

**CHALLENGES EXPERIENCED BY SOCIAL WORKERS IN PLACING CHILDREN
LIVING WITH HIV IN FOSTER CARE IN JOHANNESBURG**

BY

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DECLARATION

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I hereby declare that this research report (mini-dissertation) is my original work. All secondary material used has been appropriately referenced and acknowledged in accordance with the regulations of the University of Pretoria.

Signature

Date

DEDICATION

This study is dedicated to all the children who are living with HIV in South Africa and around the globe particularly those who are in need of care and protection for various reasons. God loves you.

ACKNOWLEDGEMENTS

I wish to thank all those who contributed towards the success of this study. Special thanks go to the Almighty, the Creator for His abundant and everlasting love.

My sincere gratitude also goes to my parents for their love as well as their vision on education as a precursor of all mindfulness and a fulcrum of development.

I am also highly indebted to my beloved wife and our two daughters for their support, fortitude and diligence during the study period. Without their support, this project could not have been successful. I would like to urge them to remain steadfast and unbendable.

I would also like to express my heartfelt appreciation to my supervisor, Mrs. Bila for her professional guidance throughout the study period.

Finally, I gratefully acknowledge and appreciate the support I received from my family, friends, colleagues and participants for this project to be successful.

Ndinotenda. God bless!

ABSTRACT

CHALLENGES EXPERIENCED BY SOCIAL WORKERS IN PLACING CHILDREN LIVING WITH HIV IN FOSTER CARE IN JOHANNESBURG

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DEGREE: **MSW HEALTH CARE**

Estimates suggest that over one third of South Africa's population is under the age of eighteen years. This shows that children constitute a substantial percentage of the country's population. Where developmental issues are concerned, all children are any country's future. This includes children who are living with HIV and need care and protection. Thus, this population group is seen as a time-bomb ready to explode, unless there are ways of enabling them to fulfil their aspirations. The high rate of HIV infection has left many South African children's future in obscurity. It has also exposed these children, particularly those already in need of care and protection, to a number of predicaments, among them failure to secure suitable foster care. Nonetheless, foster care is still the most viable option in South Africa, in the event that natural family care fails.

The goal of this study was to investigate the challenges experienced by social workers in placing children living with HIV in foster care in Johannesburg from an empowerment perspective. The research utilised a qualitative approach through focus group interviews with designated social workers and foster parents. The research participants were selected using purposive sampling.

Findings of the study revealed numerous fears and challenges regarding the foster care placement of children living with HIV. These include myths and misconceptions about HIV; fear of losing the child through death; stress; financial concerns; lack of education and information on HIV; stigma and discrimination; lack of support from social workers; fear to disclose a child's HIV status; compliance and adherence to medication; shortage of foster parents and; shortcomings of the Children's Act No. 38 of 2005 (as amended). Further, social workers play a critical role in recruitment and screening of prospective foster parents as well as educating, training and supervising the foster parents of children living with HIV. Finally, empowerment of social workers and foster parents through provision of comprehensive HIV education and training, support groups, incentives, and facilitating collaboration of all role players is fundamental to successful fostering of children living with HIV.

Based on the findings in this study, the researcher concluded that the challenges in placing children living with HIV in foster care are a result of a complex combination of sociological, psycho-social, medical and economic factors. Since these factors are interconnected, they should not be addressed in isolation.

Recommendations from the study include a thorough examination of factors which motivate foster parents to bring children into their care; addressing foster parents' fears and challenges concerning fostering HIV positive children; provision of a comprehensive HIV education and training for foster parents and social workers; giving incentives to the foster carers of children living with HIV; formulation and implementation of specific policies regarding the care of children living with HIV who are in need of care and protection, and collaboration and empowerment of all role players.

KEY WORDS

HIV, Children, Child in need of care and protection, Social workers, Foster care, Foster parents, Empowerment

ACRONYMS

| | |
|--------|--|
| ADF | African Development Foundation |
| AU | African Union |
| DSD | Department of Social Development |
| HSRC | Human Sciences Research Council |
| IFSW | International Federation of Social Workers |
| NPO | Non-Profit Organisation |
| OAU | Organisation of African Unity |
| PLHIV | People Living with HIV |
| SACSSP | South African Council for Social Service Professions |
| SAIRR | South African Institute of Race Relations |
| SANAC | South African National AIDS Council |
| SAPA | South African Press Association |
| SASSA | South African Social Security Agency |
| UNAIDS | United Nations Programme on HIV/AIDS |

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CHAPTER ONE

GENERAL INTRODUCTION AND ORIENTATION OF THE STUDY

1.1. Introduction

The human immunodeficiency virus (HIV) has changed the world forever as it does not only affect individuals' immune system, but also impacts profoundly on people's belief systems, as well as their social, sexual, economic and political lives (Van Dyk, 2012:4). It is undisputed that Africa continues to be heavily affected by the human immunodeficiency virus and children are always at the receiving end of the devastating effects of the epidemic. When family care is inadequate, the onus is on other members of society to care for children. This is the case because negative experiences in childhood can have long-term effects into adulthood, and on the future of a society (Deacon & Stephney, 2007:1). Therefore, it is vital to secure alternative placement for HIV-infected children needing care and protection.

Foster care has become an alternative form of care in both the developed and developing countries, though it is still underutilised in many developing countries. The underutilisation of foster care in some developing countries may be attributed largely to lack of the wherewithal on part of the governments to sustain foster care as a resource (Manukuza, 2013:1). To an extent, it is also a consequence of entrenched traditional beliefs (Mupedziswa, 1995:92), which discourage bringing a stranger to stay as part of the family for more than two years. These traditional beliefs may become more prominent in cases where the child is diagnosed with HIV. Among many people, a perception is that the HIV positive child will eventually die and the foster family will have to bear the emotional consequences and the cultural responsibilities associated with the death of a family member (Mupedziswa 1995:92). These sentiments are not baseless since foster parents develop meaningful relationships with the children in their care (Jo'Burg Child Welfare, 2013).

Foster care remains the most viable option in the event that natural family care fails. Dlamini (2014) and Skelton (2012:1) estimate that there are more than half a million children in foster care in South Africa. Although specific figures are scarce,

Johannesburg is one of the leading regions providing foster care for a large number of children in need of care and protection (Statistics South Africa, 2007:1). This may not be surprising as the city is host to a multitude of people from all walks of life. In this respect, social upheavals prompting the removal of children from the care of their parents and/or guardians are common.

Due to some of the factors alluded to in the preceding paragraphs; some prospective and existing foster parents have become sceptical and reluctant to foster children living with HIV (Rungani, 2013). Moreover, there is inconsistency among presiding officers on what constitutes 'visible means of support' (Section 150 of the Children's Act). This has resulted in some of them repudiating social workers' recommendations to place children in related foster care (Manukuza, 2013:2; Skelton, 2012:2). This leaves the designated social workers with no option other than placing these children in institutions. It becomes more problematic with children diagnosed with HIV as many foster parents shun these children (Manukuza, 2013:2). As a result, these children end up in child and youth care centres for long periods despite the fact that institutionalisation should be regarded as the last option in the care of children (De Jager, 2011:2). In the event that children are institutionalised, it must be for the shortest period as possible (Children's Act No. 38 of 2005; Muronda, 2009:62). Muronda (2009:62) observed that most of these children in institutional care develop a distorted sense of belonging, lack motherly touch and family love which is critical in child development; thus exacerbating their delicate situation.

1.1.1. The study's key concepts

The key concepts for this study are:

HIV

HIV is an abbreviation for human immunodeficiency virus, the virus that causes AIDS (Gale Encyclopaedia of Medicine, 2008). The terms HIV and AIDS have been used in several instances as if they were one and the distinction between them appears too constricted to comprehend. This distinction is however critical in helping people to understand what it means to be diagnosed with HIV hence the terms are treated not as one in this study. Having a positive reaction on a test for HIV does not mean that one has developed AIDS. Persons with HIV can live for many years provided

that they receive medication, sensitive counselling, information regarding transmission of the virus and close supervision of their health status (*Miller-Keane Encyclopaedia and Dictionary of Medicine, Nursing, and Allied Health*, 2003). This study therefore focuses on children living with HIV as opposed to those who have developed AIDS which is the final phase of HIV infection and may need end-of-life care.

AIDS

AIDS is an acronym for acquired immune deficiency (or immunodeficiency) syndrome; disorder of the immune system characterised by opportunistic diseases such as candidiasis, among others (*Medical Dictionary of the Health Professions and Nursing*, 2012). It is a fatal condition (UNAIDS, 2008:8). In this study, AIDS is regarded as the final stage of the HIV infection.

Foster care

Foster care is generally defined as the statutory substitute care within the family circle for children who cannot be cared for by their own parents in the short, medium or long term (Johnson, 2004:1; Manukuza, 2013:7; Swanepoel, 1999:ix). The Children's Act No. 38 of 2005 (as amended) further defines foster care as the legal placement of a child who is in need of care and protection "in the care of a person who is not the parent or guardian of the child..." Foster care can be related which is also referred to as kinship care (Swanepoel, 1999: ix) or non-related. As the terms suggest, a child in need of care and protection may be placed in the legal care of a relative or a non-relative (Manukuza, 2013:19).

For purposes of this study, foster care is regarded as the legal placement of a child living with HIV who is in need of care and protection with a suitable foster parent, whether related or non-related.

Foster parents

The Children's Act No. 38 of 2005 (as amended) defines a foster parent as "a person who has foster care of a child by order of the children's court..." In this study, foster

parents are those persons whom the children's court has legally placed children in need of care and protection. These children include those living with HIV.

Designated social workers

These are persons registered as social workers with the South African Council for Social Service Professions (SACSSP) in terms of the Social Service Professions Act No. 110 of 1978. They have the legal mandate to perform statutory work which includes the placement of children in need of care and protection in foster care by virtue of being "in the service of the Department or a provincial department of social development, a designated child protection organisation or a municipality" (Children's Act No. 38 of 2005 as amended).

Johannesburg

The 'Greater Johannesburg Metropolitan Area' covers several areas: the Johannesburg Central Business District (CBD) and the surrounding suburbs such as Sandton, Randburg, Northgate, Soweto, East Rand and West Rand among others. In this study, Johannesburg shall mean the Johannesburg CBD where Jo'Burg Child Welfare provides child protection services.

1.2. Theoretical framework

The Empowerment theory is one of "those new social theories that are attempting to connect the personal and the social, the individual and society, the micro and macro" (Sadan, 1997:137). Van Dyk (2012:149) commented that according to this theory, "empowerment is a central tenet of community organization practice, which refers to the process by which individuals and communities are enabled to take power and act effectively in transforming their lives and environments."

The Empowerment theory provides the theoretical framework for this study because of its emphasis on participation and empowerment as well as the attempt to connect the individual and collective at micro and macro levels. The placement of children in need of care and protection, including those living with HIV in alternative care such as foster care, is meant to empower them by giving them equal life opportunities as other children raised in natural families. Similarly, the designated social workers

responsible for placing them in alternative care and the foster parents raising these children need empowerment.

A detailed description of the theory is provided in chapter two (Section 2.8) of this report.

1.3. Rationale and problem statement

HIV infection has left many South African children's future in obscurity. These children, especially those who need care and protection, encounter many challenges securing foster parents (Rungani, 2013). It is generally agreed that children with chronic conditions such as HIV and AIDS are among the top list of vulnerable members of any society (Cohen & Nehring, 1994; Department of Social Development, 2011:3). A myriad of studies on children and HIV and AIDS have been conducted, so literature on children living with HIV is extensive. Despite this, there are still gaps such as the foster care of children living with HIV which need studying. It is therefore this researcher's conviction that specific research on foster care of children living with HIV and AIDS in the South African context is scarce. Secondly, practical advice on handling prospective foster child placements and the subsequent care of the children living with HIV in foster care is needed. Therefore, this study's findings will complement the few available studies on the topic.

Based on work experience, the researcher was also perturbed by the increasing number of designated social workers in the Johannesburg area seeking placements for children diagnosed with HIV in child and youth care centres, and the subsequent institutionalisation of these children. Simultaneously, the institutionalised children are also struggling to secure foster parents once the social workers disclose their HIV status to the prospective foster parents (Mandikonza, 2013).

Scrutiny of the phenomenon suggests that the placing of children living with HIV in foster care is becoming a persistent problem, hence a veritable concern for the affected children and the social workers who are supposed to place them (Mandikonza, 2013). Despite all these difficulties, foster care remains a preferred alternative to being placed in a residential care facility as it is hoped that the foster

parents would provide an ideal family environment, love and care (Jo'Burg Child Welfare, 2013). Therefore, there was need to identify and understand the challenges experienced by designated social workers in placing children living with HIV in foster care so as to make informed recommendations.

The study's primary research question was:

What are the challenges experienced by social workers in placing children living with HIV in foster care in Johannesburg?

The sub-questions were:

- What are the specific policies regarding the placement of HIV-infected children in South Africa?
- What are the views and concerns of foster parents regarding fostering children living with HIV?
- To what extent do these views and concerns contribute to the challenges faced by social workers in placing children living with HIV in foster care?

1.4. Goal and objectives of the study

1.4.1. Research goal

The goal of the study was to investigate the challenges experienced by social workers in placing children living with HIV in foster care in Johannesburg.

1.4.2. Research objectives

The specific objectives were as follows:

- To conceptualise HIV in children within the empowerment theory;
- To explore the policies (if any) regarding the placement in alternative care of children living with HIV in South Africa ;
- To identify the challenges faced by social workers in placing children living with HIV in foster care;
- To establish the views and concerns of foster parents regarding caring for children living with HIV;

- To examine the contribution of these views and concerns towards the challenges in placing HIV-infected children in foster care; and
- To propose strategies that will improve the placement of children living with HIV in foster care.

1.5. Research methodology

This is a qualitative applied research, using the collective case study design. The case study design was used in this study mainly for its popularity in qualitative research as well as its use of focus group discussions with a number of participants. Focus group interviews were conducted with the designated social workers and foster parents. The research methodology will be discussed in detail in chapter three of this report.

1.6. Limitation of the study

All the participants in the study were Africans; therefore their views on the topic under investigation might not reflect the views of other racial groups in South Africa. Nonetheless, the majority of foster parents and social workers in South Africa are Africans, given the racial distribution of the country's overall population. Furthermore, gender representation of the foster-parent participants was skewed as only one out of eleven was male. The views of females regarding the foster care of HIV positive children might be different to those of males. Finally, the study utilised a small sample which might not represent the views of all foster parents and social workers in the Johannesburg area and South Africa at large.

1.7. Division of the research report

The research report has four chapters. Chapter 1 is a general introduction and description of the orientation of the study. The study's key terms are also defined, followed by a brief description of the theoretical framework, the rationale and problem statement, the goal and objectives of the study, the research methodology and limitations of the study.

Chapter 2 is a review of literature on foster care of children living with HIV in South Africa. This is discussed within an empowerment approach.

In Chapter 3, a detailed discussion of the research methodology and research findings is provided. The discussion of the research findings is blended with relevant literature.

Finally, Chapter 4 gives a summary of the research findings, conclusions and recommendations thereof. An explanation of how the research goal and objectives were achieved is also provided in this chapter.

CHAPTER TWO

CONTEXTUALISING FOSTER CARE OF CHILDREN LIVING WITH HIV IN SOUTH AFRICA WITHIN THE EMPOWERMENT THEORY

2.1. Introduction

Foster care is an alternative care option for children in need of care and protection, inclusive of those living with HIV. The chapter begins with a summary on HIV globally and HIV in South Africa. It continues with a discussion of the psychosocial impact of HIV on the infected children and their caregivers (foster parents). A brief description of foster care in South Africa is also given. In addition, previous research on foster care of children living with HIV is discussed. The role of social workers in the foster care process is highlighted. Finally, the empowerment theory, which was selected to inform the study's theoretical framework, features prominently in the chapter.

It should be stressed, that the discussion and elucidation of a given phenomenon using a single theory is inadequate as some overlap among theories is inevitable. The selection of one theory over another may therefore be a choice of the researcher. This of course does not discredit the point that one theory may be more relevant than the other in the exploration and explication of a given phenomenon. As such, the empowerment theory is the most applicable for this study since the research is expected to contribute to the understanding of challenges of securing suitable foster care for children living with HIV, upon which appropriate interventions can be based to empower children living with HIV, foster parents and social workers who deliver services in this context.

2.2. HIV in children globally and in South Africa

Vranda and Mothi (2013:19) note that increased access to antiretroviral treatment has resulted in increased survival rates among the children infected with HIV in many countries, and improved quality of life of seropositive children. The authors however bemoan the number of HIV infected children who are still dying of AIDS, especially in India and Africa.

A report by UNAIDS (2012) estimated that by the end of 2011, about 34 million people were living with HIV globally and 3.3 million were children. During the same period, there were 1.7 million AIDS-related deaths and 330 000 children were newly infected with HIV. It was further reported that Sub-Saharan Africa remains the most heavily affected region in the world, with an estimated number of 23.5 million people living with HIV. Although several strides have been made in relation to the HIV epidemic in Africa as a continent, several reports by UNAIDS still point out that Sub-Saharan Africa continues to lead in terms of HIV prevalence in the world. Southern Africa accounts for the highest HIV prevalence in the world (UNAIDS, 2012).

In the context of South Africa, the findings of the 2012 South African National HIV Prevalence, Incidence and Behaviour Survey indicate that nationally, approximately 6.4 million people are living with HIV (Human Sciences Research Council, 2014:xxiv). It was believed that about 460 000 children were living with HIV by the end of 2011 (UNAIDS, 2012). Although there has been a substantial decline in mother-to-child transmission of HIV lately, the number of children living with the virus remains a veritable area of concern (HSRC, 2014:xx).

HIV and AIDS in children results in medical and social problems which cannot be overlooked (Cohen & Nehring, 1994:60). One of the most troubling effects of the HIV and AIDS epidemic is that it leaves many children orphaned and infected with the virus. These children face an uncertain future, thus disrupting their lives, especially where there are no means to assist them (De Jager, 2011:1). The provision of alternative care has thus become an acceptable option for many governments, including the South African government.

2.3. Psychosocial support for children living with HIV

2.3.1. Special needs of children living with HIV who are in need of care and protection

The government recognises the fundamentality of psychosocial support of children affected by HIV and AIDS and has formulated various policies to this effect. The Department of Social Development (DSD) (2011:3) identifies core principles which underpin psychosocial care and enhance the psychosocial wellbeing of all children

including those living with HIV. These principles are: “protection from harm; the best interests of the child; child participation; family-based care, *Ubuntu*, social and community integration; social development; inter-sectorial collaboration; mainstreaming psychosocial support; prevention; cultural appropriateness; gender sensitivity; and age and developmental appropriateness” (DSD, 2011:3). Through the Children’s Act No. 38 of 2005 (as amended) and other policies, the government has ensured that the above principles are respected.

