the community's responsibility to foster such characteristics as trust, shared information, and positive norms of behaviour for everyone's mutual benefit. Putnam, asserts that social life, networks, norms, and trust enable participants to act together more effectively to pursue shared objectives. Therefore, HIV programmes that promote social cohesion, social inclusion, and strengthen a community's ability to intervene on its own behalf (similar to collective efficacy) will be more likely to succeed than one that bypasses these principles (Kreuter & Lezin, 2002:245)

❖ Lin's social capital theory

Lin (2001:53) argued that understanding why people act is necessary for a complete understanding of access to and distribution of social capital. "From the resource perspective, action is important and is given equal significance relative to structure. Motivated action guides interactions. Instrumental action, in particular, motivates investing seeking out and mobilising in relations and connections that may provide access to social resources".

Lin's theory is concerned with explaining capital inequality between social groups, genders, classes, and races. He framed the theory of social capital as a tool to understand how valued resources are distributed, allocated, and obtained in situations ranging from employment to

community to nation. He was concerned with “the extent to which inequality in social capital contributes to social inequality across social groups” (Lin, 2001:120).

Latkin and Knowlton (2005:106) agree with Lin that for many individuals, HIV prevention may be a concern but is not a priority. Among disadvantaged individuals, HIV may be a lower priority compared to meeting basic needs of food, shelter and safety. The challenge for intervention is to link HIV prevention to individuals’ other priorities. By integrating HIV prevention with goals relevant to the population, it is then possible to increase participants’ motivation.

Hean, Cowley, Forbes, Griffiths and Maben (2003:1066) state that social capital theory suffers from much criticism for being poorly defined and conceptualised. This problem largely stems from the fact that social capital is multi-dimensional with each dimension contributing to the meaning of social capital although each alone is not able to capture fully the concept in its entirety. However, the importance of social capital theory is apparent from the literature with many empirical studies that purport to show the importance of social capital to a very wide-ranging set of socio-economic phenomena (Durlauf 2002:460; Krishna 2001:9).

2.6.3 Dimensions of social capital

According to Kaasa (2007:8) social capital is a complex concept with many dimensions. Analysis by Onyx and Bullen (2001:106) suggested that there are eight distinct dimensions of social capital; many are related to each other. Other authors have identified different groups of dimensions, for example Liu and Besser (2003) identified four dimensions of social capital, which are; informal social ties, formal social ties, trust, and norms of collective action.

According to the researcher, the diagram below by Narayan and Cassidy (2001:60) identifies a range of dimensions as discussed by several authors (Liu & Besser, 2003; Onyx & Bullen, 2001:106).

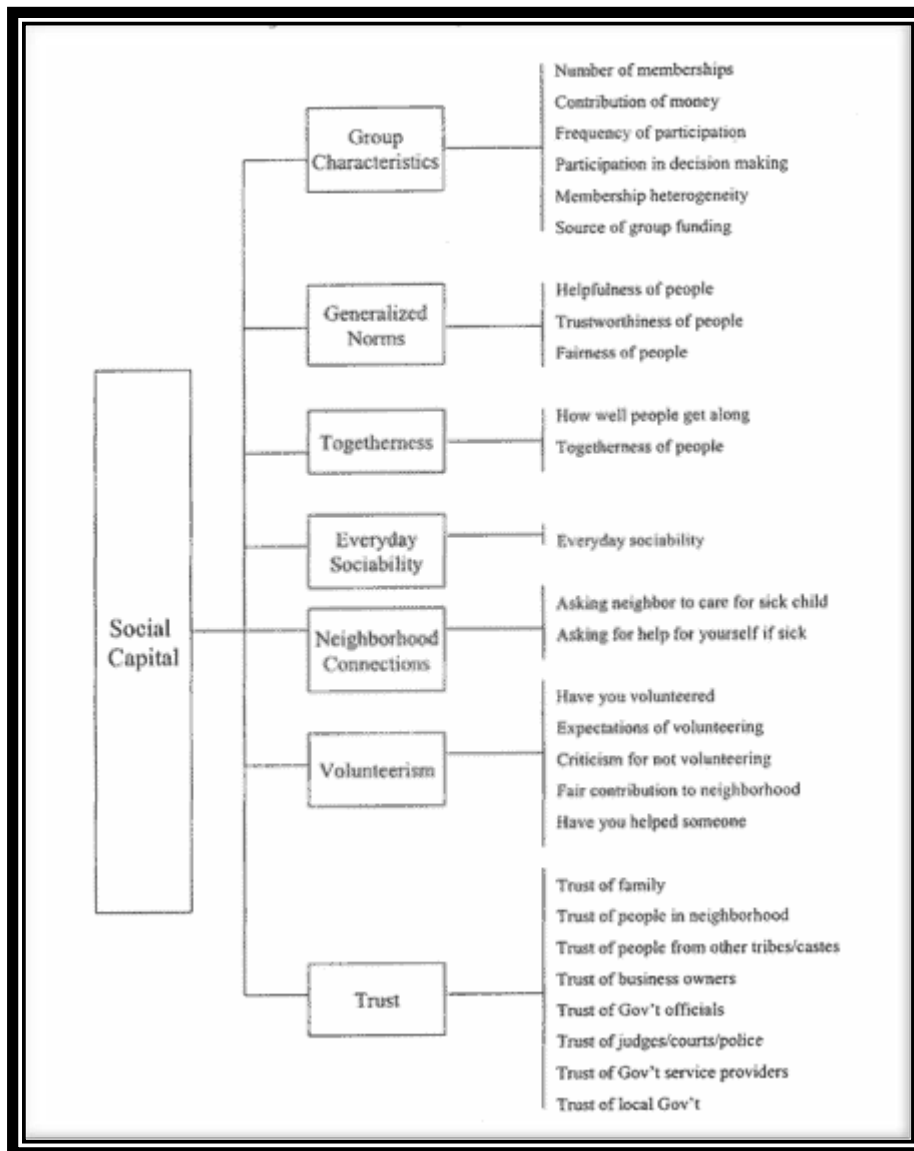


Figure: 1. The dimensions of social capital defined by Narayan and Cassidy (2001).

Figure 1 illustrates that increasing evidence shows that social cohesion and social capital is critical for poverty alleviation and sustainable human and economic development. Furthermore, several authors have linked the HIV and Aids pandemic to social capital (David, 2007:2), usually pointing out how factors related to the disease such as stigma, discrimination lowers trust and the costs posed by care for the sick as well as orphans erode and put pressure on social capital.

Haacker (2004) posits that HIV and Aids has an effect on social and economic institutions of a country, which in turn would affect economic development. He argues that the epidemic contributes to deteriorating security at the individual, community and national level, in particular as governments' capacities are eroded leading to increased crime and instability.

Overall, one can conclude that HIV and Aids is likely to have an impact on social capital through stigma and discrimination, through the burden it poses on traditional social networks that mitigate risks and through increased insecurity.

Dekker and Uslaner (2001:1) sum this discussion up by identifying that it is clear that the components of social capital need to be treated as multi-dimensional rather than one-dimensional.

2.6.4 Levels of social capital

Further to dimensional problems, social capital has been located at the level of the individual, the informal social group, the formal organisation, the community, the ethnic group and even the nation (Bankston & Shou 2002:286). There are divergent views in the literature; some authors posit social capital at the individual level. Baum and Siersch (2003:321), at the community level (Brewer, 2003:6), and others have a more dynamic view.

Kilby (2002:2) stated that social capital exists within levels or scales as one feels belonging to family, community, profession, and country simultaneously. Adler and Kwon (2002:18) supported this stating that social capital's sources lie in the social structure within which the actor is located. Thus, social capital can be thought of as having an individual as an aggregate component (Buys & Bow, 2002; Slangen, Louis, van Kooten & Suchanek, 2003:150). Social capital belongs to the group and can be used by the group or individuals within the group (Sander, 2002:214).

Coleman (1988:96) postulates that social capital is defined by its function. It is not a single entity but a variety of different entities, with two elements in common: they all consist of some aspect of social structures and they facilitate certain actions of actors, whether persons or corporate actors within the structure. Furthermore, social capital, like physical and human capital, is not completely fungible but may be specific to certain activities.

Glaeser, Laibson and Sacerdote (2002:437) identified that post-Coleman has almost universally viewed social capital as a community-level attribute. Social capital and civil society are essentially social and collective property of social systems, not a characteristic of individuals (Piassa-Georgi, 2005:462). The key empirical difference between human and social capital is that social capital exist in relations between individuals and groups, not in individuals per se (Preece, 2004:38). The general consensus in the literature is that social capital is identifiable from the individual level to the level of the nation; however, it is clear that social capital is evident at any level where there is identification and belonging. The classification into micro (individual), meso (group) and macro (societal) is useful in analysis of social capital (Van der Gaag & Snijders, 2003:199).

2.6.5 Types of social capital

Attempts to more thoroughly conceptualise social capital have resulted in many authors identifying different types and characteristics, the most common being the distinction of structural and cognitive, and bonding and bridging. Most of the literature on social capital focuses on the structural characteristics of social relations. Halpern (2002:3) identified the following main types of social capital:

❖ **Bonding social capital**

Bonding social capital exists within the individual's capabilities to harness the resources that exist/occur within a given relationship. Interpersonal interactions that generate mutual trust, understanding, reciprocity, and shared norms are the building blocks of bonding social capital (Loeffler et al., 2004).

Bonding is horizontal, among equals within a community. Hawkins and Maurer (2010:1777) referred to bonding capital as localised which he defined as being found among people who live in the same or adjacent communities, for example family members and friends. It is closely related to "thick trust" (Anheier & Kendall, 2002:343).

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According to Ogden (2011:1) bonding social capital comes from relationships between like individuals (e.g., groups of people living with HIV). The concept of social capital embraces the idea that the connections one has, be it with family, friends, community members, or power brokers are assets that can be called upon for support and to leverage resources that create or maintain well-being. The importance of social capital for HIV responses can be seen at the individual level, for example, by reducing the isolation and internal stigma experienced by people living with HIV and improving adherence to treatment and health-seeking practices. Its impact is also evident at the systems level, whereby engagement of communities in policy formulation and monitoring improves responsiveness and accountability of HIV programmes.

❖ **Bridging social capital**

Bridging is vertical between communities (Dolfsma & Dannreuther 2003:406; Narayan 2002; Leonard, 2004:928), and which extends to individuals and organisations that are more removed. It

is closely related to “thin trust”, as opposed to the bonding (splitting) social capital (Anheier & Kendall, 2002:344).

Bridging social capital connects formal and informal support networks. Involvement in faith communities, self-help organisations, and connection with professional peers can all help to generate bridges that provide access to resources such as physical, financial, political, or human capital. Oftentimes, bridging extends relationships across communities (Loeffler et al., 2004).

Bridging social capital connects people who are alike but in different circumstances (e.g., connections between groups of HIV-positive people in one country or region with those in another). Bridging connections are crucial for the influx of new ideas, resources, and energy across groups. For example, bridging social capital between HIV programmers and tuberculosis (TB) programmers can create the synergies needed to ensure that no one living with HIV dies from TB (Ogden, 2011:1).

❖ **Linking social capital**

According to Woolcock and Sweetser (2002:26), linking social capital pertains to connections with people in power, whether they are in politically or financially influential positions.” Linking social capital also includes vertical connections to formal institutions (Mayoux, 2001;Woolcock, 2001).

Linking social capital describes the value created by reciprocal bonds of trust between networks that are connected vertically—across lines of power and privilege. Examples of linking social capital include participatory policy processes that bring together people living with or affected by HIV, policymakers, health service providers, and other influential groups (e.g., police/law enforcement, religious leaders, media). This interaction can help ensure that decisions are transparent; policies and programmes are responsive to communities; and resources are used effectively and targeted to those most in need—all hallmarks of good governance of health systems.

Linking social capital is considered by some analysts to be the most crucial for creating sustainable improvements in health, because without viable linkages to those with power and influence, community groups may fail to get the traction they need to create the change they envision. Linkages between scales and levels provide needed resources and legitimacy for advocacy to reach the ambitious getting to zero goals. i.e. ,zero new HIV infections through better application of effective prevention efforts; zero Aids-related deaths through universal access to treatment, care, and social protection; and zero discrimination through legislative and normative change to eliminate HIV-related stigma and discrimination and gender inequalities (UNAIDS, 2010:33).

2.6.6 Determinants of social capital

The determinants of social capital are numerous and varied and there is both a lack of consensus and a lack of evidence to support the propositions. Several influential studies have suggested that social capital's roots are buried in centuries of cultural evolution (Fukuyama, 2001:9). Other investigators suggest that social capital can be created in the short term to support political and economic development (Delhey & Newton, 2005:314; Rothstein & Stolle, 2003:143). Halpern (2005:38) suggested that the main determinants of social capital include: history and culture; whether social structures are flat or hierarchical; the family; education; the built environment; residential mobility; economic inequalities and social class; the strength and characteristics of civil society; and patterns of individual consumption and personal values.

Warde and Tampubolon (2002:156) identified a different set again, including: family and kinship connections; wider social networks of associational life covers the full range of formal and informal horizontal arrangements; networks; political society; institutional and policy framework which includes the formal rules and norms that regulate public life; and social norms and values.

2.6.7 Benefits of social capital

Adam and Roncevic (2003:177) stated that: “despite problems with its definition as well as its operationalisation, and despite its (almost) metaphorical character, social capital has facilitated a series of very important empirical investigations and theoretical debates which have stimulated reconsideration of the significance of human relations, of networks, of organisational forms for the quality of life and of developmental performance”.

Szreter and Woolcock (2004:654) suggested that the importance of social capital lies in that it brings together several important sociological concepts such as social support, integration and social cohesion. This view is supported by Rothstein and Stolle (2003:51) who stated that the real strength of social capital theory is the combination of macro-sociological historical structures with micro-level causal mechanisms, a rare feature in the social sciences.

Social capital is an important variable in educational attainment (Aldridge et al., 2002; Israel, Beaulieu & Hartless. 2001:45), public health (Coulthard, Walker & Morgan, 2003:3; Subramanian et al., 2003), community governance, and economic problems (Bowles & Gintis, 2002:422), and is also an important element in production (Day, 2002:1076). Economic and business performance at both the national and sub-national level is also affected by social capital (Aldridge et al., 2002). Others have emphasised the importance of social capital for problem solving and how only certain types of social capital contribute to this (Brewer, 2003:24; Castle, 2002:335).

Since social capital operates through relationships, it can function as an asset to facilitate information flow, exert influence on agents, support individuals' social credentials, or reinforce identity and recognition (Lin, 2001:57; Veenstra, 2004:549).

2.6.8 Disadvantages of social capital

According to Aldridge et al. (2002:1), the same characteristics of social capital that enable beneficial, productive benefits have the potential to cause negative externalities. Potential downsides of social capital include: fostering behaviour that worsens rather than improves economic performance; acting as a barrier to social inclusion and social mobility; dividing rather than uniting communities or societies; facilitating rather than reducing crime, education underachievement and health-damaging behaviour.

Michael and Stanfield (2003:399) purport that “every feature of social structure can be social capital in the sense that it produces desired outcomes, but also can be a liability in the sense that it produces unwanted results”. The kinds of groupings and associations which can generate social capital always also carry the potential to exclude others (Frane & Roncevic, 2003:160). Social capital can become a constraint to individuals' actions and choices (Small, 2002:38).

The next section will be discussing social development theory and the work of other key theorists who contributed to the knowledge on social development.

2.7 Social development theory

Patel (2005:49) postulates that social development emerged to counteract market- oriented approaches and the curtailment of welfare expenditure by governments. This process culminated in the adoption of the ten principal commitments at the World Summit for Social Development, Copenhagen, in 1995 and the Millennium Development Goals (MDGs) in 2000. For the proponents of social development, the introduction of social development was not regarded as an ideological act, but rather an adequate response to social needs (Midgley, 2003:834).

Midgley (1995:25), a world leader in social development studies, defines social development as “a process and planned social change designed to promote the well-being of the population as a whole in conjunction with the dynamic process of economic development”. Gray's definition (2006:53) is in agreement with Midgley, namely that social development is a theory and approach to social welfare that posits a macro-policy framework for poverty alleviation that combines social and economic goals.

Furthermore, Lombard (2008:163) posits that it is the social development theory and approach that provides the social welfare sector with the key to making a meaningful contribution to the alleviation of poverty and inequities in society and to establishing professionals like social workers who are important social partners in achieving social development (end) goals.

Social development theory acknowledges the challenges of society and of social problems which requires focused interventions from the state and non-state actors, the development of organisational and institutional arrangements at national level to harmonise economic and social policies within a comprehensive commitment to people-centred development. In addition, social service interventions are to be locally relevant, sustainable through attending to people's human, social and economic development (Fitzgerald, McLennan & Munslow, 1997:4, Gray, 1996:10, Midgley, 2001:43, Midgley & Tang, 2001:246).

2.7.1 The goal for social development

The goal of social development is to harmonise the social and economic developmental goals and investing in human capacities, by focusing on interventions that targets the poor and socially excluded groups (Patel, 2005:33), with the view to eradicate or, at least, reduce poverty, which is identified in social development terms as a socio-economic phenomenon. In order to alleviate poverty, social policy priorities must be invested in people, social workers must help develop human capacity and human resources, and they must be linked directly with economic development measures (Gray, 2002:6). HIV and Aids is most prevalent in socially and economically impoverished communities (Nelson Mandela/ The Human Sciences Research Council (HSRC) Study of HIV and Aids, 2002). Social workers by virtue of their employment in HIV and Aids organisations play an important role in poverty alleviation, promotion of indigenous support networks such as savings schemes, income generation, and provide HIV and Aids care and support.

2.7.2 Principles of social development

Social development is firmly rooted in rights-based principles, which are aimed at achieving social justice, a minimum standard of living, equitable access and equal opportunity to services and benefits, and a commitment to meeting the needs of the most disadvantaged in the society (Patel, 2005:98). The principles are classified as follows:

- i. Social and economic justice;
- ii. Empowerment;
- iii. Collective action to promote public benefit; and
- iv. Equitable distribution values (Patel, 2003:89).

- **Social and economic justice:** This principle challenges social workers to continue to use their professional expertise in their work with government and non-government sectors to protect and promote human, economic, political and social rights of populations at risk, especially people living with and affected by HIV to contribute to the achievement of social justice (Lombard, 2008:128). Social and economic justice is the view that everyone deserves equal economic, political and social rights and opportunities. Social workers are regarded to have adequate knowledge and skills to play a major role in the service delivery to vulnerable groups and to promote social and economic justice amongst welfare service users, such as people affected and infected with HIV.
- **Empowerment.** Kirst-Ashman (2003:21) defines empowerment as the “process of increasing personal, interpersonal or political powers so that individuals can take action to improve their life situation”. This principle alludes to the role of social workers in facilitating the empowerment of individuals, groups and communities who are infected and affected by HIV in communities to take personal or collective action to address their own situation through locally-specific terms.
- **Collective action to promote public benefit:** Collective action can be defined as voluntary action taken by a group to achieve common interests (Meinzen-Dick & Di Gregorio, 2004:3). Since HIV and Aids is not merely a medical problem, but a social problem as well, there is a increasing need for cooperation and comprehensive collaboration between social workers, communities, governmental and non-governmental organisations to manage the impact of HIV at all levels.
- **Distributive justice** is defined by Maiese (2013:1) as a “fair allocation of resources among diverse members of a community. This principle proposes that social workers and other professionals distribute services equally. Furthermore, service providers should ensure that the implementation of HIV and Aids programmes are equitable and these programmes are regarded as legitimate by the people affected by them, particularly people living with HIV.

One way of giving effect to the goals and principles of social development is for social workers to practice developmental social work. Developmental social work can be defined as “the practical and appropriate application of knowledge, skills and values to enhance the well-being of individuals, families, groups, organisations and communities in their social context” (Patel, 2005:206). When working with HIV and Aids on the macro/community levels, social workers should focus on implementing rights-based development programmes and service-oriented approaches directed at people affected and infected by HIV. Social workers should also utilise social development as a strategy to address poverty, income inequality and disease burden and continue

to challenges traditional social work practice to promote social integration and to integrate strength and asset-based, anti-oppressive and reflective approaches to facilitate the empowerment of individuals, families, groups, communities and organisations (Lombard, 2008:167).

South African social policies, such as the *White Paper for Social Welfare* (1997) and the ISDM (2005), provide the mandate for social workers to not only contribute to social development, but to practice from a social development theoretical framework, such as the operationalisation of development social work, to attend to a key social ill in society, i.e., HIV and Aids.

The next section will provide a summary of the chapter.

2.8 Summary

HIV and Aids impact negatively on the whole society. In many societies, HIV and Aids adds to household costs, endangers livelihoods and food security, deepens poverty, increases the vulnerability of women and children, and leads to the adoption of coping mechanisms, such as the selling of household assets, which can result in irreversible destitution. These processes may strain community safety nets, undermine extended kinship ties, and alter civic and cultural norms, including values linked to reciprocity and collective action (Ambert, 2004:4).

According to HIV and Aids and Local Government Learning Network (2009: 2) HIV and Aids is much more than a health issue. It affects all levels and spheres of government, and should be at the top of the agenda for developmental local government in South Africa. HIV and Aids can't be the sole responsibility of municipalities and mainstreaming HIV and Aids should involve all arms of government working in an area. Mainstreaming is critical, because HIV and Aids is linked to social, economic and environmental issues, and so it can be affected by everything a municipality does.

Birdsall and Kelly (2005:4) and Hawkins and Maurer (2011:15) argue that the way in which households and communities engage with the HIV and Aids epidemic in its many dimensions, from prevention efforts, to care and support of people living with HIV and their families, can provide social workers with insight into the nature of social life within the community and, inter alia, the capacity of a community to engage in collective action to address a shared challenge. This insight places social workers in the unique position to engage in a multi-level approach to social capital generation through research and policy.

HIV and Aids policies come from a desire by governments to protect basic human rights, preserve the integrity of individuals, families and communities; reduce costs associated with HIV and Aids, and respond to what is recognised as a global challenge. HIV and Aids policies need to reflect comprehensive approach, including education, destigmatisation, non-discrimination, reducing

infections, health and wellness, and improving the quality of lives for infected and affected individuals and their families (HSRC, 2004:34).

Social capital has been reported as an important factor influencing HIV prevention and social support upon infection. Communities with high social capital may also be more able to advocate for people's health needs, create a more tolerant and positive environment for people with HIV and Aids, and join together to undertake collective action in response to challenges (Kelly & Donk, 2009:4).

In the next chapter, the focus will be on the research methodology that guided the empirical study, and furthermore a presentation and interpretation of the research findings.

Chapter 3

Research methodology, empirical findings and interpretation

3.1 Introduction

The goal of this study was to explore and describe the roles of social workers in enhancing social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities. The focus of this chapter is specifically on the following objectives, namely: To explore the views of social workers about the roles they play, or could perform, in enhancing social capital in the communities of Johannesburg and Ekurhuleni Metropolitan Municipalities to manage HIV and Aids; and to explore the views of community members involved in HIV and Aids work about the role social workers play, in enhancing social capital in the communities of Johannesburg and Ekurhuleni Metropolitan Municipalities to manage HIV and Aids.

Subsequently, this chapter presents an overview of the research methods, which were utilised to undertake the empirical research of this study, by focusing on the research question, research approach, the type of research, research design, methods of data collection, data analysis and trustworthiness of the qualitative data collected, as well as the ethical considerations. This will be followed by an analysis and interpretation of the research findings.

3.2 Research question

According to Fouché and De Vos (2011: 308) researchers need to formulate research questions to guide them in their study. The qualitative approach often utilises research questions, because it is inductive in nature and thus more focused on understanding rather than explaining phenomena (De Vos, Schulze & Patel, 2005:5).

This study was guided by the following questions: “Based on the views of social workers, what are the roles of social workers in enhancing social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities? and “Based on the views of community members, what are the roles of social workers in enhancing social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities?”

3.3 Research methods

This chapter deals with the research methods employed for the study, including, research paradigm, approach, purpose, design, population, sample and data- collection method.

3.3.1 Research paradigm

This study was rooted in a constructivist paradigm in order to explore and describe the roles that social workers play, or should play, in enhancing social capital in communities to manage HIV and Aids from the frame of reference of both social workers involved in practice and affected community members (Ponterotto & Casas, 2002:402). A constructivist paradigm was used because what people say construct their own understanding and knowledge of the world, through experiencing things and reflecting on those experiences (Linda, 2004:233).

3.3.2 Research approach

As the study envisaged to explore the role of social workers in enhancing social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities, a qualitative research approach was considered the most relevant and appropriate approach to guide the study, specifically as the focus of the study was on the experiences, views and opinions of the participants (cf. Fouchè & Delport, 2011:77). As Neuman (2011:16) indicates, qualitative research aims to provide an in-depth understanding of the world as seen through the eyes of the people being studied, *viz.* their views, opinions, and experiences. The researcher collected verbal data from the participants during focus group discussions, which were analysed, to explore and describe the views of the participants.

Some of the questions that were asked to the social workers in order to explore their role in the building of social capital in communities to succeed in the management of HIV and Aids, included (see research question 1):

1. What is your role as a social worker in working with communities to manage the impact of HIV and Aids?
2. How do policies (national, provincial, district level) guide your work with communities affected by HIV and Aids?
3. What can social workers do to build social capital in communities in order to manage HIV and Aids?

On the other hand, some of the questions that were asked to the volunteer community members in order to reach an answer to research question 2, included the following:

1. What have been your experience in working with social workers on HIV and Aids projects?
2. What is your view on the role of social workers in helping communities to manage the impact of HIV?
3. Why do you think that social workers have adequate knowledge of what they should do to support you in your projects?

3.3.3 Research purpose

The study pursued an exploratory purpose, whereby the researcher explored the views of both social workers and community members on *what* is the role of social workers in enhancing social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities. Exploratory research usually follow a qualitative approach to gain insight into answers on a subject, in this particular study the role of social workers in building social capital to manage HIV and Aids, about which very little is known, and no research has yet explored in the Johannesburg and Ekurhuleni Metropolitan Municipalities (Neuman, 2011:38). The latter was confirmed through literature reviews and the SABINET database.

This study was applied in nature as the researcher's primary aim was to find a solution to a specific concern, as is usually the case in applied social sciences, such as Social Work (Bless & Higson-Smith, 2000:155). This study does not only conclude with answers to the research questions. The research findings are taken a step further by the researcher to draft practice guidelines for social workers to enhance social capital in communities in order to mitigate the impact of HIV and Aids (see Chapter 4). As a result, the findings of this study directly inform recommendations for practice about addressing a social problem, namely HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities.

3.3.4 Research design

In this study, the collective case study design was followed to explore the common views of two population groups, namely social workers and community members, about their views on the role of social workers in enhancing social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities. The collective case study was considered the most adequate research design for this study as the researcher was interested in obtaining answers to the research questions, not only based on the opinion of one or two isolated cases, but rather the collective view of two groups of people (Nieuwenhuis, 2010b:70).

3.3.5 Research population, sample and sampling method

Two populations, or specific pool of cases as Neuman (2003:201) calls it, were necessary in this study in order to answer the research questions. The first population was social workers, male or female, of different age groups who were involved in community-based HIV and Aids initiatives in the Johannesburg and Ekurhuleni Metropolitan Municipalities. The second population was made up of community members, male or female, of different age groups, who were involved in community-based HIV and Aids initiatives in the Johannesburg and Ekurhuleni Metropolitan Municipalities. Tembisa, Vosloorus, Katlehong, Thokoza, Orange Farm and Soweto were the research sites of the study. The residents of the municipal areas were far from formal employment opportunities in the nearby cities and towns, and the majority of the township residents contribute significantly to the worryingly high statistics of unemployed people in Johannesburg and Ekurhuleni Metropolitan Municipalities (currently 27%) (DSD, 2010:2).

Furthermore, these townships show signs of low social capital, have high crime rates, and these areas are characterised by frequent service delivery riots as the inhabitants feel helpless that the government does not care (O'Donovan, 2011:1). As such, social workers working in these areas were able to provide valuable insights into the challenges that are faced in practice to manage HIV and Aids in communities where social capital is low. Furthermore, the community members involved in the study, who reside in these areas, were able to share their opinion about how social workers could empower them to manage HIV and Aids through developing their social capital.

In this study, the researcher adopted a non-probability sampling technique as it was of more importance to explore the views of people directly involved in HIV and Aids initiatives in Johannesburg and Ekurhuleni Metropolitan Municipalities, than including any social worker or community member and probe their views. Qualitative research uses non-probability sampling as it does not aim to produce a statistically representative sample or draw statistical inference (Ritchie & Lewis, 2003:104). Purposive sampling, which is often employed in exploratory research, was considered the best sampling technique to be followed in the study, because it enabled the researcher to select participants who have an interest in, and experience in the field of HIV and Aids initiatives in the Johannesburg and Ekurhuleni Metropolitan Municipalities (Neuman, 2011:268).

The advantage of using purposive sampling was that it is used in special situations where sampling is done with a specific purpose in mind and where selected cases are especially informative (Maree & Pietersen, 2010:178; Neuman, 2011:268). One of the disadvantages of using purposive sampling was that the cases selected, are rarely representative of the entire population (Neuman, 2011:268). Nevertheless, the researcher considered purposive sampling to be the relevant sampling technique because; the selected research participants, i.e. social workers and

community members, were able to provide valuable information that provided answers to the research questions (Strydom, 2005:202).

The researcher was guided by the specific criteria in the recruitment of the participants, as purposive sampling is guided by parameters that guide the researcher (Strydom & Delport, 2005:329). For this study ten social workers and ten community members were recruited by means of purposive sampling. Freeman (2006:492) and Krueger and Casey (2001:2) suggest that between six and twelve participants are selected for focus group discussions, as this number of participants is small enough for everyone to contribute, yet large enough to share diverse opinions across the whole group rather than fragmenting into smaller parallel discussions. A focus group discussion consisting of ten participants was large enough to gain a variety of perspectives because sample size depended on what the researcher wanted to know, the purpose of the inquiry, what was at stake, what was useful and what had credibility and what was done with available time and resources (Patton, 2002:244).

The participants were selected based on the selection criteria below:

❖ **Criteria for the recruitment of social workers:**

- Social workers must have been registered with the South African Council for Social Services Professionals (SACSSP);
- Social workers must have been involved in community HIV and Aids work for at least one year with the following organisations, Africa Tikkun, Heartbeat Foundation, Abraham Kriel, and Amcare, and working in Tembisa, Vosloorus, Katlehong, Thokoza, Orange Farm and Soweto; and
- Social workers had to provide consent, in writing, to participate in the focus group discussions (See Appendix H).

The researcher considered the social workers who met the selection criteria above to be the best suited for the study, as they engage with community members on a daily basis in an attempt to mitigate the impact of HIV and Aids in the communities of Johannesburg and Ekurhuleni Metropolitan Municipalities.

❖ **Criteria for the recruitment of community members:**

- Community members had to reside in Tembisa, Vosloorus, Katlehong, Thokoza, Orange Farm and Soweto where social workers are rendering HIV and Aids related services;

- Community members had to be volunteers delivering the following services to their communities: care for orphans and other vulnerable children, HIV prevention, care and support, food support to families affected by HIV, and income generating projects.
- Community members had to be volunteers at the following organisations: Africa Tikkun, Heartbeat Foundation, Abraham Kriel and Amcare.
- Community members must have been volunteers in community HIV and Aids initiative for at least one year;
- Community members had to provide consent, in writing, to participate in the focus group discussions. (See Appendix I)

The researcher considered the community members who met the selection criteria above to be the best participants because their views were representative of the grass roots community members and, because they interact with social workers on a regular basis, were able to share their opinions regarding the role social workers play, or should play, in enhancing community social capital towards the mitigation of HIV and Aids.

3.3.6 Data collection method

In accordance with a qualitative study, focus group discussions were used to collect data from two groups, i.e. social workers and community members. Focus group discussions enabled the researcher to collect the collective views of a group of participants, instead of individuals, and as such it effectively linked with the collective case study research design adopted for the study (Greeff, 2005:300; Neuman, 2011:459). In this study it was important that both samples were interviewed in a set-up where they expressed themselves freely and in an informal situation, because the intention of the researcher was not to obtain “right” and “wrong” answers, but to explore the participants’ views about specific issues, such as, perceived roles of social workers in working with the community to mitigate the impact of HIV and Aids and the mandate of social workers in their role to deliver social services to the communities.

The researcher conducted two separate focus group discussions, i.e. one focus group discussion with social workers and community members, respectively. The focus group discussions were guided by two different focus group interview schedules (see appendix F & G). The interviews with social workers were conducted in English and the one with the community members was conducted in isiZulu. The researcher sought the help of the research assistant to assist the researcher in taking comprehensive notes, operating the audio recorder and handling logistics. Greeff (2005:307) encourages the use of the research assistant whose main responsibility will be to assist the research in handling distractions and also act as a backup to the recorded communication. The focus group discussion for social workers were held at the office building of

Amcare in Alberton, Johannesburg, and the focus group discussion for community members were held in Ivory Park. Some of the participants were requested to pay for their own transport and were reimbursed when they reach the interview venue, other participants travelled with the researcher.

❖ **Pilot testing of data collection instrument**

The data collection instrument was not piloted because piloting of the focus group was impractical. However, the researcher ensured the validity of the data collection instrument by requesting the supervisor, the Postgraduate and Research Ethics Committees of the Faculty of Humanities, to determine the validity on face value (Pietersen & Maree, 2010:217). In this particular study, the data collection instrument was considered valid, on face value, if it was asking social workers and community members to describe the role that social workers should play in working with communities to mitigate the impact of HIV and Aids through the development of their social capital.

3.3.7 Data analysis

Qualitative data analysis is an iterative approach aimed at understanding and exploring the views of social workers and community members on the role of social workers in enhancing social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities (Nieuwenhuis, 2010a:103).

In this study, the researcher followed Creswell's (1998) qualitative data analysis process, to specifically undertake thematic analysis, and the process was as follows:

Step 1: Planning for recording data

The researcher started out by establishing the availability of the participants and ensured that the focus group discussions did not interfere with participant's daily and work commitments. Interviews were conducted on the date and time convenient to all participants. Before the interviews, the researcher requested participants to consent to the use of an audio recorder during the focus group discussions. The researcher explained to the participants the importance of using an audio recorder. The researcher ensured that the venue where the focus group discussions were conducted was easily accessible, safe and with good ventilation. The researcher was aware that collecting data alone was going to put undue strain on the process. The researcher utilised the services of the research assistant during the focus group discussions. The role of the research assistant was to take notes while the researcher is facilitating the discussion. Neuman (2011:443) argues that information overload is common in research and stretches an individuals' ability no matter how skilled the person is in recording data. The research assistant was required to sign an informed consent form and to uphold confidentiality.

Step 2: Data collection and preliminary analyses

During the focus groups the researcher identified concepts and meanings. In line with Nieuwenhuis' (2010b:92) recommendation the researcher wrote her own reflective notes on what was observed during the focus group session and transcribed the focus group discussions immediately following the sessions.

Step 3: Manage or organise data

The collected data were organised into computer files, divided into observation data and focus group interview data; with dates of the focus group, places where focus group interview took place and participants' identification information (codes and/or numbers) (Nieuwenhuis, 2010a:99).

Step 4: Reading and writing memos

The researcher listened and had the audio recordings transcribed verbatim, i.e. word for word by an expert transcriber. The researcher also read the data several times to ensure familiarity with the data in an attempt to understand what information has been obtained (Liamputtong, 2009:133).

Step 5: Generating categories, themes and patterns

The researcher categorised the data according to concepts or topics that have emerged from data that the researcher need to explore to reach an answer to the research questions (Braun & Clarke, 2006:87).

Step 6: Coding the data

The researcher created a coding scheme by coding each piece of data with a label or a name that best defines the themes that have been identified and provided a way to break up the data for further analysis (Charmaz, 2006:3).

Step 7: Testing the emergent understanding

The researcher evaluated the information provided by the participants against what the literature reports about the research theme.

Step 8: Searching for alternative explanation

The researcher challenged the patterns and investigated alternative reasons and/or explanations for emerging themes and sub-themes (De Vos, 2005:339).

Step 9: Writing the report

The researcher presented the findings in a form of a report that communicated the methods and findings of the research project (Neuman, 2011:543).

3.4 Trustworthiness

Lietz, Langer and Furman (2006:444) purport that trustworthiness is important in qualitative studies as a way of preserving scientific rigour and also manage subjectivity, by engaging in activities that assist the researcher in giving priority to the meaning of participants over those which are their own. Guillemin and Gillam (2004:275) also agree that social work has an ethical responsibility to conduct qualitative research that is rigorous, and that efforts taken to manage issues of reactivity and bias can help social work researchers to describe qualitative data in a way that is credible. Fawcett and Hearn (2004:205) state that approaches to qualitative research necessitates researchers' values, prejudices, beliefs and attitudes being stated and interrogated, and their likely influence on the research being appraised.

The researched used the following strategies at different stages of research process to ensure trustworthiness of the data to reflect that the qualitative research conducted as closely as possible reflect the thoughts, feelings and experiences of the participants.

Reflexibility

Reflexibility is defined by Horsburgh (2003:308) as active acknowledgement by the researcher that his/her own actions and decisions will inevitably impact upon the meaning and context of the experience under investigation. This reflection occurs both in individual thought and through dialogue with others that acknowledges the researcher's own experiences and perspectives (Johnson & Waterfield, 2004:122).

In order to produce valid and accurate research findings, the researcher conducted a process of introspection regarding her viewpoint and experience as a social worker working in the HIV and Aids field. The researcher went through this self-reflection process to ascertain if there was a possibility to be biased in the way research data will be analysed. The researcher took notes, during the interviews and also recorded the interviews conducted with social workers and those conducted with community members. The interviews were recorded so as to allow the researcher to review and verify during data analysis to avoid the influence of the researcher's predetermined knowledge and experience.

The researcher engaged in an extensive dialogue regarding the goal and purpose of the research study with the participants via emails and telephone communications and situating herself social and emotionally in relation to the participants as a way to ensure reflexivity as purported by Mauther and Doucet (2003:419). This reflexivity was a critical part of establishing trustworthiness in this study, because acknowledging how ones' identity could both help and hinder interpretation of the narrative date is important (Reich, 2003:353).

Voluntary participation and guarantee of anonymity

The researcher used voluntary participation and guaranteed anonymity as another strategy for establishing trustworthiness of the research study. According to Li (2004:303) in order to encourage subjects to be truthful in their responses and to minimise the chances of subjects intentionally supplying data they believe is being sought, the investigator needs to brief the subjects about the purpose and the method of the study, especially what the subjects are required to do in the experiment, what will happen to the data, and how their anonymity will be ensured during and after the study. The subjects' participation should be voluntary.

The researcher ensured that information provided by the participants was kept confidential; this process was enforced by signing of confidentiality agreement by the researcher and research assistant. To ensure anonymity participants included in the research were not called by names but were assigned codes so that they are protected from identification.

The researcher also ensured that all participants are taking part in the study out of their free will and without coercion. The researcher achieved this by informing the participants through the informed consent form that participation in the study is voluntary and that participants have a right not to participate in the study or to withdrawal of consent at any given stage of the research study.

3.5 Feasibility of the study

It was feasible for the researcher to conduct the research study because the social workers and community members made themselves available for the focus group discussions. There are approximately 2 558 social workers working in Non-Governmental Organisations (National Coalition of Social Services [NACOSS], 2007), such as Heartbeat Foundation, Africa Tikkun, Abraham Kriel Child care and Amcare, alone who are involved in community-based HIV and Aids work in Gauteng under which the Johannesburg and Ekurhuleni Metropolitan Municipalities falls. There are 10 442 social service and health registered organisations with committed volunteers (Department of Social Development, 2011:5). Before the researcher started to conduct the research study, the researcher sought the approval from Research Ethics Committee from the

Faculty of Humanities at the University of Pretoria, and permission was granted (See Appendix A). The researcher was also able to receive permission from social workers, their employers and community members for their inclusion in the study. (See Appendix B, C, D & E).

3.6 Ethical considerations

The subject of HIV and Aids is very sensitive and deals with confidential issues. Therefore, the researcher attended to several aspects to ensure that the study was conducted in an ethical manner.

3.6.1 Avoidance of harm

HIV is an emotional subject to discuss with anyone, because there is no one who is not affected by HIV. In order to prevent both physical and emotional harm to the participants, the researcher was able to protect participants from physical harm by conducting the focus group discussions in a safe and relaxed environment, while emotional harm was prevented by refraining from asking personal questions (Strydom, 2005:58). The researcher had secured the services of a counsellor to refer the participants for intervention should an emotional situation arise. The participants in both groups of social workers and community members did not request the services of the counsellor during and after the interviews.

3.6.2 Informed consent

No participant was forced to take part in the study. The researcher ensured that participants had adequate information regarding the research study, by explaining the purpose of the study and the procedures to be followed, before they provided their informed consent (see appendix H & I) (Strydom, 2005:59). In addition, the information provided on the informed consent form was translated in the local languages of the participants. Participants agreed that the research data will be archived for a period of 15 years on UP premises in accordance with UP Policy. With specific reference to the focus group discussions, the participants provided consent to the use of an audio recorder and the assistance and presence of a research assistant. The research assistant also had to sign an informed consent form and obliged to uphold confidentiality.

3.6.3 Deception of participants

The goal and objectives of the research were discussed in advance with the participants; therefore, deception did not occur. The researcher did not mislead the participants (Neuman, 2011:229).

3.6.4 Violation of anonymity and confidentiality

The researcher and research assistant ensured, as proposed by Smythe and Murray (2001:318) that the information provided by the participants is kept confidential; signing of confidentiality agreement by the researcher and research assistant enforced this process. To ensure anonymity participants included in the research were not called by names but were assigned codes so that they are protected from identification.

3.6.5 Actions and competence of the researcher

The researcher regarded herself competent to conduct the proposed study as she completed research as part of her Bachelor's degree in Social Work and she is a registered social worker. The researcher has also completed a research methodology module on postgraduate level. Furthermore, the researcher has 10 years' experience working in the field of HIV and Aids. Akerlind (2008:245) postulates that the experience and knowledge of the researcher could contribute to the successful completion of the research study.

3.6.6 Release of findings

The researcher informed the participants that research findings will be released through a mini-dissertation and that the findings might also be released through publication in a scientific journal. The participants were also informed that if the opportunity arises the research findings might be presented at a relevant conference, because as Fernandez, Kodish and Weijer (2003:12) contend, results should be offered to all participants, both those who may directly benefit and those who may not benefit directly.

3.6.7 Debriefing of participants

The researcher at the end of the focus group interview debriefed the participants. A psychologist was available to provide further counselling to the participants should they indicate the need thereto. According to Kraut, Olson, Banaji, Bruckman, Cohen and Couper (2004:15) debriefing of participants is also important in providing an explanation of the nature, results, and conclusions of the research and it was delivered as soon after the research findings were available.

3.7 Empirical findings and interpretation

This section will discuss the findings and interpretation of the research findings. The researcher will first present the data obtained from the social workers and provide an interpretation thereof. More specifically, the findings and the interpretation of data from the focus group interview with social workers will be presented as follows: biographical information, gender of the participants, age of

the participants, highest qualification and positions of the participants and the number of years working in the HIV and field. The following sub-section will focus on themes and sub-themes originating from the focus group interview.

Section A

This section will analyse the research participant's biographical information. The purpose of this section is merely to orientate the reader broadly about the social workers who were participants in this study.

3.7.1 Social workers biographical information

The biological information of the participants is presented as follows:

(i) Gender of the participants

All (n=9) participants who were interviewed for the study were female.

(ii) Age of the participants

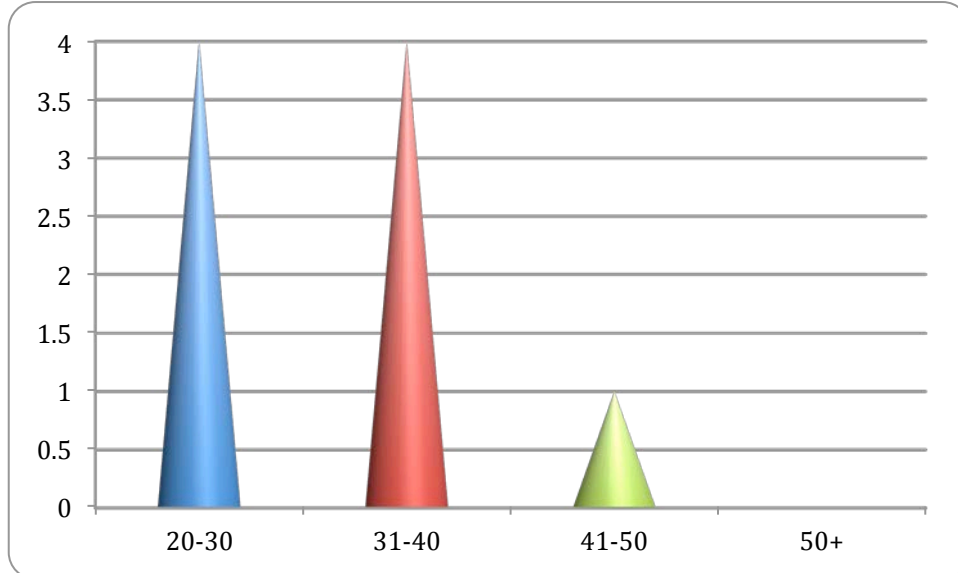


Diagram 1: Age of the participants

Diagram 1 reflects that out of the 9 participants who participated in the study, 44.5% (n=4) fell in the 20 to 30 year old age group. Another 44.5% (n=4) of the participants within this segment were between the ages of 31 and 40. 11% (n=1) of the participants were in the 41 to 50 year age group. There were no participants from the age of 51 and above represented in this study.

(iii) Highest qualification of the participants

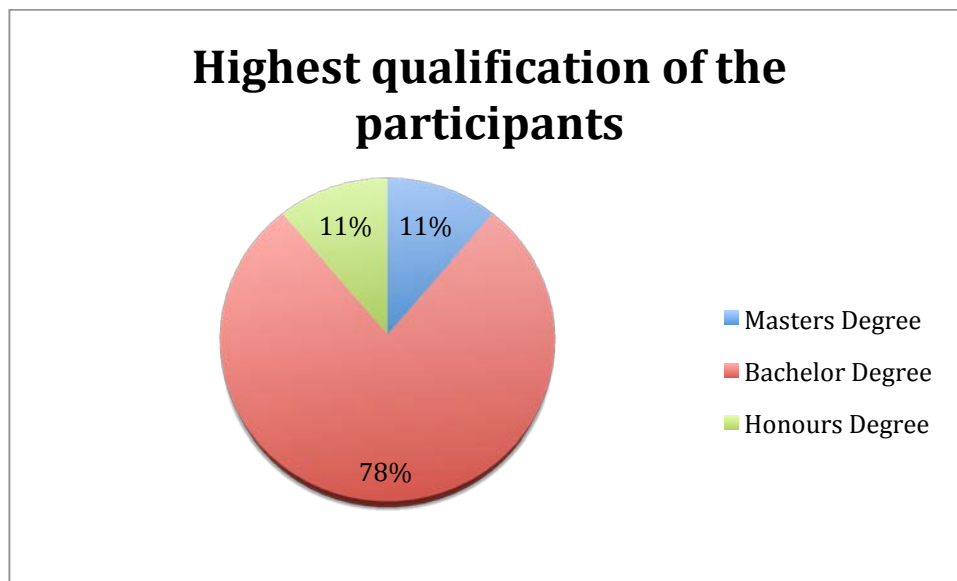


Diagram 2: Highest qualification of the participants

According to Diagram 2, out of the 9 social workers who participated in this study, 11% (n=1) had a Master Degree, 78% (n=7) was in possession of a Bachelor Degree, and another 10% (n=1) had an Honours degree qualification in Social Work.

(iv) Position of the participants

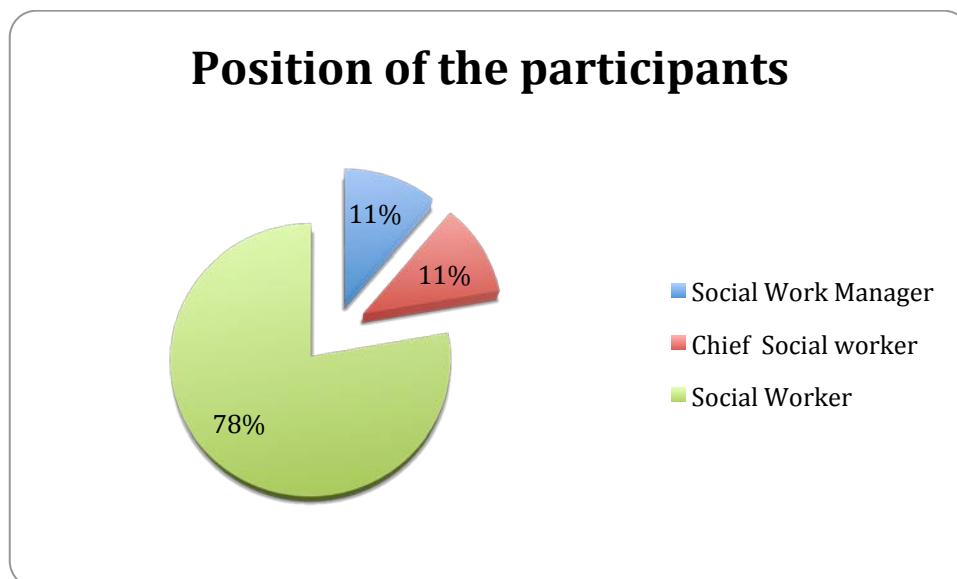


Diagram 3: Positions of the participants

According to Diagram 3, 11% (n=1) of the participants who participated in the study occupied the position as the social work manager in the organisation, another 11% (n=1) of the participants held

the position of the chief social worker in her organisation. 78% (n=7) of the participants occupied positions as social workers within their organisations.

(v) Number of years in the field of HIV and Aids

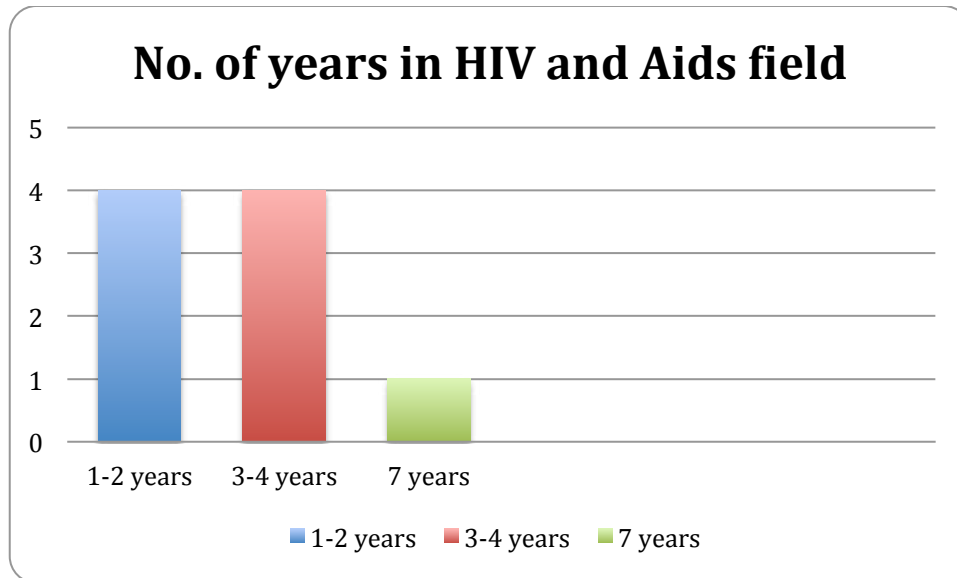


Diagram 4: Number of years in the field of HIV and Aids

Diagram 4 reflects that out of a total number of 9 participants who were interviewed for this study, 44.5 % (n=4) had between one to two years’ experience of working in communities within the HIV and Aids field. Another 44.5% (n=4) of participants who participated in the study had between three to four years’ experience. 11% (n=1) had seven years’ experience.

The next section will discuss the themes and sub-themes that emerged from the data analysis originating from the focus group interview with the social workers.