It is pertinent to define who is a child in need of care and protection. In section 150 (1) of the said Act, a child is need of care and protection if the child is found in one or more of the following circumstances:

- ✓ has been abandoned or orphaned and is without any visible means of support
- ✓ lives in or is exposed to circumstances which may seriously harm that child’s physical, mental or social well-being
- ✓ may be at risk if returned to the custody of the parent, guardian or care-giver of the child as there is reason to believe that he or she will live in or be exposed to circumstances which may seriously harm the physical, mental or social well-being of the child
- ✓ is in a state of physical or mental neglect
- ✓ is being maltreated, abused, deliberately neglected or degraded by a parent, a care-giver, a person who has parental responsibilities and rights or a family member of the child or by a person under whose control the child is.

According to the Children’s Act No. 38 of 2005 (as amended), a child found in the above-stated circumstances should “be referred for investigation by a designated social worker”. After proper investigations and taking necessary measures to assist the child, if the social worker believes that the child needs care and protection as stipulated in the said Act, they should compile a report and bring the child in question before a presiding officer of a children’s court. In terms of sections 46(1) and 156 (1), the children’s court may make an order or orders which are in the best interest of the child.

If the court finds the child needs care and protection, the following considerations for child placement are made:

- ✓ foster care with a suitable foster parent
- ✓ foster care with a group of persons or an organisation operating a cluster foster care scheme

Alternatives to foster care in terms of the Children's Act No. 38 of 2005 (as amended) include the following:

- ✓ adoption, including inter-country adoption
- ✓ shared care where different care-givers or child and youth care centres alternate in taking responsibility for the care of the child at different times or periods
- ✓ a child and youth care centre designated in terms of section 158 that provides a residential care programme suited to the child's needs
- ✓ a child-headed household subject to section 137
- ✓ a facility designated by the court which is managed by an organ of state or registered, recognised or monitored in terms of any law, for the care of children with disabilities or chronic illnesses in the case of a child with a physical or mental disability or chronic illness, and if it is in the best interests of the child to be cared for in such facility.

Despite the availability of these alternative care options for children in need of care and protection, foster care still remains the most viable option for many children including those living with HIV (Jo'Burg Child Welfare). This is in spite of the challenges in securing suitable foster care placement for these children.

Therefore, it is essential to stress that being HIV positive and being a child in need of care and protection at the same time is not easy (UNAIDS, 2001:13). Children living with HIV and their families or caregivers often find themselves in a complex situation as they try to navigate their "illness and treatment as well as the adverse psychological circumstances and poverty in which many live" (Vranda & Mothi, 2013:19). In addition to health needs such as regular medical attention and good nutrition, Vranda and Mothi add that children living with HIV are also subjected to life

stressors such as illness and death of parent(s), stigma and discrimination, abuse, loneliness and isolation, and family conflict and disintegration. Depending on the child's age, disclosure of one's HIV status to peers, friends and significant others can be troubling. Consequently, children with chronic illnesses in general and those living with HIV in particular are at greater risk for psychiatric problems and psychological distress, including depression, anxiety and feelings of isolation (Vranda & Mothi, 2013:20; DSD, 2011:3). According to these authors, depression and anxiety may undermine adherence to treatment.

Ross and Deverell (2010:106) point out that although many chronic illnesses are stigmatized, HIV carries a double stigma – that of being a terminal illness and a sexually transmitted disease. As a result, many HIV infected children and their families prefer to live in what Vranda and Mothi (2013:21) refer to as a “conspiracy of silence” and shame. The children and families become “withdrawn, socially isolated and emotionally cut off from traditional support systems” (Vranda & Mothi, 2013:21). This self-imposed secrecy and reactions to social stigma “may preclude families from procuring necessary treatment and seeking assistance with permanent planning for infected children, and obtain needed forms of social support” (Vranda and Mothi, 2013:22). Nevertheless, as HIV infected children move through adolescence and become sexually active, disclosure to friends and significant others becomes vital. These children require significant support through continuous education so that they can manage the complex issues of integrating healthy sexual development with their HIV infection, as well as making informed decisions regarding their actions and life choices (Vranda & Mothi, 2013:22).

Research has established that psychosocial support is critical for the health and development of children living with HIV as this may increase treatment adherence (Vranda & Mothi, 2013; Van Dyk, 2012; DSD, 2011:3). At this juncture, it is worth stressing that psychosocial support for these children's caregivers is equally essential, since caring for a child living with HIV is a gargantuan and stressing task (Charlesworth & Newman, 2006:235; UNAIDS, 2001:13). The caregiver or foster parent of a child living with HIV deals with crisis, illness, lack of resources and social isolation. Therefore, these caregivers or foster parents need medical, psychological

and social services (Vranda & Mothi, 2013:22, UNAIDS, 2001:16). The same authors propose interdisciplinary interventions oriented to improving the quality of life for these children and their caregivers. They also advocate for family-centred approaches to address family stressors, adaptation and cultural factors impacting on the whole family, as well as connecting the families to services and community resources and respite care through case management. All this needs to be done within an empowerment framework.

2.4. Foster care as an alternative care option for children in need of care and protection

Johnson (2004:1), Manukuza (2013:7) and Swanepoel (1999: ix) define foster care as the statutory substitute care within the family circle for children who cannot be cared for by their own parents in the short, medium or long term. The Children's Act No. 38 of 2005 (as amended) also defines foster care as the legal placement of a child who is in need of care and protection "in the care of a person who is not the parent or guardian of the child..." Foster care can be related, which is also referred in some literature as kinship care (Swanepoel, 1999: ix), or non-related. This means that a child in need of care and protection may be placed in the legal care of a relative or a non-relative (Manukuza, 2013:19).

Foster care is preferred as an alternative care option in the provision of basic needs for children in need of care and protection (Jo'Burg Child Welfare, 2013) including those children living with HIV (provided they are also in need of care and protection). The assumption or intention is that, in liaison with social workers, the foster parent/s will be able to provide adequate care and protection for these children, thus filling the gap left by the children's biological parents (De Jager, 2011:3). Unlike adoption, foster care is more acceptable as an alternative care option in many traditional communities mainly due to its temporary nature. Adoption is permanent and requires that the adopted child discard his or her biological lineage in favour of the one of the adopting family (Van Dyk, 2012:366, Mupedziswa, 1995:92). This becomes more unacceptable in cases of unrelated adoptions involving male children who are expected to continue with their biological family lineage (Van Dyk, 2012:366).

Approximately more than half a million children are currently in foster care in South Africa (Dlamini, 2014; Skelton, 2012:1). Based on these figures, one can point out that the country has almost the same number of children in foster care as those in the United States (Bruskas, 2008:70). However, South Africa has far a larger percentage of children in foster care than the USA, given the differences in the countries' national populations. Compared to the USA, most of these foster parents in South Africa are not well-resourced to deal with the several challenges associated with caring for children with special needs, including those living with HIV (De Jager, 2011: ii; Kganyago, 2006:11). Apart from the foster child grant that the foster parents receive from the government through the South African Social Security Agency (SASSA), there appears to be no further motivation for foster parents to care for HIV positive children.

2.5. Policies regarding foster care of children living with HIV in South Africa

A review of literature on policies shows that there are no specific policies and services in South Africa regarding the recruitment and special training of prospective foster parents of children living with HIV. In other words, HIV positive children are regarded as akin to other children in need of care and protection in spite of clear evidence that these children have unique and specific care needs (De Jager, 2011:3; Warwick, 2013:26). Their special needs are regular medical check-ups and emotional support (Harber, 1999:4). Added to these needs are issues of stigma and fear (Deacon & Stephney, 2007; Warwick, 2013: 53) that could influence potential foster parents' willingness or unwillingness to foster. Generally, there is a shortage of foster parents in South Africa (Swanepoel, 1999: i; Skelton, 2012:1; Mawere, 2009: iv). Thus, the children's unique needs and the associated stigma and fear further complicate the situation of securing foster parents for children living with HIV.

2.5.1. Legislative framework and rights of children

The United Nations Convention on the Rights of the Child is one of the international legal documents that set minimal acceptable standards for the wellbeing of all children (Van Dyk, 2012:357; UNAIDS, 2001:16). Many countries are signatories to this Convention and they are legally bound to conform to its standards. The South

African government signed the Convention in 1995, committing itself to abide by the Convention's guiding principles, namely:

- All children have the inherent right to life, survival and development
- All children should be treated equally (non-discrimination)
- In all policies and decisions regarding children, the wellbeing of the child should be the primary consideration, and
- The views of children should be respected and taken into account in all decisions concerning them (Van Dyk, 2012:357).

In 1990 member states of the then Organisation of African Unity (OAU), presently African Union (AU) adopted the African Charter on the Rights and Welfare of the Child entered into force in November 1999 (OAU, 1999). This was to reaffirm the member states' adherence to the principles of the rights and welfare of the child contained in the United Nations Convention on the Rights of the Child and other African declarations and conventions. In addition to the guiding principles of the Convention on the Rights of the Child mentioned above, the African Charter on the Rights and Welfare of the Child also recognises that:

- ✓ The child occupies a unique and privileged position in the African society and that for the full and harmonious development of his personality, the child should grow up in a family environment in an atmosphere of happiness, love and understanding, and
- ✓ The child, due to the needs of his physical and mental development requires particular care with regard to health, physical, mental, moral and social development, and requires legal protection in conditions of freedom, dignity and security.

In short, all children have the right to survival, protection, development and participation (Smart, 2003:175; Van Dyk, 2012: 357). This includes children living with HIV. Both the United Nations Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child recognise the importance of a family environment in the healthy upbringing of a child. As such foster care remains an important option when natural family care fails. This is despite the challenges faced by designated social workers in placing children living with HIV in foster care.

The South African government put in place a piece of legislation on children that emphasises the best interests of the child as well as participation in decisions that concern the child (UNAIDS, 2001:16) to show its commitment to children's rights and the guiding principles of both the United Nations Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child. The Children's Act No. 38 of 2005 (as amended) ensures that the rights of all children, including those living with HIV who need care and protection, are not infringed. Such legislation is meant to empower vulnerable children by addressing stigma, discrimination and labelling which operate against these children's wellbeing (Vranda & Mothi, 2013:20). Similarly, the placement in foster care of children in need of care and protection is meant to protect the child's right to survival, protection and development (Van Dyk, 2012:365).

In spite of the obvious strengths of the Children's Act No. 38 of 2005 (as amended), there are also some loopholes with regard to the placement of children living with HIV in alternative care. The said Act vaguely mentions that a children's court may issue an order placing a child found to be in need of care and protection in a facility provided that the court finds that "the child has a physical or mental disability or chronic illness" and if it is in the best interests of the child to be cared for in such facility. It remains a conjecture whether HIV is among the chronic illnesses referred to in this section of the Act. Moreover, it is debatable whether such facilities exist in many parts of the country and/or are adequately equipped to deal with children living with chronic illnesses such as HIV.

Foster care remains the most viable option for the care of children in the event that family care fails in South Africa (Jo'Burg Child Welfare, 2013; Mawere 2009:1). The most available literature on foster care states the important aspects of effective foster care. Manukuza (2013), De Jager (2011), Kganyago (2006) and; Swanepoel (1999) concur in their conclusions that a lot still needs to be done in order to improve the current foster care system within the country. The current policies and legislation in South Africa do not adequately address the plight of children living with HIV in terms of securing suitable foster care placement.

2.6. Previous research on the foster care of children living with HIV

Due to the devastating effects of HIV and AIDS, no other virus has led to so much research and new developments than HIV (Van Dyk, 2012:11). Within the plethora of studies on HIV and AIDS and foster care in South Africa and Africa in general, researchers have devoted more effort on kinship foster care (Manukuza, 2013; Swanepoel, 1999), the foster care of AIDS orphans (De Jager, 2011; Chidakwa & Majoni, 2004), stigma (Deacon & Stephney, 2007), and child-headed households (Muronda, 2009). The flood of information has therefore dwelt largely on the 'affected' children than the 'infected' ones. In other words, most research has concentrated mainly on the care of children orphaned by HIV and AIDS compared to those living with the virus (De Jager, 2011:1).

Noteworthy, nonetheless, is that most of these previous studies have discovered that the foster care system particularly in relation to victims of HIV whether infected or affected, is still marred with some challenges. For instance, De Jager's (2011) study confirmed that the needs of AIDS orphans differ from those of other foster children and that, social workers still face numerous obstacles in their plight to render effective support and training to foster parents. In a similar vein, Manukuza's (2013) study concluded, among other issues, that social workers rendering foster care services require intensive on-the-job training so as to ensure quality service delivery.

Warwick (2013) conducted an almost similar study, however focusing on the experiences and needs of foster carers of HIV positive children. She found out that, foster carers of HIV infected children face multifaceted challenges, among them, finances, stigma and fear, interactions with biological parents, dual diagnoses, and the foster carers' own physical and mental health (Warwick, 2013:2). Thus, Warwick (2013:96) recommended that further research which includes other role players such as social service practitioners would go a long way in addressing the plight of children living with HIV as well as informing policy.

Other few studies that focus on the foster care of children living with HIV have been conducted outside Africa (Cohen & Nehring, 1994), making it difficult to generalise

the findings in the African context mainly due to differences in culture, availability of resources as well as the impact of the epidemic.

There are still some research gaps on HIV infected children who are in need of care and protection and their plight to secure adequate care in the form of foster care. There is also the need to probe into the causes of the reluctance by some parents to foster children living with HIV. As the HSRC notes, “stigma towards and discrimination of people living with HIV (PLHIV) remains a major barrier to effective HIV prevention, as well as to the provision of treatment, care and support” (2014:99). The issue has been ignored by many researchers who have conducted studies in the past. This research was therefore intended to address this dearth of information through the gathering of data on the views of foster parents regarding the fostering of children living with HIV.

It is also noted that most of the available information on HIV (UNAIDS, 2010; SANAC, 2011), especially from surveys conducted by UNAIDS, is quantitative in nature. Therefore, there is need to explore the challenges in placing children living with HIV in foster care through qualitative research.

2.7. Role of social workers in the placement in foster care of children living with HIV

According to the National Association of Social Workers (NASW) (2008:1) “the primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people with particular attention to the needs and empowerment of people who are vulnerable, oppressed and living in poverty”. Put differently, social work strives towards enabling “all people to develop their full potential, enrich their lives, and prevent dysfunction through intervention at the points where people interact with their environments” (International Federation of Social Workers, 2012:1). Equally, the purpose of social work includes the promotion of social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being (IFSW, 2012:1).

The role of social workers remains critical in securing alternative care for children in need of care and protection in general and those living with HIV in particular. Working with these children in foster care “will remain a demanding and rigorous aspect of social work practice as difficult decisions in fast moving and often complex situations have to be made with a vast array of legislation, law and social policy to understand” (Brown, 2014:1). Social workers provide, among other things, supportive and cognitive therapy to children living with HIV and their foster parents; bearing in mind that these children and their caregivers are most vulnerable to mental health problems, separation and loss (Vranda & Mothi, 2013:21). They perform these functions while recognising the central importance of human relationships (Hepworth, Rooney, Rooney & Strom-Gottfried, 2013:7).

In essence social workers will continue to be useful in providing the following services for HIV positive children:

- Age-appropriate counselling to the children and their foster parents
- Sexual abuse counselling where appropriate
- Promoting the development and implementation of policies that establish the right of the children not to suffer discrimination and stigma, for example, at schools and other places
- Promoting measures that enable the children to stay in school
- Developing special foster and adoptive schemes for the children
- Establishing support networks such as nutrition and day care centres
- Providing practical support and mobilise financial and material resources
- Ensuring that foster parents are in receipt of the foster child grant for these children
- Helping the foster parents understand the psychosocial needs of the children
- Helping dispel myths about HIV and AIDS and promote positive attitudes towards the children within families and communities
- Encouraging and equip community members to support these children in ways that will not stigmatise them, and
- Mobilising and training peer-educators (Harber: 1999:2-4).

2.7.1. Importance of HIV education by social workers in the caring of children living with HIV

Charlesworth and Newman (2006:236) define education in the context of HIV as “those interventions” by social workers “designed to provide specific information about the disease process and care giving skills.” The purpose of HIV education by social workers “is not only to disseminate information, but also to change attitudes and behaviour, to empower people with the necessary life skills, to empower them to prevent the spread of HIV and to help them care for people who are already infected” (Van Dyk, 2012:152). Van Dyk (2012:152) adds that the purpose of HIV education “is further to empower people to understand their rights and to insist that these rights are respected and honoured by the community, by society, and by government.”

As professionals who seek to enhance the social functioning and wellbeing of individuals, social workers in the health care setting are expected to be active, albeit within a multidisciplinary team (Dhooper, 2012:1), in areas such as the provision of HIV education particularly in the context of children in need of care and protection. This education is given to the children living with HIV themselves, their caregivers (foster parents) as well as the community at large. Teenagers living with HIV need repetitive education on daily living with the virus, and how it will mould the decisions they make in their social lives (Vranda & Mothi, 2013:22). These decisions involve managing their own health, disclosing to friends and significant others and making healthy sexual choices. In the same way, caregivers or foster parents need to be educated and empowered on caring skills particularly when HIV infection progresses to AIDS; a stage when caregivers are overwhelmed and have difficulty in communicating with the child about issues related to prognosis and death (Vranda & Mothi, 2013:21).

2.8. The essence of empowerment in the foster care of children living with HIV

A review of definitions of empowerment reveals that the term has different meanings in different disciplines, socio-cultural and political contexts (World Bank, 2011:10). Nonetheless, all these definitions point to a common inference that empowerment is relevant at both the individual and collective levels. The World Bank (2011:1) defines

empowerment as “the process of enhancing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes. Central in this process is action which builds individual and collective assets, and improves the efficiency and fairness of the organisational and institutional context which govern the use of these assets.” Foster parents’ and foster children’s capacities need to be enhanced so that their voices are well-heard in the foster care process.

Although the Children’s Act No. 38 of 2005 (as amended) emphasises the importance of participation by all role players involved, including the foster parents and children, this is not the case in practice as foster parents and children are still not fully involved in issues affecting their lives (Sibanda, 2014:88). They therefore need to be more empowered. Similarly social workers also feel not fully empowered by the said Act as more powers in determining whether a child is in need of care and protection are vested in the presiding officers of the children’s court. This in turn contributes towards the challenges faced by designated social workers in placing children living with HIV in foster care (Sibanda, 2014).

2.8.1. Summary of the empowerment theory

Van Dyk (2012:149) summarises the empowerment theory by stating that it involves processes and outcomes. The processes of empowerment include participation in community organisations, collective decision-making and shared leadership and collective action to access government and other resources. The outcomes may include situation-specific perceived control and resource mobilisation skills, development of organisational networks, organisational growth and policy leverage, evidence of pluralism (or diversity), existence of organisational coalitions and accessible community resources. Resource mobilisation such as finances (raising the foster child grant) is critical in empowering both the children living with HIV, the foster parents who take care of the children and the social workers who place the children. These resources will enhance the fostering of children living with HIV. Inclusion and participation are also core elements within an empowering approach. However, an effort to sustain inclusion and informed participation usually requires changing the rules to create space for people involved in the foster care of children

living with HIV “to debate issues and participate directly or indirectly in local and national priority settings, budget formation, and delivery of basic services” (World Bank, 2011:1). In this regard role players such as social workers should be actively involved both at local and national levels on issues like policy formulation and budget formation. They need to state the challenges which they face in placing children living with HIV in foster care and possible ways of addressing these challenges.