3.7.2 Themes and sub-themes: social workers

During the data analysis process, the researcher extrapolated themes and sub-themes for both social workers and community members. In order to voice the views, perceptions and experiences of the respective participants, verbatim quotations will be presented where applicable. This section will focus exclusively on the social work participants

Table 1: Themes and sub-themes: Social Workers

Theme	Sub-theme
1. Social work knowledge base	1.1. Skills and attitudes 1.2. Understanding of the community (Belief systems and Behaviours)
2. Methods for providing holistic HIV and Aids support to communities	2.1. Case work 2.2. Group work 2.3. Community Work ❖ Community development ❖ Community education
3. Promoting community participation	3.1. Lack of community commitment 3.2. Partnerships
4. Challenges of working with communities	4.1. Stigma associated with HIV 4.2. Disclosure of HIV status

Theme 1: Social work knowledge base

Under the theme 'social work knowledge base', two sub-themes emerged, namely the skills and attitudes social workers should possess and the importance of understanding the community.

Whitaker, Weismiller and Clark (2006:16) postulate that globally, social workers are proactively providing critical services to individuals, families, and communities affected by HIV and Aids. Social workers are employed in a wide range of community settings, including public, non-profit, and for-profit organisations. Therefore, working with a diverse and changing population in supportive, clinical, and administrative roles requires that social workers be capable of providing up to date expertise on research, policy, and evidence-based clinical approaches. Even social workers not directly serving persons living with and/or affected by HIV should have an understanding of their complex and unique challenges (Tomaszewski, 2012:1).

Sub-theme 1.1: Skills and attitudes

HIV and Aids is still a sensitive subject for individuals, families and communities. Social workers working in the field require certain key skills and attitudes to be able to engage communities in a meaningful way. Zastrow (2007:35) identifies some of the competencies or core practice skills that social workers should possess:

- Identify and assess situations in which relationships between people and social institutions need to be initiated, enhanced, restored, protected and terminated;
- Develop and implement a plan for improving the well-being of people, based on problem assessment and the exploration of obtainable goals and available options;
- Enhance the problem solving, coping, and developmental capacities of people.

Martin (2008:1) purports that social work cannot be defined as a specific skill or a specific body of knowledge; rather it is an eclectic range of different skills and expertise. What social workers have to offer is like a patchwork, with lots of different bits and pieces. The social worker's ability to put the right bits and pieces together in response to different situations is what makes them unique and versatile and able to deal with each person as an individual. This diversity, this ability to be flexible, to be responsive, to be person-centered is what makes social work unique and valuable.

Several participants agreed that in order to support communities in the fight against HIV and Aids, social workers need to have relevant skills to ensure that they heal the communities and not add to their problems due to incompetency and a non-caring attitude. The social workers elaborated on the issue of necessary skills and attitudes as follows:

"I also do lots of report writing about my clients' situation and other projects that I am involved in."

"So you have to come in to listen, facilitate and educate, though we have a clinic sister there I go with the sister for home visit and try to listen to and educate the family as well as the patient myself."

"I know we've got cultural issues about things that's not supposed to be discussed and we are supposed not to judge those culture, but we...we sitting then with a generation of...of neglected children. Emotionally neglected children because of that."

Reports are important management tools for influencing future actions and can promote scale up as a vital aspect of community response to HIV and Aids and facilitate the exchange of information on the NGO or CBO HIV and Aids work among local, national and international stakeholders.

Through reports, information can be shared and consequently lessons learned (International HIV/Aids Alliance, 2008:6).

Shortt (2004:15) alluded to the fact that the technical capacity of community members must be built in order for them to access relevant and effective HIV and Aids community-based services where relevant. Trained community resource persons, such as social workers, home-based carers, religious leaders, traditional leaders, CBO workers and skilled and retired individuals, among others can help to ensure that communities are well-informed and supported in regards to access to services, referrals, follow up, adherence to HIV treatment regimes.

Given the complex physiological, psychological and social problems faced by persons living with HIV and Aids and their communities, it is essential that service providers work in collaborative teams to provide the best possible service for this client group in a professional, positive and non-judgemental manner to combat ignorance and discriminatory treatment of people infected and affected by HIV and Aids (Olivier & Dykeman, 2003:600).

The researcher concurs with Spies (2007:143) in that according to social development viewpoint social workers involved in service delivery in HIV and Aids should specifically convey acceptance, warmth, respect, empathy and confidentiality. People living with HIV not only suffer from the disease but are often also subjected to discrimination, stigma and disrespect.

Because of the skills and attitudes in their possession, social workers, are better placed to understand and appreciate diversity of their clients, in terms of, religion, gender, age, access to resources, ways in which people make a living, ability and proximity to people with influence in the community.

The focus now turns to the next sub-theme, namely understanding of the community.

Sub-theme 1.2. Understanding of the community

Thompson (2009:25) argues that good social work practice requires understanding. To engage in macro practice, the social worker must understand the problem, the background of the people infected, the population, and the arena (community or organisation) within which the problem occurs. Understanding communities and organisations adds a dimension of complexity to social work practice, but this understanding is a critical precursor to successful macro-level intervention.

It is also important for social workers to understand how the phenomenon of HIV and Aids affects the local community (the overlap between problem and area), and to what extent the needs of the population are understood and addressed in the local community (overlap between population and

area). Ultimately, during macro practice, the objective is to work towards an understanding of the area where all three circles overlap.

The social workers gave the following examples to reiterate the issues relating to understanding the communities in which they work:

“Um, my role as a social worker in HIV. Um, I’m doing, community HIV and Aids needs assessments, mapping of community structures and resources and raise awareness on HIV and Aids.”

“To add on what you saying in terms of, uh, partner...partnering with or...with...with the organisation that are working within the community, and help each other to understand what other services can be accessed by our clients to avoid duplication of efforts and funding.”

The HIV prevention planning process at community level requires an assessment of HIV prevention needs based on a variety of sources and different assessment strategies. This assessment serves as the basis for the development of a comprehensive HIV prevention plan. Tailored need assessments enable the community worker to make informed decisions about the adequacy, availability, and effectiveness of specific services that are available to the community (Centre for Disease Control and Prevention, 2007:2).

The above quotes from the participants supports the notion by Epstein, Mooney, Ryser and Pierce (2004:355) that a social development approach is vital for the social work profession to promote social change, problem solving in human relationships, and the empowerment and liberation of people to enhance their well-being.

The next section will discuss the second theme that was extrapolated from the data analysis namely, Methods for providing holistic or comprehensive HIV and Aids support to communities.

Theme 2: Methods for providing holistic or comprehensive HIV and Aids support to communities

HIV and Aids have implications for every aspect of development and social services. This includes health, social well-being and education, as well as local economic development, water, sanitation, housing and food security. Addressing the multifaceted effects of the epidemic requires a sustained multi-sectoral response (Department of Health [DoH], 2006:32), which must continuously learn, and evolve with experience and the changing demands of the epidemic.

The following three sub-themes emerged under this theme, methods for providing holistic or comprehensive HIV and Aids support to communities. These sub-themes are, casework, group work and community work. The last sub-theme, namely community work has two finer distinguishing factors, i.e. community development and community education and this will also be discussed under this section of sub-themes.

Sub-theme 2.1: Case work

Zastrow (2009:49) states that social casework is a method of helping people solve problems. It is individualised, scientific, and artistic. It helps individuals with personal, as well as with external and environmental matters. It is a method of helping through a relationship that taps personal and other resources for coping with problems. Interviewing and assessment are major skills of casework.

The social workers also highlighted the skills that they use in casework as follows:

“I am also making referrals to link a family or person to needed services. I also do follow with the clients to ensure that they received needed services.”

“I do the assessment, after the assessment we place them [OVC] in the Early Childhood Development (ECD) programme and it’s for free for the OVC children.”

Referral services comprise a range of services intended to support HIV-positive individuals and their partners in making healthy choices and receiving appropriate health care, as well as to promote healthier communities by reducing the spread of HIV (Hogben, McNally, McPheeter & Hutchinson, 2007:89).

Rwomire (2011:2) postulates that using their professional skills and knowledge, social case workers help in assessing the clients’ needs and applying agency, community and public welfare resources and programmes to address relevant social, health or economic problems. They help clients who become eligible for a variety of services designed to improve their economic, social and/or health functioning, thereby working toward improving the clients’ quality of life or standard of living.

The next sub-theme will focus on group work as the second method for providing holistic or comprehensive HIV and Aids support to communities.

Sub-theme 2.2: Group work

An HIV diagnosis can be very isolating, as people frequently cut themselves off from the world when diagnosed with HIV. Social support groups help people to challenge the idea that HIV equals

death. In doing so, support groups help build confidence and strength (Getzel, 2005:48). Toseland and Rivas (2005:61) postulate that support groups help members to cope with stressful events. They provide reality testing, emotional support, socialisation, and education. In addition, groups neutralise stigma and allow members to practice new behaviours (Wood, 2007:11).

The participants highlighted their roles in terms of group work as follows:

“I am running support groups with infected persons and also therapeutic groups with the affected persons as well. This is to create an atmosphere for them to share the similarities that they have in their life.”

“To manage the impact of HIV and Aids is, I’m doing counselling, group work, HIV awareness in the community and, um, running different programmes in...um, the programmes that, uh, is for people that are living with HIV and Aids so we’ve got this group that we are running every month, once in a month. Then we’ve got another group for the grannies.”

Bhana, McKay, Mellins, Petersen and Bel (2010:6) postulate that social networks that are developed through community groups are important in building social capital and sustainable interventions and should be encouraged. With HIV, support groups have to go beyond psychological support and also focus on improving services and to ensure that the rights of people living with HIV are respected. Support groups promote “shared confidentiality” openness about HIV status with a limited circle of trusted people, opening up channels of support and care. They steer responses to Aids across communities and connected informal resources of authority to the formal HIV programme (Low-Ber & Sempala, 2010:6).

From a social development perspective the use of group work within social work will often address a broader range of social and personal problems than those designed for group psychotherapy. For group work, these can include the desire to:

- Achieve personal change (i.e. changes in attitude or behaviour);
- Achieve social, environmental or political change;
- Foster relationships/gain support;
- Pool resources, and;
- Facilitate learning (Trevithick, 2005:86).

The next sub-theme will focus on community work as the third method for providing holistic or comprehensive HIV and Aids support to communities.

Sub-theme 2.3: Community work

Suraj-Narayan (2007:4) purports that Aids knows no social, racial or cultural barriers. Yet, the rates of infection spiral especially among the poor, the disenfranchised and among people who struggle with inequality and oppression. Throughout the pandemic, people living with HIV across the world have shown, and continue to show, a commitment to community-based action. They have not acted alone. Often social workers have provided essential leadership and support in mobilising community response to HIV and Aids. Together, they have shown an unbending resolve to work towards wellness, to openly engage the communities, and to assert and protect fundamental rights. This action is a potent reminder of the duty of compassion that binds us all.

The social workers highlighted their role in community work as follows:

“Uh, I’m doing, community awareness in HIV and Aids and I also have a team of, oh, ten people, who are working with OVC”.

“I come more from a child welfare organisation...or background and the one thing that worked for me was...or rather is where you... capacitate the people. There are so many people in the community that are not physically busy or not physically working, is that you...that you use them, um, through an incentive to look after the children in the community and not just say, I know there’s Ubuntu and all that stuff, but...not...making or...or starting to worry about the people around you.”

The researcher concurs with Chitereka (2009:153) on the notion that social workers employed in NGOs can be commended because by and large they utilise the community work method of social work in the course of their work, which is consistent with the social development paradigm. Developing social capital in people and in the community at large is social workers’ recurrent task.

Individuals, families and communities experience uneven levels of social capital, and these have implications for the ways in which policy and services are delivered to families and communities (Stone, 2003:14).

Progressive community work should lead to developed and educated communities. These two elements emerged from the data analysis and will be discussed next.

❖ Community development

The United Nations Research Institute for Social Development [UNRISD] (2005:1) reports that HIV and Aids has documented, negative, effects on economic growth that have undermined efforts to widen economic opportunity and inclusion. It deepens poverty and increases inequalities at every

level, from household to global, confounding efforts to deal with these problems. Numbers poorly express the losses and costs caused by HIV and Aids-related diseases. The most critical, but often least recognised costs, are within households, where HIV and Aids can lead to complete collapse. At this level, loss of income, diversion of assets to caring, and weakened family and social networking have been shown to divert labour from production to care, leading to falling household production and rising spending, particularly on medical care and funerals. Household members, and particularly women, have to make hard choices about the allocation of their time between production, meeting household needs, child care and care of the sick (UNRISD, 2005:1). These effects are associated with new poverty, widening exclusion and increasing economic inequality.

Social workers who were interviewed highlighted their roles in community development as follows:

“I think, that’s the one thing we push from our side is we make sure that our clients have government documents like IDs, make sure there’s birth certificates, we push, push, push, push to get those things so that they can get a grant which can mean possible income later on.”

“Just to add on what she said I would say that it’s to... encourage the clients that are HIV-positive to do more with themselves not always for us as organisations to bring everything to them to...for...for them to...to start businesses, to start, mm, maybe gardens and whatever they can do by themselves just to encourage them that they are still human and they are still able to do things by, uh...by their...by themselves.”

Community development is widely recognised in social work and the social services professions as the intervention strategy most suited in addressing poverty, community participation and empowerment and social and economic development (Maritz & Coughlan, 2004: 31). It is an approach in development programmes that aims to improve the living conditions of people in a particular area. It is also a strategy for reaching and involving village and communities in the process of building their own life, which consequently would contribute to the national progress. It also is a movement linked to local governments to promote better living conditions for the whole community with active participation, and possible initiatives of the community (Nikkhah & Redzuan, 2009:170).

It has been well demonstrated that social capital, positively on frequent occasions affects the level of community development (Yokoyama & Ishida, 2006:10). Thus, the concept of social capital is to a great extent useful in discussing how to more effectively formulate community development programmes for the purpose of enhancing the well-being of communities.

The next topic emerged under the sub-theme of community work.

❖ **Community education**

Education has a key role to play both in preventing HIV and Aids and in mitigating its effects on individuals, families, communities and society. HIV and Aids is affecting all areas of the globe with devastating impact. Effective HIV and Aids education can help to prevent new infections by providing people with information about HIV-infection, and in doing so equip individuals and with the knowledge to protect themselves from becoming infected with the virus (UNAIDS, 2011:7).

The following statements from the social workers provide the extent to which the participants view their role as community educators:

“I think, uh, awareness or educational programmes with this regard can assist more because in most cases our communities we...our communities HIV lack more understanding in terms of what is HIV, how does it...how does it impact our lives.”

“The most important thing as much as we do workshops, eh, for our youth we then decided that it’s going to be more effective if the youth themselves are the ones who are running these workshops to talk to their peers about this HIV and then so...so that they can be free to talk to the person of their same age.”

Strug, Grube and Beckerman, (2002:7) postulate that social workers will increasingly become involved in primary prevention efforts through education due to the fact that medical intervention alone is not sufficient to prevent new infections. People infected with HIV will need a wide variety of medical and psychosocial support service for long periods of time, since HIV and Aids becomes a chronic condition.

Stigmatisation of people living with Aids is a key obstacle to HIV prevention and Aids care. It is now generally accepted that efforts to reduce stigma should be an integrated part of all HIV and Aids programming (Campbell et al., 2005:808).

Lawson (2005:155) supports the social development perspective on community education, by stating that through education and empowerment, social workers strive to achieve three related aims. First, they aim to improve the health and well-being of poor, vulnerable, and oppressed people across the life course. Second, they aim to improve the places where these people live. More specifically, social workers strive to develop special kinds of local communities that promote people’s health and well-being and, at the same time, contribute to sustainable, integrated social and economic development. Third, social workers aim to improve governments and policies. In

particular, they are strong, persistent advocates for social, economic, political, and environmental justice.

The next theme will discuss the potential roles of social workers in promoting community participation, and commitment and the importance of partnerships to bring about social change in the communities they work in.

Theme 3: Promoting community participation

The advent of HIV in the last few decades has presented considerable challenges to the health and community system throughout the world. Many countries developed measures to combat the spread of the virus and the trends are improving, mostly due to the introduction of potent new combination of medication, the development of effective prevention strategies and increased community awareness and participation. The improvements would not have been possible without the mobilisation of communities, who in recognising their vulnerability have taking collective action to curb the propagation of HIV (Mbuagbaw & Shurik, 2011:113). Community participation in the response to HIV has been accepted as an essential element within health services and programmes for variety of reasons. Ramirez-Valles and Brown (2003:52) postulate that community participation has played a central role in the fight against HIV since the onset of the epidemic. It has a positive effect of safer sex practices, social integration and identity.

Gregson, Terceira, Mushati, Nyamukapa and Campbell (2003:2120) argue that participation in local community groups is often positively associated with successful avoidance of HIV, which, in turn, is positively associated with psychosocial determinants of safer behaviour and enhanced social capital. Programmes that are more participatory and address underlying structural and community level factors appear to be essential.

The next section will focus on the first sub-theme, namely lack of community commitment.

Sub-theme 3.1: Lack of community commitment

Community participation in HIV activities is often hampered by a lack of community willingness to take ownership of the initiatives. Most of the community members expect external support and supplies that cannot be generated from the community is crucial to ensure continuity (Olico-Okui, 2004:7).

With poor government leadership, ground has been left open for international development agencies and externally funded NGOs. The discourses of HIV prevention are often the discourses of western science and policy, regardless of the extent to which these are appropriate for local conditions. Projects are often designed by 'overseas experts', with only minimal and tokenistic

consultation of local people, who may have little sense of 'ownership' of project proposals and lack the conceptual understandings, technical skills, or trained staff to implement them properly (Campbell, 2003:439).

The social workers had different views on the extent of community commitment and support that the community members provide to the NGO projects. Most participants reported their experiences of lack of commitment by community members in the following quotes:

"For me, one, it starts with your ward counsellor. Your ward counsellor, um, might not think, um, that... there's a challenge of HIV or Aids, but there's no political will to... do anything from his side. He wants to be in charge of the community but we battle to get these guys part of... the strategy."

"The other thing is also...what I think was said earlier, or NT said earlier, sorry, um, is that people are still waiting for somebody else to make it happen for them."

"We basically have to bribe people to come for groups and stuff through bread. Um, I'll give you a sarmie if you come, I'll give you a sarmie. Um, we...we'll give out free, um, uh, um, seeds and stuff, neh, but it's still a mission for people to come. So for me it's also a need from the community members themselves to also say I want to. I can do this."

Uys and Cameron (2009:181) add that there is general consensus that interventions to assist HIV and Aids affected and infected people should be based in, and owned by, the affected communities themselves.

Patterson and Cole (2006:173) argued that strong political commitment is a fundamental prerequisite to setting up a national strategic response to HIV and Aids, which includes multi-sectoral participation and action at the community level.

When social capital declines, a community experiences increased social disorder, reduced participation in civic activities, and potentially more distrust between community members (Ellison, Steinfield & Lampe, 2006:7). Increased social capital increases commitment to a community, and ability to mobilise collective actions, among other benefits. Social capital is seen as a positive effect of interaction between participants in community networks (Helliwell & Putnam, 2004:1463).

The next section will focus on the second sub-theme, namely partnerships.

Sub-theme: 3.2. Partnerships

Campbell, Nair and Maimane (2007:12) argue that people are most likely to work collectively to achieve goals of mutual interest (in this case more effective HIV and Aids management) in the context of trusting and supportive relationships. Such relationships also provide the optimal context for the (i) effective dialogue in safe social spaces, (ii) sense of ownership and responsibility for tackling HIV and Aids, and (iii) sense of confidence and agency in relation to local strengths that we refer to above. It is also within such communities that people are most likely to challenge the stigmatisation of people with HIV and to treat them and their families with respect and dignity, creating a more supportive context for Aids-care. In relation to HIV-prevention, it is within such humane conditions that HIV-vulnerable people are less likely to respond to the epidemic with fear and denial, and more likely to feel confident to seek out information about prevention and/or testing.

During the focus group discussion the social workers highlighted that partnerships are crucial to the development of communities, and that each partner has something valuable to bring to the table. They highlighted the following on the subject of partnerships:

“I also think churches can do more to help in this fight of HIV. Yes, we are an organisation of Methodists but in the community, on the ground level, it’s hardly spoken about in the churches so I think churches can take the stand also with...especially with the youth, if they can make sure that they can talk about HIV sessions.”

“We can also have the...the support groups in the community, not necessarily with those who we are working with but we are in a way of creating awareness of HIV in the community, have a support group of the affected families, even if some...those are not affected but everybody can get together and support each other in...in this, uh, issue of HIV and Aids. I think that will also work.”

“I think the other thing that could bridge the...the gap is, um, partnering with other organisation. Like where I’m coming from we’ve got a, uh, forum with all the NGOs that are in the area that are doing OVC, others are doing, um, just anything that, uh, the organisation will be giving, so we come together then you come with different ideas then you see how to...to bridge the gap.”

Patel (2005:107) purports that attempts to promote contexts that support HIV prevention efforts are most likely to succeed where it is possible to build ‘bridges’ between small local projects and more powerful local and extra-local actors or agencies in the public sphere (e.g., health and education departments), the private sector (e.g., employers and funding agencies) and civil society (e.g.,

national youth organisations or activist groupings who have the political or economic influence to assist in achieving programme goals).

Bridging social capital is particularly important for a challenge such as HIV and Aids, because the problem of HIV and Aids, with its complex mix of biomedical, behavioural and social roots, is too complex for any one constituency to deal with, particularly the poorest and most marginalised communities which are the most vulnerable to the epidemic (Campbell, Foulis, Maimane & Sibiya, 2005:11).

The researcher concurs with Dhillon (2009:701) in that social capital can be used as a resource to support and sustain a partnership and can function to compensate for lack of financial capital, such as the targeted funding streams provided by governments to support 'partnerships'. This suggests that in understanding the basis of sustainability of partnerships there is a need to look beyond the simplistic model of targeted short-term funding to promote effective partnership working, 'joined-up working' and 'joined-up thinking'.

To fulfil the social development mandate and to overcome major changes, challenges, and hardships in human service delivery, organisations no longer able to operate as independent or competitive entities. Rather, they must develop collaborative networks for service delivery in order to survive and thrive (Wertheimer, Beck, Brooks & Wolk, 2004:124).

The next section will focus on theme four; the challenges encountered by social workers in working with communities to build their social capital.

Theme 4: Challenges of working with communities

HIV and Aids is one of the most complicated and bewildering social challenges faced by contemporary society (Visser, Makin & Lehobye, 2006:42). It is critical to note that the impact of HIV and Aids on individuals has multi-faceted dimensions ranging from social, cultural, psychological and economic which culminate in interlocking and penetrative effects on the livelihoods of people infected and those affected. It is also clear that HIV and Aids affects individuals but also families, groups, and communities that are part of the client base of social workers, and in this way, the profession is presented with many challenges when confronting this scourge (Nakazibwe, 2008:3).

The next section will focus on the first sub-theme, namely stigma associated with HIV.

Sub-theme 4.1: Stigma associated with HIV

The UNAIDS (2003:1) purports that over the world, the Aids epidemic is having a profound impact, bringing out both the best and the worst in people. It triggers the best when individuals group together in solidarity to combat government, community and individual denial, and to offer support and care to people living with HIV and Aids. It brings out the worst when individuals are stigmatised and ostracised by their loved ones, their family and their communities, and discriminated against individually as well as institutionally.

Social workers expanded on the issue of stigma in the community as follows:

“Stigmatisation and discrimination is still a big challenge because you find that the affected people or families, they don’t want to come out and seek help because they’re afraid of stigma. So even when we are there and want to render services, they will say no, I’m positive and everyone can see care givers coming to my house then they will know that I have HIV. So stigma is still a big issue so the people will wait ‘til they’re in their last stages or in their dying stages. That’s when they’ll come out and already it will be too late to do anything or get the medication or anything because of stigma.”

“Um, in our organisation we also have a clinic. Uh, they call it a youth friendly clinic where they provide testing for HIV. We encourage youths to test, but when they (youth) get home, when they tell their parents that our counsellor or our group facilitator encourage us to test for HIV and this is what I have done. The parents become angry asking why did you do that? What if you find out that you HIV positive? Do you want people to talk about you?” ... like the stigma that she was talking about.”

Stigma is perceived as a major limiting factor in primary and secondary HIV and Aids prevention and care, and has interfered with voluntary testing and counselling, and access to care and treatments (Holzemer & Uys, 2004:165). All things considered, Aids stigma becomes yet another life obstacle in the path of many of the very people who are already faced with social and economic obstacles. Combating stigma remains an important task for social workers around the globe (CDC, 2011; IFSW, 2006).

Sivaram, Zelaya, Srikrishnan, Latkin, Go, Solomon and Celentano (2009:233) argue that social capital has been reported as an important factor influencing HIV prevention and social support upon infection. To realise better prevention and care outcomes for HIV, particularly to reduce stigma in communities, social capital may be a relevant strategy for many reasons. First, the

source of stigma is often community or health systems based (Mawar, Shay, Pandit & Mahajan, 2005:743). Second, there is evidence in the literature that when the social network and social support aspects of social capital are strengthened, desirable HIV-related outcomes are achieved (Campbell et al., 2002:41; Gregson, Terceira, Mushati, Nyamukapa & Campbell, 2004:2123).

In addition to HIV related stigma, the other challenge identified by social workers relating to challenges of working with communities is the non-disclosure of HIV status. This will be discussed as the second sub-theme.

Sub-theme 4.2: Disclosure of HIV status

Mbonu, Van den Borne and De Vries (2009:1) argue that the stigma and discrimination associated with HIV and Aids make it difficult for people living with HIV to be open about or to disclose their HIV-positive status. Disclosure has many implications, and in particular for the relationship between the parents and children. While advantages of disclosing have been identified within the workplace to ensure that the employer creates a supportive environment for the employee living with HIV and Aids, these advantages have not been translated into the home and community environment (Brink & Pienaar, 2007: 81).

There is a general silence and fear of disclosure about HIV and Aids both from those infected and affected by HIV and Aids (Brown, Macintyre & Trujillo, 2003:50). The community speaks in “codes” about HIV and uses names that are stigmatising those that are infected (Notshe, 2007:10).

During the interviews, the social workers expressed some of the challenges related to disclosure of HIV status as follows:

“The community is still scared to come out, to feel free, to do that test, to know their status because they’re scared of being stigmatised. But though those results are confidential, but they don’t understand that even if when you’re doing the counselling with the kids, you talk about the confidentiality of the result but it’s still a problem with the family.”

“Some of the children grow up taking this medication or treatment, eh, living with the grandparent who is aware that the child is HIV positive but no...doesn’t have the guts to tell the child. And that child grows up taking this medication, not knowing what the medication is for. So, at some point it becomes very difficult whereby a grandparent passes away without having told the child the truth.”

Reluctance and anxiety to disclose HIV-positive status, and fears of being rejected and discriminated against are evidence of the persistent nature of Aids-related stigma in communities

and households. Aids-related stigma remains one of the barriers to curb the further spread of the disease amongst people who are aware of their HIV-positive status (Peltzer, Nzewi & Mohan, 2004:96). Thus, in the South African context, Aids-related stigma poses a major challenge to the efficacy of risk reduction interventions for People Living with HIV and Aids (PLWHAs) and other risk groups.

Smart (2002:122) postulates that disclosure is a positive response that has many benefits but it is made very difficult, or indeed impossible, in situations where stigma and discrimination are present. This cause and effect cycle where disclosure is compromised because of stigma needs to be broken before any real progresses in terms of HIV prevention, treatment, care and support, and impact mitigation can take place.

Although social exclusion and stigma appear to be declining, they still stand as major challenges to PLWHAs and as such pose a threat to social unity. The rising of HIV support groups reflects the application of social capital remedies to a set of previously neglected problems; that they bring what were thought to be private problems into the public realm (Jamil & Muriisa, 2004:11).

People living with HIV in the community with effective social capital have higher rates of disclosure and greater access formal institutional support through local NGOs and government social services and greater opportunities to take a positive leadership role as HIV positive individuals in the community (Norman, Chopra & Kadiyala, 2005:ii). The creation of an enabling, resource-rich environment for HIV disclosure holds the potential to form a virtuous cycle whereby individuals are more likely to disclose, thus offering personal and community benefits, and further perpetuating disclosure at all levels within society. Given the devastating impacts, and the nature of social tragedies caused by HIV and Aids, the role of the state in this regard may be inadequate. Social capital building through solidarity, network, and strengthening civil society may facilitate social inclusion of those people living with HIV and Aids and encourage them to disclose their status (Jamil & Muriisa, 2004:8).

The next section will discuss Part B of empirical findings and interpretation in relation to the second group of the research participants: community members.

Section B

This section provides an overview of the community member, as research participants' biographical information, and outlines the research findings obtained from them and offers an interpretation thereof.

3.7.3 Biographical information of community members

The biographical information of the participants is presented with the view of orientating the reader about the people who formed the members of the focus group discussion.

(i) Gender of the participants

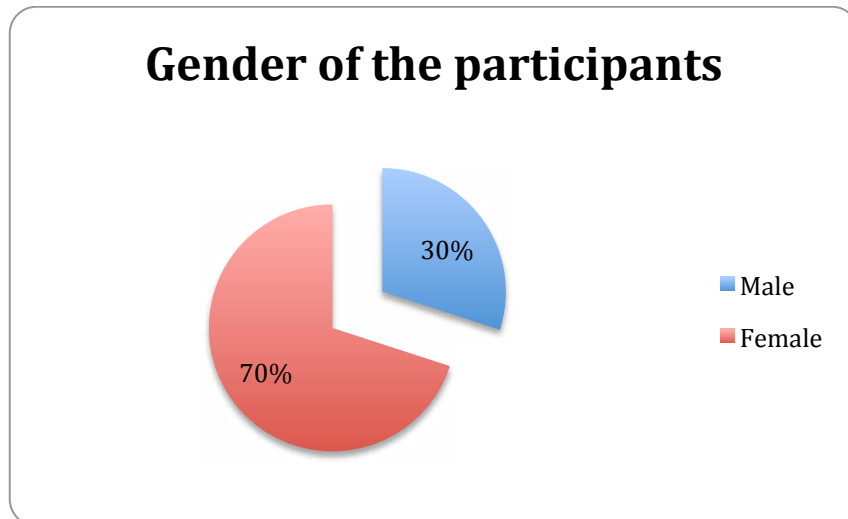


Diagram 5: Gender of the participants

Out of a total of 10 participants who participated in this study, 70% (n=7) were female and 30% (n=3) were male.

(ii) Age of the participants

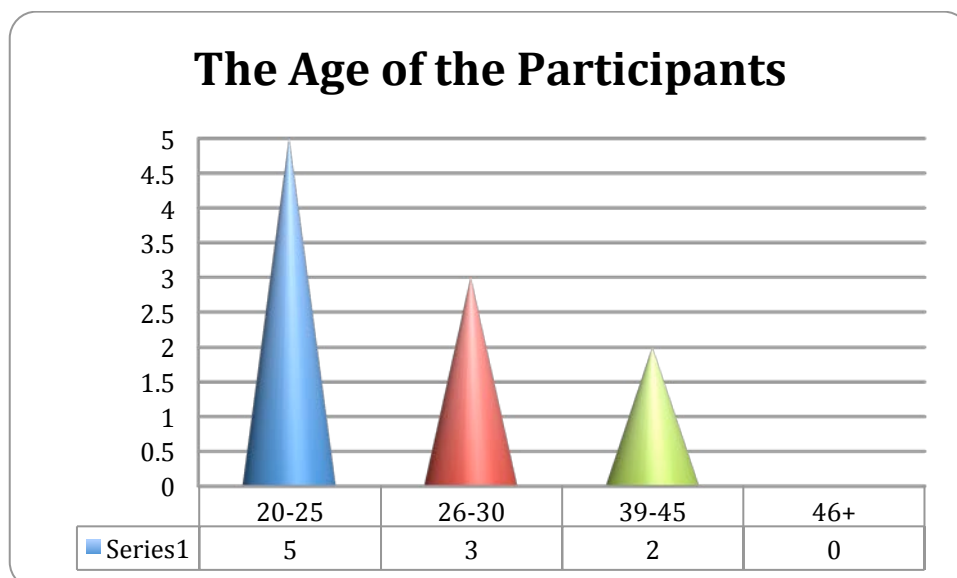


Diagram 6: Age of the participants

Diagram 6 reflects that out of the 10 participants who participated in the study, 50% (n=5) fell in the 20 to 25 year old age group. 30% (n=3) of the participants were between the ages of 26 to 30. 20% (n=2) of the participants were in the 39 to 45 year old age group. There were no participants from the age of 46 and above.

(iii) Type of community volunteer

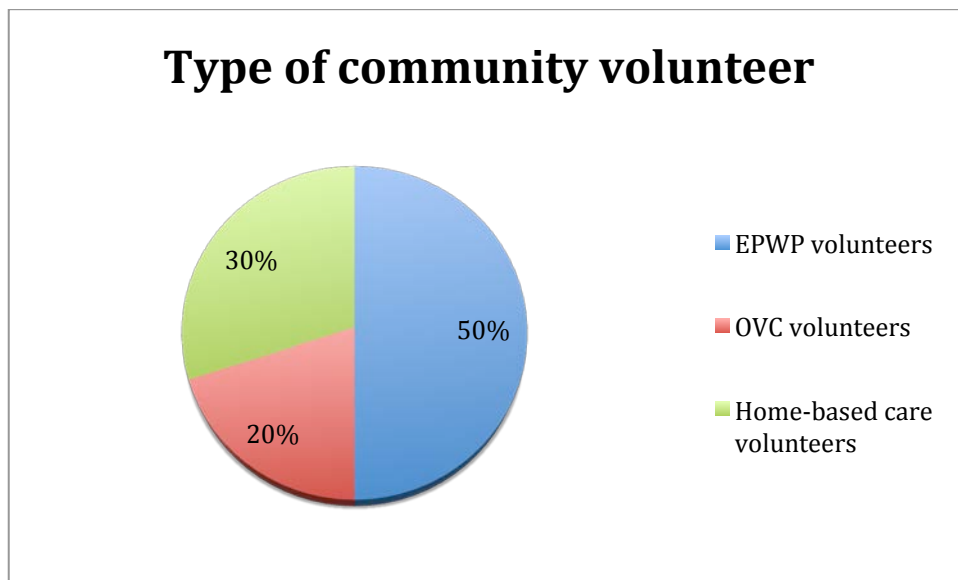


Diagram 7: Type of community volunteer

According to Diagram 7, 50% (n=5) of the participants who participated in the study was volunteers from the Department of Social Development (DSD), specifically the Expanded Public Works Programme (EPWP). 30% (n=3) of the participants represented volunteers working with Orphans and Vulnerable Children (OVC). 20% (n=2) of the participants represented Home-based Care volunteers.

(iv) Number of years of voluntary services

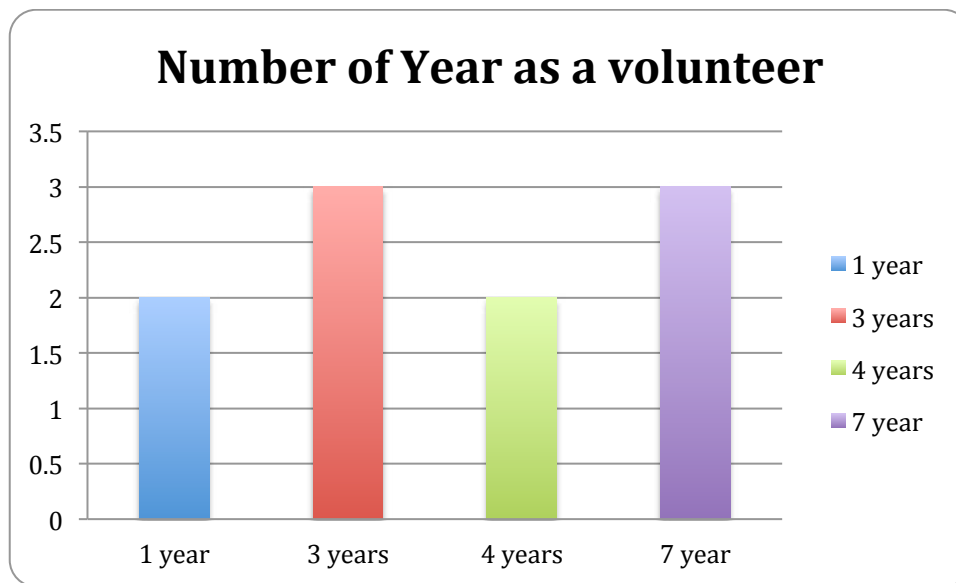


Diagram 8: Number of years of voluntary services

Diagram 8 indicates that 20% (n=2) participants who have participated in the study have been volunteers in community HIV and Aids initiative for at least one year. 30% (n=3) of participants who have participated in the study have been volunteers for 3 years. Furthermore, 20% (n=2) participants who have participated in the study have been volunteers for 4 years. 30% (n=3) of participants who have participated in the study have been volunteers for 7 years.

The next section will discuss the themes and sub-themes that emerged from data analysis of the focus group discussion with the community members.

3.7.4 Themes and sub-themes: community workers

During the data analysis process the researcher extrapolated themes and sub-themes for both social workers and community members. In order to voice the views, perceptions and experiences of the respective participants, verbatim quotations will be presented where applicable. This section will focus exclusively on the community members as participants. Although the focus group interview was conducted in isiZulu and Northern Sotho (Sepedi), only the translated English quotes are offered in this section.

Table 2: Themes and sub-themes: Community Members

Theme	Sub-theme
1. Delivery of social work services to communities	1.1. Meeting individual needs 1.2. Meeting community needs
2. Social workers' knowledge and experience	2.1. Relevant qualification 2.2. Knowledge of social issues
3. Promotion of social well-being of children and families	3.1. Roles of social workers <ul style="list-style-type: none"> ❖ The social worker as counsellor ❖ The social worker as advocate ❖ The social work as assessor of risk and of need 3.2. Access to social welfare services
4. Challenges faced by the communities	4.1. Poverty 4.2. Family disintegration

Theme 1: Delivery of social work services to communities

All nations need both social and economic resources to achieve national development goals. In this regard, social workers can generally mediate the process of development through enabling individuals, and society at large, to reach out to each other to cherish mutual assistance for self-fulfilment. Thus, social workers are mandated to mobilise and deliver a wide range of services to client systems (Rwomire, 2011:3). Rwomire (2011:4) further contends that social workers are expected to assist in restoring, maintaining and enhancing the social functioning of individuals and the society; this responsibility entails the development, procurement and/or delivery of resources and services to meet the many and varied needs of their clients. In this sense, social work can be seen to be playing a major role in national social development through empowerment of the most vulnerable and disadvantaged groups of people in many countries, both developed and less developed.

According to the DSD (2005:5) services in South Africa are rendered through the three broad programmes, namely: Social Security, Social Welfare and Community Development. These programmes should be integrated and enable the target groups to deal effectively with all social

issues, such as psychological stress, chronic poverty, food insecurity and other adverse social conditions.

Stone (2003:14) states strengthening bonding, bridging or linking relationships may be critical for building family and community capacity, linking families to services and supports, improving safety nets for prevention and early intervention, and for empowering family and community members.

Under the theme ‘delivery of social work services to communities’, two sub-themes emerged, namely meeting of individual needs and meeting of community needs by social workers.

Sub-theme 1.1: Meeting individual needs

HIV and Aids has profound effects on individuals. It is a medical condition that also has social, psychological, and economic implications (Hardy & Richter, 2006:85). Apart from the direct issues, such as ill health and unemployment, the impact of HIV and Aids is experienced through increasing social disintegration, such as family disorganisation, mental health problems, crime, substance abuse, commercial sexual exploitation, homelessness and children living and working on the street (DSD, 2004a:11). All these issues are the preserve of social work practice through activities (both statutory as well as non-statutory) that span from assistance in the application for the disability grants, planning for the future; bereavement counselling; supporting the physical and emotional aspects of placement of children into foster care; to counselling and rehabilitation for substance abuse. Their escalation has exponentially increased the need for social work services (Earle, 2007:22).

Community members highlighted their need for social workers to assist individuals and families with the following services:

“We need social workers in [our] communities so as to help children who have lost their mothers by applying on their behalf for foster care grants, child grants and food parcels.”

“They make sure those children that don’t have birth certificates at least [get them]...for grants also they need birth certificates before a child may get that grant... There is a process [to follow] before a child can get that certificate and then [things like] foster care grants.”

“The social workers help people by registering people in community programmes that will ensure that they earn income, such as public works programmes and other community development activities.”

Patel (2005:177) argues that in the view of the grave consequences of the HIV and Aids for the society, the developmental approach to social welfare and social work practice is the appropriate means of intervention. The International Federation of Social Workers (IFSW) (2012:4) further purports that social work makes a real difference in and has a significant impact on the lives of thousands of people. Social workers take action, they engage in securing human rights for individuals and communities, they work alongside people facing major crises and, when necessary, they take action to protect those who are most at risk.

Lombard (2009:377) argues that from the perspective of human rights, a developmental approach enshrines the right to social security, as indicated in the Constitution of the Republic of South Africa, 1996 which indicates in the Bill of Rights that everyone is entitled to social security and appropriate social assistance, including those that are unable to support themselves and their dependants. According to the DSD (2004b:16) given the high levels of income poverty in South Africa, social assistance plays a critical role in supporting children and families. Social grants on households are developmental in nature, and have positive impacts for reducing poverty, addressing the problem of hunger, providing greater household access to piped water, promoting job search and increasing school attendance (DSD, 2004b:2)

The focus now turns to the next sub-theme, namely meeting community needs.

Sub-theme 1.2: Meeting community needs

The social and economic effects of the HIV and Aids pandemic are complex and potentially devastating for families and communities (Brookes, Shisana & Richter, 2004, xi). The profound impact of HIV and Aids on communities is increasingly pointing to the importance of people working collaboratively to address the challenges associated with the pandemic. Such collaborative efforts require multi-sectoral, integrated responses, involving national and regional role players (Brouard, Maritz, Pieterse, Van Wyk & Zuberi, 2005).

Rwomire (2011:1) states that in working with communities, social workers work in cooperation with the community to identify the needs and to develop or improve services and systems to meet those needs. Social workers aim to improve socio-economic systems and generate resources so that more people in the community will have access to the services they need to function at the optimal level of social functioning. They usually work for, or with governmental, private, faith-based or community-based organisations to determine community needs, and to recommend and develop new or appropriate resources.

During the focus group discussion, community members highlighted the type of services provided by social workers to build the capacity of the poor to achieve self-reliance:

“Social workers in [our] communities help children who have lost their mothers by applying on their behalf for foster care grants, child grants and food parcels. Some children have no parents at all; they live [in] child-headed [families]. So, social workers are needed in order to give them support as regards food and to apply... and to help them apply [for] grants.”

“Social workers are there for counselling community members if they need to be counselled. They have their support groups and also teach people how to take care of people living with HIV. As well as facilitating their groups and income generating... like veggies... (inaudible).”

“Social workers bring as being... matters of... they make sure that children that don't have birth certificates at least [get them]... grants, also need birth certificates before a child may get that grant... There is a process [to follow] before a child can get that certificate and then [things like] foster care grants. So, those are [some of the] things they (social workers) help with so as to improve [children's] lives.”

The Bill of Rights laid a solid foundation for the creation of a developmental social welfare with the recognition of a range of socio-economic rights for everyone, including additional protection for children (Lombard, 2009:377). In particular Section 28(1) recognises children's rights to family care, basic nutrition, shelter, basic health care services, social services and protection (Giese, 2008:17). According to Lombard (2009:377) the right to both social assistance and development is captured succinctly in a statement by the Minister of Social Development at the Children's Act Conference (DSD, 2008:1): “Our responses to poverty are to empower people to access economic opportunities, while creating a comprehensive social safety net to protect the most vulnerable in our society.”

In line with its development agenda South Africa adopted the *White Paper for Social Welfare* (RSA,1997), which embraces a developmental approach to social welfare, intending to address poverty and inequity and promote social development by integrating social interventions with economic development (DSD, 2006a:2). The developmental approach provides the social welfare sector with the key to making a meaningful contribution to the alleviation of poverty and inequalities in society and to establishing social services professionals, such as social workers, as important social partners in achieving social development in an approach and strategy that facilitate and achieve integrated human, social, and economic development (Lombard, 2007:300)

The next section will discuss the second theme that was extrapolated from the data analysis, namely social workers' knowledge and experience.

Theme 2: Social worker's knowledge and experience

Social workers working in the HIV and Aids field have considerable experience working in programmes aimed at changing risky behaviours, such as encouraging injecting drug users to use sterile needles for injection drug use, educating persons practicing unsafe sex in how to properly use condoms, and in working with men and women on negotiating safe sex with their partners (Barker, 2003: 399).

Social work is considered a professional activity, which requires a particular body of knowledge, values and skills as well as a discrete purpose that guides one's practice activities (Kirst-Ashman & Hull, 2009:20). The range and scope of knowledge that effective social workers might use in the context of their service are wide and varied. It involves how to form relationships with clients, help them share information with you, define issues and problems, identify strengths, collect and assess information and identify and evaluate numerous alternatives for action (Barker, 2003: 399).

Participants elaborated to their perception of social workers' knowledge and experience by highlighting the following:

"Because social workers understand protocol, they play a role of directing and advising people of steps to be followed when faced with problems. You tell them your problem, and then they tell you how they can assist you, and then they deal with your matter."

"Ok, as for me, I think, social workers are understanding and polite people; they can make you open up and talk about things that you would otherwise not want to discuss with anyone else."

"Social workers have knowledge and skills to deal with practical issues of this kind. So, most of the time you find that when a person discovers that they are HIV-positive, the person just reckons that s/he is about to die. So, social workers are able to correctly explain to them that they won't be dying anytime soon. Volunteers can explain [just] here and there about HIV and how to overcome some hardships, but be deficient in some areas as we may find that they have questions and we don't have the answers, you see."

Under the theme 'social work knowledge and experience', two sub-themes emerged, namely the importance of relevant qualification and knowledge of social issues by social workers.

The next section will focus on the first sub-theme, namely relevant qualification of social workers.

Sub-theme 2.1: Relevant qualification

The Social Service Professions Act 100 of 1978, as amended, provides for the recognition of the profession of social work. Acquired knowledge and understanding of HIV and Aids through training and accreditation of social workers can help one to work more effectively with people affected by the disease and gain a valuable insight into the lives and needs of people living with HIV and Aids (Patel, 2005:251).

Osei-Hwedie and Rankopo (2008:207) purport that social workers provide basic health and social care to the communities, on home-based care, especially HIV and Aids and other terminal illnesses. They are also involved in other activities, such as organising community infrastructural development, public education on social and community health issues, orphan care and nutritional programmes. Such activities are consistent with the needs of the people and social workers qualify as legitimate providers.

During the focus group discussion the community members highlighted the fact that the social workers they are working with have relevant social work qualifications by expanding on the topic as follows:

“Yes, the social workers do have qualifications because those are trained people and they know which doors to knock at when someone is in need of something”.

“Since we are EPWP’s volunteers when we go to the field and encounter problems that we are unable to solve, that need someone professional, a, that’s where social workers play their role; they use their training and skills to deal with that issue or problem [with] the right person... because everything is supposed to follow protocol.

“

The Standards Generating Body (SGB) developed the standards for social work education for Social Work and these were registered with the National Qualification Framework with South African Qualification Authority (SAQA) (Patel, 2005:266). Along with social workers becoming professionals with a ‘protected title’, which only they could use, achieving degree status sent a clear signal about what social work is a profession made up of highly skilled, highly qualified practitioners, whose expertise continuously develops throughout their career (Healy & Meagher 2004: 250).

The next section will focus of the second sub-theme, namely knowledge of social issues by social workers.

Sub-theme 2.1: Knowledge of social issues

The South African society is highly unequal, with large numbers of very poor people living alongside a small but very wealthy upper class (Hochfeld, 2010:358). Along with poverty, HIV and Aids and a resultant surge in orphans and vulnerable children, discrimination, stigma, high levels of violent crime, rapid urbanisation, and violence against women and children in epidemic proportions are all social ills that social workers face in their daily practice in South Africa (Triegaardt, 2009:3).

During the focus group discussion the community members highlighted the social workers knowledge of social issues as follows:

“A social worker compiles a community profile of the area where they are working. They know the problems of that area... they know the community, their struggles, everything. They establish the problems of the area through community profiles. They meet with managers and stakeholders so as to establish the situation in the community.”

“Yes I do think that they have enough knowledge, because in everything that they do, they first do their research and then obviously counting the fact that they have [requisite] training in what they do. So, I think they know their field and everything relevant thereto.”

Social work is a professional approach to ameliorating social problems. It is generally understood as a helping profession that utilises professionally qualified personnel who use its knowledge base to help people tackle their social problems (Mupedziswa, 2005:277). Social work is a profession, which seeks to help and empower vulnerable groups in society such as women, persons with disabilities, children and the elderly as well as people living with HIV and Aids (Chitereka, 2009:145).

Gray and Fook (2004:640) argue that South Africa social development provides the macro policy perspective within which social workers are being asked to transcend traditional boundaries and make an impact on problems of mass poverty, unemployment and social deprivation through greater use of diverse social work methods, such as advocacy, community development, empowerment, consultation, networking, action research, and policy analysis. In short, the social development perspective challenges social workers to revisit their values relating to social justice and to redirect their services to the poor by finding effective ways of addressing poverty.

The next section will focus on the third theme that was extrapolated from data analysis, namely promotion of social well-being of children and families.

Theme 3: Promotion of social well-being of children and families

Axford (2009:370) purports that the focus of any intervention should be on needs, usually involving assessing the needs of children and families within specific communities, and on improving the quality of life of children, through a range of initiatives and interventions.

Social work should identify the individuals and groups in society that are most vulnerable and seek to strengthen their potential and capacity by providing protection where this is warranted. Poverty hinders access to a number of services. Most people are vulnerable because of their socio-economic conditions and thus are more susceptible to HIV-infection. Improving the lives of poor communities is therefore necessary to ensure that people do not place themselves at risk of infection (Viljoen, 2005:82).

Social workers help people enhance or restore their capacity for social functioning. They work to change societal conditions that may hinder people from improving their social functioning (Zastrow, 2003:27). According to Morales and Sheafor (2004:35) "social work is the professional activity of helping individuals, groups or communities enhance or restore their capacity for social functioning and creating societal conditions favourable to that goal".

Proudlock and Jamieson (2008:35) argue that complex social challenges, such as widespread poverty, social fragmentation, a culture of violence, high rates of unemployment, and the HIV and Aids pandemic, means that there is an increase in the number of vulnerable children and families in dire need of social services. HIV and Aids has thus joined a host of other factors, including extreme poverty, conflict and exploitation, to impose additional burdens on the youngest and most vulnerable members of society, our children (Andrews, Skinner & Zuma, 2006:269). To assist children and households affected by HIV and Aids, there is thus a need to go beyond addressing only Aids-related problems; other causes of children's vulnerability cannot be overlooked. While not all orphaning is due to HIV and Aids, it remains the most visible, extensive and measurable impact of Aids on children (Bray, 2003:40).

Families are a central structuring element of society and are the social structure in which the majority of people live. The role of the family in modelling and developing social values is central to civil society. Parenting is an important influence in the development of values, such as reciprocity, trust and cooperation, which characterise social capital. Strengthening families and through the communities is an important goal of current public policy, that social capital data may help inform (Australian Bureau of Statistics, 2002:17).

The next section will focus of the roles of social workers as a first sub-theme to be discussed under the theme, Promotion of social well-being of children and families.

Sub-theme 3.1: Roles of social workers

The roles of social workers in South Africa are mandated by the *White Paper for Social Welfare* (abbreviated as White Paper) (RSA, Ministry for Welfare and Population Development, 1997). Within this mandate the White Paper challenges the welfare system to devise appropriate and integrated strategies to address the alienation and the economic and social marginalisation of the vast sectors of the population who are affected and infected by HIV, living in poverty and are vulnerable and have special needs (Lombard, 2008:25).

According to Patel (2005:148) in doing their day-to-day work, a social worker is expected to be knowledgeable and skilful in a variety of roles. The role that is selected and used should ideally be the role that is most effective with a particular client, in the particular circumstances. The literature indicates that there are a number of roles which social workers play and include the social worker as broker, mediator, educator, counsellor, facilitator and advocate (Kirst-Ashman & Hull, 2009:24).

The researcher highlights that the majority of participants believe that the extent to which social workers align themselves with any particular role may also assist them to respond appropriately the need of families and children. The community members further elaborated their perceptions of social workers' roles as follows:

❖ The social worker as counsellor

The counsellor role is applicable in social work with individuals, families and groups addressing issues of a psychosocial nature (Kirst-Ashman, 2003:90). Social workers are expected to provide support and guidance and inform their clients about their needs and rights, and counsel them about their choices and options in addressing their social and economic needs (Patel, 2005:149).