2.8.2. Connection between the empowerment theory and other social theories

The empowerment theory encompasses concepts from other social theories such as feminism, ecological and social network (Sadan, 1997:138; Van Dyk, 2012:149). Payne (2005:295) observes that the empowerment theory borrows certain philosophies from related theories like Radical and Democratic theories, Community Development, Feminist and Anti-Discriminatory theories, Strength-Based theories, and the Psychodynamic theory. This in turn makes it a very strong approach to social change, especially in the context of people living with HIV who still suffer stigma and discrimination in society (HSRC, 2014:99; Van Dyk, 2012:153). Due to this stigma and discrimination, children living with HIV continue to be side-lined by prospective foster parents thus resulting in the challenges faced by social workers in securing suitable foster care placement for these children.

2.8.3. Social inclusion and participation as tenets of empowerment in the foster care of children living with HIV

Social inclusion is the process of “improving the terms for individuals and groups to take part in society. It is about enabling people and communities to fully participate in society” (World Bank, 2013:1). Social inclusion “aims to empower poor and marginalised people to take advantage of burgeoning global opportunities and ensures that people have a voice in decisions which affect their lives and that they enjoy equal access to markets, services and political, social and physical spaces” (World Bank:2013:2) The African Development Foundation (ADF) (2013:1) defines participation as “a process through which all members of a community or organisation are involved in and have influence on decisions related to development activities that will affect them”. Scrutiny of the definitions of the terms social inclusion

and participation shows that inclusion is about the participation of individuals, groups and communities in activities and decisions that affect their lives.

The placement in alternative care (such as foster care) of children in need of care and protection including those living with HIV is meant to empower the children so that they may have equal life opportunities as other children raised in natural families. The designated social workers responsible for placing them in alternative care and the foster parents raising these children equally need empowerment. Empowered people have freedom of choice and action. In turn, this enables them to influence the course of their lives and decisions which affect them better (World Bank, 2011:1). The empowerment theory is one of “those new social theories attempting to connect the personal and the social, the individual and society, the micro and macro” (Sadan, 1997:137). Van Dyk (2012:149) also notes that according to this theory, “empowerment is a central tenet of community organization practice, which refers to the process by which individuals and communities are enabled to take power and act effectively in transforming their lives and environments.”

Participation and empowerment are critical aspects in the foster care of children living with HIV. In fact, participation is a cardinal element of empowerment (World Bank, 2011:1). Therefore, social workers have to create a partnership with the foster parents, not as superiors but as equal partners, though with the overall role of overseeing the quality care of children living with HIV. In essence, empowerment also means that social workers have to tap into and mobilise the foster parents’ power by collaboration with them to develop their competence to alter or improve their situation (Hepworth et al., 2013:420). Consequently, “when individuals in a community have access to and can manage their own development resources such as information and skills training, they develop a sense of control over their lives, which can ultimately lead to a stronger involvement in their community’s health and their own growth” (ADF, 2013:3). A sense of ownership on issues that affect individuals or communities will result in fervour by those individuals to ensure that they fully utilise resources or projects at their disposal so that these resources or projects do not turn into white elephants (Hepworth et al., 2013:420).

Thus, an empowering approach to participation in the foster care of children living with HIV treats all players, including poor people such as some foster parents and the children themselves, as co-producers with authority and control over decisions and resources devolved to the lowest appropriate level (World Bank, 2011:1).

Empowerment also aims at bringing social change among individuals and society through dialogue; to build up a critical perception of the social, cultural, political and economic forces that structure reality, and by taking action against forces that are oppressive (Sadan, 1997:138; Kiragu & Pulerwitz, 1999:3). In other words, empowerment should increase problem-solving in a participatory fashion and should enable participants to understand the personal, social, economic, and political forces in their lives in order to take action to improve their situations. This is very important in exploring and addressing challenges in the foster care of children living with HIV. Also inherent in empowerment is the premise that professionals such as social workers should relinquish authoritative positions and engage as partners and advocates on the users' terms (Askheim, 2003:233). Social workers need to pay attention to the issues raised by foster parents with regard to the challenges foster parents face in raising a child living with HIV. This will help in formulating strategies that will improve the status quo.

2.8.4. Benefits of an empowering approach in the foster care of children living with HIV

The benefits of an empowering approach in the foster care of children living with HIV are worth-mentioning. Empowerment seeks to capacitate vulnerable members of society, women and children included. As De-Graft Aikins, Boynton and Atanga (2010:3) observe "... the empowerment theory views participation as a means of empowering marginalised people to make their own choices and critically foregrounds as its broader objective socio-political change". The World Bank (2011:1) also adds that "inclusion of people and other traditionally excluded groups in priority setting and decision-making is critical to ensure that limited public resources build on local knowledge and priorities and to build commitment to change". Thus both the foster parents and children in their care need to fully participate in issues about challenges that they face.

By recognising the plight of marginalised groups, an empowerment theory can therefore be regarded as anti-discriminatory and gender-sensitive (Sadan, 1997:138; DSD, 2011:3). This obviously is a welcome development, particularly in the case of adults and children living with HIV, who continue to endure some negative attitudes, stigma and discrimination in some circles of society (HSRC, 2014:99). Van Dyk (2012:153) argues that “one of the underlying themes through all our attempts to change behaviour (on an individual, social and structural level) is negative attitudes.” She adds that HIV-related “stigma and discrimination remain the greatest obstacles to people living with HIV infection or AIDS. Stigma and discrimination increase people’s vulnerability, isolate them, deprive them of their rights, care and support, and worsen the impact of infection” (2012:153) This recognition of traditionally excluded groups is also a positive development on the part of women who form the majority of foster parents and who have been undermined, exploited and underprivileged since time immemorial.

Furthermore, an empowering approach views social problems from multi-dimensional angles (Sadan, 1997:136; De-Graft Aikins et al., 2010:4). These angles are political, economic, social, religious, cultural, personal and environmental. Individuals’ perceptions and attitudes towards people living with HIV may also be influenced by a complex combination of factors – religious, economic, social, political and environmental. As Van Dyk (2012:153) cogently points out that those factors such as stigma and discrimination against people living with HIV do not arise in a vacuum but “emerge from and reinforce other stereotypes, prejudices and social inequalities relating to gender, nationality, ethnicity and sexuality”. Therefore, Hick (2006:381) advances the notion that empowerment is a sense that individuals, groups and communities “can create and take action on their own behalf to meet their physical, spiritual and psychological needs to enhance wellbeing and increase personal and interpersonal power”. Foster parents should be empowered to come up with solutions to address challenges that they face in caring for children living with HIV. This can be achieved by linking them to support groups where they can discuss problems which affect them and the children in their care.

Noteworthy, in this definition is the notion that empowerment aims to address the holistic needs of individuals, groups and communities for the betterment of their lives. It is “a multi-dimensional social process that fosters power in people for use in their own lives, their communities and in their society, acting on issues they define as important” (Page & Czuba, 1999:3). Such an approach is ideal and relevant in dealing with the challenges of placing children living with HIV in foster care.

2.9. Summary

The chapter has reviewed literature on the foster care of children living with HIV. The empowerment theory was also discussed in detail. The available literature, policies and services seem to be fragmented, thus failing to directly address the plight of children living with HIV, foster parents and the social workers who are supposed to place these children in foster care. It is the researcher’s opinion that the challenges designated social workers currently face in placing children living with HIV in foster care need urgent intervention before the situation reaches monumental proportions. Largely, this can be addressed through empirical data gathering, which is what this study sought to achieve. Therefore, the findings and recommendations from this study will inform responsible authorities and the public about children living with HIV who are in need of care and protection.

Chapter 3 will centre on the research methodology and empirical findings of the study.

CHAPTER THREE

RESEARCH METHODOLOGY AND EMPIRICAL FINDINGS OF THE STUDY

3.1. Introduction

The focus of this chapter is on the research methodology as well as the research findings. The goal of the study was to investigate the challenges experienced by social workers in placing children living with HIV in foster care in Johannesburg. The chapter begins with a description of the research question(s), research approach, type of research, research design, research methods as well as the ethical considerations made in this study. The research findings are presented in the second part of the chapter; starting with the biographical details of the participants then a discussion of the themes and subthemes that emerged during data collection and analysis. These themes and subthemes are amalgamated with literature where necessary. The chapter ends with a summary.

It is vital to state that due to the exploratory nature of the study, the findings might not be generalised to all foster parents and social workers in the service of child protection organisations vis-à-vis foster care of children living with HIV but are particular to the study population under investigation.

3.2. Research question

The primary research question of the study was:

What are the challenges experienced by social workers in placing children living with HIV in foster care in Johannesburg?

Alpaslan (2010:8) observes that research questions should evolve from and be closely related to the research topic and the research problem. In other words, the research question “specifies what intrigues you and focuses on what you will study” (Jansen, 2007:3). It delimits the focus of the research and is like a summary of the research problem as it presents the research problem in a single statement in the form of a question. A good research question is usually linked with the review of the

literature (Fouché & Delpont, 2011:108) that is, directing the researcher to appropriate literary sources as well as providing with a focus for data collection (Jansen, 2007:3).

It is therefore very clear that the above primary research question is directly speaking to the research topic. Furthermore, the research question is open-ended (as it starts with the word 'what') thus allowing participants to give "a multitude of possibly diverse answers (that is, views, thoughts, perceptions and experiences). The question conveys an open and emerging design" (Alpaslan, 2010:9).

Maree and Van der Westhuizen (2007:25-26) emphasize the importance of secondary questions flowing from the primary question. However, Alpaslan (2010:9) warns that the qualitative researcher should be aware of asking no more than five to seven sub-questions. In this regard, the following were the secondary or subsidiary (Jansen, 2007:11) questions for the study:

- What are the specific policies regarding the placement of HIV-infected children in South Africa?
- What are the views and concerns of foster parents regarding fostering children living with HIV?
- To what extent do these views and concerns contribute to the challenges faced by social workers in placing children living with HIV in foster care?

The main or primary question as well as the secondary or subsidiary questions usually informs the formulation of the research goal and objectives (Alpaslan, 2010:10; Fouché & Delpont, 2011:108). This is what happened in this study that the research questions informed the research goal and objectives.

3.3. Research approach

Nieuwenhuis (2007:51) postulates that "qualitative research is concerned with understanding the process and the social and cultural contexts which underlie various behavioural patterns and the emphasis is on the quality and depth of information". Since qualitative research is concerned mostly with exploring the 'why' questions of research (Nieuwenhuis, 2007:51), this approach was relevant for this

study since the purpose of the study is to explore the challenges and the reasons thereof in placing children living with HIV in foster care. Furthermore, the phenomenon was investigated in a naturalistic context with the players involved in foster care without any manipulation of variables or situations (Holloway & Wheeler, 1996; Nieuwenhuis, 2007:51).

Fawole, Egbokhare, Itolia, Odejide and Olayinka (2006:6) advance that qualitative research has the strength of understanding context, diversity, nuance, and process in this complex and multi-dimensional social world. The researcher therefore utilised qualitative research techniques in order to build rapport with the participants easily and to get as much information as possible (Obono, Ajuwon, Arowojolu, Ogundipe, Yakubu & Falusi, 2006:45).

3.4. Type of research

The type of research was applied. In the words of Fouché and De Vos (2011:94), applied research, is “the scientific planning of induced change in a troublesome situation.” Its emphasis is on addressing and solving immediate problems facing practising professionals within a given discipline. It is evident that there were already some perceived problems in the fostering of children living with HIV (Rungani, 2013; Mandikonza, 2013). The designated social workers were and still are experiencing challenges in performing their legal mandate of placing children in need of care and protection in foster care. There was therefore need to address this problem in practice.

3.5. Research design

The collective case study design was selected for this study. Referring to the choice of a case study, Fouché and Schurink (2011:322) argue that it is not easy to keep to one type of case study as there is always an overlap among the different types of case studies. Nonetheless, the collective case study was specifically chosen mainly for its popularity in qualitative research as well as the use of focus group discussions with a number of participants. Secondly, a typical characteristic of case studies is that they strive towards a holistic understanding of relationship and interaction among participants in a specific situation and the way they give meaning to a

phenomenon under study (Nieuwenhuis, 2007:75). Nieuwenhuis (2007:75) adds that “Case studies offer a multi-perspective analysis in which the researcher considers not just the voice of one or two participants in a situation, but also the views of other relevant groups of actors and the interaction between them”. Nieuwenhuis (2007:75) also identified another advantage of the case study method as the utilisation of multiple sources and techniques in the data gathering process. Therefore, the researcher collected data from designated social workers and foster parents.

Critics of the case study design argue that it lacks scientific rigour and generalizability. However, Nieuwenhuis (2007:76) points out that this is not the purpose of case study research as it aims to gain greater insight and understanding of the dynamics of a specific situation. Nevertheless, in view of the criticism levelled against case studies, the researcher ensured that these challenges did not affect the quality of the study by continuously monitoring all interpretations and eliminating biased views (Hinckley, 2007).

3.6. Research methods

The following section focuses on the research methods adopted for this study.

3.6.1. Study population and sampling

3.6.1.1. Study population

Strydom (2011:223) states that population “refers to individuals in the universe who possess specific characteristics.” This study was conducted at Jo’Burg Child Welfare (formerly Johannesburg Child Welfare Society). In this regard, the population for the study were all the designated social workers in the service of Jo’Burg Child Welfare who render foster care services to children, including children living with HIV, in need of care and protection, and all foster parents recruited and supervised by the organisation. Jo’Burg Child Welfare was chosen specifically for its experience and expertise (Nieuwenhuis, 2007:79) in rendering child protection services in general, and foster care in particular. Jo’Burg Child Welfare has been in existence for more than a century. It has more than twenty social workers who render foster care services to a large client group, mainly in the Johannesburg CBD. Therefore, it was

the researcher's opinion that this organisation would be ideal in providing the designated social workers as well as foster parents as participants for this study.

3.6.1.2. Sampling

Sampling refers to the process used to select a portion of the population for study (Nieuwenhuis, 2007:79). Qualitative research is generally based on non-probability sampling (Strydom, 2011:228; Nieuwenhuis, 2007:79). The researcher used purposive sampling to select designated social workers as well as foster parents. Nieuwenhuis (2007:79) states that purposive sampling "simply means that participants are selected because of some defining characteristics that make them the holders of the data needed for the study."

Criterion sampling, as part of purposive sampling technique, implies that the researcher decides at the design stage the typical characteristics of participants to be included (Nieuwenhuis, 2007:80). In this regard, the following selection criteria were utilised in selecting the two samples from the designated social workers and the foster parents.

- **Selection of the designated social workers:**
 - ✓ Minimum of three years' experience in rendering child protection services
 - ✓ To be in the service of Jo'Burg Child Welfare and in the team that renders services in the Johannesburg CBD
 - ✓ Working in the Child and Family Unit (CFU) (responsible for the recruitment and screening of foster parents as well as the placement of children in need of care and protection in foster care)
 - ✓ Competent in both spoken and written English
 - ✓ Available for and willing to participate in the study.

For the selection procedure, the researcher first sought permission from the organisation's management to interview the participants. After permission had been granted, the researcher requested for the list of all social workers in the CFU department from the organisation's management. The first thirteen social workers who met the above selection criteria were involved in the study. The researcher

selected participants whom he believed were 'informed and information-rich' because they had experience of the phenomenon under investigation, thus were the most suitable to answer the research questions (Alpaslan, 2010:21).

▪ **Selection of the foster parents**

The researcher requested social workers to recruit foster parents. The criteria for the selection for the foster parents were:

- ✓ Minimum of three years' experience in fostering children who were placed and supervised by Jo'Burg Child Welfare
- ✓ Residing in the Johannesburg CBD
- ✓ Able to communicate in English
- ✓ Available for and willing to participate in the study

The first eleven foster parents who met the required selection criteria and volunteered to participate were involved in the study.

3.6.2. Data collection

The researcher used interviewing as a data collection technique for this study. Interviewing is a common mode of collecting data or information in qualitative research whereby there is a direct interchange with an individual or group believed to possess the knowledge being sought (Greeff, 2011:352). Many authors write about the communication and other techniques required in interviewing and stress the point that the researcher needs to be conversant with tips such as attentive listening, clarification, probing, reflection, among others (Greeff, 2011; Fawole et al., 2006; Nieuwenhuis, 2007).

The focus group interviews or discussions were selected for primary data collection. Focus group interviews or discussions were conducted with the social workers and the foster parents. Two focus group meetings were held with the social workers and another two with foster parents. One group of social workers consisted of seven participants whilst the other had six participants. With regards to foster parents, one group had six participants and the other group consisted of five participants. Dividing

participants into small groups made the focus group discussions manageable and allowed every member to participate fully (Greeff, 2011:366).

Nieuwenhuis (2007:91) points out that, in a focus group “a moderator directs discussion with the purpose of collecting in-depth qualitative data about a group’s perceptions, attitudes and experiences on a defined topic.” In this case, the researcher was the moderator or facilitator of the discussions (Greeff, 2011:360). The researcher was assisted by a registered social worker in taking notes and observing certain features such as nonverbal cues and interactive process (Fawole et al., 2006:10). The researcher and the assistant were very attentive during the focus group discussions with designated social workers and foster parents.

A “funnel structure” (Nieuwenhuis, 2007:91) was used as a format for the focus groups. The researcher started with broad and less structured questions to make the participants comfortable to be interviewed and to obtain their general perspectives on the issues to be discussed. As the participants became actively engaged in the discussion, the moderator’s questions became more structured and focussed on the study topic. Every member was encouraged to participate and was given an opportunity to express their views.

An interview guide (Greeff, 2011:352; Alpaslan, 2010:22) together with supportive data gathering techniques in interviewing such as note-taking, recording proceedings and capturing non-verbal cues were used during the focus group discussions. The interview guide assisted the researcher in resolving some of the common shortcomings of unstructured interviews. The interview guide had themes that the researcher constantly referred to during the focus group discussions. All the interviews were tape-recorded (after first seeking both verbal and written consent from the participants) in order to allow the researcher ample time to analyse and interpret the participants’ “perceptions, attitudes, understanding, knowledge, values, feelings and experiences” about the phenomenon (Nieuwenhuis, 2007:99).