“They [social worker] also help people who need counselling, like heart to heart talk, when the two of you are talking and you tell her your problem, she keeps it as confidential.”

“Social workers also do traditional HIV and Aids counselling, where they provide you with pre and post counselling... they teach you about importance of counselling to help people to accept their status.”

The idea of the social worker as someone who works with or counsels individuals has been a recurrent and powerful notion in social work throughout its history. It has also been closely associated with some of the key values of social work and in particular recognising the inherent worth of the individual and respecting the person. Counselling also appeals to those whose view of

social work as a whole is one in which helping or supporting individuals is a key component (Asquith, Clark & Waterhouse, 2005:18).

❖ **The social worker as advocate**

Social workers fight for the rights of others and work to obtain needed resources by convincing others of the legitimate needs and rights of members of society. Furthermore, social workers are particularly concerned for those who are vulnerable or are unable to speak up for themselves. Advocacy can occur on the local, provincial or national level (Suppes & Cressey-Wells, 2003: 280).

“Children don’t have birth certificates and others come from outside [South Africa] but social workers are then able to write a letter perhaps for children to be admitted in our after-care facilities because every child has a right to education.”

“We also work with a lot of foster children where they’ve never been told that something happened to their parents. That their parents died because of AIDS. We work with nurses and community health volunteers to help the family have open discussions about their status, and ensure that they access necessary health care and remain taking their treatment.”

Asquith, Clark and Waterhouse (2005:20) indicate that the social worker can also be viewed as an advocate on behalf of the poor or socially excluded. The advocacy role can also be played for individuals or groups such as families or communities and in some respects the advocacy role can also be associated with community work.

❖ **The social work as assessor of risk and of need**

Increasingly, social workers have been given a major role in the assessment of need and risk over a number of client groups. The concern has been that whereas assessment is an important task for social workers it may well be at the cost of other activities important for social workers such as fulfilling the casework role and working with individuals, families and groups. Similarly, the assessment role may also be seen to be associated with a policing or surveillance role (Garrett, 2004:58).

“Cause they [social worker] are trained, they can understand a person’s story and know that if it is like this [or that] this is this how I should respond. So without them I don’t think that the..., the information would be communicated appropriately. So they play a big role.”

“A social worker compiles a community profile of the area where they are working. They know the problems of that area... they know the community, their struggles, everything. They establish the problems of the area through community profiles. They meet with managers and stakeholders so as to establish the situation in the community.”

The researcher concurs with Schneider (2004:15) in that social workers need to extend their various roles to add to the linking social capital whereby community members are often connected to those who control key resources like government, employers, citywide financial institutions, or foundations to create trust-based relationships with the people that rely on these powerful organisations’ resources. At the same time, community-based people and institutions need to know how to work with those in power to build trust-based linking relationships.

The next sub-theme will focus on access to social welfare services.

Sub-theme 3.2: Access to social welfare services

Hosegood, Preston-Whyte, Busza, Moitse and Timaeus (2007:1249) state that households experience HIV and Aids in a complex and changing set of environments. These include health and welfare treatment and support services, HIV-related stigma and discrimination, and individual and household social and economic circumstances. There is an increasing level of destitution due to HIV and Aids. The numbers of families in need, people who are unable to meet their most basic needs, are growing continuously (Palitza, 2012:2).

The government alone cannot and should not take responsibility for the eradication of poverty and the social welfare needs of citizens. Partnership between government, the community and organisations in civil society should be strengthened, and individual and community responsibility for welfare and development is fundamental (Bak, 2004:85).

Community members agreed that social workers are needed to assist the families and children to access social welfare services. They expanded on this issue as follows:

“We need social workers in [our] communities so as to help children who have lost their mothers by applying on their behalf for foster care grants, child grants and food parcels.”

“Some children have no parents at all; they live [in] child-headed [families]. So, social workers are needed in order to give them support as regards food and to apply... and to help them apply [for] grants.”

Social welfare focuses, *inter alia*, on income protection, attaining livelihoods and minimum living standards, and the meeting of needs of populations at risk such as children, youth, women and families, the elderly, people with physical and mental disabilities and chronic illnesses including HIV and Aids (Patel, 2005:20).

A social development approach requires purposeful intervention from state and non-state actors to have a comprehensive commitment to people centered development (Midgley & Tang, 2001:246) to ensure that economic development (social security) can translate into social improvements and that the benefits of growth reach all people equally.

The next sub-theme will focus on the challenges faced by the communities.

❖ **Theme 4: Challenges faced by the communities**

Kalichman, Leickness, Simbayi, Kagee, Toefy, Jooste, Cain and Cherry (2005:1648) argue that communities living in poverty face multiple immediate threats to life, several of which are more pressing and immediate than HIV and Aids. It is therefore understandable that Aids does not command the attention of an imminent threat among many people in poverty. It can be daunting to consider Aids within the context of other social problems that themselves appear insurmountable. However, a unique feature of Aids relative to most every other serious personal threat of poverty including discrimination, poor education, unemployment, crime, and violence is that HIV infection can in many cases be controlled by an individual.

HIV and Aids has undermined social cohesion by straining households, kinship ties, and various community structures (Office of the Special Adviser on Africa (OSAA), 2003:21). In many communities, HIV and Aids adds to household costs, endangers livelihoods and food security, deepens poverty, increases the vulnerability of women and children, and leads to the adoption of coping mechanism such as the selling of household's assets, which can result in irreversible destitution (Kelly & Van Donk, 2009:3).

The next sub-theme will focus on poverty as the challenge faced by the communities due to HIV and Aids.

Sub-theme 4.1: Poverty

The majority of the world's HIV infections occur in communities ravished by poverty. Although HIV is a worldwide problem, it is the people living in the poorest communities who are feeling the effects most deeply. HIV thrives in situations of poverty, inequality and conflict. Poor people, particularly women, youth, children and elderly carers, are the most vulnerable, be it physiologically, economically and socially (Kalichman et al., 2005:1641).

Patel (2005:180) states that HIV and Aids can lead to the impoverishment of families due to loss of income cause by illness. It may lead to the loss of employment, loss of income of a breadwinner or members of household, or it may compromise the capacity of a household to earn a livelihood.

Community members expanded on the issue of poverty in their community by saying the following:

“We were trained on food gardening, and, have to go and tell or train children’s parents to have their own vegetable gardens in their backyards. Maybe they will sell the veggies to make some money or they will eat them... just to fight poverty.”

“We asked mothers and grandmothers to use some of the grants money to start small business of making vat cakes and sell them by the side of the road. This will help the family to survive much longer and not be hungry anymore.”

Poverty intersects with human rights at every possible juncture; both the civil and political and the economic, social and cultural rights of the poor are affected. One of the most basic human rights guaranteed to everyone is the right to life and to physical integrity; however, people living in extreme poverty may lack access to food and adequate shelter, face greater risk of disease, not registered with the Department of Home Affairs or do not register the birth of their children, and so may experience difficulties in obtaining social grants or registering their children for school (Ehrenreich, 2007:48).

United Nations Educational, Scientific and Cultural Organization (UNESCO) (2008:13) postulates that poverty reduces the chances of poor people to build social capital, since poor people do not form or participate in the same kind of organisations as the non-poor, and their non-participation in political and civic life is part of political poverty, which is so closely connected to other forms of poverty. The time constraint created by poverty reduces participation in networks organised around non-profit activities. Instead, networks of the poor are often found to be related to strategies for survival. While community workers and others do try to develop and strengthen networks among the local population that can reach into the broader community, the tendency is that the poorest groups do not become lasting members of these networks.

This next sub-theme will focus on family disintegration as the challenge faced by the communities due to HIV and Aids.

Sub-theme 4.2: Family disintegration

The effect of the HIV and Aids pandemic on families is reflected in the increasing numbers of orphans and child-headed households. More and more children are growing up with absent fathers, and in single parent households. Children growing up with one parent, or without their fathers, are

at a significant disadvantage. Poverty exacerbates the impact of family breakdown on children (South African Institute of Race Relations, 2011:1).

The HSRC (2004:11) stipulates that families in South Africa are subjected to tremendous changes and that they continue to experience difficulties in fulfilling their social roles, due to the challenges they are facing. Dysfunctionality within the family and the disintegration of family life impacts on the well-being of family members and leads to the moral decay in families, thus affecting the fibre of society. This is particularly so where there are high levels of poverty and unemployment.

Community members who participated in the focus group discussion expanded on the issues of family disintegration as follows:

“Some children have no parents at all; they live [in] child-headed [families]. So, social workers are needed in order to give them support as regards food and to help them apply for grants.”

“There is the problem of children who end up in the streets after their parents have died [from Aids] social workers helps them to get a good shelter, food, and to be able to go to school”.

Edwards, Franklin and Holland (2003:4) purport that families are often regarded as a wellspring of social capital generation. Changing family structures lead to a deficit of social capital, specifically in terms of increases in single mothers, ‘absent’ fathers, and mothers working outside the home, and of decreases in extended family households.

The next part of this chapter will focus on comparison of research findings between the social workers and community members.

Section C

3.7.5 Comparison of research findings

This section will compare and discuss the research findings from the focus group discussions with the social workers and community members, respectively. The comparison of findings will be presented as follows: key agreements between social workers and community members, key disagreements between social workers and community members, and noteworthy findings.

The research findings showed that there were some similarities and differences between what social workers perceived at their roles in enhancing social capital in the communities of

Johannesburg and Ekurhuleni Metropolitan Municipalities to manage HIV and Aids to be and what community members' understanding of social workers roles were.

3.7.5.1 Agreements between social workers and community members

The agreements are elaborate on in the following section.

❖ Social work knowledge base

The data from both social workers and community member revealed that social workers possess the knowledge and skills to work effectively with individuals who are living with HIV and Aids and those affected by the disease, including family members, friends, partners, and children. Social workers bring the unique skill of working with people within the context of their environment and advocating change that best meets the needs of clients (Schultz, 2013:1).

Both the social workers and the community members agree that social workers have both the skill and experience in providing HIV counselling and education services. Since social workers interface with people with HIV, they need to provide support for HIV medication adherence, appointment keeping, and lifestyle adjustments. Social workers are often required to advocate for people living with HIV and people living with Aids so that stigma is decreased and education and access to resources, including medications, is increased (Cox, 2002:364-365).

The two groups also agreed that joining a support group allows for information about coping with HIV to be freely shared in a safe environment. Most community-based Aids service organisations run a variety of HIV-related support groups.

❖ Promoting community participation

From the research findings it is clear that the community members values and appreciate services provided by social workers. What is also interesting to point out is that community member's trust of social workers, because of their education, training and experience. This is in line with the goals of community engagement which is to build trust, enlist new resources and allies, create better communication, and improve overall health outcomes of communities as successful projects evolve into lasting collaborations (Shore, 2006:32; Wallerstein, 2002:73).

❖ Challenges of working with communities

A primary issue arising from the impact of HIV and Aids on households is the ability and willingness of extended family members to assist in the care of remaining family members, especially children who have been orphaned. A prevailing assumption in many national HIV and

Aids policies is that "traditional" family structures can and will cope with the pressures caused by the epidemic. However, results from a number of field studies conducted on the subject cast doubt on this assumption is often referred to as the "extended" family has evolved into numerous forms across South Africa, bringing in turn numerous variations in coping with the impact of HIV and Aids (Tshoose, 2010:413).

❖ **Impact of HIV on families and children**

Both the social workers and community members agreed that the profound effect of HIV and Aids continue to wreak havoc on many households in South Africa. Some of its effects include the loss of a breadwinner, which in turn results in a decline in household income and obliges other household members to take care of sick relatives. At the same time, households have to reallocate their spending to devote a much greater share to health care, including not only medication and doctors' fees, but also supplies for home care (Haacker, 2004:45).

Social workers and communities acknowledged the difficulties households experience in responding to the epidemic. Problems such as discrimination, stigmatisation and uncertainty about the future may influence the care provided to a household member living with HIV and Aids stigmatisation is a deterrent to persons obtaining knowledge, getting help, and helping others. Gadling-Cole and Crewe (2001:4) purports that stigmatisation is a deterrent to persons obtaining knowledge, getting help, and helping others. Thus, the stigma of HIV has become a major player for the continued number of families infected and affected by HIV. Seeking help is in itself difficult for many.

❖ **Provision of social work support and services to communities**

The following section will focus of the services that are provided by the social workers in the communities.

• **Case work and meeting individual needs**

On an individual level, social workers provide a broad range of services and supports to those living with HIV and Aids. Schulz (2013:1) argues that social workers are familiar with community resources such as income support establishments, education/training programmes and career planning, short- and long-term disability programmes, housing, human rights legislation, addictions services, legal services, services and nutrition and food security. Social workers often work with those living with HIV and Aids to navigate these systems, while empowering clients to make informed decisions affecting their health.

- **Community work and meeting community needs**

Both social workers and community members concurs with Schulz (2013:1) that in the community context, social workers continue to advocate on behalf of those living with HIV and Aids through community organisation and policy development. They also provide education to reduce the incidence of HIV through harm reduction and health promotion. Social workers understand that determinants of health have an impact on a person's overall health and well-being. These determinants include social status and income, education, and social support networks. Social workers strive to eradicate social exclusion and poverty across all fields of practice.

3.7.5.2 Disagreements between social workers and community members

The following section will focus on the key disagreements between social workers and community members regarding social worker's services to communities.

- ❖ **Methods for providing holistic HIV and Aids support to communities and delivery of social work services to communities**

Social workers' focus

Social workers seem to be focused on social development approach, which is more people centered, and promotes citizen participation and strengthens the voice of the poor people (Patel, 2005:30). This focus was delivered in terms of two social work methods, that is group and community work. Their focus of development efforts seem to be more on human (education transfer) capital and the creation of social capital (development of trust/networks/norms among people). Some of the community support approaches which have been utilised by social workers that were interviewed emphasised many of the same principles, namely: empowerment of the poor and other marginalised groups, responsiveness to beneficiary demand, and enhancement of local capacities through provision of awareness raising activities (Helling, Serrano & Warren, 2005:i).

However, as much as the social workers planned and developed their programmes using the social development approach, they were often met with challenges from the communities, such as lack of commitment and participation to projects by community members.

Community members who were interviewed did not refer to social workers as providers of community development services, despite being involved in community projects that had support of social workers. Could the challenges experienced by social workers stem from the fact that community members are not aware of the developmental roles of social worker and that they still view social workers as providers of remedial social welfare services? Developmental social work

is defined as a practical and appropriate application of knowledge, skills and values to enhance the well-being of individuals, families, groups, organisations and communities in their social context (Patel, 2005:206).

According to the White Paper (RSA, Ministry for Social Welfare and Population Development, 1997:31) social welfare policies and programmes provides for cash transfers, social relief, and enabling and developmental services ensure that people have adequate economic and social protection during times of unemployment, ill-health, maternity, childrearing, widowhood, disability, old age and so on. Social welfare programmes of this nature contribute to human resource development by enabling impoverished households to provide adequate care for their members, especially children and those who are vulnerable. When such programmes are combined with capacity building, people can be released from the poverty trap.

It is important to understand that social development is not the same as, nor equal to, social security. As a planned process of change, social development incorporates both social security and developmental social services. It aims to promote the active participation of people in their own development and employ a multi-faceted, multi-sectoral approach that encourages partnership between government (at the different levels) and all other stakeholders in social welfare (Maistry & Vasi, 2010:6).

Community member's experience

The community members did not share the focus on community development by social workers. What transpired from the community member's focus group interviews was that social workers' services were more focused to social security services. Social security is meant to provide initial basic material assistance to poor, vulnerable and needy individuals. On the other hand, and as a long-term strategy, programmes under developmental social services discourages dependency, emphasises self-reliance and people's participation in their own social and economic development. It further provides support to individuals who slip the safety net of social security. The integration of social security and developmental social services are meant to contribute significantly to poverty reduction and social inequality from both national and provincial perspectives (Maistry & Vasi, 2010:6; Patel, 2005:124).

The community members noted social worker's various roles in terms of access and provision of the following social grants:

- Care dependency grant: for caregivers of children with disabilities;
- Child support grant: for caregivers of children up to age 18 years;

- Foster care grant: for non-related caregivers who are willing to provide a child with a secure and nurturing home environment.

❖ **HIV and Aids activities in communities**

This section will focus on the interaction for social workers and community members in the community.

Social workers' view

During the focus group interview the social workers alluded to the fact that they conduct on-going HIV awareness activities in the community, to educate the community members about HIV and Aids prevention and care for people living with HIV. Social workers need to strive to assist people with personal and social problems to improve their quality of life through empowerment, education and by supporting people and by helping them to change their social environment (IFSW, 2012:3).

Community member's view

According to the community members' the last training they received from social workers in relation to HIV was in 2009. There is also no significant interaction with the social workers in the community, due to reasons unknown to community members.

3.7.5.3. Noteworthy findings

The section will focus on the findings that the researcher finds to be of significant value to the study.

❖ **Social Capital as a concept**

The researcher discovered that both the social workers and the community members did not know the concept 'social capital' as it can be deemed a very new concept. However, what the data revealed is that there was recurring efforts by social workers to encourage community members to form networks that will enable people to act collectively on HIV and Aids-related matters.

❖ **Lack of policy knowledge by social workers**

During the interview with the social workers, it became apparent that social workers are not familiar with national and provincial social welfare policies and guidelines. The researcher found this aspect very interesting because, various government policies and frameworks mandate organisations on how to deliver social welfare/work services that are in line with national strategic plans. The researcher is wondering how social workers and organisations can be certain that the

services they are providing to the communities are supported and endorsed by government, and that these services compliments governments efforts is reducing the burden of social ills, such as HIV and Aids and poverty in communities?

While developmental social work is firmly established in national welfare policy and broadly endorsed by the social work fraternity, a significant knowledge gap exists about the theory and practice of the approach, which has hampered its translation into practice. Previous patterns of social work continue in present day practice, namely casework, statutory services, and institutional care (Patel & Hochfeld, 2012:10).

According to Gray and Mazibuko (2002:198) the social work profession must adapt to local conditions and take the lead in developing appropriate developmental intervention strategies, education programmes and solutions at both macro and micro practice levels. Social workers must become involved in political and policy related activities. They cannot continue to be passive implementers of social policies.

3.8 Conclusion

In this chapter, the researcher was exploring the views of social workers on the roles they play, or could perform, in enhancing social capital in the communities of Johannesburg and Ekurhuleni Metropolitan Municipalities to manage HIV and Aids; and to also explore the views of community members involved in HIV and Aids work on the role social workers play in enhancing social capital in the communities of Johannesburg and Ekurhuleni Metropolitan Municipalities to manage HIV and Aids.

This chapter presented an overview of the research methods, which were utilised to undertake the empirical research of this study.

Subsequently, this chapter focused on the analysis and interpretation of the research findings. Through this chapter the researcher presented the empirical findings from two groups of participants, namely the social workers and the community members. The empirical finding for social workers were presented along four key themes, namely social work knowledge base, methods for providing holistic HIV and Aids support to communities, promoting community participation and challenges of working with communities. The empirical finding for community members were also presented according to the four key themes, namely: delivery of social work services to communities, social workers' knowledge, promotion of social well-being of children and families and challenges faced by communities.

These findings were presented according to the views of social workers pertaining the roles they play, or could perform, in enhancing social capital in the communities of Johannesburg and Ekurhuleni Metropolitan Municipalities to manage HIV and Aids; and to also according the views of community members involved in HIV and Aids work pertaining the role social workers play, or could perform, in enhancing social capital in the communities of Johannesburg and Ekurhuleni Metropolitan Municipalities to manage HIV and Aids. Where possible, the findings were verified through literature control and interpreted from the theoretical framework underpinning this study.

The researcher conducted the comparison of the research findings between social workers, and community members was also undertaken to allow for themes and sub-themes as well as research findings to interact and engage in dialogue.

Generally, it appears that although the social workers and community members were not familiar with the concept of social capital, the research findings revealed that all social workers activities are pointing to their role in enhancing the social capital of communities they work with. The social workers are found by community members to be instrumental in linking, assisting and providing them with relevant services in managing HIV and Aids (“linking” social capital) and also agreed that social workers plays key role in building relationships between people and groups when they encourage community members who are living with HIV to become member/s of support groups or youth groups (“bonding” social capital) (See Chapter 2, paragraph 2.6).

However, the findings also highlighted some differences in terms of what services are received by community members compared to what services social workers reports to be providing to communities. The community members did not share the focus on community development by social workers. The community members’ data revealed that social worker’s services were more focused on social security services.

These differences did not seem to alter the notion that social workers are found by community members to be helpful in connecting, assisting and providing the community members with relevant services in managing HIV and Aids, thereby enhancing their social capital.

In the next chapter, the researcher will summarise the findings of the study, determine whether the goal and objectives of the study were reached, and provide recommendations on the roles of social workers in enhancing social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities.

Chapter 4

Conclusions and recommendations

4.1 Introduction

This chapter concludes the research report. In this final chapter, the researcher will outline the research results with regard to the role of social workers in enhancing social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities. In presenting the empirical findings of this study, the researcher will indicate whether the goal and objectives of the study were accomplished, and will thereafter answer the research questions. The researcher will then proceed to present the key findings, conclusions and recommendations. In terms of recommendations, the chapter will provide an overview of guidelines to social workers to build social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities. Lastly, the chapter offers some recommendations for future research.

4.2 Research goal and objectives of the research study

The **goal** of this study was to explore and describe the roles of social workers in enhancing social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities.

This goal was achieved through the objectives that are outlined below, and the description of their respective accomplishments.

The **objectives** of the study were as follows:

- **Objective 1:** To determine the roles of social workers in enhancing social capital to manage HIV and Aids according to international, regional and national policy.

This objective was achieved in Chapter 2 (see paragraph 2.4.1.) where key international, regional and national policies, treaties and frameworks that stipulate the role of social workers in enhancing social capital to manage HIV and Aids, were discussed.

The relevant **international policies** discussed, include the *International Law on Human Rights and HIV and Aids* (2002), and the *International Federation of Social Work manifesto on HIV and Aids* (2012).

The **regional policy** that guides social workers in enhancing social capital to manage HIV and Aids, is the *SADC HIV and Aids Strategic Framework (2009-2015)*.

In the **Republic of South Africa (national)**, social workers' role in enhancing social capital to manage HIV and Aids is specified in the following policies and documents: *The Constitution of the Republic of South Africa (1996)*; *the HIV & Aids and STI Strategic Plans for South Africa (2012-2016)*; *the White Paper for Social Welfare (1997)*; *the Integrated Service Delivery Model for Social Services (ISDM) (2005)*; *the Social Development Plan on HIV and Aids (2009)*, and *the Policy on Financial Awards to Service Providers (PFASP) (2011)*.

- **Objective 2:** To explore the views of social workers about the roles they play, or could perform, in enhancing social capital in the communities of Johannesburg and Ekurhuleni Metropolitan Municipalities to manage HIV and Aids.

This objective is comprehensively addressed throughout Chapter 3 (see Section A) under Themes 1 and 2 and related sub-themes. Following the data analysis process, the presentation and interpretation of the research findings highlight the roles of social workers in enhancing social capital in the communities to manage HIV and Aids. These findings were interpreted from social development and social capital as theoretical frameworks. Thereafter, a range of conclusions are reached regarding the role of social workers in enhancing social capital in the communities of Johannesburg and Ekurhuleni Metropolitan Municipalities to manage HIV and Aids. These conclusions are presented in Chapter 4 (see paragraph 4.4).

- **Objective 3:** To explore the views of community members involved in HIV and Aids work about the roles social workers play, or could perform, in enhancing social capital in the communities of Johannesburg and Ekurhuleni Metropolitan Municipalities to manage HIV and Aids.

This objective is addressed throughout Chapter 3 (see Section B) under Themes 1 and 2 and related sub-themes. Following the data analysis process, the presentation and interpretation of the research findings highlight the view of community members regarding the roles of social workers in enhancing social capital in the communities to manage HIV and Aids. These findings were interpreted from social development and social capital as theoretical frameworks. The findings resulted in a range of conclusions regarding the views of community members regarding the role of social workers in enhancing social capital in the communities of Johannesburg and Ekurhuleni Metropolitan Municipalities to manage HIV and Aids. These conclusions are presented in Chapter 4 (see paragraph 4.4).

- **Objective 4:** Based on the outcomes of the study, to draft guidelines for building social capital in communities towards the management of HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities. Furthermore, recommendations for further social work research will be made.

Chapter 4 (see paragraph 4.4) outlines the guidelines for building social capital in communities towards the management of HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities. Subsequently, the recommendations for further social work research are also presented in Chapter 4 (see paragraph 4.5.).

The study aimed to answer two **research questions**, namely:

- 1) Based on the views of social workers, what are the roles of social workers in enhancing social capital in the communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities?
- 2) Based on the views of community members, what are the roles of social workers in enhancing social capital in the communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities?

The research findings between the social workers and community members indicated strong correlation on their views regarding the role of social workers in enhancing social capital in the communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities (see Chapter 3, Section C). The answers to the questions are also highlighted below.

In response to **Question 1**, namely: Based on the views of social workers, what are the roles of social workers in enhancing social capital in the communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities? The following roles were identified:

- Since HIV and Aids is still a sensitive subject to individuals, families and communities, social workers provide critical services in the identification and assessment of situations in which relationships between people and social institutions need to be initiated, enhanced, restored, protected and terminated;
- Social workers play a crucial role in the promotion of social change, problem solving in human relationships, and the empowerment and liberation of people to enhance their well-being;
- Social workers help clients who become eligible for a variety of services designed to improve their economic, social and/or health functioning, thereby working towards improving the clients' quality of life or standard of living;

- Social workers provide essential leadership and support in mobilising community response to HIV and Aids. Social workers have shown an unbending resolve to work towards wellness, to openly engage the communities, and to assert and protect fundamental rights;
- Social workers strengthen bonding, bridging or linking relationships that are critical for building family and community capacity, linking families to services and supports, improving safety nets for prevention and early intervention, and for empowering family and community members;
- Social workers increasingly become involved in HIV and Aids primary prevention efforts through education, due to the fact that medical intervention alone is not sufficient to prevent new infections;
- Social workers strive to develop special kinds of local communities that promote people's health and well-being and, at the same time, contribute to sustainable, integrated social and economic development; and,
- Combating stigma through education and awareness raising remains an important task for social workers around the globe, as stigma is perceived as a major limiting factor in primary and secondary HIV and Aids prevention and care, and has interfered with voluntary testing and counselling, and access to care and treatment.

In response to **Question 2**, namely: Based on the views of community members, what are the roles of social workers in enhancing social capital in the communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities? The following roles were identified:

- Since HIV and Aids have profound effects on individuals, social workers play a critical role in assisting in the application for the disability grants, planning for the future; supporting the physical and emotional aspects of placement of children into foster care; and bereavement counselling;
- The role of social workers is to assist in restoring, maintaining and enhancing the social functioning of individuals and the society; through the development, procurement and/or delivery of resources and services to meet the many and varied needs of the community members;
- Social workers' role is of assisting people in the application of social security and appropriate social assistance, to those that are unable to support themselves and their dependants;
- Social workers' role is furthermore to work in cooperation with the community to identify the needs and to develop or improve services and systems to meet those idiosyncratic needs;
- Social workers are involved in community activities, such as organising, public education on social and community health issues, orphan care and nutritional programmes;

- Social workers, in their role as counsellors, provide support and guidance and inform community members about their needs and human rights;
- The social worker, in their role as an advocate, stand up for the those who are vulnerable or are unable to speak up for themselves;
- The social worker, in their role as assessor of risk, continues to assess the needs and risks of community members; and,
- Social workers are needed to assist the families and children to access social welfare services.

After answering the two research questions briefly, the attention of this chapter shifts to the key findings of the study, and proceed with conclusions and concomitant recommendations.

4.3 Key findings, conclusions and recommendations

The key findings, conclusions and recommendations that are listed below are the results of three sources of data, namely the literature review, and focus group interviews with both social workers and community members.

4.3.1 Literature review

(i) Key findings: literature review

- HIV and Aids is a global pandemic that affects individuals, families, and entire communities around the world and has profound social and economic implications, more especially in Southern African countries, including South Africa.
- HIV and Aids is increasingly being recognised as not merely a medical problem, but a social problem as well.
- Gauteng is the province with the third highest prevalence in South Africa. Ekurhuleni has the highest number of people infected with the HI-virus in the Gauteng Province (Gauteng Provincial Government, 2011:1).
- Social workers are using their skills and knowledge to proactively provide critical services to individuals, families, and communities affected by HIV and Aids.
- Social workers, in working with communities to manage the impact of HIV and Aids, are guided by international, regional and national policies, frameworks and guidelines on how to effectively perform those roles.
- In pursuing their professional mission of working with HIV and Aids in communities, social workers generally perform the following roles: educator, enabler, mediator, advocate, lobbyist, and service broker.

- Worldwide, women constitute more than half of all people living with HIV and Aids. South Africa, in particular has the highest number of women infected with HIV in the world (Statistics South Africa, 2011).
- Social capital has been linked to improved child development and adolescent well-being, increased mental health, lower violent crime rates and youth delinquency, reduced mortality, reduced HIV incidence, less mental health problems, less substance use, and higher perceptions of well-being and self-rated health.

(ii) Conclusions: literature review

Based on the literature review, the researcher concludes the following:

- The eradication of HIV and Aids represents one of humanity's greatest challenges, one that requires cooperation and comprehensive collaboration between scientific disciplines, governments, social institutions, the media, the social work profession and health care professions, and the general public.
- Medical advances alone, no matter how effective in reducing the number of Aids-related deaths, cannot decrease the number of new infections.
- The high prevalence of HIV and Aids in the Gauteng Province in general, the Ekurhuleni metropolitan council in particular, has significant governance and developmental challenges for the country and council. The pandemic has a profound impact on municipalities, constraining their capacity to effectively promote and advance a developmental agenda.
- Given the high incidence of HIV in South Africa, social workers' professional skills and knowledge enable them to take an active stance to mitigate the overwhelming psychological and social effects, including the inequality of access to medical care and the lack of education and prevention.
- Knowing the law will empower social workers, to use their knowledge and skills to function more effectively, ethically, actively, and legally in all practice settings.
- The social work profession, through their various roles, promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being.
- Gender-based inequalities, for example in education, income and employment, limit the ability of girls and women to protect their health. Women's own needs for health care are often poorly addressed, especially in rural and poor communities.
- Social capital building strategies could be used to facilitate coordination and cooperation, and are essential ways to achieve better social, economic and health outcomes and sustainable development.

(iii) Recommendations: literature review

- South Africa need to intensifying efforts to eliminate HIV and Aids through the implementation of progressive laws and policies in support of the multisectoral response to HIV. The wide delivery of effective behaviour change strategies is central to reversing the global HIV pandemic.
- Efforts should be continued, through rights-based, evidence-informed, and community-owned programmes that use a mix of biomedical, behavioural, and structural interventions, prioritised to meet the HIV prevention needs of particular individuals and communities, to have the greatest sustained impact on reducing new infections.
- Municipalities should continue to implement strategies highlighted in the *Framework for an Integrated Local Government Response to HIV and Aids* (Department of Provincial and Local Government, 2008:4).The Framework serves to guide municipalities and provincial government on how they can respond, in partnership with other stakeholders using the Integrated Development Plan/Planning (IDPs), as tools for planning, integration and coordination between and across all spheres of government to manage HIV and Aids (Department of Provincial and Local Government, 2008:4).
- Social workers should continue to utilise their skills and knowledge in the process of social mobilisation, whereby social partners and allies are brought together to determine and provide for communities felt needs and demand government to resume in the provision of essential HIV and Aids services, consisting of both preventive HIV interventions, as well as treatment and care services to those who need them.
- It is recommended that social workers continue with their professional development to enable them to be in a unique position of understanding major social needs, policies and legislation in the South African social welfare context and the social worker's role and contribution to society in general.
- Social workers should continue to strive for prevention and elimination of social problems from a social development and a social justice perspective, by utilising their specialised roles to investigate and address the deep-rooted causes of social problems, such as poverty, unemployment, illness, anti-social behaviour and other social inadequacies.
- It is recommended that broader strategies such as poverty reduction, increased literacy, training and education, and increased opportunities for participation in economic, social and political activities be extended to women and girls in order to improve their health.
- The researcher recommends that interactions between people living with or affected by HIV, social workers, policymakers, health service providers, and other influential groups (e.g., police/law enforcement, religious leaders, media), be continued and/or encouraged to ensure continuous development of programmes and policies that

enhance levels of social capital in low health communities to improve health seeking behaviours amongst community members and increase resilience to HIV and its impacts in communities.

4.3.2 Social workers

The next section will focus on the key findings, conclusions and recommendations from the focus group interview with **social workers**.

(i) Key Finding: social workers

The key findings from the focus group interview with social workers are listed below:

- The research findings established that the social workers are not familiar with the national and provincial social welfare policies and guidelines that are supposed to guide their work with communities, specifically within the field of HIV and Aids.
- The concept social capital was not known to both the social workers and the community members. However, the research findings revealed that all social workers activities are pointing to their role in enhancing social capital of communities they work with.
- Social workers possess the knowledge and skills to work effectively with individuals who are living with HIV and Aids and those affected by the disease, including family members, friends, partners, and children.
- Social workers, through linking community members with the South African Social Security Agency (SASSA), who pay out social grants, assist individuals and communities who are facing difficulties, inequality and injustice in society. These services are based on the principle of respect and protection of human rights of community members by social workers.
- Social workers focus predominantly on service delivery, care and support, such as counselling, support for people living with HIV, promoting community care, support groups, support to families and caregivers, nutrition support, and support to orphans and vulnerable children. On the other hand, social workers are hesitant to address and challenge barriers, inequalities and injustices that exist in society; and as a result hinder the self-reliance and capital development of community members by not encouraging communities and individual people define their own development according to their own needs, values and aspirations.
- There is no quick or easy fix for most community development challenges. It is not easy for communities to achieve their goals with regards to building self-reliance and developing

social capital, progress is achieved through the involvement of all stakeholders, including community members, social workers, government and the beneficiaries of services.

- Intervention strategies used by social workers in their daily work involved the provision of counselling services, referrals to relevant service providers as income support establishments, career planning, short- and long-term disability programmes, housing, as well as community empowerment through education and capacity building.

(ii) Conclusions: social workers

The following conclusions are drawn from the key findings pertaining to the social workers:

- Law and policy can be a daunting subject because it cannot be falsified. Lack of, or a limited knowledge of legislation and policy, can lead social workers to use knowledge of the law in ways which further oppress and disempower service users, or exercise it in a manner which misinforms service users of their entitlements, protect their rights and enhance their quality of life.
- Social workers lack of knowledge regarding social capital as a concept, could lead to missed opportunities to build social networks and encourage interactions that could enable people to build communities, to commit themselves to each other, and to knit the social fabric.
- Given the high incidence of HIV in South Africa, social workers' professional skills and knowledge enable them to take an active stance to mitigate the overwhelming psychological and social effects, including the inequality of access to medical care and the lack of education and prevention.
- HIV and Aids is still a priority in the work that the social workers do with communities.
- Social workers serve not only to respect the individual rights of all, but also have more responsibility to safeguard and promote the fundamental rights of individuals to make social service and systems embody the principles of social justice.
- Despite having adopted a developmental approach, which means the integration of social intervention with economic development, social workers in the NGO sector continue rendering welfare services and link people to social security instead of focusing on economic development initiatives, such as cooperatives, social entrepreneurship and income-generating projects.
- Traditional methods of care and support are put under tremendous pressure as families lose their capacity to cope. Social workers are at the forefront of the battle to provide effective care, counselling and support to those affected, and to develop new interventions to prevent the spread of HIV infection.

(iii) Recommendations: social workers

The following section highlights, based on the key findings and conclusions, the recommendations for social workers in building social capital in communities towards the management of HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities.

- Organisations that are employing social workers should include relevant policies, guidelines and other relevant statutes as part of their orientation programme. These documents must be signed for by social workers as been received and they must act as their frame of reference when providing services to community members that involves protection their human rights and enhancing their quality of life, amidst the challenges faced by HIV and Aids in the community.
- It is recommended that social capital as a concept should be emphasised in the tertiary education curriculum of social workers. Social workers should endeavour to overcome their lack of knowledge of and confidence in the social development approach, through Continuing Professional Development (CPD) training and workshops with regards to social capital development.
- In the provision of services social workers should continue to use the primary and secondary methods of social work practice, including casework, group work, community work, research and administration, the variety of skills, techniques and processes in the engagements with the community members. They should also challenge themselves to utilise these methods to promote the economic development of the clients that they serve.
- To avoid a resurgence of the HIV and Aids epidemic in South Africa, HIV prevention efforts need to be urgently and continuously strengthened and sustained by social workers through CPDs in the knowledge as well as skills in dealing with HIV and Aids and confronting/addressing personal stereotypes. Training should address the stigma, misconceptions and lifestyle skills among other challenges related to HIV and Aids intervention.
- It is recommended that social workers transition from needs orientation to human rights affirmation, whereby the needs of their clients are met not as a matter of choice, but as an imperative of basic justice.
- The researcher recommends that the NGO sector should include developmental social work as the fundamental purpose of social work service delivery. Development social work is an integrated, holistic approach to social work and social capital building which incorporates identified themes critical to practice such as empowerment, diversity, the meeting of human needs (Midgley & Conley, 2010:xiii). This will certainly facilitate social workers taking on a more active role in engineering economic and welfare transformation

leading to equitable social structures, which can offer people security and development while upholding their dignity.

- In the current situation whereby families are unable to provide adequate care and support to other family members, it is recommended that there be coordination and open discussions of support and interpersonal networks that cross the boundaries between the government and civil society between NGO-based social work and other community-based service providers, like the Faith Based Organisations and other relevant Government Departments responsible for mitigating HIV and Aids, to provide additional support.

4.3.3 Community members

The next section will focus on the key findings, conclusions and recommendations from the focus group interview with community members.

(i) Key findings: community members

The key findings from community members are listed below:

- Community members value and appreciate services provided by social workers, they trust social workers, because of their education, training and experience.
- The community members did not share the focus on developmental social work by social workers. Social work is seen by the community members as a synonym of social welfare, whereby it is associated primarily with and for people who are marginalised, at risk, or people in need.
- HIV and Aids continues to undermine social cohesion by straining households, kinship ties, and various community structures.
- Social workers are helping communities to deal with the profound impact of HIV and Aids by increasingly encouraging people to work collaboratively to address the challenges associated with the pandemic.
- Community members describe social workers as helpful in connecting, assisting and providing them with relevant services, such as access to education, counselling, basic nutrition, shelter, basic health care services, social services and protection in managing HIV and Aids. This leads to enhanced social capital, whereby collective structures within the community are facilitated through coordination and cooperation for mutual benefit for community members.
- Social work is known for its critical and holistic approach to understanding and intervening in social problems, such as mass poverty, unemployment and social deprivation. These

leads to reduced social capital whereby the willingness of people to help each other overcome the hardships is compromised.

- The roles of social workers in enhancing social capital in the communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities, have been identified under Objective 4.

(ii) Conclusions: community members

The following conclusions are drawn from the key findings of community members:

- The social workers are an asset to the communities. In the provision of services, social workers discharge their services with integrity, commitment and exercise their professional discretion to the best interest of the client as required by the professional body (South African Council of Social Services Professions).
- Social work as a synonym of social welfare is an incorrect perception. The social work profession has adopted empowerment and well-being of individuals, groups and communities as its core practice and is to be grounded on social justice, guided by perspectives that are developing and critical, nurturing people's strength, and emphasising human diversity.
- Joint HIV prevention programmes between community members, social workers and other government departments, could lead to coordinated community response to HIV by mobilising financial, human and social capital.
- Enhanced social capital may help to prevent large-scale Aids epidemics within communities and to mitigate the impact of HIV and Aids in areas of high prevalence. Linkages have been made between levels of social capital and public health, it is reported that societies with high social capital and social cohesion may have better overall population health (Mohseni & Lindstrom, 2007:1380).
- Social workers are trained to help communities and individuals deal with the consequences the many social problems in different areas of their lives.
- Through the execution of their roles, social work professionals demonstrate commitment to social justice, protection of human rights and to the eradication of poverty and inequality.

(iii) Recommendations: community members

The following section highlights the recommendations, based on the key findings and conclusions, for community members in building social capital in communities towards the management of HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities.

- In the provision of services, and to remain important, social workers should continue to discharge their services with integrity, commitment and exercise their professional discretion to the best interest of the client as required by the professional body (South African Council of Social Services Professions).
- The social work profession should demonstrate to the public that it is not about social welfare, and it has the capacity to facilitate successful projects that are sustainable through developmental social work and social capital building among networks and communities from across different sectors in the society.
- The community members should continue to seek support from social workers, government departments and other stakeholders to start and promote local cooperative activities in response to the impact of HIV, as this will bring in and/or increase their income and help them to cooperate on economic projects. This could lead to higher degrees of mutual trust and support among community members (United Nations Division for Social Policy and Development [UNDSPD], 2010:1).
- It is recommended that communities should continue to work closely with social workers and other government departments to ensure that there is broad-based community participation in HIV prevention and in the identification of priority HIV prevention needs, in order to improve their overall health through social and economic development projects.
- Communities should continue to work very closely with other communities, social workers and other government officials in order to be strengthened in a way that will allow them to receive capacity and life skills that will help them tackle daily social challenges and to improve their lives, thereby increasing social capital.
- In the provision of services social workers should continue to use their various roles in accordance to the *Integrated Service Delivery Model* to encourage community's social and economic systems integration and collaboration.

4.4 Guidelines for social workers to building social capital in communities towards the management of HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities²

Based on the key findings, conclusions and recommendations of this study, the following guidelines are offered to social workers for building social capital in communities, working towards the management of HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities.

❖ Who does these guidelines apply to?

The guidelines apply to persons who are registered as social workers with the South Council for Social Service Professions (SACSSP), and are employed in by the Non-Governmental Organisations in the Johannesburg and Ekurhuleni Metropolitan Municipalities.

The guidelines are divided into five sections, which are linked to, and respond to the findings/ conclusions and recommendations based on the focus group interviews with social workers, community members and literature review.

A. HIV and Aids impact in communities

This section will address the following

- i. What is the prevalence of HIV in South Africa?
- ii. Why is the South African HIV and Aids prevalence so high?
- iii. The impact of HIV and Aids

Legal framework for social workers in South Africa

There are a number of legislation and policy governing social workers in their profession and in their work with HIV and Aids affected communities in South Africa. These laws and policies were developed for the following reasons:

- To ensure that social workers are qualified and equipped, through continuous and appropriate training, to administer legislation and policy effectively, correctly and consistently, in accordance with fundamental human rights and accepted values with a sense of account.
- To ensure that the clients of social workers are offered comprehensive, integrated, equitable, multidisciplinary and development-oriented services that complement and strengthen people's efforts, enhance their self-respect and independence and is responsive

² The extensive guideline is provided in appendix J

to the range of social, cultural and economic conditions in communities (RSA, Ministry for Social Welfare and Population Development, 1997:12).

Related legal frameworks are highlighted but not limited to the following:

a. South African Legal Framework: Legislation

- i. The Constitution of the Republic of South Africa, 1996
- ii. Social Service Professions Act, 1978 (Act 110 of 1978)
- iii. Social Assistance Act, 2004 (Act 13 of 2004)
- iv. South African Social Security Agency Act, 2004 (Act 9 of 2004)
- v. Non-profit Organisations Act, 1997 (Act 71 of 1997)
- vi. PFMA - Public Finance Management Act, 1999 (Act 1 OF 1999)
- vii. Children's Act, 2005 (Act 38 of 2005), as amended

b. South African Legal Framework: Policies

- i. White Paper for Social Welfare Service (1997)
- ii. White Paper on Population Policy (1998)
- iii. Policy on Financial Awards to Service Providers (PFASP) (2011)
- iv. Social Development Strategic Plan 2010 – 2015 (2009)
- v. HIV/Aids/STD Strategic Plan for South Africa, 2012-2017
- vi. Integrated Service Delivery Model for Social Services (2005).

c. Regional Legal Framework

- i. SADC HIV and Aids Strategic Framework (2009-2015)

d. International Legal Framework

United Nations International Law of Human Rights and HIV and Aids

International Federation of Social Work (IFSW): Social work manifesto on HIV and Aids

Human Rights

This section addresses the following.

- i. What are human rights?
- ii. The Bill of Rights
- iii. Types of Rights
- iv. The South African Human Rights Commission

Developmental approach to social work

Patel (2005:177) purports that in the view of the grave consequences of HIV and Aids for the society, the developmental approach to social welfare services and social work practice is the most appropriate means of intervention. HIV and Aids services should be mainstreamed through all welfare programmes. This means that all social services should have a HIV and Aids service component.

- Social and economic justice
- Empowerment
- Collective action to promote public benefit
- Distributive and liberatory values

The NGO sector should include a developmental social work approach in its service delivery. Developmental social work is a type of social work that affirms the profession's commitment to poverty alleviation and social inclusion, recognises the link between social and economic development, and construes welfare as an investment in human capital rather than a drain on limited resources (Gray, 2002:13). It is a type of social work which diverges from the residual, service-oriented approach directed at special categories of people in need to strengths-based, respectful people-centered approaches, and which place people in local communities at the center of development. Developmental social work shares ecosystems thinking about holistic interventions at different levels of activity, individual, family, group, community, policy, local, and global. The strengths perspective is ideally suited to this form of social work for at its core is a belief in people and their propensity to change (Gray, 2002:13).

Social capital development by social workers

This section is divided into 4 parts that form part of the process of social capital development for social workers, namely:

- i. Part 1: Rationale of social capital development
- ii. Part 2: Training workshop for social workers on “social capital as a concept”
 - Definition of social capital
 - Types of social capital
 - Levels of social capital
 - Why does social capital matter?
 - Benefits and importance of social capital
 - Determinants of social capital

- Dimensions of social capital theory
 - Disadvantage of social capital
- iii. Part 3: Proposed activities for social workers in building social capital of communities.
 - iv. Part 4: Potential interventions and strategies for social workers in building social capital.
 - v. Part 5: Critical enablers of social capital building.
 - vi. Part 6: Proposed activities for social workers in building social capital of communities.

The last section will discuss the recommendations for future research.

4.5 Recommendations for future research

It is recommended that:

- Similar research study be extended to other Metropolitan Municipalities in the Gauteng Province, in order to compare whether social workers in other municipalities can identify with the findings of the current study.
- Social capital as a community development tool for social work in the context of HIV prevention and management to be investigated further in the South African context, serving as a guide for social workers on the role they could play in the efforts to prevent and manage HIV infection at community level.
- To implement the guidelines originating from this study in practice and determine their strengths and limitations.

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APPENDIX A

Ethical Clearance



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Office of the Deputy Dean

2012-05-02

Dear Prof Lombard

Project: Enhancing social capital in communities to manage HIV and Aids: the role of social workers in the Johannesburg and Ekurhuleni Metropolitan Municipalities
Researcher: MP Sesane
Supervisor: Dr LS Geyer
Department: Social Work and Criminology
Reference Number: 10414925

Thank you for the application that was submitted for review.

The application was **approved (with comments)** by the **Postgraduate Committee** on 17 April 2012, and **approved** by the **Research Ethics Committee** on 26 April 2012. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research proposal and ethical clearance.

The Committee requests you to convey this approval to the researcher.

Sincerely

Prof John Sharp
Chair: Postgraduate Committee &
Research Ethics Committee
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: john.sharp@up.ac.za

APPENDIX B

Permission Letter: Afrika Tikkun



JOHANNESBURG Ground Floor, Eastwood, 57 Sixth Road, Hyde Park, Johannesburg, 2196, P.O. Box 895, Saxonwold, 2132.
Tel: +27 11 325 5914 Fax: +27 11 325 5911

CAPE TOWN Unit 1 & 2, Building 23 B, Waverley Business Park, Kotzee Road, Mowbray 7925, Cape Town, South Africa.
P.O. Box 34509, Grootte Schuur, 7937, Cape Town, South Africa. Tel: +27 21 448 0120 Fax: +27 21 447 1307

PATRON IN CHIEF Nelson Mandela

www.afrikatikkun.org Email: info@afrikatikkun.org

Dear Malebo Sesane

I acknowledge the receipt of your application for conducting research with Afrika Tikkun social workers.

It is with great pleasure for me to accept and welcome you at our organisation.

Looking forward to hearing from you soon.

Yours Truly
Rita Mkwanazi

Arekohaneng Cetre (Afrikat Tikkun)

General Manager

Rita Mkwanazi

Orange Farm

Tell: 087 741 1033

Cell: 073 582 9232 / 074 893 7936

Skype: Rita.mkwanaziA



EXECUTIVE DIRECTORS Bertie Lubner O.M.S.S. (Chairman),
Herby Rosenberg (Executive Deputy Chairman),
Marc Lubner (CEO), Arnold Forman (Financial Director)

CO-FOUNDER The late Chief Rabbi Cyril Harris OBE

PRESIDENT Chief Rabbi Dr Warren Goldstein

Public Benefit Organisation No. 18/1/13/2470 - Non Profit Organisation No. 021-8924NPO - Association incorporated under Section 21 No. 95/1552/08 - VAT No. 4910185539

CENTRES: Alexandria, Diepsloot, Inner City Hillbrow, Orange Farm, Deift, Mfuleni

INTERNATIONAL OFFICES: London New York Sydney

"A Jewish led initiative"

NON EXECUTIVE DIRECTORS Arnold Basserabie, Moonyeen Castle (Alt) U Boikin,
Ann Harris, Bongani Khumalo, Rabbi David Hazdan, Russell Loubser, Karuna
Mohan

PATRONS Raymond Ackerman, Yvonne Chaika Chaka, Ronnie Lubner, Gill
Marcus, Irene Menell, Eliot Ostin, Cyril Ramaphosa

APPENDIX C

Permission Letter: Abraham Kriel

110 Years of caring

Abraham Kriel Childcare
Abraham Kriel Kindersorg

my anker van hoop

my anchor of hope

Posbus / P.O. Box 60066
Langlaagte 2012.
www.abrahamkriel.org
admin@abrahamkriel.org
T: +27 (0)11 839 3058
F: +27 (0)11 839 1080

The Supervisor
University of Pretoria
Pretoria

13/02/2012

Re: Permission for Malebo Sesane for Research Study

To whom it may concern:

The undersigned Social worker grant permission to the above mentioned student to do her research from Abraham Kriel.

Regards
Pinkie Bodibe
Social Worker
011931 6034
084 4863 997

Directors/Direkteurs:
GW le Roux (Chairman); PG Mosen (Chief Executive);
JD de Villiers; I Fourie; SM Hay; MS Matgale; LB Motshwa (Vice-Chairman);
CM Ssefort; PM Strydom; DJ Taiwe
Board of Patrons/Raad van Beskermersone:
Judge CJ Claassen; LT Janse van Vuren; Ms J January; Mr B Dlamini; AKA Zola
Sinodale Kommissie vir die Diens van Barmhartigheid, NG Kerk Hoiveld.
Abraham Kriel Maria Kloppers Children's Home/Kinderhuis trading as
Abraham Kriel Childcare NPC/Abraham Kriel Kindersorg NPC.
Reg. no. 52/0001008; NPC no. 001-173.



Langlaagte
Maria Kloppers
Satellite homes
Johanna Malan ECDC
Emdeni Skills Development Centre
Community Services
Drop-in Centres & Home-based care

APPENDIX D

Permission Letter: Heartbeat



HEARTBEAT

Centre for Community Development

Section 21 Reg. no. 2000/001288/08, Reg. no. 015-242-NPO

25 October 2011

To whom it may concern

Heartbeat hereby grants permission to Me Malebo Sesane to utilize the Organization's Social workers for the required research study as indicated as:

Research Topic: Enhancing social capital in communities to manage HIV and AIDS: The role of social workers in Gauteng.

Goal of the study: To explore the roles of social workers in enhancing social capital in communities to manage HIV and AIDS in the Gauteng Province.

Heartbeat is in favor with the procedure of conducting focus groups which will centre on the following topics as indicated:

- The role of social workers in enhancing social capital to manage HIV and AIDS according to international, regional and national policy.
- The views of social workers about the roles they play, or could perform, in enhancing social capital in the communities of Gauteng to manage HIV and AIDS.