3.6.3. Data analysis

Babbie (2007:378) defines qualitative data analysis as the “...nonnumeric examination and interpretation of observations, for the purpose of discovering underlying meanings and patterns of relationships.” Many authors concur that data analysis in qualitative research is an on-going and iterative process; meaning that there is an intertwinement among data collection, processing, analysis and reporting (Nieuwenhuis, 2007; Schurink, Fouché & De Vos, 2011; Creswell, 2009). The researcher continuously analysed the feedback from the participants as the research progressed. Although it is generally agreed that the process of data analysis is eclectic and there is no one size fits all (Alpaslan, 2010:25), in addition to what has already been stated above, the researcher adopted a “step-wise format” for qualitative data analysis proposed by Creswell (2009:186). This included the following:

- The audio-taped interviews were transcribed word for word and typed on A4-sized papers.
- The transcripts were read several times in order to get a sense of the whole and deduce meaning from the transcribed data. Notes of ideas and thoughts were written in the margins of the transcripts. This was done together with the field notes which were collected during data collection phase in order to group similar views together. Data from foster parents were organised separately from the social workers’ data.
- Recurrent views were identified and similar topics were grouped together (Schurink et al., 2011:402). A comparison of the information collected from designated social workers and foster parents was made in order to identify the similarities and differences in the views expressed by these groups.
- These similar topics were regrouped into themes and sub-themes.
- The themes were grouped according to their categories (Schurink et al., 2011:402,410). Data themes were allocated different codes in the form of numbers and colours.
- The researcher re-examined themes that emerged from the discussions. This was done in order to ensure that there was no redundancy of the same information contained in the themes.
- Reporting of findings then followed.

3.6.3.1. Trustworthiness of qualitative data

Lietz, Langer and Furman (2006:444) state that trustworthiness in qualitative research “is established when findings as closely as possible reflect the meanings as described by the participants.” Guba (1981:75) proposes four criteria when pursuing trustworthiness of qualitative data. These are credibility, transferability, dependability and conformability. Credibility or authenticity which is the alternative to internal validity deals with the question of “how congruent are the findings with reality” (Shenton, 2004:64). In order to describe the research findings in a way which authentically represents the meanings as described by the participants and minimise threats to data trustworthiness, the researcher used a variety of strategies. Peer debriefing was used to interpret the data (Nieuwenhuis, 2007:80; Schurink et al., 2011:420). The researcher also applied member checks whereby participants were asked to verify the accuracy of the data by considering whether or not their words matched what they actually intended (Shenton, 2004:68). In addition, credibility was enhanced through triangulation. This involved combining data from the interviews with social workers and foster parents with the available literature on the topic (Shenton, 2004:66). The researcher made necessary comparisons whether the data pointed to the same conclusions (Nieuwenhuis, 2007:80; Schurink et al., 2011:420).

Another construct, transferability, refers to “whether the findings of the research can be transferred from a specific situation or case to another” (Schurink et al., 2011:420). The term transferability is used in qualitative data in preference to external validity or generalisability (Shenton, 2004:64). Several authors such as Schurink et al. (2011:420) and Shenton (2004:70) mention the challenges associated with this strategy and warn that researchers should try to minimise threats to data trustworthiness. The researcher involved two groups of participants namely designated social workers and foster parents in order to enhance trustworthiness of the data. In addition, the researcher also indicated in the study limitation section that findings of this study should be considered in the context of the setting in which the study was conducted.

Schurink et al. (2011:420) note that dependability is the alternative to reliability. The researcher seeks answers on whether the research process is logical and whether

similar results would be obtained if the work were repeated. Schurink et al. (2011:421) argue that “This assumption of an unchanging world is in direct contrast to the qualitative/interpretive assumption that the social world is always being constructed, and the concept of replication is itself problematic.” However, based on Shenton’s (2004:71) observation about the close ties between credibility and dependability, the researcher believes that the strategies applied to ensure credibility also enhanced dependability.

Lastly, conformability, which is the alternative to objectivity means that the researcher needs to ask whether the findings could be confirmed by another (Schurink et al., 2011:421). The researcher ensured conformability through reflectivity and audit-trail. A detailed description of the research methodology was also provided in order to enable readers to determine how far the data and constructs emerging from it may be accepted (Shenton, 2004:72).

3.6.4. Pilot study

Strydom and Delport (2011:394) note that the pilot study in qualitative research “is usually informal, and a few participants possessing the same characteristics as those of the main investigation can be involved in the study, merely to ascertain certain trends.”

With regards to focus group discussions, Greeff (2011:370) states that “although pilot testing is a cardinal rule of research, it presents problems with focus groups.” She concludes that the true pilot test is the first focus group with the participants. The researcher nevertheless pilot tested the focus group discussions with two designated social workers and two foster parents (from Jo’Burg Child Welfare) so that results from participants in the main study could be included in the data. Purposive sampling was also utilised in selecting participants for the pilot study. Only social workers with minimum of three years’ work experience in rendering child protection services and foster parents were also expected to have minimum of three years’ experience in fostering children formed the pilot study participant group. Both the social workers and foster parents were willing to participate in the study.

Findings made during the pilot study were not used in the main investigation but the information was useful for making amendments to the interview guide where appropriate. The pilot study was also helpful in ascertaining the feasibility of the study overall.

3.7. Ethical considerations

For the purpose of this study, the researcher used the ethical considerations template from the Faculty of Humanities of the University of Pretoria (Delpont, 2012:22). The following ethical issues were addressed:

3.7.1. Informed consent and voluntary participation

Neuman (2006:96) states that a fundamental principle of research is that participation must be voluntary. This can only be achieved if participants are aware of all aspects of the research process and procedures, and give informed consent. Consent was sought from the designated social workers and foster parents prior to the study. With regards to foster parents, the researcher compiled an introductory letter which the social workers used to recruit foster parents. This introductory letter contained information such as identification details of the researcher, goal of the study, issues of confidentiality, among any other important information regarding the study. The researcher only engaged directly with the foster parents to finalise meeting arrangements after the foster parents had already communicated their availability for the study with the social workers. Verbal consent from the social workers and the foster parents was obtained through a telephone conversation.

Before the focus group discussions commenced, the researcher presented the participants with letters of informed consent where the research process was described. The information included the duration of the study, the risks and discomfort that might be associated with participation, guarantee on anonymity and confidentiality, any benefits or compensation that might be provided to participants, and an offer to provide a summary of the findings. Each participant was given an opportunity to read the letter, ask questions for clarity and sign the informed consent letter if s/he was willing to take part in the research. The participants were reminded about their right to withdraw at any point of the process if they so wished.

The researcher also sought consent from the participants to tape-record the interviews. This information was contained in the letter of informed consent given to each participant. Participants were also informed in the letter of informed consent that raw data would be stored at the University of Pretoria for fifteen years.

3.7.2. Avoidance of harm

Many authors agree that an important principle of social research is that it must not expose participants to undue physical, emotional or psychological harm (Leedy & Ormrod, 2005; Babbie, 2010). Strydom (2011:115) argues that although physical injury cannot be completely ruled out, emotional harm is the most dominant in social science research. Therefore the researcher should make an effort to minimise risks prior to the commencement of the study than attempting to repair and minimise these risks afterwards. Thus, measures to assist participants to access services in the event of any emotional harm were made available.

3.7.3. Privacy, anonymity and confidentiality

All the information from participants was kept private and the results and findings of the study are presented anonymously in order to protect the participants' identities. The participants were also informed about the purpose of the study and that data were only going to be accessed by the research team members and the supervisor(s). They were also assured that confidentiality was going to be maintained in the study in order to protect the privacy of participants, even where their identities were known to each other (as was the case among most of the participants) and the researcher (Strydom, 2011:120). Participants were also assured that any information such as names and addresses that might physically identify them would not be included in the transcriptions, the research report or any further publication; bearing in mind that views on HIV could be a sensitive matter. The researcher highlighted in the informed consent letter that raw data would be securely stored by the University of Pretoria for a minimum period of fifteen years as per the University's stipulations.

3.7.4. Debriefing of participants

In qualitative research participants are usually taken through a directed and reflective process which can affect them as they discover things about themselves that they did not know before (Strydom, 2011:122). Consequently problems created by the research experience needed to be corrected through debriefing. In addition to other precautions against harm, the researcher ensured that participants got “the opportunity to work through their experience and aftermath” (Strydom, 2011:122) of their participation in the research. They had to freely discuss their experience and express and share their feelings. Debriefing further served the purpose of clarifying any misconceptions related to the research.

3.7.5. Deception of participants

Strydom (2011:118) notes that deception refers to misleading participants and the deliberate misrepresenting of facts or withholding of information from participants usually with the intention of generating meaningful research information. The researcher did not use any form of deception in this study.

3.7.6. Compensation

Strydom (2011:121) reasons that the reimbursements for costs incurred by participants may not be regarded as unethical. In this regard, the participants’ transport costs were reimbursed. They were also given refreshments during the focus group discussions as a token of appreciation.

3.7.7. Actions and competence of the researcher

The fact that the researcher is a registered social worker who, as part of his studies, did courses in research methodology both at the undergraduate and postgraduate levels are sufficient indications that he possessed the necessary skills to conduct the study. The researcher conducted himself in an honest, respectful and competent manner throughout the research process.

3.8. Empirical findings of the study

The findings of this empirical study are presented in detail in this section. The section begins by providing the biographical profile of the participants. This is followed by a

discussion of the themes and sub-themes that emerged during the focus group interviews with the social workers and the foster parents. First, the themes and sub-themes are presented in a table, followed by a thorough discussion of these themes and sub-themes, supported by voices of the study participants. Finally, the emerging themes and sub-themes from the social worker and foster parent groups are combined and discussed together, citing differences and similarities where necessary. Relevant literature to support the research findings is provided throughout the discussion.

3.8.1. Biographical profile of participants

Noteworthy is that there were two groups of participants; the social workers and the foster parents. Their profiles are presented separately in table format. Pie charts or graphs are also presented where necessary.

3.8.1.1. Foster parents

Eleven foster parents participated in the study. The vital information of the participants' profiles included age, gender, race, years of experience as foster parents, and whether or not they were fostering children living with HIV. The participants' profiles are summarised in Table 3.1.

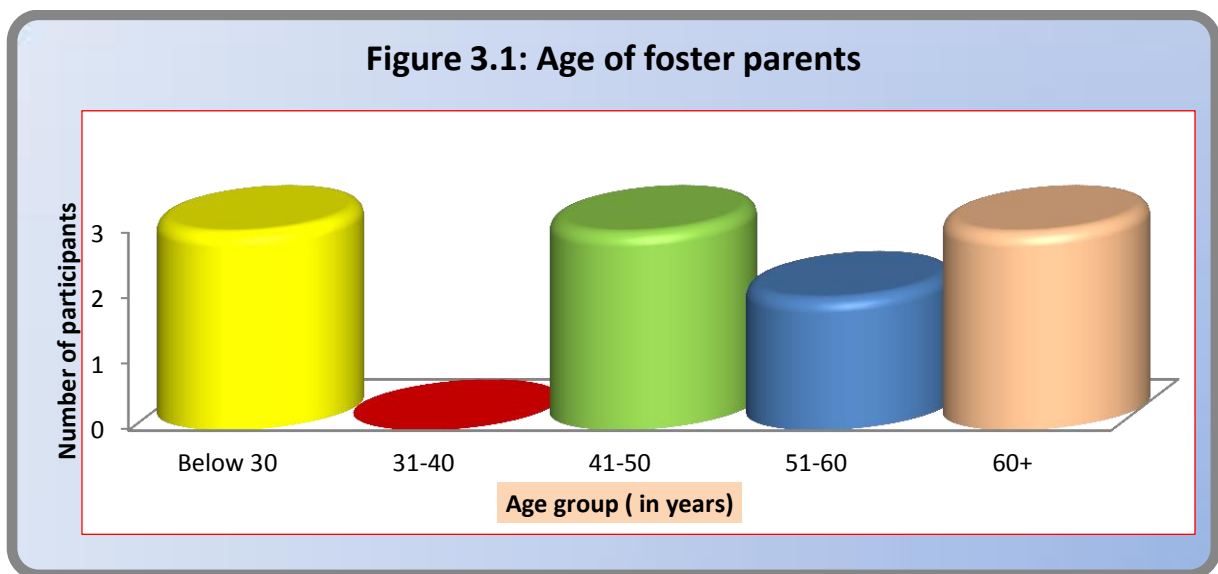
Table 3.1: Biographical profile of foster parents

| Biographical information | Sub-category | Number of participants |
|---------------------------------|---------------------|-------------------------------|
| Age (in years) | Below 30 | 3 |
| | 31-40 | 0 |
| | 41-50 | 3 |
| | 51-60 | 2 |
| | Above 60 | 3 |
| Gender | Male | 1 |
| | Female | 10 |
| Race | African | 11 |
| | White | 0 |
| | Coloured | 0 |
| | Indian | 0 |
| | Other | 0 |
| Marital status | Never married | 4 |
| | Married | 1 |
| | Divorced | 1 |

| | | |
|--|-----------------------|---|
| | Widowed | 5 |
| | Living with partner | 0 |
| Foster care experience (in years) | 3-5 | 6 |
| | 6-10 | 3 |
| | 11-15 | 2 |
| | More than 15 | 0 |
| HIV status of children being cared for by foster parents | HIV positive children | 2 |
| | HIV negative children | 9 |

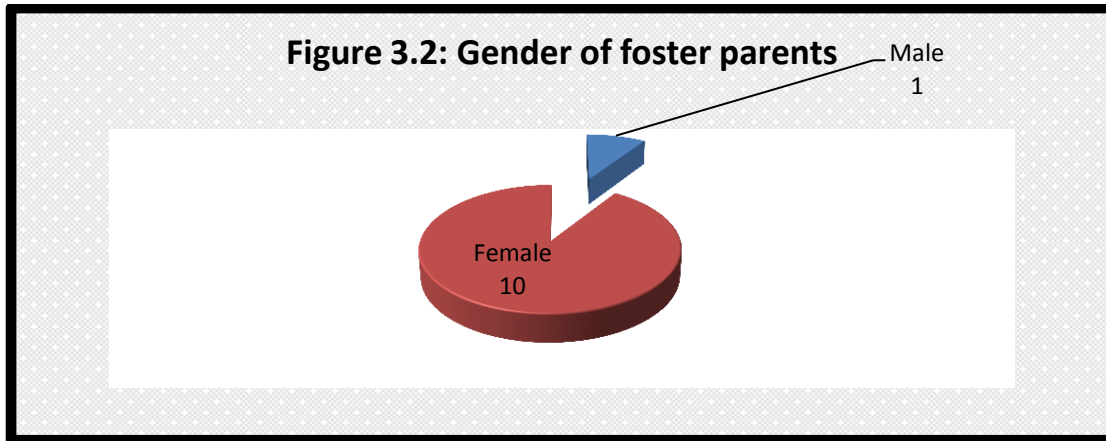
3.8.1.1.1. Age

As indicated in Table 3.1, there was the same number (3) of foster parents in the age groups of between below thirty years, 41-50 years and above sixty years whilst those in the age group of 51-60 years were only two. None of the participants was in the age group of 31-40 years. This might be attributed to the fact that none of the foster parents in this age group met the selection criteria during the sampling process. Figure 3.1 below shows the ages of the foster parents.



3.8.1.1.2. Gender

Table 3.1 shows that ten of the participants were female whilst only one foster parent was male. This is evidence that most of the foster parents at Jo'Burg Child Welfare in particular and South Africa in general are female. The gender of the participants is summarised in the form of a pie chart below.

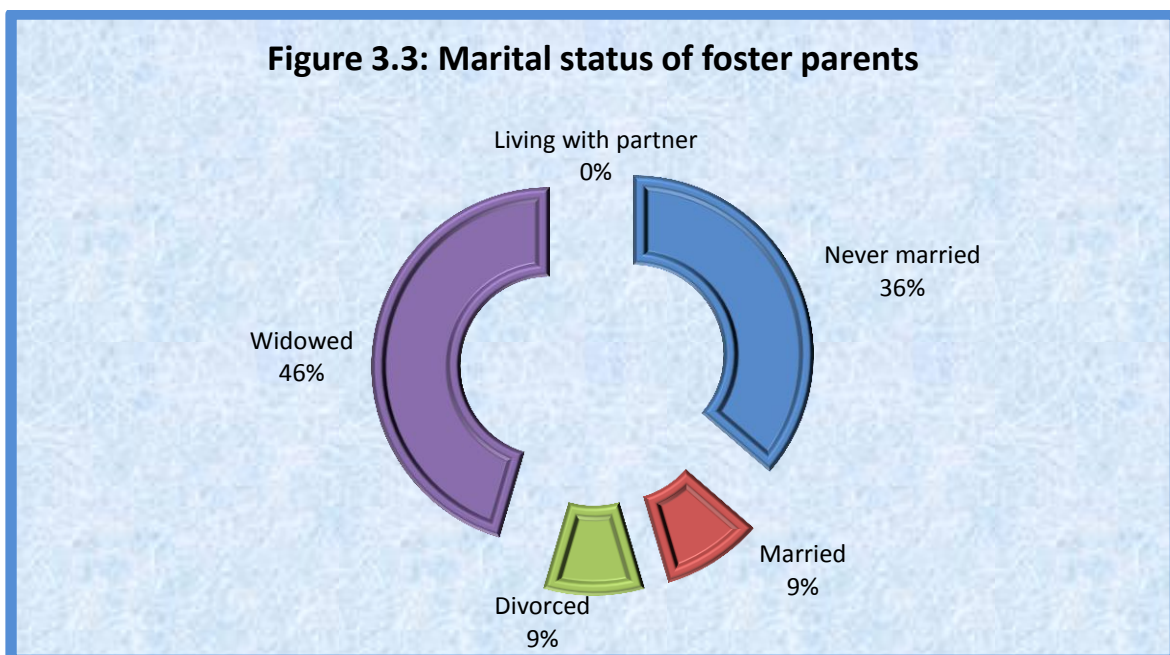


3.8.1.1.3. Race

All the foster parents who participated in the study were Africans. This might be a manifestation that most of the people who reside in Johannesburg CBD are Africans and that most of the foster parents at Jo'Burg Child Welfare fall within the African race.

3.8.1.1.4. Marital status

Of the eleven foster parents who participated in the study, four reported that they were never married, one was married, one was divorced and five were widows. These findings show that most of the foster parents are single females. The pie chart below summarises this information.



3.8.1.1.5. Experience in foster care

The highest number of the foster parents (6) had between 3-5 years' foster care experience whilst none of the participants had more than fifteen years' experience in fostering children.

3.8.1.1.6. HIV status of children being cared for by foster parents

Although the majority of foster parents reported that they did not have problems with fostering children who are HIV positive, only two out of the eleven participants had HIV positive children in their care. This might point to the fact that most of the foster parents are still sceptical of fostering HIV positive children.

3.8.1.2. Social workers

The researcher gathered information from the thirteen designated social workers on their age, gender, race, professional qualifications as well as experience in rendering child protection services, including foster care.

Table 3.2: Biographical profile of social workers

| Biographical information | Sub-category | Number of participants |
|--|-------------------------|------------------------|
| Age (in years) | 20-30 | 6 |
| | 31-40 | 7 |
| | 41-50 | 0 |
| | Above 50 | 0 |
| Gender | Male | 7 |
| | Female | 6 |
| Race | African | 13 |
| | White | 0 |
| | Coloured | 0 |
| | Indian | 0 |
| | Other | 0 |
| Qualification | Bachelor of Social Work | 8 |
| | Postgraduate (Master's) | 5 |
| Experience as a social worker (in years) | 3-5 | 5 |
| | 6-10 | 7 |
| | 11-15 | 1 |
| | More than 15 | 0 |
| Experience in rendering foster care services (years) | 3-5 | 5 |
| | 6-10 | 8 |
| | More than 10 | 0 |

3.8.1.2.1. Age

All the participants were in the age group of 20-40 years.