Criteria for the recruitment of social workers:

- Heartbeat's Social workers are registered with the South African Council for Social Services Professionals (SACSSP);
- Heartbeat's Social workers are involved in community HIV and AIDS work for at least one year, and are working in Tembisa, Vosloorus, Katlehong.

P.O. Box 72294
Lynnwoodridge 0040,
Tel +27 (12) 460 2345,
Fax +27 (12) 346 3090
e-mail: info@heartbeat.org.za
www.heartbeat.org.za

Yours faithfully



Me Sanneljie Marais
Programmes Manager



Me Yolandi Freudiger
CE Manager

Board Members: Prof. S. Steyn (née Pienaar, Executive Chairperson);
Mr. B. Greyling (Treasurer); Ms. C. Dyant; Mr. A. Raiz; Mr. J. van Tonder;
Mr. P. Seodi (COO)

APPENDIX E

Permission Letter: Amcare



Dear Malebo and supervisor

Receipt of your email, is hereby acknowledged.

I had a discussion with the Marihet, our Social Work Manager on 9 March 2012 and she explained your proposed project to me. According to the email you are requesting permission to have focus groups with HIV social workers employed at AMCARE.

One of the legs in which AMCARE delivers services is HIV & AIDS. We render a comprehensive HIV & AIDS service – starting with VCT, Home/Community-based care, facilitation of ARVs and compliance to ARVs. We also work with children infected and affected by HIV & AIDS, many of them having lost at least one parent in the pandemic.

AMCARE is willing and able to assist Ms Sesane with her research project.

A liaison person on our Social Work staff, Nadine Mason, Chief Social worker was identified. She will assist with arrangements re the focus groups .

Regular Research meetings between the Social Work Manager, the Chief Social worker, myself and Ms Sesane will be scheduled to ensure the smooth progress of the project.

Kind regards

Deacon Dr Vernon van Wyk
Chief Executive Officer
Date: 9 March 2012

APPENDIX F

Interview Schedule: Social Workers

1. Ethical Considerations

Ethical considerations that will guide the focus groups discussions are:

- i. The researchers will ensure that full information about the purpose and uses of participants' contributions is given.
- ii. The researcher will be honest and keep participants informed about the expectations of the group and topic.
- iii. Participants will be encouraged to keep the discussed information confidential.
- iv. The researcher will conduct her professional work with integrity and in such a way as to not jeopardise future research, the public standing of researchers or the ability of others to publish and promote the findings of their research.
- v. The rights and dignity of all those who are involved in by the research will be respected at all times.
- vi. The researcher will ensure, as far as possible, that the physical, social and psychological well-being of all those who take part in the research are not compromised.
- vii. The research assistant will uphold all of the above ethical considerations.

2. Group Rules

The following are some guidelines or "ground rules" to help establish the group norms:

- i. Before beginning the focus group, the researcher will obtain informed consent from the participants.
- ii. Maximum duration of a focus group interview will be 90 minutes.
- iii. Participation is voluntary and based on informed consent.
- iv. A counselor will be available after focus group interviews for those participant who may require emotional support.
- v. Participants should speak about their experience instead of generalizing ("I" instead of "they," "we," and "you").
- vi. When necessary, the focus group interview will be halted to allow participants to take breaks.
- vii. Only one person talks at a time.
- viii. No side conversations.
- ix. Confidentiality is assured. "What is shared in the room stays in the room."
- x. It is important to hear everyone's ideas and opinions. There is no right or wrong answers to questions – just ideas, experiences and opinions, which
- xi. are all valuable.
- xii. It is important to hear all sides of an issue, both the positive and the negative.
- xiii. It is important for women's and men's ideas to be equally represented and respected.
- xiv. Only those participating in the focus group will be allowed to contribute.

3. Social workers' biographical profile (will be recorded in writing before the focus group interview)

1. Age:.....
2. Gender:
3. Name of Employer :
4. Position:
5. Highest qualification:
6. Number of years in the Community HIV and AIDS field:

4. Focus Group Questions

1. What is your role as a social worker in working with communities to manage the impact of HIV and Aids?
2. How do policies (national, provincial, district level) guide your work with communities affected by HIV and Aids?
3. What is your understanding of social capital?
4. What opportunities can social workers identify in their communities to build social capital in the fight against HIV and Aids? [Bonding and bridging social capital will be explored.]
5. What challenges do you face in your work with communities with regards to mitigating the impact of HIV and Aids through social capital development?
6. How does social work interventions in building social capital take family disintegration in those communities worst affected by HIV and Aids, into account?
7. How do you involve community members in programmes and other integrated strategies to curb the depletion of household income earning capacity and of household savings and assets brought upon by HIV and Aids?
8. Which social work values, ethical principles, knowledge and skills do you implement when working with communities in the field of HIV and Aids?

APPENDIX G

Interview Schedule: Community Members

1. Ethical Considerations

Ethical considerations that will guide the focus groups discussions are:

- i. The researcher will ensure that full information about the purpose and uses of participants' contributions is given.
- ii. The researcher will be honest and keep participants informed about the expectations of the group and topic.
- iii. Participants will be encouraged to keep the shared information confidential.
- iv. The researcher will not disclose the identifying information of participants.
- v. The researcher will conduct the research with integrity and in such a way as to not jeopardise future research, the public standing of researchers or the ability of others to publish and promote the findings of their research.
- vi. The rights and dignity of all those who are involved in the research will be respected at all times.
- vii. The researcher will ensure, as far as possible that the physical, social and psychological well-being of all those who take part in the research are secured.
- viii. The research assistant will uphold all of the above ethical considerations.

2. GROUP RULES

The following are some guidelines or "ground rules" to help establish the group norms:

- i. Before beginning the focus group, the researcher will obtain informed consent from the participants in accordance with the procedures of the research protocol.
- ii. Maximum duration for focus group interviews will be 90 minutes.
- iii. Participation is voluntary and based on informed consent.
- iv. A counselor will be available after the focus group interviews for those participants who might require emotional support.
- v. The participants should speak about their own experiences instead of generalizing ("I" instead of "they," "we," and "you").
- vi. When necessary, the focus group interview will be halted to allow participants to take breaks.
- vii. Only one person talks at a time.
- viii. No side conversations.
- ix. Confidentiality is assured. "What is shared in the room stays in the room."
- x. It is important to hear everyone's ideas and opinions. There is no right or wrong answers to questions – just ideas, experiences and opinions, which are all valuable.
- xi. It is important to hear all sides of an issue – both the positive and the negative.
- xii. It is important for women's and men's ideas to be equally represented and respected.
- xiii. Only those participating in the focus group will be allowed to contribute.

3. Community members' biographical profile (obtained in writing before the focus group interview)

1. Age:.....
2. Gender:
3. Name of Employer :
4. Position:
5. Highest qualification:
6. Number of years in the Community HIV and AIDS field:
7. Number of years as an active volunteer in the field of HIV and Aids:

4. FOCUS GROUP QUESTIONS

1. Why do you think communities need social workers' support in their efforts to manage HIV and Aids?
2. What is your view on the role of social workers in helping communities to manage the impact of HIV?
3. What has been your experience in working with social workers on HIV and Aids projects?
4. What changes, if any, did the social worker bring about in your community through his/her involvement in HIV and Aids projects?
5. Why do you think that social workers have adequate knowledge of what they should do to support you in your projects?
6. What skills and/or vocational training have you received from social workers to help your community to manage HIV and Aids?
7. What type of services did you receive from social workers to curb the depletion of household income earning capacity and of household savings and assets brought upon by HIV and Aids?
8. When you think of HIV and Aids and your community. Complete the following sentence: "If I were the social worker ..."

APPENDIX H

Informed Consent: Social Workers



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Social Work & Criminology

Researcher: M.P Sesane

Contact number: 083 505 4140

Participant's identification details:

Informed Consent: Social Worker

- Title of the study:** Enhancing social capital in communities to manage HIV and Aids: The role of social workers in the Johannesburg and Ekurhuleni Metropolitan Municipalities.
- Goal of the study:** The goal of this study is to explore the roles of social workers in enhancing social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities.
- Procedures:** I the participant expect to be part of the focus group interview to be conducted by the researcher. The focus group discussion will centre around the following topics:
 - The role of social workers in enhancing social capital to manage HIV and Aids according to international, regional and national policy.
 - The views of social workers about the roles they play, or could perform, in enhancing social capital in the communities of the Johannesburg and Ekurhuleni Metropolitan Municipalities to manage HIV and Aids.

The focus group interview will be conducted to the maximum of 90 minutes. It will be scheduled on a time convenient for participants, and be held at a venue where the safety of participants will be ensured.

- Risks and discomforts:** There are no risks and/or discomforts associated with this study. If I experience any distress, I will inform the researcher. I expect the researcher to arrange a debriefing session for me with suitably qualified counsellor.

Department of Social Work & Criminology
University of Pretoria
PRETORIA 0002
Republic of South Africa

Tel: Number 00 27 12 420 2325/2030
Fax: Number 00 27 12 420 2093

www.up.ac.za

5. **Benefits:** I as a participant understand that there are no known direct benefits for me participating in the study. The results of the study will, however, be used to draft practical guidelines for social workers working in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities.
6. **Participants' rights:** The participant they may withdraw from participation in the study at any time and without negative consequences.
7. **Financial compensation:** I will receive no financial compensation from the researcher for my participation in the study.
8. **Confidentiality:** In order to accurately record what I say during the focus group interviews, a tape recorder will be used. The tape will be listened to by the researcher, research assistant and research supervisor. I understand that the data obtained will be kept confidential unless I ask that it be released. The result of the study may be published in the researcher's final document or scientific journal or may be presented at professional conferences. However, no information will be revealed, unless required by law.
9. **Queries:** If I have any questions or concerns, I can call Malebo Phillipine Sesane at 083 505 4140

I, the participant, understand my rights as a research participant and I voluntarily consent to participate in this study. I understand what the study is about, how and why it is being done. I am aware that the data will be stored for 15 years.

.....

Signature of Participant

Date

.....

.....

Signature of Researcher

Date

APPENDIX I

Informed Consent: Community Members



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Social Work & Criminology

Researcher: M.P Sesane

Contact number: 083 505 4140

Participant's identification details.....

Informed Consent: Community member

1. **Title of the study:** Enhancing social capital in communities to manage HIV and Aids: The role of social workers in Johannesburg and Ekurhuleni Metropolitan Municipalities.
2. **Goal of the study:** The goal of this study is to explore the roles of social workers in enhancing social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities.
3. **Procedures:** I the participant expect to be part of the focus group interview to be conducted by the researcher. The focus group discussion will centre around the following topics:
 - The role of social workers in enhancing social capital to manage HIV and Aids according to international, regional and national policy.
 - The views of community members, on what is the role of social workers in enhancing social capital in communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities?

The focus group interview will be conducted to the maximum of 90 minutes. It will be scheduled on a time convenient for participants, and be held at a venue where the safety of participants will be ensured.

4. **Risks and discomforts:** There are no risks and/or discomforts associated with this study. If I the participants experience and distress, I will inform the researcher. I expect the researcher to arrange a debriefing session for me with suitably qualified counsellor.
5. **Benefits:** I as a participant understand that there are no known direct benefits for me participating in the study. The results of the study will, however, be used to draft practical guidelines for social workers working in communities to manage HIV and Aids in Johannesburg and Ekurhuleni Metropolitan Municipalities.
6. **Participants' rights:** The participant they may withdraw from participation in the study at any time and without negative consequences.

7. **Financial compensation:** I will receive no financial compensation from the researcher for my participation in the study.

8. **Confidentiality:** In order to accurately record what I say during the focus group interviews, a tape recorder will be used. The tape will be listened to by the researcher, research assistant and research supervisor. I understand that the data obtained will be kept confidential unless I ask that it be released. The result of the study may be published in the researcher's final document or scientific journal or may be presented at professional conferences. However, no information will be revealed, unless required by law.

9. **Queries:** If I have any questions or concerns, I can call Malebo Phillipine Sesane at 083 505 4140

I, the participant, understand my rights as a research participant and I voluntarily consent to participate in this study. I understand what the study is about, how and why it is being done. I am aware that the data will be stored for 15 years.

.....

Signature of Participant

.....

Date

.....

Signature of a Researcher

.....

Date

APPENDIX J

Guidelines for social workers to building social capital in communities towards the management of HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities

A. Who does these guidelines applies to?

The guidelines apply to persons registered as social workers with the South Council for Social Service Professions (SACSSP), and employed by non-governmental organisations (NGOs) in the Johannesburg and Ekurhuleni Metropolitan Municipalities, specifically focusing on HIV and Aids-related services.

B. Guidelines structure

The guidelines are divided into five sections, which are linked, and respond to the findings/conclusions and recommendations of the study. The sections are as follows:

- The impact of HIV and Aids on communities
- Legal framework for social workers in South Africa
- Human Rights
- Developmental approach for social work
- Social Capital development for social workers

Section A: HIV and Aids in South Africa

- What is the prevalence of HIV in South Africa?

Sub-Saharan Africa is the region worst affected by HIV and Aids. HIV and Aids in South Africa is a prominent health concern; South Africa has the highest prevalence of HIV and Aids compared to any other country in the world, with 5.6 million people living with HIV, and 270,000 HIV-related deaths recorded in 2011 (UNAIDS, 2012).

- Why is the South African HIV and Aids prevalence so high?

Many factors contribute to the spread of HIV. These include: poverty; inequality and social instability; high levels of sexually transmitted infections; the low status of women, especially in a patriarchal society; sexual violence; high mobility (particularly migrant labour); limited and uneven

access to quality medical care; and a history of poor leadership in the response to the epidemic (AIDS Foundation of South Africa, 2012:1).

Research shows high levels of knowledge about the means of transmission of HIV and understanding of methods of prevention. However, this does not translate into HIV-preventive behaviour. Behaviour change and social change are long-term processes, and the factors that predispose people to infection, such as poverty and inequality, patriarchy and illiteracy cannot be addressed in the short term. Vulnerability to, and the impact of, the epidemic are proving to be most catastrophic at community and household level (AIDS Foundation of South Africa, 2012:1).

- The impact of HIV and Aids

The AIDS Foundation (2012:1) purports that the hardship for those infected and their families begins long before people die. Stigma and denial related to suspected infection causes many people to delay or refuse testing; fear and despair often follow diagnosis, due to poor-quality counselling and lack of support. Furthermore, poverty prevents many infected people from maintaining adequate nutrition to help prevent the onset of illness. Limited access to clinics, waiting lists for antiretroviral (ARV) drugs treatment programmes and eligibility criteria for access to ARVs mean that many people become seriously ill before accessing treatment (Nachega, 2009:3).

Loss of income and support when a breadwinner or caregiver becomes ill, and the diversion of household resources to provide care exacerbate poverty. The burden upon family members, particularly children and older people caring for terminally ill adults, and the trauma of bereavement and orphanhood compromise the physical and mental well-being of entire households, where 2,100,000 children orphaned due to AIDS in South Africa in 2011 (UNAIDS, 2011). This all happens in a society where the majority of children live in poverty, with 25% of the economically active population currently unemployed.

Section B: Legal framework for social workers in South Africa

There are a number of legislation and policies governing social workers in their profession and in their work in working with communities in South Africa when it comes to HIV and Aids-related services. These laws and policies were developed for the following reasons:

- To ensure that social workers are qualified and equipped, through continuous and appropriate training, to administer legislation effectively, correctly and consistently, in accordance with fundamental human rights and accepted values with a sense of account.
- To ensure that the clients of social workers are provided with comprehensive, integrated, equitable, multidisciplinary and development-oriented services, that will complement and

strengthen people's efforts, enhance their self-respect and independence and will be responsive to the range of social, cultural and economic conditions in communities (RSA, Ministry for Social Welfare and Population Development, 1997:12).

Applicable legislation

The following existing laws or parts thereof, can be regarded as constituting the legislative mandate for social workers working in communities within the field of HIV and Aids (Department of Social Development [DSD], 2009).

- Constitution of the Republic of South Africa, 1996

The Constitution is the supreme law of South Africa. Chapter 2 of the Constitution sets out the fundamental rights and freedoms of all persons. Laws and conduct that conflict with the Constitution are invalid. The Bill of Rights guarantees every person - including people affected by HIV and AIDS - the right to equality and to protection from unfair discrimination (Section 9).

The Constitution lays the foundation for an open society based on democratic values, social justice and fundamental human rights and is hailed worldwide as very progressive. It is the supreme law of the country and ensures government by the people under the Constitution. In other words, the Constitution is the highest law of the country and everyone must act according to its provisions and principles.

- Social Service Professions Act, 1978 (Act 110 of 1978, as amended)

This Act provides for the establishment of a South African Council for Social Service Professions (SACSSP) and to define its powers and functions; for the registration of social workers, student social workers, social auxiliary workers and persons practicing other professions in respect of which professional boards have been established; for control over the professions regulated under this Act; and for incidental matters.

The SACSSP developed guiding principles for social workers working with persons who are HIV and Aids infected or affected and the *Guidelines for Management of Clients with HIV infection or AIDS* (SACSSP, 2006:44).

SACSSP Principles:

- Cannot discriminate/ refuse to render services to HIV and Aids infected or affected clients
- Ethically obliged to maintain client confidentiality
- Maintain fundamental human rights
- Do not discriminate against infected or affected colleague (SACSSP, 2006:44).

Guidelines for the management of clients with HIV-infection or Aids

- Relationship must be based on mutual trust
- Social worker should commit to good professional and ethical practices
- Social workers should maintaining STRICT confidentiality regarding HIV Status of the client
- Social workers should encourage clients to be tested and treated if needed
- Social workers should obtain WRITTEN consent from clients before disclosure of status – even to colleagues/other professionals
- There is no legal clarity on divulging status to client's partners, but suggest that:
 - Social worker to counsel on prevention of HIV transmission
 - Social worker to offer and provide support to make this disclosure
- If refusal still evident, counsel on:
 - Professional's ethical obligation to disclose such information and requesting consent to do so, possibility of liability on delictual grounds for non-disclosure and negligent infection of another person criminal prosecutions that may be instituted
- Discuss consequences of disclosure:
 - Violence
 - Discord
 - Estrangement
- If the client still refuses, obtain this in WRITING as a last resort, and should there be clear and imminent danger to the well-being of significant others or the community at large, inform HIV-positive person of the professional's intention to disclose to those in immediate danger, unless HIV-positive person obtains an urgent court interdict to prevent the professional from doing so. Client should be given no more than three (3) days to respond (SACSSP, 2006:44).
- Social Assistance Act, 2004 (Act 13 Of 2004)

The Social Assistance Act aims to provide to everyone that has the right to have access to social security, including, if they are unable to support themselves and their dependants, appropriate social assistance, and obligates the state to take reasonable legislative and other measures, within the parameters of available resources, to achieve the progressive realisation of each of these rights (Department of Social Development, 2002:219).

The major shares of the social assistance are in HIV and Aids and poverty alleviation programmes. Funding in both these programmes consists mainly of the different conditional grants for HIV and Aids and the integrated social development services grant, which form part of the poverty

alleviation sub-programme – especially through the food relief programme, and through the extension of the child support grant. Further expansion of support to individuals and households affected and infected by HIV and Aids (Department of National Treasury, 2013:65).

- South African Social Security Agency Act, 2004 (Act 9 of 2004)

The Act provides for the establishment of the South African Social Security Agency as a schedule 3A public entity in terms of the Public Finance Management Act (PFMA). The principle aim of the Act is to make provision for the effective management, administration and payment of social assistance and service through the establishment of the South African Social Security Agency (SASSA) (DSD, 2008:1).

Simchowitz (2004:14) argues that, in the absence of comprehensive unemployment benefits or a universal basic income grant, a broader definition of disability is required, one which focuses not on the traditional understanding of disabilities, but rather on the social and environmental factors that are disabling. Within this framework, not only do people with HIV and Aids deserve social assistance, but importantly, all people living in poverty without access to education, to employment, and to healthcare deserve state support as mandated by South Africa's Bill of Rights.

- Non-profit Organisations Act, 1997 (Act 71 of 1997)

The Non-profit Organisations Act 71 of 1997 (NPO Act) was enacted to establish an administrative and regulatory framework within which non-profit organisations can conduct their affairs through a registration facility.

An NPO is defined, in terms of Section 1 of the NPO Act, as “a trust, company or other association of persons established for a public purpose and of which its income and property are not distributable to its members or office bearers except as reasonable compensation for services rendered” (Department of Social Development, 2011:1). NGOs and community-based organisations (CBOs) are collectively known as non-profit organisations (NPOs) (DSD, 2012:1).

In recognition of the invaluable contribution of the NPO sector to South Africa's economy and social well-being, government enacted the NPO Act in 1997 to create an enabling environment and align them with the Constitution. The activities of the sector have expanded from anti-apartheid petitions and protests to active service delivery initiatives in key areas of HIV and Aids, child care, poverty reduction, victim empowerment programmes, social crime prevention, economic development and policy advocacy (Khumalo, 2012:1).

- Public Finance Management Act, 1999 (Act 1 of 1999)

The Act is an extremely important piece of legislation as it promotes the objective of good financial management in order to maximise delivery through the efficient and effective use of limited resources. Its objective is to ensure accountability and the sound management of revenue, expenditure, assets and liabilities (DSD, 2010:20). Section 38 (j) outlines procedures to be followed before transferring any funds to service providers for services provided outside the DSD.

Departments should ensure that HIV and Aids priorities, policy developments and legislation with HIV and Aids implications are part of their budget documentation.

Conditional grant funds for the HIV and Aids services within the Home and Community-Based Care (HCBC) programmes flow to NGOs via both the Department of Health and DSD, and each NGO is responsible to comply with the PMFA for funds distributed to services providers. By implication, CBOs and NGOs in receipt of public funds are also called upon to comply with the Act and Guidelines.

- Children's Act, 2005 (Act 38 of 2005), as amended

The Children's Act provides for the establishment of children's courts and the appointment of commissioners of child welfare, the protection and welfare of certain children, the adoption of children, the establishment of certain institutions for the reception of children, and the treatment of children after reception. It was amended in 1996 to provide for legal representation for children, and the registration of shelters. It was further amended in 1998 to provide for the rights of natural fathers in respect of the adoption of children born out of wedlock, and for notice to be given. It was again amended in 1999 to provide for the establishment of secure care facilities and the prohibition of the sexual exploitation of children for commercial purposes (DSD, 2010:10).

This Act gives effect to these and other constitutional rights mainly through the provision of a range of social services for children and families. These include, amongst others: crèches and early childhood development programmes, and prevention and early intervention programmes (including home-based care for families affected by chronic illnesses such as HIV/AIDS, parenting programmes, and child and family counselling) (Prinslean, Proudlock & Jamieson, 2010: 3).

A child may be tested for HIV if testing is in the best interests of the child and consent is given by the child or the child's parent or caregiver. According to the Department of Health's *HIV Counselling and Testing (HCT) Policy Guidelines 21* "... an HIV test will be in the best interests of the neonate, infant or child if it is clear that the test will provide access to the continuum of care and promote a child's physical and emotional welfare ..." (Department of Health, 2010:31).

Applicable policies

The following policies or parts thereof, can be regarded as constituting the professional mandate for social workers working in communities within the field of HIV and Aids (DSD, 2009).

- White Paper for Social Welfare Service (1997)

The *White Paper for Social Welfare* (RSA, Ministry for Social Welfare and Population Development, 1997) provides the overarching policy framework for the DSD and its stakeholders, and states that social welfare services and programmes must be based on the respect for human rights and fundamental freedoms as articulated in the Constitution of the country. The social development approach, as prescribed by the *White Paper for Social Welfare*, is relevant as it embraces human rights values and ensures socio-economic development. It is therefore of immense importance for the social work profession to incorporate the new approach into its professional interventions.

- White Paper on Population Policy (1998)

This White Paper aims to promote the integration of population issues in development planning with the view to achieving sustainable human development (DSD, 2009:11). The DSD is responsible for monitoring population trends and for supporting national, provincial and local spheres of government through capacity building, research and information dissemination on population issues.

- Policy on Financial Awards to Service Provider (2011)

This policy is primarily aimed at ensuring that government, together with the NPO sector, and where appropriate, the private sector organisations, achieve the mission of the DSD, namely “to ensure the provision of comprehensive social services which protect the poor and vulnerable within the framework of the South African Constitution and subsequent legislation, create an enabling environment for sustainable development, and deliver integrated sustainable, quality services in partnership with all those committed to building a caring society” (DSD, 2011:13).

This policy is intended to facilitate the achievement of strategic priorities of the DSD through services that are integrated and developmental in nature, and to ensure the care and support of poor and vulnerable groups, and those with special needs such as children, youth, older persons, persons with disabilities, women, victims and survivors of violence and abuse, persons affected by substance abuse and those infected and affected by HIV and AIDS.

- Social Development Strategic Plan 2010 – 2015

The priorities of the Strategic Plan are supported by specific goals and interventions covering welfare, comprehensive social security, and community development services. The DSD will facilitate the implementation of these services through its provincial partners, public entities, statutory bodies and civil society, especially NGOs.

The key priorities of the plan, include the following:

- Caring for and protecting vulnerable groups, especially children, women, people with disabilities and people living with HIV.
- Strengthening families and communities.
- Transforming social relations, with a specific focus on gender and victim empowerment.
- Providing comprehensive social security, including income support, and a safety net for the destitute.
- Strengthening institutional capacity to deliver quality services.
- Reinforcing participation in key bilateral and multilateral initiatives that contribute to poverty eradication (DSD, 2009).

- HIV/Aids/STD Strategic Plan for South Africa, 2012 – 2017

This plan is the overarching framework that guides all responses to HIV and Aids in South Africa. The Plan's primary goals are to reduce the number of new HIV infections and to reduce the impact of HIV and AIDS upon individuals, families and communities. The Strategic Plan is multi-sectoral in orientation, foreseeing roles for government, civil society and the private sector within its broad parameters. The Plan is structured into four key areas of intervention: prevention; treatment, care and support; research, monitoring and surveillance; and legal and human rights (DSD, 2009:18).

- Integrated Service Delivery Model for Social Services (2005).

The DSD (2005) through its ISDM proposes the rendering of three broad programmes: Social Security, Social Welfare and Community Development. These programmes should be integrated and enable the target groups to deal effectively with all social issues, such as psychological stress, chronic poverty, food insecurity and other adverse social conditions, such as HIV and Aids. A developmental approach to service delivery is an approach that is based on the strengths of the individual, group or community, and that recognises their capacity for growth and development.

The desired outcome of the ISDM is the implementation of a comprehensive, efficient, effective and quality service delivery system, which will contribute to a self-reliant society, and which is

based on the principles of Batho Pele, the *White Paper for Social Welfare*, and the constitutional, legal and international obligations that inform the mandate of the DSD in the provision of services.

Regional legal framework

The legal framework for the Southern African Development Community (SADC) response to the HIV and AIDS epidemic is the SADC HIV and Aids strategic framework. This document serves as a guideline for social workers in the HIV and Aids work in the region.

- SADC HIV and Aids Strategic Framework (2010-2015)

This Strategic Framework is a multidimensional response to HIV and Aids by the SADC. It is aimed at intensifying measures and actions to address the devastating and pervasive impact of the HIV and Aids pandemic in a comprehensive and complementary way. The focus of the response is on the prevention of HIV and Aids, care and support and the mitigation of the impact of the epidemic in order to ensure sustainable human development in the SADC region (SADC, 2009:2).

International legal framework

Internationally, social workers are mandated to adhere to some laws and regulations to ensure that their HIV and Aids work contributes to the development and well-being of communities.

- International Law of Human Rights and HIV and Aids

The World Health Organization (2002:965) identified the *International Law of Human Rights and HIV and Aids* as a comprehensive framework to which public health practitioners could anchor responsibility for addressing the underlying causes of HIV and Aids, trauma and other threats to health. Human rights are a set of universal entitlements that individuals enjoy irrespective of their sex, nationality, religion, culture or other status, that are inherent to human beings and that are proclaimed and protected by international law. Human rights have major relevance for shaping appropriate responses to the HIV epidemic and other global health challenges, including offering system-wide public health responses and identifying deficiencies in public health research agendas.

- International Federation of Social Work (IFSW): Social work manifesto on HIV and Aids

This IFSW policy acknowledges that HIV and Aids is both a social and a health issue, and it is also an issue regarding human rights and social justice. Social workers, by virtue of their training, their commitment to human rights, and the fact that they are uniquely placed within a wide variety of health and welfare settings, can play a very effective role in strengthening social capital of communities to address the HIV and Aids epidemic (IFSW, 2012).

Section C: Developmental approach to social work

Patel (2005:177) purports that in the view of the grave consequences of HIV and Aids for the society, the developmental approach to social welfare services and social work practice is the most appropriate means of intervention. The study from which this guideline originates was also moulded within a social development theoretical framework. Therefore, it is opined here that HIV and Aids services should be mainstreamed through all welfare programmes. This means that all social services should have a HIV and Aids service component.

The NGO sector should include a developmental social work approach in its service delivery. “Developmental social work is a type of social work that affirms the profession's commitment to poverty alleviation and social inclusion, recognises the link between social and economic development, and construes welfare as an investment in human capital rather than a drain on limited resources” (Gray, 2002:13).

Services that should underpin the work of social workers, working in communities in the field of HIV and Aids, and who follow a developmental approach:

- Care and social support: this involves providing psychological support to individuals, groups and families who are infected and affected by HIV and Aids, such as pre-test, post-test counseling, guidance on issues of HIV status disclosures and personal protection and care.
- Community mobilisation and mitigation of impact: this should happen in communities that are heavily infected and affected by HIV and Aids, through utilising strategies that are targeted at strengthening the capacities of families and communities in geographic areas most affected through community based programmes that have proven to be the most effective and sustainable way to address the crises.
- Home and community care: this is the provision of health and social services by formal and informal caregivers in the home in order to promote, restore and maintain a person's maximum level of comfort, function and health.
- Education and prevention: Education on the forms of behaviour that increase the risk of HIV infection such as unprotected sex, engaging in sex with more than one partners, mother to child transmission and way to prevent infection to HIV. A lack of HIV and Aids related knowledge, such as modes of transmission, proper condom use, misconceptions, and peer pressure increases the risk of contracting HIV.
- Poverty reduction and livelihoods strategies: HIV and Aids can lead to the impoverishment of families due to loss of income caused by illness; social workers should encourage community members to engage in poverty reduction activities that could improve their livelihoods.

- Gender sensitive and non-discriminatory practice: Malherbe (2002:339) purports that unequal gender relations and social, economic and cultural factors are directly connected to the high infection rates among women.
- Social planning: Social workers should conduct community-based research to design programmes that are appropriate, effective and sustainable.
- Social policy, legislation guidelines and advocacy: social workers should be involved in the development of policies and legislation that are responsive to the needs and rights of among others people living with and affected by HIV. They should also play an active role in advocating for the legislative and policy reform and reviews.

Section D: Human rights

It is difficult to form bridging or linking forms of social capital if the communities and its members do not agree on critical issues such as human rights. The Office of the United Nations High Commissioner for Human Rights (OHCHR) represents the world's commitment to universal ideals of human dignity (OHCHR, 1996:1). The OHCHR have a unique mandate from the international community to promote and protect all human rights.

1. What are human rights?

Human rights are rights inherent to all human beings, whatever their nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status. People are all equally entitled to human rights without discrimination. These rights are all interrelated, interdependent and indivisible (OHCHR, 1996:1).

Universal human rights are often expressed and guaranteed by law, in the forms of treaties, customary international law, general principles and other sources of international law. International human rights law lays down obligations of Governments to act in certain ways or to refrain from certain acts, in order to promote and protect human rights and fundamental freedoms of individuals or groups.

2. Bill of Rights

This Bill of Rights is a cornerstone of democracy in South Africa. It enshrines the rights of all people in the country and affirms the democratic values of human dignity, equality and freedom. It states that the state must respect, protect, promote and fulfil the rights in the Bill of Rights (Department of Justice and Constitutional Development, 2005).

i. Application

The Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state.

ii. Categories of Rights

Many of the rights are included in the Bill of Rights, some of which can directly linked to social workers service in the field of HIV and Aids, namely: the rights to:

1. Equality (Section 9)

- All South Africans are born free and equal in dignity and rights.
- No individual or group shall receive privileges or be subjected to discrimination, domination or abuse on the grounds of race, colour, language, gender, or creed, political or other opinion, birth or other status.
- All men and women shall have equal protection under the law.

2. Human dignity (Section 10)

- Everyone has inherent dignity and the right to have their dignity respected and protected.

3. Life (Section 11)

- Everyone has the right to life.

4. Freedom of association (Section 18)

- Everyone has the right to freedom of association.

5. Citizenship (Section 20)

- No citizen may be deprived of citizenship.

6. Freedom of movement and residence (Section 21).

- Everyone has the right to freedom of movement.
- Everyone has the right to leave the Republic.
- Every citizen has the right to enter, to remain in and to reside anywhere in, the Republic.
- Every citizen has the right to a passport.

7. Housing (Section 26).

- Everyone has the right to have access to adequate housing.
- The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right.
- No one may be evicted from their home, or have their home demolished, without an order of court made after considering all the relevant circumstances. No legislation may permit arbitrary evictions.

8. Health care, food, water and social security (Section 27).

- Everyone has the right to have access to
 - a. health care services, including reproductive health care;
 - b. sufficient food and water; and
 - c. social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

9. Education (Section 29).

- Everyone has the right
 - d. to a basic education, including adult basic education; and
 - a. to further education, which the state, through reasonable measures, must make progressively available and accessible.

3. The South African Human Rights Commission

The South African Human Rights Commission (SAHRC) is the national institution established to entrench constitutional democracy. It is committed to promote respect for, observance of and the protection of human rights for everyone without fear or favour (SAHRC, 1995:1)

Section E: Social capital development for social workers

All registered social workers who are practicing the social work profession in management of HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities should implement social capital development, to assist communities to develop social cohesion that will enable societies to prosper economically and for development to be sustainable (World Bank, 2011:1). To assist social workers in this regard, an accredited training service provider who has been approved by the SACSSP could provide training. Ideally, such training could consist of the following topics.

Part 1: Rationale of social capital development

This section provides social workers with the rationale of why they need to build social capital as a strategy to manage the pandemic of HIV and Aids within in the communities they serve in the Johannesburg and Ekurhuleni Metropolitan Municipalities. The rationale is as follows:

- To establish community-based working groups for care of people infected with HIV and lead the effort to reduce stigma associated with HIV.
- To provide opportunities for community members to interact and mobilise to promote effective and sustainable prevention of the spread of HIV.

- Building community-based support systems for individuals and families affected by HIV and Aids through facilitating small agricultural and food security initiatives.
- To establish links between local community groups that brings together people living with HIV, community stakeholders and health providers to develop partnerships, address gaps and challenges, and support families and individuals, creating a comprehensive community response.
- To encourage a sense of community pride and ownership with regards to identifying priority HIV-prevention needs and measures to ensure that HIV-prevention resources are targeted to priority populations and interventions in a comprehensive plan.
- Support social change communication and mobilisation so community members become aware of common HIV and Aids concerns or needs and decide to take comprehensive action with regards to prevention, treatment, care and support services of HIV and Aids.
- To attract further external funding to strengthen prevention, care and health service delivery in communities affected by HIV and Aids (Frumence, 2011:43-45).

Part 2: Training workshop for social workers on “social capital” as a concept

During the social capital building workshop the social workers could be guided through a process of understanding social capital as a concept for managing HIV and Aids. The training could follow the format below:

1. Definition of social capital

The *Encyclopaedia of Social Work* (2008:34) defines social capital as “a feature of empowering interventions in neighbourhoods and community development, as is collective efficacy, which is a measure of working trust that exists among residents.” Social capital is defined as the internal social and cultural coherence of society, the norms and values that govern interactions among people and the institutions in which people and their norms are embedded to coordinate action to achieve desired goals (World Bank, 2003:1).

2. Types of social capital

There are three types of social capital, namely bonding, bridging and linking social capital.

– Bonding social capital

Bonding social capital exists within the individual’s capabilities to harness the resources that exist/occur within a given relationship. Interpersonal interactions that generate mutual trust, understanding, reciprocity, and shared norms are the building blocks of bonding social capital (Loeffler et al., 2004). Bonding is horizontal, among equals within a community. Hawkins and

Maurer (2010:1777) referred to bonding capital as localised which he defined as being found among people who live in the same or adjacent communities, for example family members and friends. It is closely related to “thick trust” (Helmut & Kendall, 2002:343).

Ogden (2011:1) purports that bonding social capital comes from relationships between individuals, such as (e.g., groups of people living with HIV). The importance of social capital for HIV responses can be seen at the individual level, for example, by reducing the isolation and internal stigma experienced by people living with HIV and improving adherence to treatment and health-seeking practices.

- Bridging social capital

Bridging is vertical between communities (Dolfsma & Dannreuther, 2003:406; Leonard, 2004:928; Narayan, 2002), and which extends to individuals and organisations that are more removed. It is closely related to “thin trust”, as opposed to the bonding (splitting) social capital (Helmut & Kendall, 2002:344). Bridging social capital connects formal and informal support networks. Bridging social capital connects people who are alike but in different circumstances (e.g., connections between groups of HIV-positive people in one country or region with those in another). Bridging connections are crucial for the influx of new ideas, resources, and energy across groups. For example, bridging social capital between HIV programmers and tuberculosis (TB) programmers can create the synergies needed to ensure that no one living with HIV dies from TB (Ogden, 2011:1).

- Linking social capital

According to Woolcock and Sweetzer (2002:26), linking social capital pertains to connections with people in power, whether they are in politically or financially influential positions. Linking social capital also includes vertical connections to formal institutions (Mayoux, 2001:436; Woolcock, 2001:12).

Linking social capital is considered by some analysts to be the most crucial for creating sustainable improvements in health, because without viable linkages to those with power and influence, community groups may fail to get the traction they need to create the change they envision. These linkages are instrumental in providing needed resources and legitimacy for advocacy to reach the ambitious (Ogden, 2011:1).

3. Why does social capital matter?

The tenet of the social capital theory is that social relationships among people can be productive resources (Coleman, 1990:302). Putnam (1995:64) suggested that social capital facilitates

coordination and cooperation for mutual benefit. Social capital is the “glue” that holds individuals, communities and societies together.

Social capital has elicited a great deal of interest because of its potential as a means for better understanding community mechanisms underlying health and HIV and Aids. In recent health literature, social capital has been linked to improved child development and adolescent well-being, increased mental health, lower violent crime rates and youth delinquency, reduced mortality, reduced HIV incidence, less mental health problems, less substance use, and higher perceptions of well-being and self-rated health (Szreter & Woolcock, 2004: 652).

4. Levels of social capital

Social capital has been located at the level of the individual, the informal social group, the formal organisation, the community, the ethnic group and even the nation (Bankston & Zhou, 2002:286).

HIV prevention highlights the necessity of collective action in the context of decentralised and multi-level governance where national programmes need to coordinate with community activities. Effective HIV prevention programmes require financial and human capital but also resources in social networks which can influence behaviour, communication and norms (Low-Beer & Sempala, 2010:2).

5. Determinants of social capital

Halpern (2005:38) and Warde and Tampubolon (2002:156) suggest that the main determinants of social capital include: family and kinship connections; wider social networks of associational life covers the full range of formal and informal horizontal arrangements, history and culture; whether social structures are flat or hierarchical; the family; education; the built environment; residential mobility; economic inequalities and social class; the strength and characteristics of civil society; and patterns of individual consumption and personal values.

6. Dimensions of social capital theory

According to Kaasa (2007:8) social capital is a complex concept with many dimensions. An analysis by Onyx and Bullen (2001:106) suggest that there are eight distinct dimensions of social capital; many are related to each other. Other authors have identified different groups of dimensions, for example Liu and Besser (2003) identified four dimensions of social capital: informal social ties, formal social ties, trust, and norms of collective action.

The diagram below by Narayan and Cassidy (2001:60) identify a range of dimensions as discussed by several authors (Liu & Besser, 2003; Onyx & Bullen, 2001:106).

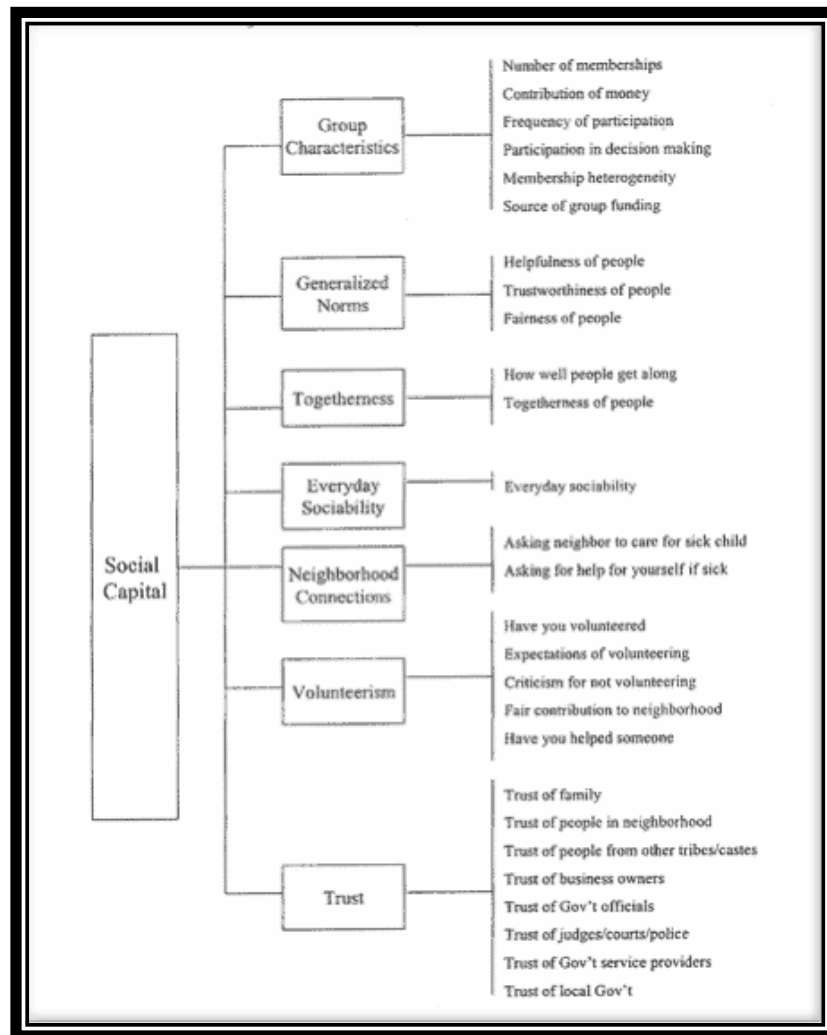


Figure 1: The dimensions of social capital defined by Narayan and Cassidy (2001)

Figure 1 illustrates that increasing evidence shows that social cohesion and social capital is critical for poverty alleviation and sustainable human and economic development. Furthermore, several authors have linked the HIV and Aids pandemic to social capital (David, 2007:2), usually pointing out how factors related to the disease such as stigma, discrimination lowers trust and the costs posed by care for the sick, as well as orphans erode and put pressure on social capital.

Dekker and Uslaner (2001:1) sum up by identifying that it is clear that the components of social capital need to be treated as multi-dimensional rather than one-dimensional.

7. Benefits and importance of social capital

Szreter and Woolcock (2004:654) suggested that the importance of social capital lies in that it brings together several important sociological concepts, such as social support, integration and social cohesion. This view is supported by Rothstein (2003:51) who stated that the real strength of

social capital theory is the combination of macro-sociological historical structures with micro-level causal mechanisms, a rare feature in the social sciences.

Ogden (2011:1) purports that successful efforts to address HIV have long depended upon the energy and commitment generated through bonds of common purpose, trust, and shared hope within and connecting communities, civil society organizations, local health workers, national health policymakers, and the international development community.

8. Disadvantage of social capital

Stanfield and Stanfield (2003:399) purports that “every feature of social structure can be social capital in the sense that it produces desired outcomes, but also can be a liability in the sense that it produces unwanted results”. The kinds of groupings and associations, which can generate social capital, always also carry the potential to exclude others (Frane & Roncevic, 2003:160). Social capital can become a constraint to individuals' actions and choices (Small, 2002:38).

Limited resources create conditions where individuals, households, and communities face severe challenges in “getting by” much less “getting ahead” (Briggs, 2004:152). Economic (e.g., unemployment and poverty) and social (e.g., stigmatisation), create significant obstacles to health and well-being, for example, socio-spatial stigmatisation due to HIV and Aids diagnosis. Individuals, households, and communities, require more than their own resources to enable daily survival (Takahashi, 1997:188).

Part 3: Potential interventions and strategies for social workers in building social capital

- Interventions to Strengthen Social Capital

Below are types of interventions that have been used most successfully to promote community participation in building social capital. Social workers can adapt and integrate them in their roles while facilitating activities for building social capital of communities to manage HIV and Aids.

Animation	Assisting local people stimulate their own critical awareness, to examine and explain issues in their own words, and to realise what they can do to bring about change.
Structuring	The development of internal cohesion and solidarity among people, and some form of structured organisation.

Facilitation	A service role which assists people to undertake specific actions; these actions include the acquiring of particular technical and managerial skills, gaining access to available resources or translating their own ideas into feasible projects.
Intermediary	To serve as a go-between in relation to other external services. To establish contacts with existing services and introduce people to the procedures and mechanisms for dealing with these services.
Linking	To help develop links between people in similar contexts, and facing similar problems.
Withdrawal	A progressive redundancy of external intervention.

Based on: Oakley (1991)

The above interventions, as highlighted by Oakley (1991:17), purports that “participation is concerned with human development and increases people's sense of control over issues which affect their lives, helps them to learn how to plan and implement and, on a broader front, prepares them for participation at regional or even national level. In essence, participation is a 'good thing' because it breaks people's isolation and lays the groundwork for them to have not only a more substantial influence on development, but also greater independence and control over their lives”.

Part 4: Evaluation of activities

The main aim of evaluating activities is for community members or attendees to assess if they have gained adequate skills and knowledge from social workers or peers to work together as a team in identifying challenges and finding solutions to the HIV and Aids situation in their communities.

After each activity, the social worker facilitates an evaluation process whereby community members or attendees answer the following questions:

- Has the community worked together in the planning and implementation of activities in their communities?
- Has the community developed adequate capacity to identify social and economic problems and opportunities, and mobilised to address them?
- Has the community developed the capacity to foster the conditions that strengthen its ability to plan, develop, implement, and maintain effective community HIV and Aids programs that will build the problem-solving capabilities of communities?
- Has the community developed new and effective ways doing things that are often associated with new norms and values?

- Is there sufficient political will and skill in the community to pursue new lessons and decisions made for future actions?
- Has the community identified most effective practices and processes in developing social capital to manage HIV and Aids?

The following section focuses on the critical elements that would ensure the success of social workers' efforts in building social capital of communities to manage HIV and Aids in the Johannesburg and Ekurhuleni Metropolitan Municipalities.

Part 5: Critical enablers of social capital building

An enabler is any practice or condition that makes a process more likely to occur (Dutton & Ragins, 2007:330).

The following critical enablers play an important role in guiding social workers on what is needed to ensure success of the projects that are aimed at building social capital to manage HIV and Aids within the communities of the Johannesburg and Ekurhuleni Metropolitan Municipalities:

- Planning and ongoing consultation

Extensive planning and consultation are crucial to effective community building programmes. This phase is usually the longest lasting part of the project as building trust and collaboration between social workers and community members is the primary objective of the project.

- Enthusiastic and dedicated social workers

Enthusiasm and dedication of social workers are crucial to effective collaboration with a community, but they are inefficient unless they exist within an understanding environment and are supported by the social work management.

- Involving participants in management and decision-making about the project and its activities

Involvement of residents in decision-making processes creates many benefits for a community; it also makes an NGO's work easier as many of the tasks are performed by enthusiastic volunteers.

- Alignment to existing policies and national strategic plans

Using existing and relevant national, provincial and district level policies and strategic plans as guidelines, to ensure successful implementation of the planned projects.

Part 6: Proposed activities for social workers in building social capital of communities

The HIV and Aids community project's objectives are to be centred on building close networks between the people and community and providing a structure for enhancing the existing networks in the community. The project particularly should target isolated members of the community, such as support groups of people living with HIV, grandmother looking after orphans and vulnerable children and single parents. Social workers are encouraged to use the following activities as a way of building social capital in communities.

Workshops

The main aim of workshops will be for social workers to apply and transfer skills and knowledge acquired through their CPD-training in the field of social capital building. The advantage is that holding a workshop is a cost-effective way of training a big group of people, who can then be monitored uniformly, as they have received the same skills at the same time.

Workshops are:

- Short training courses (running for 2-5 day);
- Hosted and facilitated by social workers and/or community leaders
- For a group of 15-25 participants (mainly from community members)
- Organised on a community of district basis;
- Using participatory, "learning through doing" methodology;
- Designed to teach a set of skills or identify lessons learned (Southern Africa Aids Trust, 2008:33).

Types of workshops (Southern Africa Aids Trust, 2008:33):

- Skills training workshops (usually 3-5 days)

Skills training workshops introduce skills and techniques in programming (e.g. HIV counselling or peer education) or organisational practice (e.g. strategic planning and financial skills).

- Lesson-sharing workshops

Lesson-sharing workshops aim to pull together and document key experience on a building social capital in communities. Social workers invite participants with relevant experiences in social capital building in managing HIV and Aids from other organisations and communities, to identify and analyse key lessons in relation to the topic. The lessons learnt are documented in a report. Often,

reports become the basis of community-based manuals or publications, which are distributed locally and regionally.

- Training of trainer (TOT) workshop

A few specialists should be identified to facilitate a regional workshop for team of facilitators from different communities. The teams then return home to run community level workshop on the same topic.

- Thematic network meetings or critical thinking workshops

These meeting will provide an opportunity to social workers and community members to come together to discuss the following:

- Networking;
- Coordination;
- Open discussions of interpersonal networks that cross the boundaries between the government and civil society between NGO based social work and other community-based service providers like the Faith Based Organisations and other relevant Government Departments responsible for mitigating HIV and AIDS;
- Analysis of the way the HIV and Aids epidemic is changing and potential roles for social workers and community members in introducing and adapting to the changing environment.
- The way the communities are changing because of HIV and Aids and how these changes can be used as learning platforms to build social capital; and,
- Development, analysis, cultivation, and encouragement of sound policies and programmes in response to the HIV epidemic (Goldstein, 2013:1).

The following activities are additional activities that social workers and community members can embark on in order to continue to apply and transfer skills and knowledge acquired:

- Study visits

The purpose of the study visit is to help a “new” community learn how to manage its social capital building activities and efforts through observing day-to-day work of an experienced community.

- Support and monitoring visits

The purpose of the visits is to check the social capital building of the community regarding HIV and AIDS, identify capacity needs and plan future capacity building activities for the community. To

check that the “new” community is implementing and sharing what they have learned through social workers social capacity building interventions.

- Community Events

Social workers should encourage community member involvement in a series of popular events, such as, networking meetings, being involved with various coalitions, task forces, art festivals, youth events, parents and children clubs, tree planting and many others. These events could serve as ongoing consultation mechanisms, where residents are informed on progress of community projects and given opportunities to provide feedback.

- Regular meetings

Social workers could help the communities to schedule and meet monthly or on regular basis. These meetings could also be used to generate and publish regular newsletter that contains upcoming community events and how members of the communities could assist to make those events a success.

- Youth groups

Some of the project could involve drama, refurbishing the local playground and providing a space for older children to ‘hang out’, and talk about challenges faced by youth regarding HIV and Aids and how they can work together to mitigate the spread of HIV in their communities.

Section F: Conclusion

These guidelines should enhance the social work profession’s aim of promoting social change, problem solving in human relationships, and the empowerment and liberation of people to enhance well-being. It is also the responsibility of the NGO to inform social workers, and for social workers to familiarise themselves with these guidelines. Social workers should act in accordance with the ethical code of their profession, while implementing these guidelines.

APPENDIX K

Confirmation of Editing

Trisha Naicker: Copywriter, Proofreader, Editor

Confirmation of Editing Services

23 October 2013

To whom it may concern,

This serves as a letter of confirmation that the Dissertation titled:

Enhancing social capital in communities to manage HIV and Aids: The roles of social workers in the Johannesburg and Ekurhuleni Metropolitan Municipalities

compiled by **Ms. Malebo Sesane** has been edited and checked for language and grammatical errors.

Regards,

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