3.8.1.2.2. Gender

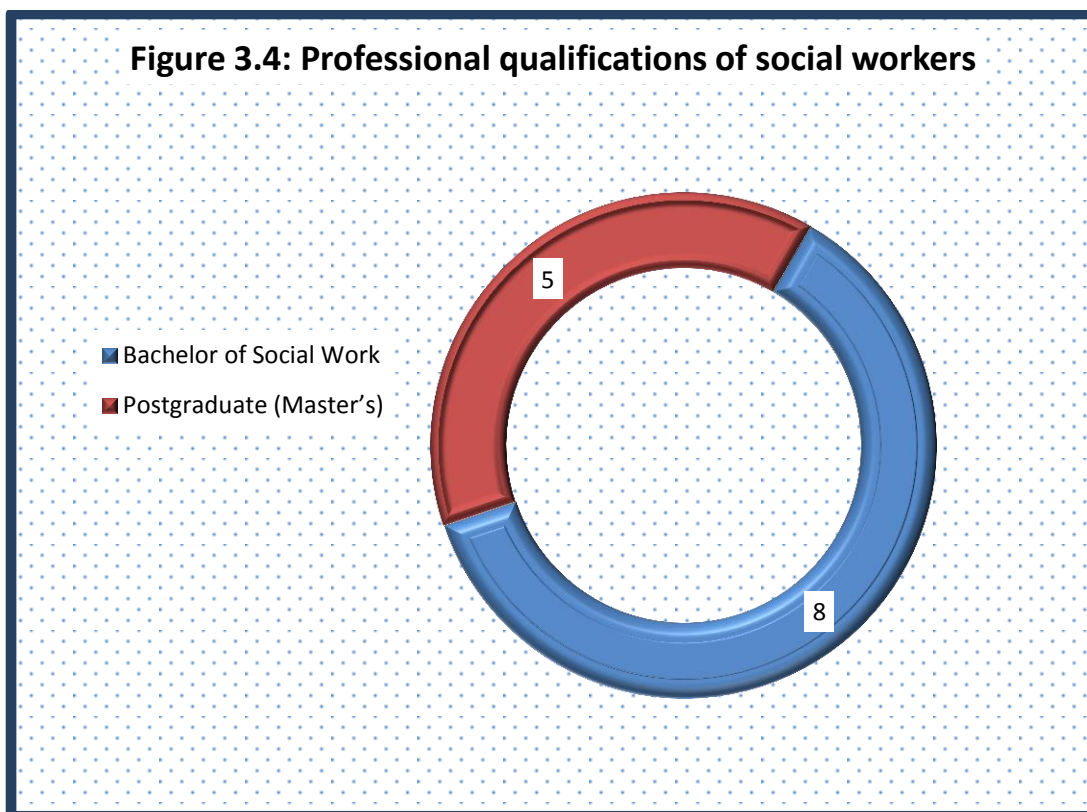
There were seven male and six female participants. This could be due to the fact that the interviews were conducted during the weekend, so more male participants confirmed their availability than female participants.

3.8.1.2.3. Race

All the participants were Africans. This was expected since more than ninety per cent of the social workers in the employment of Jo'Burg Child Welfare, particularly those who render foster care services, are Africans.

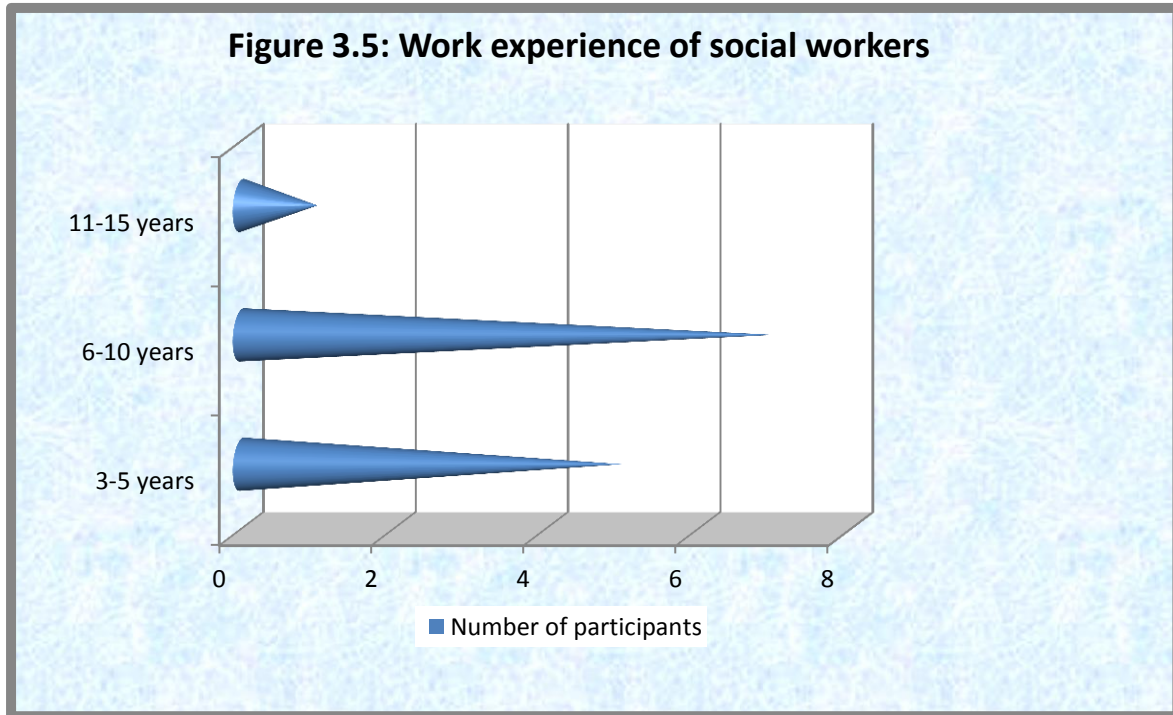
3.8.1.2.4. Professional qualifications

Eight participants had undergraduate qualifications whilst five indicated that they were in possession of postgraduate qualifications (Master's degree). These findings are presented below in the form of a pie chart.



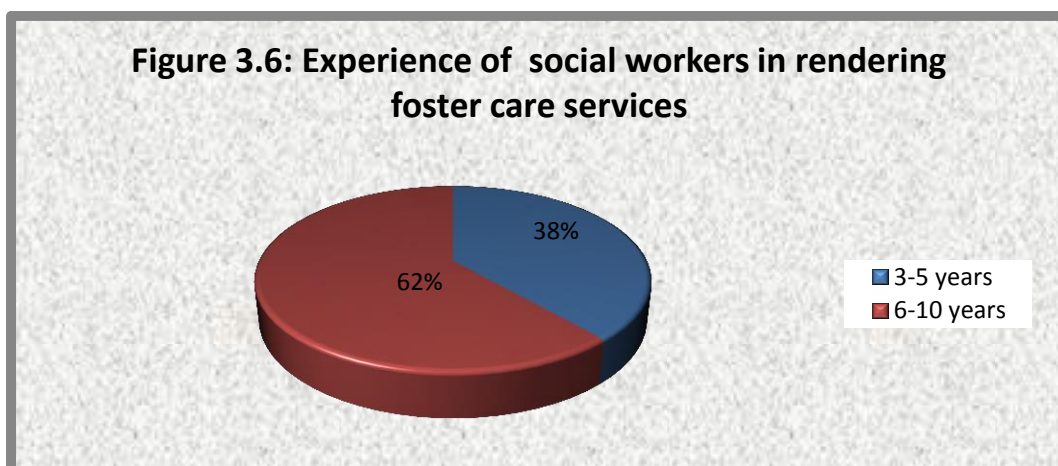
3.8.1.2.5. Experience as a social worker

Of the thirteen social workers interviewed five had between three and five years' work experience; seven had six to ten years whilst one had between eleven and fifteen years. The bar graph below summarises these findings.



3.8.1.2.6. Experience in rendering foster care services

Five participants indicated that they had 3-5 years' experience whilst eight had 6-10 years' experience in rendering similar services. This shows that all the participants were quite knowledgeable about the subject under discussion. The pie chart below shows these findings in percentage.



3.8.2. Themes and subthemes

The recurrent themes and subthemes that emerged during data processing and analysis are discussed in this section. They are initially summarised and presented in table format. As the discussion progresses, these themes and sub-themes are supported by direct quotations from the participants. Although data from foster parents and social workers were processed and organised separately, the themes and sub-themes that emerged from both groups are merged and discussed together, highlighting differences and similarities through direct quotations from the participants. The discussion of the themes and sub-themes is simultaneously integrated with literature where necessary.

Table 3.3: Themes and subthemes

| Themes | Subthemes |
|--|---|
| 1. Motivation to foster children | 1.1. Personal factors and experiences 1.2. Social responsibility to help the need 1.3. Financial reward |
| 2. Views on fostering children living with HIV | 2.1. Most foster parents have positive viewpoints 2.2. Positive viewpoints are not always put into practice |
| 3. Fears and challenges in fostering children living with HIV | 3.1. Myths and misconceptions about HIV 3.2. Losing the child through death 3.3. Physical and emotional stress 3.4. Financial issues 3.5. Lack of education and information on HIV 3.6. Stigma and discrimination 3.7. Lack of support from social workers 3.8. Disclosure of a child's HIV status 3.9. Compliance and adherence to medication 3.10. Shortage of foster parents 3.11. Shortcomings of the Children's Act 38/2005 (as amended) |
| 4. Role of social workers in the foster care of children living with HIV | 4.1. Screening and recruitment of prospective foster parents 4.2. Education, training and supervision by social workers |
| 5. Empowerment in the foster care of | 5.1. Comprehensive HIV education |

| | |
|--------------------------|---|
| children living with HIV | and training for both foster parents and social workers 5.2. Support groups 5.3. Incentives for foster parents and social workers 5.4. Involvement of child's biological parents 5.5. Collaboration by all role players |
|--------------------------|---|

3.8.3. Discussion of findings

As mentioned earlier, the findings will be discussed and simultaneously integrated with literature in this section.

Theme 1: Motivation to foster children

Prospective foster parents are motivated to bring foster children in their care by several motives. The factors mentioned during the discussions were: the foster parents' personal or life experiences, understanding that it is their social responsibility to help the needy, and the financial benefits associated with foster care. This multiplicity of motives plays a fundamental role in the quality of care which the child will get. As Delaney (n.d.:1) cogently states that "foster parents' motives for bringing children can be complex and range from positive to problematic."

Subtheme 1.1: Personal factors and experiences

The responses from some of the foster parents showed that personal factors and experiences play an essential part in driving prospective foster parents to take children into their care. These factors range from childhood experiences such as abuse to loneliness, among other issues. This can be corroborated by the following quotes from some of the participants:

"The reason why I chose to foster children was my upbringing. I grew up without my biological father but my mother and stepfather. As a result my stepfather was maltreating me because I was not his biological child. I used not to get food and would eat at my friends' family. My stepfather even raped me when I was eight years old. Therefore I said to myself I should take care of children who are in need because I know how it is like to grow up without your parents."

“What triggered me to foster children was that my son was about twenty years old and he wanted a brother or sister because he was alone. He was always bothering me about the issue and I decided why not take a child who does not have privileges like my son rather than making another child.”

“The thing is that I only have one child and now she is old. So when I saw those children on TV with no place to stay, suffering I decided to take them because I have got much space to stay and I haven’t got children in the house.”

The issues that the participants raised above support the findings of some studies which have been conducted in the past. For example, Sebba (2012:5) discovered that own experiences may play a vital role in motivating one’s decision to foster. These motivations include “extending the family/providing a sibling for a lone child, putting something back into the community, personal experience of being fostered or growing up with foster children” (Sebba, 2012:6).

Subtheme 1.2: Social responsibility to help the needy

The majority of the foster parents interviewed indicated that they believed that it was part of their social responsibility to help the needy. The following voices from both groups of participants bear testimony to that:

“I mean, being a Christian counts and helps me a lot, just making a difference in society, whether we get enough money or not but for the love of the kids.”

“There are foster parents who are foster parents because it’s a calling to them; they are committed to that because they believe it’s their responsibility to help the need, even children living with HIV.”

The above accounts indicate that some foster parents find solace in doing what they believe is their social responsibility to assist the deprived. As Sebba (2012:6) argues, “the main drives for finding out more about fostering are intrinsic and essentially altruism ones. Intrinsic motivation is usually the most powerful form of motivation. It resides within the individual, gives direction to their intentions and actions and includes their values, beliefs and emotions.” Another study by Tyebjee (2003:702) reports that factors such as “make a difference in a child’s life; would like to provide a

child with a positive family experience, there are so many children in need, add meaning to your life, religious/spiritual beliefs about providing for children” play a fundamental role in motivating foster parents to take children in their foster care. These findings are congruent with what was discovered in this study, with evidence from some of the voices quoted above.

Subtheme 1.3: Financial reward

Both groups of participants were of the view that some foster parents take children into their care because of the financial benefit that comes in the form of the foster child grant. Although there was consensus among the participants that not all foster parents are motivated by money and that the foster child grant was not enough anyway, they still believed that a section of foster parents are still driven by the financial reward. As some of the foster parents vividly said:

“Some foster parents just take the children for money. They don’t care about the children but because they get something that’s why they take the children. Although it’s not all of them but I can say that seven out of ten are like that and you can find that only three out of ten are passionate about caring for the children.”

“Some people are just taking children for that money and they even want to use it to take care of their own children.”

And one social worker supported by stating, thus:

“At times you find out that we have foster parents who are foster parents because they have a lot of other hidden agendas, chief among them being the financial reward which is associated with fostering a child.”

The above responses from some of the participants confirm Sebba’s (2012:6) assertion that some foster parents are driven by extrinsic motivation which relates to external factors such as rewards which shape their behaviour.

Theme 2: Views on fostering children who are living with HIV

Subtheme 2.1: Most foster parents have positive viewpoints

The majority of foster parents interviewed noted that they did not have problems in fostering children living with HIV as these children are also human beings who need love and dignity. Some of the foster parents, for example, had this to say:

“Yes I can take the child...For me I wouldn’t mind at all.”

“Well, I cannot see any problem at all of fostering a child who is HIV positive since I know that you cannot shut your door because someone is sick, it’s not her fault.”

“My view is that there is no problem with fostering a child with HIV and AIDS because those children need love and care from us. We need to show them that even if you have this disease it’s not the end of the world, at least there is someone out there who loves you.”

Subtheme 2.2: Positive viewpoints are not always put into practice

The sentiments of the majority of the foster parents were in sharp contrast with what the social workers reported. The social workers said they still find it very difficult to place children living with HIV in foster care as several foster parents always give different excuses why they cannot take care of children who are HIV positive. The few foster parents who were fostering HIV infected children were of the viewpoint that many prospective foster parents are scared and wary of the challenges associated with caring for a child living with HIV (which are discussed in Theme 3). Responding to the question asked by the researcher on “What are some of the challenges that you are facing in terms of placing children who are living with HIV in foster care?” one social worker responded as follows:

“In response to the question, I should emphasise the fact that it has been quite a challenge to place children who are HIV positive in foster care. I mean the placement of children in general has been quite a challenge and to be specific the main challenge has been with the children who are HIV positive.”

Another one echoed:

“During our recruitment process we ask foster parents whether they are prepared to take children who are HIV positive or any other illness or special needs and they give us their word that they will be able to take those children. But when it comes to the actual placement we phone them and ask them whether they are prepared to take these children but the response that we get there is negative in say 90% of the cases.”

And another social worker added:

“Placing HIV positive children in foster care has been a huge and gigantic challenge. Every time when there is a new child

that needs to be placed and we phone a foster parent and ask for placement from that particular foster parent, the first question that the foster parent asks is whether the child is HIV positive or negative and the moment we say he is HIV positive, the next statement you will hear is that let me start by discussing the issue with my relatives and so on. For some reason foster parents during recruitment and screening processes would actually agree that they will be able to look after children with HIV but when it comes to the practicality of placing the child there that's when they will start giving you excuses."

The responses from most of the foster parents (Subtheme 2.1) on their views on fostering children living with HIV support the findings of Warwick (2013:72) that foster carers of HIV positive children "felt their foster child was 'their' child and that they were the parent." However, unlike in Warwick's study in which the participants were already foster carers of children living with HIV, the majority of the participants in this particular study did not have children living with HIV in their care. Consequently, one cannot safely conclude that the responses of participants in this study sincerely represent their views on the subject. It is debatable whether the majority of the participants who did not have HIV positive children in their care were mere coincidence or it is a reflection of their perceptions in relation to fostering children who are infected with HIV. If the above quotes from the social workers (Subtheme 2.2) have an iota of truth and are to be considered, it means most foster parents are still sceptical about taking care of children living with HIV.

Theme 3: Fears and challenges in fostering children living with HIV

It was clear from the participants' responses that there are still a lot of fears surrounding HIV in general and caring for a child who is HIV positive in particular. Whilst some of the fears were genuine, there was also evidence of myths and misconceptions with regards to the issue of HIV. Some of the fears are also a consequence of the challenges associated with caring for a child who is living with HIV.

Subtheme 3.1: Myths and misconceptions about HIV

All the participants agreed that there are still myths and misconceptions clouding HIV and AIDS. These myths and misconceptions emanate from certain cultural beliefs as well as lack of knowledge, especially how the virus is transmitted from one individual to another. The following voices from participants support the myths and misconceptions about HIV:

“I think out there in society and in communities, the perception about HIV and AIDS hasn’t really changed from denial to acceptance and that might be the function of the background which South Africa had always had in terms of the approach towards HIV and AIDS. So that is the reason I realised it makes it a difficult task to place a child who is HIV positive with a foster parent.”

“Most parents or people look at HIV and AIDS as a death sentence that it’s inevitable that the child at one point is going to die.”

“It is easier for a child who has biological parents or relatives where reunification services are being rendered but for a child who has no relative or biological parents in the picture, the question to the foster parent is that ‘Am I responsible to bury a child whom I do not even know their totem and a child who has no relative?’ This is important because these are cultural societies which have cultural beliefs which emphasise on things like it’s not easy to just bury a stranger.”

“I think most people are scared of dangerous diseases and they don’t think of fostering a child who is HIV positive because they think that what if at the end of the day that child will infect their kids.”

“I know that most people believe that when you have that kind of disease then it means you were sleeping out or things like that.”

“I think there are times when you get this belief that HIV positive children have got behavioural problems. So already it’s a negative sign for someone who would want to take these children in their care because no parent would want to experience behavioural problems with a child. So these myths and misconceptions play a negative role in getting more foster parents who are genuine.”

It is apparent from the voices of the social workers and the foster parents that the area of HIV and AIDS is still surrounded with myths and misconceptions. This mirrors a report by Muperi (2015:6) that “society is still tense in accepting HIV positive people, worse young people, owing to prejudices and perceptions that the disease is acquired by promiscuous and reckless people only.” Ross and Deverell (2010:106) add that although many chronic illnesses are associated with stigma, HIV is considered to carry a double stigma – that of being a terminal illness and a sexually transmitted disease. Unfortunately this forces the infected people to keep their status to themselves; not even sharing with “relatives and partners for fear of reprisal and discrimination – a situation which does not help with national infection rates” (Muperi, 2015:6).

Subtheme 3.2: Losing the child through death

Some of the foster parents expressed fear as they felt that they could not afford to take a child they knew is living with a fatal disease. They felt they would not cope with the grief and trauma of losing someone very close to them through death. Both the foster parents and the social workers said the following regarding the issue:

“Part of my fear is that after bonding with the child for two, three or more years and all of a sudden something happens to him, the child passes away. I think it’s going to traumatise me a lot, but you have to accept it.”

“One of the questions facing most foster parents is ‘What will I do if the child dies tomorrow?’ Therefore the thought of the child dying is hard for the foster parents and shrinks down the pool of foster parents who are willing to accept children with HIV in their care.”

“I think it also comes with the fact that most of the foster parents sometimes look at the long-term plan with the child because most of the foster parents take children into foster care sometimes anticipating to take that child into adoption. So if the child is HIV positive they believe that they don’t have any long term plan with that child as they think that the child will pass on in the near future and it’s one of the factors which the foster parents take into consideration.”

The participants’ sentiments may not be snubbed since foster parents form meaningful relationships with the children in their care (Jo’Burg Child Welfare, 2013)

hence they will have to bear the emotional effects in the event that the child dies. Added to this are also traditional beliefs and cultural responsibilities (Mupedziswa, 1995:92; Van Dyk, 2012:366) associated with the death of a family member, in this case, the foster child. As indicated earlier, it suffices to note that some people still regard being diagnosed with HIV as a death sentence in spite of clear evidence that people living with the disease can lead long lives, provided that they take good care of themselves as well as receiving good care from others (Vranda & Mothi, 2013:20).

Subtheme 3.3: Physical and emotional stress

One of the fears that most of the participants reported with regards to fostering children living with HIV is the stress that is associated with the task. Apart from financial stress, it was also generally agreed among participants that caring for a child who is HIV positive is an arduous task which is both physically and emotionally demanding. It was reported that this becomes more demanding for parents who have more than one child in their foster care as well as those who are not full-time foster parents but also have other work commitments.

One female foster parent in her late twenties reported that:

“The other challenge is that maybe sometimes when I have to go to work and I have to take the child to a doctor for check-up because he has to go and see the doctor and so it becomes a challenge.”

Her concerns were supported by one social worker who also noted that:

“You can also note that some of these foster parents are not full-time foster parents. They are actually men and women who also go to work. So if you are to place an HIV positive child with them and now to them there will be that fear of saying it means ‘I have to be constantly absent from work so that I can take this child to the hospital for medication, also for the doctor’s appointment.’ As a result that becomes another issue.”

Another social worker said:

“We should not expect foster parents to perform miracles because remember some are living far from health care service centres and they have to comply with all the child’s health demands. They have to walk long distances whereby you have to travel with the child not only to the local clinic but at times to

see a dietician, for example, and so forth. There is just a whole lot more that is involved and I think that is why foster parents' pool thus shrinks because of these factors."

One social worker concluded by expressing this view:

"I think also to note is that foster parents or prospective foster parents also think about the level and quality of care that you have to invest in that particular child, is it not harder in terms of taking care of the child and his health? You think that there are hospital issues concerned, maybe I need to go every month to collect ARVs for the child as well as the type of diet that the child needs. So it becomes very stressing physically and emotionally over time. As a result they will think it's much better to have a child who is healthy than a child who has to be looked after specially to meet his or her needs because he is HIV positive. So those are the other things that are coming to mind when they think of having a child who is HIV positive in their care."

Responses from the participants authenticate Vranda & Mothi's (2013:22) observation that the caregiver or foster parent of a child living with HIV is a caregiver dealing with crisis, illness, lack of resources, social isolation, and in need of medical, psychological and social services. Consequently, psychosocial intervention for caregivers of these children is equally and inevitably essential as caring for a child living with HIV is both a colossal and gruelling task (Charlesworth & Newman, 2006:235).

Subtheme 3.4: Financial issues

A dominant subject during the discussions regarding the fears and challenges in the foster care of children living with HIV was the issue of finance. Both groups of participants were unanimous in stating that financial challenges were preventing some prospective foster parents from taking care of HIV positive children. The majority of the participants stated that although some of the foster parents might not be motivated by the financial reward, the foster child grant itself was not enough to take the foster parent throughout the whole month, considering the financial demands associated with regular medical check-ups, a healthy diet and nutrition, among other special needs of the child living with HIV.

Below are some of the concerns raised by the foster parents regarding finance in general and the insufficiency of the foster child grant to meet the needs of a child living with HIV.

“The other challenge is financial issue because the child needs attention and also that the child needs to go to the clinic for medication, so money for transport is a problem. The grant that we get is not enough because she also wants to eat, wear, money to go to school, so the money is not enough. The other challenge is the issue of the grant because R800 is not enough to look after a child, you cannot raise a child with R800, even your own children you cannot. That’s why some of the foster parents end up maltreating these kids, taking their own stress to the children and say that this child is like this or that but it’s because of the money that we are talking about because in the middle of the month the foster parent can’t do anything.”

These statements from foster parents also mirrored what social workers were to say in separate interviews. Some of the social workers noted the following:

“We find that many times we just place these children and we expect the foster parents to rely on the foster care grant which is just over R800, but honestly speaking if we were to care for children like a normal child who does not have HIV or any other special needs, would that R800 be enough? Yet we expect foster parents to cope.”

“One issue is about who is responsible for bearing the cost of running the funeral, it’s very expensive here in South Africa, probably to go and get a grave in the cemetery costs thousands of rand, the expenses on transport, food and other things are just too much. And that’s their mentality to say whatever comes with a child who has HIV who bears all those costs?”

In separate studies, De Jager (2011:1) and Kganyago, (2006:11) discovered that many foster parents are not well-resourced to deal with the numerous challenges associated with caring for children with special needs, including those living with HIV. Their findings validate what was expressed by participants in this study. Apart from the foster child grant that the foster parents receive from the government through the South African Social Security Agency (SASSA), there appears to be no further financial and material support from the government and other agencies for foster parents who care for HIV positive children.

Subtheme 3.5: Lack of education and information on HIV

It emerged during the discussions that many people are still ignorant about HIV issues. This ignorance is partly due to some entrenched traditional and societal beliefs as well as lack of education and enough information on HIV/AIDS. There are still a lot of myths and misconceptions regarding HIV and AIDS, especially on how the virus develops and progresses within an individual's body. This in turn leads to stigma and discrimination against people with HIV infection.

This issue of lack of education and information was demonstrated by one of the foster parents in her late sixties. When she was asked by the researcher whether she had a child in her care that was HIV positive, she said:

“No I don't have, but he was but now he is fine.”

Quizzed about what she meant by 'he was and now he is fine' and on whether the child tested HIV positive or any other condition, she continued:

“He was sick but now he is okay. He was tested because his mother was HIV positive. I used to take him for treatment but not now because he finished his appointment three years back, he is right now. It was not like TB but HIV but they treated him. Every month or after every three months they checked his blood.”

Most of the participants indicated that lack of education and information on HIV was one of the most contributing factors towards stigma, discrimination and reluctance by some foster parents to take children living with HIV in their care. In addition to some quotations which have already been given in the preceding discussions which are relevant to the issue of lack of education and information, below are some of the participants' views:

“I think the unwillingness of some foster parents to take children who are HIV positive is because they haven't experienced that thing maybe if there is no one from their family who has this disease. So now when they hear that this child has HIV it becomes a problem to them because they will not know what to do first or how to take care of that child or what is needed to be done.”

“To be specific with children who are HIV positive, for some reasons, the foster parents, whether it's lack of information or

lack of education on HIV, really give you different excuses and they will ask whether the child is healthy, whether the children are on medication or things like that, and they don't commit to take those children in as foster children.”

“Because of lack of information and knowledge these foster parents are actually thinking that it needs special training, it needs a special meal, special fruits, special bed, special school and it needs a special type of resources to look after HIV positive children. They think that if the child is HIV positive that child should automatically go to a special school. So I think lack of information is a major challenge which then leads to stigma.”

Deacon and Stephney (2007:6) state that there is a relationship between stigma and ignorance. HIV education therefore becomes vital in informing people about the disease, thereby erasing some of the myths and misconceptions surrounding the disease. The purpose of HIV education is not only to disseminate information, but also to change attitudes and behaviour and to help them care for people who are already infected (Van Dyk, 2012:152).

Subtheme 3.6: Stigma and discrimination

All the participants were of the view that stigma and discrimination against people living with HIV continue to hamper social workers' and foster parents' efforts to assist children living with HIV who are in need of care and protection. The stigma and discrimination is enshrined in many societies and communities and even extends to the biological children in the foster parents' families.

The following were some of the points that participants raised about stigma and discrimination against people living with HIV in general and how this affects the foster care of HIV positive children in particular:

“One of the challenges that we face as foster parents of HIV positive children is being judged by the community because there are people who discriminate people who are HIV positive. Maybe you may have told your neighbour that you are fostering a kid who is HIV positive and they will maybe judge you or even judge that child. Or sometimes even in the same house you will find out that even your own children might also discriminate this child because they don't understand why the other one is taking medication or because of the influence of the

community. This makes it very difficult especially for the infected child even to adjust to the environment.”

“I would say that in terms of the challenges regarding placing children living with HIV and AIDS in foster care, chief among the problems is the stigma which is still attached to HIV and AIDS. The attitude towards HIV/AIDS hasn’t really changed in some communities, the stigma is still there.”

“Personally I feel that the issue of stigma and discrimination of HIV positive people in general and of HIV positive children to be specific is still a huge challenge. I think perhaps foster parents do not know that a child can be HIV positive and then lead a healthy life. So basically placing an HIV positive child in foster care has been a huge challenge and it has been an unfortunate one and it’s so emotionally draining.”

Campbell, Skovdal, Mupambireyi & Gregson (2010:975) define stigma as “an attribute that is significantly discrediting, which in the eyes of society, serves to reduce the person who possesses it.” Aids-related stigma and discrimination means prejudice, negative attitudes, abuse and maltreatment directed at people living with HIV and AIDS (Campbell et al., 2010:976). The voices from some of the participants quoted above support Ramaphosa’s (2014) assertion that HIV and AIDS related stigma is frustrating efforts by the government and several role players to fight the disease. The HSRC (2014:99) also observes that “Stigma towards and discrimination of PLHIV remain a major barrier to effective HIV prevention, as well as to the provision of treatment, care and support”.

A teenage HIV activist also indicated that there is a lot of stigma regarding HIV which is mainly caused by wrong information being spread about the epidemic, resulting in HIV positive patients being judged by society (Mutupo, 2014:1). In a study by Deacon and Stephney (2007), they reported that stigma presents psychological problems such as depression, anxiety and stress. The same sentiments were echoed by some of the participants in this study; that stigma affects the children’s self-esteem which also has an adverse impact on adherence to medication. This frustrates efforts to fight the disease hence stigma presents a major barrier to effective HIV/AIDS management (Campbell et al, 2010:976).

Subtheme 3.7: Lack of support from social workers

Some of the participants felt that social workers were not giving foster parents and children in their care enough support, especially moral support. It was reported this might be a factor contributing to some foster parents' reluctance in accepting children living with HIV in their care. One foster parent stated:

“You know sometimes the social workers just come and give you a kid and they come after five years, do you know that? I am telling you! With my kids they act exactly like that and when you ask them why they don't come, they will tell you straight that I don't think that you need help to take care of the children.”

And another foster parent added:

“Social workers should also come and see how these kids are; maybe I am mistreating these kids, so how will you know if you only come after two years to see if I am getting the grant, just because we are going to the judge. They don't have to always come but at least call and find out how we are doing. Because if I am sick how am I going to look after the kids? But if they come to your home or call, they give you strength, they give you courage to go on and you feel that I am being wanted and appreciated.”

Although it was also indicated that not all social workers fail to give enough support to foster parents, the general feeling among foster parents was that most of the social workers are not doing enough. The above sentiments from the foster parents might have been exaggerated in terms of the time that the social workers take to conduct supervision through home visits but it shows that more is expected from the social workers. Social workers, on the other hand, argued that it was extremely difficult for them to conduct supervision on a regular basis due to their heavy caseloads. However, they still do best to support the foster parents. One social worker argued thus:

“Sometimes it's not like we are not willing to give support, we can give the support as much as we can but the issue comes also on the workload. Because sometimes you find out that social workers have a very big caseload and the salary which the NGOs are giving doesn't attract a lot of social workers. You will find sometimes you can go for four/ five months when you have got several posts not being filled in and its one social worker who is dealing with all the cases and sometimes you

know it's very difficult to give particular attention to all the cases, sometimes you will be rushing to cover on the due dates at court and staff like that, not that you are not willing but because you cannot manage."

Another social worker added:

"Personally I would like to believe that the actual reason is that we do not have enough social workers, which is why you see that the regulations of the Department of Social Development are that each social worker is supposed to have a caseload of about 60/65 cases but in our organisation you see some social workers having 90, 120, 130, 155. So when will the social worker get time to visit or get time to provide psychosocial and emotional support to a foster parent that has an HIV positive child. And bear in mind also that it is not only this one particular foster parent. Out of the caseload of 150 files and maybe about 90 of them they need that constant social work support. So if we had the correct number of social workers then it would have been a little bit easy but it is actually the system and not the social workers."

And another one summarised it all as follows:

"Social workers are people of a good manner; we are social workers by calling. Unfortunately we cannot perform miracles. It is a reality that social work is a scarce skill in this country. If you look at the foster care system in general, it was designed in such a way that it should accommodate only about 100 000 children, at the present moment we have about 500 000 children in foster care and with those numbers it's just a drop in the ocean the number of social workers that we have, who are not only supposed to perform foster care services, others should be performing services to the elderly, to the mental institutions and somewhere else. So the issue of shortage of social workers is really a huge concern and that's why at times social workers will end up just running rudimentary services or end up responding only to crises, why, because we just do not have enough time on our hands. Actually the thing is that foster parents should be glad that we managed to finalise the foster care case, there are a whole lot of complexity and a whole lot of issues surrounding the foster care."

The social workers' concerns cannot be discarded. The South African Institute of Race Relations (2012:3) reported that there is a shortage of social workers in the government and in non-profit sectors. The same view was also shared by Sibanda (2014). This explains why social work was declared a scarce profession by the

Ministry of Social Development. In a study by Manukuza (2013) titled “Legal placement of orphaned children in related foster care: The perspectives of social workers” it was discovered that social workers’ caseloads are too heavy and thus difficult to manage. Unfortunately, foster parents do not understand some of these dynamics and end up apportioning blame to social workers. This was congruent with findings of this study as evidenced by voices of both the social workers and foster parents.

Subtheme 3.8: Disclosure of a child’s HIV status

HIV disclosure simply means revealing one’s HIV status to another person. This can be done by the infected person or by another person. Disclosure can be voluntary, involuntary or indirect.

Participants reported that the issue of disclosure of a child’s HIV status to that particular child as well as to significant others was a challenge. For example, one foster parent said:

“Telling the child that he is HIV positive is very hard because you don’t know how he will take it. Sometimes even in the same house you will find out that children don’t understand why the other one is taking medication so you have to tell that particular child and the other children and explain to them what is happening. However this is not easy. And also because of the influence of the community and even your own children might also discriminate this child. So it’s a challenge.”

It was further reported that because of the stigma still associated with being HIV positive, disclosing one’s HIV status could lead to discrimination of the patient and the caregivers at times. Therefore, some people are scared to disclose their HIV diagnosis or that of the children in their care due to fear of the stigma and discrimination attached to HIV (Bairan, Taylor, Blake, Akers, Sowell & Mendiola, 2007:243). This also corroborates a report by Muperi (2015:6) that many people may decide not to share their HIV status with others for fear of reprisal and discrimination. This further supports Vranda and Mothi’s (2013:21) findings that many HIV infected children and their families prefer to live in a “conspiracy of silence” and shame with

HIV, resulting in the children and families being “withdrawn, socially isolated and emotionally cut off from traditional support systems”.

In a study to examine the relative importance of reasons for HIV disclosure/nondisclosure, Derlega, Winstead, Greene, Serovich and Elwood (2004:759) note that the decision to share information about an HIV diagnosis may be difficult and stressful for persons with the disease. These authors identified several factors that contribute to the decision whether or not to disclose the HIV diagnosis to significant others. These factors were similar to the ones reported by the participants of this study. They include the social environment in which people live including cultural attitudes about HIV as well as social relationships (Derlega et al., 2004:749). For children, it becomes emotionally draining and stressful as they may be bullied by their peers at school and in the community (Mutupo, 2014:1). The age of the child in question was also an important factor as some children could not comprehend what it means to be HIV positive, hence would always ask questions on why they were taking medication.

Subtheme 3.9: Compliance and adherence to medication

It also emerged during the discussions that some children were defaulting on taking their medication for various reasons. Participants also noted that at times foster parents inadvertently forget to administer medication to children in their care. The following are some of the voices from participants concerning adherence and compliance. One male foster parent said:

“Although I try my best the difficult part that I face is that sometimes I forget to give the child medication on time resulting in the child getting sick at times and I need to go to the hospital.”

Added another female foster parent:

“I think I will mention again the issue of giving the child medication. Maybe I went out somewhere and maybe it’s now time for that child to get medication and you are not there. So it is a challenge for me because first of all I am not used to giving the child medication that’s why when I go out I may forget.”

One social worker also added by saying:

“Remember that some foster parents are not only caring for one child, they have got three or four children. So it’s not they intentionally forget the hospital dates or they don’t want to comply but remember they have court to attend, they could have a school meeting for another child, they could still have a hospital appointment for this child and this is one person who needs to be in three or four places at the same time and as individuals we all know that sometimes we prioritise. So these are some of the dynamics and their hands are tied up because if they don’t go to court they get a warrant of arrest, if you don’t attend a hospital appointment then it’s like you are not complying with the child’s medical needs, and if you don’t attend a school meeting that also might have an impact.”

On the issue of adherence by some children, one social worker reported that:

“Some foster parents have come forward and they have said that the child is not taking medication. I want to talk about the age of the child in question because if it’s a smaller child may be the child is 5 years old it’s very easy for a parent to be looking after that child because the child depends largely on the adult .But if it’s somebody who is thirteen and above then sometimes the responsibility is given to the child to take the medication. But then there is a case that I dealt with of a child of about 14/15 years who stopped taking medication and we were looking at the medication, here is the medication, the child has not been taking medication. So at least a child of that age has to be told to take his meds, let him know that this is your health we are talking about and that your life depends on the medication so you are supposed to take it. And it’s not like the child forgot as such, remember we said that earlier there are issues that we tend to normally think about, issues of shelter, issues of clothes and whether the children are going to school but there are psychosocial aspects, taking the medication has got bodily changes and psychologically it affects you so just taking the medication every day you will be asking yourself questions that I was born HIV positive: What is that I did wrong? So that can also affect you in terms of adherence.”

The American Heritage Medical Dictionary (2007) defines adherence as the extent to which a patient continues “the agreed-upon mode of treatment under limited supervision when faced with conflicting demands” as opposed to compliance which means “the degree of accuracy with which a patient follows a prescribed regimen.”

Participants noted that the main problem was with adherence although compliance was also described as a challenge at times. Failure to adhere to treatment was blamed mainly on the children (of a reasonable age and development) who would deliberately skip taking of medication. This might be a result of the emotional distress that goes with being HIV positive. This is mainly because being HIV positive and simultaneously being a child in need of care and protection is not easy. Vranda and Mothi, (2013:19) therefore observe that children living with HIV often find themselves in a complex situation as they try to traverse their “illness and treatment as well as the adverse psychological circumstances and poverty in which many live.” These children are also subjected to life stressors such as illness and death of parent(s), stigma and discrimination, abuse, loneliness and isolation, and family conflict and disintegration resulting in depression and anxiety which may therefore undermine adherence to treatment. Research has established that psychosocial support is critical for the health and development of children living with HIV as this may increase treatment adherence (Vranda & Mothi, 2013; Van Dyk, 2012).

Subtheme 3.10: Shortage of foster parents

It was agreed, mainly by the social workers, that there is a shortage of foster parents for children in need of care and protection in general in South Africa. This challenge extends to children living with HIV considering the special attention they need. For example, one social worker noted during the discussions that:

“I would like to say that there is not enough number of foster parents. The few that are there are already taking care of other children, then what more of a child who is HIV positive. So I think there is need for more of them to be recruited.”

Another social worker added:

“In my experience in dealing with placing children who are HIV positive, first of all the availability of foster parents on its own is a challenge as the number is not as large as we would want it to be.”

This supports Mawere’s (2009: iv) assertion that “South Africa is facing a crisis of not having a sufficient number of foster parents, especially for children made vulnerable by the AIDS epidemic.” This problem is not unique to South Africa. It is common in

many countries. For instance, in a study carried out by Sebba (2012:4) the researcher concluded that “Internationally, the number of children and young people in care is increasing faster than the number of foster carers.”

Subtheme 3.11: Shortcomings of the Children’s Act No. 38 of 2005 (as amended)

It was pointed out by some social workers who participated in this study that the transformation from the Child Care Act No.74 of 1983 (as amended) to the Children’s Act No. 38 of 2005 (as amended) and some discrepancies in the latter was posing a challenge, thereby contributing to some of the challenges in placing children living with HIV in foster care. The participants were of the view that in spite of some obvious strengths of the new legislation, there were areas which still needed revisiting.

One social worker summarised these sentiments as follows:

“The challenges that I experience are mainly in terms of the legislation that is the Children’s Act. When I started my practice as a social worker it was not that difficult to deal with HIV positive children because kinship foster care was still acceptable. But with the change to the Children’s Act and the amendments that were effected in 2010 it is now very difficult for the placement of children especially the children who are infected with HIV in unrelated foster care as no one or the majority of prospective foster parents are not willing to look after or to accept them into their care. So the main challenge is the legal aspect of it.”

The above quote concurs with Manukuza’s (2013:43) study finding that in some cases, relatives or extended family members of children who are in need of care and protection are perceived by the Act as “visible means of support” hence having the legal duty of caring for the children without receiving the foster child grant. Social workers who participated in this study indicated that there should be clarification on this section of the Act in order to ensure consistency among children’s courts. Thus, Sibanda (2014:92) advocates for the amendment of certain sections of the Act due to some of the shortcomings.

Theme 4: Role of social workers in the foster care of children living with HIV

Another theme that emerged from the discussions mainly with foster parents concerned the role that social workers play in the foster care of children in need of care in general and those living with HIV in particular. It was evident that social workers play a fundamental role in terms of the screening, recruitment, training, education and supervision of foster parents. Foster parents also indicated that they rely on the support from social workers whom they regarded as pillars of strength and courage in the foster care process, particularly with children who are living with HIV. The role of social workers is well-documented in several national and international publications and statutes by the National Association of Social Workers, International Federation of Social Workers, South African Council for Social Service Professions, just to mention but a few. There is therefore, no need to emphasise the role that social workers play at this juncture.

Subtheme 4.1: Screening and recruitment of prospective foster parents

The foster parents and social workers reported that one of the important roles of social workers in the foster care process in general and the fostering process for a child living with HIV in particular is to screen and recruit prospective foster parents. Some of the participants however felt that although social workers need to be thorough when doing their screening and recruitment of prospective foster parents, at the same time, they need to be considerate. One social worker said:

“With regards to the welfare agencies that are placing these children you find that the criteria in terms of screening of foster parents are too high and sometimes unrealistic. You find that sometimes family members may even present themselves to care for children and then you get a decision being made that unfortunately the granny is unsuitable because the child doesn’t have her own bedroom. But if we look in the African context especially in many African communities, how many children have their own bedrooms? Even with the non-related ones, living in a shack does not equate to the level of care and love and nurturing you are going to give a child because yes you might live in a one room but you might even provide better care than a person who lives in a three-bedroom house. They should look more on the individual and what they are going to offer the child rather than only or emphasising on housing and income. So these are some of the factors that inhibit foster

parents from coming forward to present themselves to care for children.”

Manukuza (2013:18) agrees with findings of this study that social workers play a fundamental role in recruiting and screening prospective foster parents. The social workers gather important and relevant information for the effective care and in the best interests of children in need of care and protection, among them those living with HIV. Some of the sentiments expressed by the participants show and support the observation by Brown (2014:1) that working with children in foster care remains a challenging task for social workers as difficult decisions, often in multifarious situations have to be made. These decisions include ascertaining the best person to serve the best interest of a child in need of care and protection such as a child living with HIV.

Subtheme 4.2: Education, training and supervision by social workers

Participants noted that social workers execute a critical part in terms of providing information and education on HIV and foster care, training prospective foster parents as well as supervising them. It was argued that supervision would ensure quality care of children living with HIV. Both social workers and foster parents nonetheless pointed out that the supervision rendered to foster parents by social workers was not enough due to several factors discussed earlier. Although one of the participants indicated that the training offered to foster parents was intensive, the majority of participants argued that the training was rudimentary as it was not comprehensive enough to tackle the complex issues salient in the foster care of HIV positive children. One social worker argued thus:

“But it seems like in as much as my colleague would like to believe that we have a very comprehensive training, I think we need to bear in mind that our training is only for two days and to train the foster parents on issues around HIV and AIDS only within those two days, I think our training only touches these issues just like on the core surface or surface level. It actually does not go deep into the finer details which is why the foster parents actually do not have that adequate knowledge and information.”

The above sentiments by some of the participants support Manukuza's (2013:18) assertion that although social workers play a crucial role, particularly in the screening of prospective foster parents, more is still required from social workers to ensure that foster parents and communities are fully equipped with the necessary knowledge for excellent upbringing of children in need of care and protection including those living with HIV. This may be ensured by providing comprehensive training and regularly updating the foster parents and communities on new developments, especially in the area of HIV.

Theme 5: Empowerment in the foster care of children living with HIV

Suffice to note that the issue of empowerment was always coming up during the discussions with participants. All the participants indicated that they needed to be empowered in order to effectively deal with the challenges encountered in the foster care of children living with HIV. Some of the concerns raised by participants, to be discussed in detail in the subthemes below, included providing:

“Comprehensive HIV education and training, support groups, incentives for foster parents and social workers, involvement of child’s biological parents and collaboration by all role players.”

Subtheme 5.1: Comprehensive HIV education and training

The majority of participants were of the view that it would be beneficial if a comprehensive HIV training would be provided to both foster parents and social workers so that they are well-informed. As one social worker participant said:

“I think progressive efforts are still needed to dispel and demystify the misconceptions and myths around HIV/AIDS. Information needs to be available to all sectors of society especially the grandmothers and uncles who are taking care of these children.”

Some of the voices from participants concerning education and training of foster parents were as follows:

“I think if social workers or Social Development can provide us with information on how to look after children who are HIV positive because it’s very difficult for me to handle the child because I don’t have those skills.”

“I will go back to the issue of training that we need. I think we still need government to give us training because most people have a problem with fostering children who are HIV positive. I think a lot of people can foster these children but they need education because some people don’t know how to foster the children so they need to be educated.”

With regards to social workers some participants attested that:

“I think the main problem is generalisation or generic social work. You know when you put a child in foster care you won’t have a lot of knowledge but when you are specialised it becomes easier or better. Maybe social workers need to have a department within an organisation that actually specialise in issues such as HIV, I think it will help.”

“I would like to add to the issue of curricula, that most schools of social work do offer that education especially on HIV and AIDS and most social workers will have that knowledge, but in terms of exposure because one may say that I have been working for the past seven years but have you worked with people who are HIV positive, you understand, that may be the other aspect.”

“Back to what the other speakers have said, in my experience like I have said I have more than four years right now, if I were to give a client or a foster parent knowledge on how to care for a child with HIV or special needs, to be honest I am blank and chances are that many social workers are also blank, so we have superficial knowledge because we know you have to take ARVs and take your medications as you are informed by the nurses or doctors at a certain time, but there is also much more that still has to be done because this is a 24/7 job. The child will need a proper diet, some form of exercise; you know a specific routine to obviously undergo in order for the health or the CD4 count to be at a certain level. So that’s one of the aspects.”

Some of the voices of the participants in this study concerning education and training concur with Harber’s (1999:4) avowal that social workers help in dispelling and dissipating myths and misconceptions regarding HIV and AIDS and promote positive attitudes towards the children within families and communities. Education and training will also help in equipping them with the necessary skills to deal with HIV infected children. On the part of social workers, HIV education and training will assist them in giving the foster parents current and relevant information on the foster care of children living with HIV (Jo’Burg Child Welfare, 2013:8). It was revealed this

training could be provided during social work training at universities or whilst they are at work.

Subtheme 5.2: Support groups

It emerged during focus group discussions, especially with foster parents that support groups would help immensely in addressing some of the challenges that foster parents face. This might result in an increased pool of foster parents who can take children living with HIV in their care. The following voices attest to that:

“A support group will help most of the foster mothers because you share problems and ideas about the kids in our care because we all have a common goal concerning these kids.”

“We also need a support group if I am fostering a child with HIV. Support groups can help in terms of sharing ideas on how to take good care of the child while supporting foster parents to take care of children.”

The views of the foster parents are in line with the Treatment Action Campaign's (2013:66) definition of a support group as “a vehicle for people with the same problem to support each other. In a support group people with the same problem find ways to cope with and defeat the problem.” Apart from offering members with emotional and psychological support, support groups also assist in disseminating information vital for educating the community as well as fighting discrimination.

Subtheme 5.3: Incentives for foster parents and social workers

The majority of participants indicated that there was need to incentivise the process of foster care especially for children living with HIV by increasing the foster child grant or help these foster parents to access social services such as health care without hustles as well as linking them to other support structures. Some of the social workers had this to say regarding the issue:

“Well, I am not the one who is responsible for the budget but ideally if the economy could manage children who are HIV positive or have special needs should receive more money than normal foster children. But in the meantime because they're just receiving that amount that other children are getting, there should at least be some special arrangements made for example at hospitals, we know that ideally they should get

exemption from paying school fees, and other benefits because of being in receipt of a foster child grant but we find that many foster parents are paying, so you can imagine on that R800.00 you have to pay R20.00 a day for transport on its own, so even if it's increased to like R2000.00 there is still other factors where they need to be assisted and supported in order to ensure the way they care for these children is ideal or adequate.”

“You see it's funny that we actually have got another grant which is administered by SASSA which is called the care dependency grant. This grant pays up about R1280.00 per child and if the foster parents that are looking after HIV positive children were to access this grant in addition to a foster child grant and HIV positive children are actually entitled to that particular grant and the foster parents should actually receive two grants – the care dependency grant and the foster child grant. But is it easy for them to just approach SASSA and say I want to apply for a care dependency grant, you find that they will be asked to bring in paper work, you will need to bring an assessment from that doctor, that paper from there, that one from there and that one from there. So you know it becomes a red-tape, a lot of bureaucracy. If the government was to make that process a little bit simpler and user-friendly you find that we will be having more and more foster parents coming saying I want to foster an HIV positive child, why because they know they will have some money to buy apple, bananas, potatoes, vegetables, spinach, all those kind of things. Give them money then they will look after these children very well.”

It was also noted that giving incentives to foster parents whilst ignoring the social workers who are responsible for rendering the services will not be enough. Hence, there is need to motivate both the social workers and foster parents. This was confirmed by some of the social workers in the following excerpts:

“...just to speak from the position of a ‘poorly paid social worker’, I suggest that...”

“I also think one of the challenges is the number of social workers in relation to the caseload that we are having. So maybe if the government can pump more resources into the training of social workers and also increase the social workers’ salaries to motivate them I think it would be one of the solutions.”

“This challenge is multifaceted if you look at it because if we focus more on giving rewards to the foster parents who are

caring for these kids side-lining the social workers at all we will have this disaster whereby foster parents will rush into taking these kids who are HIV positive for the sake of the financial rewards, at the end of the day they don't give proper care because they don't get supervision from the social workers because there is no personnel. So we have to look at it from both ends."

The subject of the inadequacy of the social grants, particularly the foster child grant as well as salaries of social workers raised by some of the participants of this study mirrors Agere's (2014:76) finding that there are inconsistencies in the way the Department of Social Development gives incentives to government-controlled institutions and its social workers, compared to those in non-profit organisations (NPOs). In other words, social workers in NPOs receive far less salaries than those working for the government. Similarly, government-controlled institutions are well-funded as opposed to NPOs and foster carers, despite the fact that the NPOs and the foster families also care for children with needs similar to those in government institutions.

Subtheme 5.4: Involvement of child's biological parents

An issue that also emerged during the discussions was that the children's biological parents, if they are in the picture, should be actively involved in the lives of their children, albeit dependent on the reason(s) the children were removed from their care. It was argued that they can assist the working foster parents through, escorting the children to clinics and other places, for example. As one social worker stated:

"We find that some of these children placed in foster care actually have parents and the day the case is finalised the parents walk out of court and will never raise a finger in support of that child. So if the court can also in the same order bind these parents to continue even financially supporting the children or doing something because you know when your child is removed from a parent the only right that is taken from them is the right to care for the child because they won't be living with the child but still they have the right to maintain contact and they still have the right to provide for their children, and you will find that most of them are working and most of them go out and have more children why because this child is in foster care and because he is sick they don't care as well. So if the court can bind them to also say you have a duty to play in the development of your child so that they are also bound by

contributing financially or doing something but at least they will continue to be involved in the child's life so that it is not only a burden to the foster parent. Because going back to what we were saying where foster parents are looking after other children let's take a day to take your child to a hospital appointment, there is nothing that stops you as a mother to go and being in the queue at 5am at Bara because it's for your child's benefit not the foster parent's benefit but we find because after the case is finalised and the child is in foster care the parent relaxes and go on and have fun but then the social worker and foster parents are the ones who continue to face these challenges."

In the case that the family does not want to be involved, then foster parents should be given more rights and responsibilities over the children. This was echoed by one social worker as follows:

"In the Act they have put the responsibilities and the rights of the foster parents but we know that foster parents do not have as many rights as, for example a biological parent or the adoptive parent. So I think when the recommendation has been made for a child who is HIV positive to be placed in foster care, we find that because some of these children are being placed in unrelated placement these foster parents obviously will say it's not my child I can't go an extra mile but if there is something that is binding in the form of the court order concerning more rights and responsibilities, they will actually be more responsible in terms of addressing the needs of the children and meeting what is actually in their best interests."

Biological parents should therefore respect both their rights and responsibilities concerning their children. This would also help in dealing with the fears of, for example burying a stranger in the event of death, as the foster parents would know that the biological family is in the picture. However, a demarcation is supposed to be drawn between positive involvement by biological parents and interference by the biological parents or family as this might result in conflict of interest between foster parents and biological families. This is what Sibanda (2014:80) refers to as "playing power games."

Subtheme 5.5: Collaboration by all role players

It goes without saying that social workers are the pivots in the foster care system. However, they cannot do it in isolation. They need to tap into the services of others

The study participants indicated that because of the complexity of the foster care of HIV positive children, it was inevitable that all role players join hands in dealing with the challenges such as stigma and discrimination, lack of information and knowledge, among others. It was argued this would ease the burden on the social workers, resulting in the provision of better services. Below are excerpts from some of the social worker participants:

“When you look at the issue of HIV it’s the most difficult problem and you cannot solve the problem on your own. As social workers, we need to work with other professionals and service providers like nurses, doctors and so on.”

“We also have to examine the issue of the support structure that is in place to assist the foster parents. So you find that there are communities where there are social auxiliary workers or community health workers that go one on one to families to see that the child is taking their medication on time, the child is eating a balanced diet and the child is attending appointments when needed. And in some situations you find that those community workers can assist you to take that child to the hospital maybe if you are working. So the success of these placements also depend on the structures that are in place in that kind of community, so it’s also the task of the placement agency like child welfare agency to link the foster families to the support structures that are in their environment so that the issue of adherence is also catered for and it puts less strain on the foster parents and it makes the whole placement successful as well.”

“The training which is administered by social workers might not be as comprehensive as training that might probably be provided by for example a nurse, doctor or someone with a background in nursing. Although social workers are the ones placing the children there are certain issues such as a particular diet they have to adhere to and they have a particular timetable of medication which they have to take. So even though social workers do speak about it during training but its more in general than as comprehensive as one would want it to be or than if it were to be provided by a relevant practitioner in that field.”

“I also think there must be more inter-sectorial or multi-sectorial collaboration when you are placing children who are HIV positive in foster care, and I mean pre-placement and post-placement. As social workers we have to work with specialists like nurses, dieticians and everyone who is involved in HIV and

AIDS including community based caregivers. I think it will help a lot in terms of dealing with the situation although there is no legal requirement that will enforce the working relationship between social workers and other service providers.”

The above voices clearly show that there is need for collaboration among service providers. Given the fact that social workers complained about heavy caseloads, it becomes paramount to find creative ways of reaching out to people with the human resources currently available (Dlamini, 2011). Dlamini (2011) also adds that one of the creative ways is to embrace service providers such as child and youth community workers, and that there is no need for social workers to feel threatened by them as they make social workers' jobs easier. If social workers do not embrace them, the social workers will always have problems of a heavy work load. When collaborating with other professionals or service providers, the important aspect is to have a clear description of roles and tasks. This view is echoed by Sibanda (2014:80) who indicates that collaborators need to do so “using the principles of equity, equality, respect and fairness so that they avoid playing power games”.

3.9. Summary

This chapter has focused on the research methodology which was utilised and the presentation of the research findings. The findings show that there is a complex combination of factors concerning foster care for children living with HIV. Quotes from social workers and foster parents bear testimony to this. The themes arising from the focus group discussions centred mainly on these factors: motivation to foster, views on fostering children living with HIV, fears and challenges in fostering children living with HIV, the role of social workers, and empowerment of the foster carers of children living with HIV.

These themes and subsequent subthemes were discussed and integrated with literature where necessary. There were notable similarities between most of the findings in this study and related studies on the foster care of children living with HIV especially regarding the perspectives of social workers (Manukuza, 2013) and views of foster parents (Warwick, 2013). The conclusions made from the study and the subsequent recommendations are presented in Chapter 4.

CHAPTER FOUR

CONCLUSIONS AND RECOMMENDATIONS

4.1. Introduction

In this chapter, a discussion of how the goal and objectives of the study were achieved will be presented. This will be followed by a presentation of the key findings of the study from which conclusions will be made. The chapter will end with the recommendations.

4.1.1. Goal and objectives of the study

The study goal was to investigate challenges experienced by social workers in placing children living with HIV in foster care in Johannesburg. This goal was achieved through the following objectives:

Objective 1: To conceptualise HIV in children within the empowerment theory.

This objective was achieved through discussions in chapter 2 on issues such as psychosocial support for children living with HIV (section 2.3), the role of social workers in the placement in foster care of children living with HIV (section 2.7), and the essence of empowerment in the foster care of children living with HIV (section 2.8). In theme 5 of chapter 3, it was also established that empowerment is essential when dealing with children living with HIV in general and the placement of those children in need of care and protection in foster care in particular.

Diagnosis of HIV is a complex issue. It is even more complex in children as there is a lot involved, such as the physical care of the children, psychosocial issues such as stigma and discrimination, sexual issues, among others. There is therefore need to empower the children, their caregivers and everyone else involved in these children's lives. Therefore, the empowerment theory becomes cardinal and appropriate when dealing with such complex issues. Participants in this study indicated that they need to be empowered in order to deal with the foster care of children living with HIV effectively.

Objective 2: To explore the policies (if any) regarding the placement in alternative care of children living with HIV in South Africa.

The above objective was addressed in detail in section 2.5 of chapter 2. It was found that there are no specific policies regarding the placement of children living with HIV (who are in need of care and protection) in alternative care. The Children's Act No. 38 of 2005 (as amended) is the main legal instrument dealing with the welfare of children including those in need of care and protection in South Africa, but it fails to address the issue of the placement of children living with HIV who are in need of care and protection in alternative care clearly and adequately. Instead, the Act vaguely mentions in section 156(1)(g), that a children's court may issue an order placing "children with disabilities or chronic illnesses" who are in need of care and protection in a state facility if it is in the best interests of the child to be cared for in such facility.

From the discussions with the study participants, it was also established that there are no policies which are specifically about placement of children living with HIV in alternative care in the country, and the training of the foster carers thereafter. The social workers who are supposed to place these children and train the foster parents at times reported that they have superficial knowledge on HIV-related issues. These two points were discussed in depth under subthemes 3.5 and 3.11 in chapter 3. It was shown that the Children's Act No. 38 of 2005 (as amended) is expected to guide role players in the placement in alternative care of children living with HIV. For example, the said Act recognises the importance of cluster foster care as a means of moving away from placing children in need of care and protection, including those living with HIV, in residential care settings. Though the Act has some strength, it is also riddled with shortcomings.

Objective 3: To identify the challenges faced by social workers in placing children living with HIV in foster care.

This objective was addressed in detail under theme 3 in chapter 3. Designated social workers who participated in this study revealed that the challenges they face with regards to the placement of children living with HIV in foster care are multifaceted. These challenges emanate from societal perceptions of HIV which are caused by

myths and misconceptions about HIV (subtheme 3.1), and lack of education and information (subtheme 3.5). This in turn results in stigma and discrimination against people living with HIV, including children (subtheme 3.6). Moreover, the shortage of foster parents (subtheme 3.10) for children in need of care and protection in general exacerbates the situation. Designated social workers indicated that they have heavy caseloads. This complicates the scenario when it comes to rendering enough support to foster parents of children living with HIV. This in turn repels some prospective foster parents from accommodating more children who are HIV positive.

The Children's Act was also cited as failing to alleviate the situation (subtheme 3.11). For instance, the Act does not clearly define what constitutes 'visible means of support'. As a result, some presiding officers of the children's court turn down social workers' recommendations to place HIV positive children in related foster care. It was further argued that the foster child grant is not enough to cater for the needs of children living with HIV (subtheme 3.4), resulting in more foster parents opting for HIV negative children.

Objective 4: To establish the views and concerns of foster parents regarding caring for children living with HIV.

The views of foster parents in relation to fostering children living with HIV were addressed under theme 2 in Chapter 3. All the foster parents who participated in the study said that they did not have problems bringing children living with HIV into their care, despite that the majority of these foster parents did not have HIV positive children in their care. Furthermore, the discussions with designated social workers showed that most prospective foster parents were sceptical of taking care of children living with HIV. Based on this input from the social workers (who render foster care services) in the empirical study, it is safely concluded that the above objective was achieved.

Objective 5: To examine the contribution of these views and concerns towards the challenges in placing HIV-infected children in foster care.

The majority of the foster parents noted that they did not have problems with fostering HIV positive children. Thus, the views of foster parents regarding the foster

care of children living with HIV did not contribute much in understanding the challenges faced by designated social workers in placing HIV-infected children in foster care. However, the concerns they raised during the discussions helped in understanding the challenges in placing HIV positive children in foster care. The foster parents voiced their concerns as: fear of losing the child through death (subtheme 3.2), stress (sub-theme 3.3), financial issues (subtheme 3.4), stigma and discrimination (subtheme 3.6), and lack of support from social workers (subtheme 3.7), as presented under theme 3 in Chapter 3. Consequently, these concerns and fears contribute towards the challenges faced by social workers in placing HIV-infected children in foster care. To an extent, the above objective was achieved.

Objective 6: To propose strategies that will improve the placement of children living with HIV in foster care.

This objective was achieved through the recommendations made by the participants concerning the need to empower all role players in the foster care of children living with HIV in Chapter 3 (theme 5). The researcher established that empowerment could be achieved through comprehensive HIV education and training for both foster parents and social workers (subtheme 5.1), the establishment of support groups for foster parents of HIV positive children (subtheme 5.2), and collaboration by all role players in the foster care of children living with HIV.

The objective was also achieved through the thorough discussion of the empowerment approach as a strategy in dealing with the foster care of children living with HIV in section 2.8 of chapter 2.

The recommendations presented in the closing section of this chapter will build on recommendations by participants in the empirical study when proposing strategies to improve the placement of children living with HIV, thus enhancing the achievement of this objective.

4.2. Key findings and conclusions

This section presents the key findings of the study and conclusions sequentially. The challenges in placing children living with HIV are a result of a complex-combination

of sociological, psycho-social, medical and economic factors. They emanate from societal perceptions about HIV. These factors are also related to the profiles of the social workers placing the children, and the foster parents who care for them. Since these factors are interconnected, they should not be viewed in isolation.

- Foster parents bring children in need of care and protection into their care due to various reasons. The reasons include personal issues and experiences, passion to help the needy as well as financial rewards.

- ✚ One may therefore conclude that the motivation to foster can directly or indirectly contribute towards the challenges in placing children living with HIV in foster care as the quality of care that a foster parent can provide to a child depends on the motivation to foster.

- The majority of foster parents viewed fostering a child living with HIV as not a problem although social workers maintained that foster parents had problems in bringing HIV-infected children in their care.

- ✚ It can be concluded that foster parents are still sceptical of taking care of children living with HIV although they may want people to believe that they do not have problems with the issue. This could be due to fear of being judged. The fact that the majority of the participants (foster parents) did not have HIV positive children in their care is evidence supporting this conclusion.

- Numerous fears and challenges regarding the foster care of children living with HIV were revealed. These include myths and misconceptions about HIV, fear of losing the child through death. stress, financial concerns, lack of education and information on HIV, stigma and discrimination, lack of support from social workers, disclosure of a child's HIV status, compliance and adherence to medication, shortage of foster parents, and shortcomings of the Children's Act No. 38 of 2005 (as amended).

- ✚ The researcher concludes that the foster care of children living with HIV is marred by the fears and challenges described above. These fears and challenges constrain the successful placement of these children with seemingly committed foster parents.
 - Social workers play a critical role in the foster care of children living with HIV; in terms of recruitment and screening of prospective foster parents as well as educating, training and supervising these foster parents.
- ✚ The conclusion is that social workers are essential in successful placement and monitoring of children living with HIV in foster care.
 - The findings signposted that the empowerment in the foster care of children living with HIV is fundamental to successful provision of a comprehensive HIV education and training for both foster parents and social workers, support groups, incentives for social workers and foster parents, and collaboration by all role players.
- ✚ It is concluded that empowerment of all role players in the foster care of children living with HIV is cardinal for the effective placement and care of these children.

4.3. Recommendations

In light of the aforementioned findings and conclusions vis-à-vis the challenges in placing children living with HIV in foster care, the following recommendations are proposed:

4.3.1. Thorough examination of factors that motivate foster parents to bring children into their care

The onus to thoroughly examine the foster parents' motives in bringing children into their care rests largely upon social workers who recruit and screen foster parents. In order to gain a deeper understanding of the person who will take care of a child living with HIV, significant others such as family members and neighbours should also be

included in the process of interviewing the foster parents. This will help to identify foster parents with the passion and ability to care for these children instead of those only interested in the financial rewards which accompany child fostering.

4.3.2. Addressing foster parents' fears and challenges concerning fostering HIV positive children

Social workers and other relevant professionals and authorities need to address foster parents' fears and challenges regarding HIV in general and the fostering of children living with HIV through information dissemination seminars and awareness campaigns on HIV related issues. These fears and challenges, whether they are genuine or mythical, cause prospective foster parents to become pessimistic about caring for HIV positive children; as a result, the pool of those willing to foster these children shrinks.

4.3.3. Provision of a comprehensive HIV education and training for foster parents and social workers

Both foster parents and social workers need to be fully educated and trained on HIV issues. On the part of social workers, this will enable them to provide accurate and detailed information on HIV-infected children to prospective foster parents. Similarly, the foster parents will be able to deal with any concerns and problems regarding the foster care of children living with HIV. The foster parents will also be able to distinguish between myths, misconceptions and facts about HIV. They will then become more able to deal with stigma and discrimination.

4.3.4. Incentivising the foster care of children living with HIV

It is factual that children living with HIV are not akin to other children in terms of their physical and psychological needs. There are a multitude of factors to consider about the proper care of these children. For example, there should be incentives, particularly for the foster parents who care for these children. These incentives may include raising the foster child grant for children living with HIV or alternatively allowing foster parents of HIV-infected children to access the care-dependency grant without hassles. These foster parents may also be complemented with food and

clothing hand-outs for these children. Given the current shortage of foster parents, through this recommendation, the number of foster parents available for children living with HIV will definitely increase.

Considering the important role that social workers play in the care of children in general and the foster care of those living with HIV, it is important to acknowledge and appreciate them by giving them incentives. Since the social workers working in child protection organisations are the ones in the centre of rendering foster care services, including services for children living with HIV, the first incentive will be to remunerate them the same as those in government departments. This will motivate them to render quality services as well as ensuring staff detainment.

4.3.5. Formulation and implementation of specific policies regarding the care of children living with HIV who are in need of care and protection

The study's findings and the literature review show that there are no specific policies regarding the care of children living with HIV in South Africa. Therefore, there is need to formulate and implement specific policies for the care of HIV-infected children who need care and protection. Secondly, the establishment of a kinship care grant (Sibanda, 2014:92) will be another incentive for relatives to take care of their own. Furthermore, the government and other stakeholders can establish more institutions like St Peters in Johannesburg and ensure the institutions are adequately resourced and supported.

4.3.6. Collaboration and empowerment of all role players

All government, social workers, foster parents, biological families, donors and other service providers are all stakeholders in the foster care of children living with HIV. Thus, they need to work together to make the child fostering process successful. There is need for social workers to seek the assistance of health professionals (i.e. nurses, doctors, psychologists, dieticians); community based workers, among others albeit with clear task and role allocations. All these role players need to be adequately resourced and equipped in the foster care of children living with HIV. For instance, foster parents, need to be linked with support groups and other service facilities.

4.3.7. Conducting of further research

There is need for further research in the area of foster care of children living with HIV and those with other special needs, especially in other provinces of the country. This will generate numerous views and recommendations to address the challenges faced in this area.

REFERENCES

African Development Foundation. 2013. *Participatory Development Definitions*. Available:

http://www.usadf.gov/.../Participatory%20Development%20Handout_Definitions.pdf

(Accessed 2014/05/02).

Agere, L.M. 2014. *An evaluation of the role of child and youth care centres in the implementation of South Africa's Children's Act*. Alice: University of Fort Hare. (MSoc Sci Dissertation).

Alpaslan, A.H. 2010. *Social work research: A step-by-step guide on how to conduct your fourth-year research project and write the research report*. Pretoria: University of South Africa.

Askheim, O.P. 2003. Empowerment as guidance for professional social work: an act of balancing on a slack rope. *European Journal of Social Work*, 6(3):229-240.

Babbie, E. 2007. *The practice of social research*. 11th ed. Belmont: Thomson Wadsworth.

Babbie, E. 2010. *The practice of social research*. 12th ed. London: Wadsworth Cengage Learning.

Bairan, A., Taylor, G.A, Blake, B.J., Akers, T., Sowell, R. & Mendiola, R. 2007. A Model of HIV disclosure: Disclosure and types of social relationships. *Journal of the American Academy of Nurse Practitioners*, 19(5):242-50.

Brown, H.C. 2014. *Social Work and Foster Care*. London: SAGE.

Bruskas, D. 2008. Children in Foster Care: A Vulnerable Population at Risk. *Journal of Child and Adolescent Psychiatric Nursing*, 21(2):70-77.

Campbell, C., Skovdal, M., Mupambireyi, Z. & Gregson, S. 2010. Exploring children's stigmatisation of AIDS-affected children in Zimbabwe through drawings and stories. *Social Science and Medicine*, 71(5):975-985.

Charlesworth, G. & Newman, S. 2006. Clinical trials for psychosocial interventions aimed at caregivers of people with dementia. In Rockwood, K. & Gauthier, S. (Eds.) *Trial designs and outcomes in dementia therapeutic research*. London: Taylor & Francis.

Chidakwa, C. & Majoni, C. 2004. Survey of the needs of HIV/AIDS orphaned children and foster parents and the implications of these needs on caregiving: A case of Murehwa District. *Zimbabwe Journal of Educational Research*, 16(3):215-227.

Children's Act 38 of 2005 (Published in the *Government Gazette*, (28944) Pretoria: Government Printer).

Cohen, F.L. & Nehring, W.M. 1994. Foster Care of HIV-Positive Children in the United States. *Public Health Reports*. Available: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1402243/pdf/pubhealthrep00062-00062.pdf> (Accessed 2014/01/08).

Creswell, J.W. 2009. *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*. 3rd ed. Thousand Oaks, CA: SAGE.

Creswell, J.W. & Plano Clark, V.L. 2007. *Designing and Conducting Mixed Methods Research*. Thousand Oaks: SAGE Publications.

Deacon, H. & Stephney, I. 2007. *HIV/AIDS, Stigma and Children: A Literature Review*. Cape Town: HSRC Press.

De-Graft Aikins, A., Boynton, P. & Atanga, L.L. 2010. Developing effective chronic disease interventions in Africa: insights from Ghana and Cameroon. *Globalisation and Health*. Available: <http://www.globalisationandhealth.com/content/6/1/6> (Accessed 2013/09/27).

De Jager, E. 2011. *Foster Care of AIDS Orphans: Social Workers' Perspectives*. Cape Town: University of Stellenbosch. (MSW Dissertation).

Delaney, R. (n.d.) Family dynamics in foster care. Available: <http://www.fosterparentcollege.com/info/syllabi/FamilyDynamics-syllabus.pdf> (Accessed 2014/12/01).

Delport, C.S.L. 2012. *MWT 864 Research Methodology 2013*. Pretoria: University of Pretoria.

Department of Social Development. 2011. *Psychosocial support for orphans and other children made vulnerable by HIV/AIDS: A conceptual framework*. Available: <http://www.dsd.gov.za> (Accessed 2014/10/03).

Derlega, V.J., Winstead, B., Greene, K., Serovich, J. & Elwood, W.N. 2004. Reasons for HIV disclosure/nondisclosure in close relationships: Testing a model of HIV-

disclosure decision making. *Journal of Social and Clinical Psychology*, 23(6):747-767.

Dhooper, S.S. 2012. *Social work in health care: Its past and future*. 2nd ed. London: SAGE Publications.

Dlamini, B. 2011. Put people first. *News24* 28 September: 1.

Dlamini, B. 2014. eNCA interview with Ms Bathabile Dlamini, Minister of Social Development of the Republic of South Africa. 7 April. Pretoria.

Fawole, I., Egbokhare, F.O., Itolia, O.A., Odejide, A.I. & Olayinka, A.I. 2006. Definition, Spectrum and Types of Research. In Olayinka, A.I, Taiwo, V.O., Raji-Oyelade, A. & Farai, I.P. (Eds.) *Methodology of Basic and Applied Research*. 2nd ed. Ibadan: Postgraduate School University of Ibadan.

Fouché, C.B. & Delpont, C.S.L. 2011. Writing the research proposal. In Devos, A.S. (Ed.), Strydom, H., Fouché, C.B. & Delpont, C.S.L. *Research at grass roots for the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik Publishers.

Fouche, C.B. & De Vos, A.S. 2011. Formal Formulations. In De Vos, A.S. (Ed.), Strydom, H., Fouche, C.B. & Delpont, C.S.L. *Research at grass roots for the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik Publishers.

Fouché, C.B. & Schurink, W. 2011. Qualitative Research Designs. In Devos, A.S. (Ed.), Strydom, H., Fouché, C.B. & Delpont, C.S.L. *Research at grass roots for the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik Publishers.

Gale Encyclopaedia of Medicine. 2008. Belmont: The Gale Group Inc.

Greeff, M. 2011. Information collection: interviewing. In De Vos, A.S. (Ed.), Strydom, H., Fouché, C.B. & Delpont, C.S.L. *Research at grass roots for the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik Publishers.

Guba, E.G. 1981. Criteria of assessing the trustworthiness of naturalistic enquiries. *Educational Communication and Technology Journal*, 29(1981):75-91.

Harber, M. 1999. AIDS Brief for Professionals: Social workers. Available: <http://www.heard.org.za/aids-brief-for-professionals-social-workers.pdf> (Accessed 2014/03/25).

Hepworth, D.H., Rooney, R.H., Rooney, G.D. & Strom-Gottfried, K. 2013. *Direct social work practice: Theory and skills*. 9th ed. Belmont, CA: Brooks/Cole.

Heunis, J.C., Wouters, E. & Kigozi, N.G. 2012. HIV and tuberculosis in South Africa: trends, challenges and responses. In Van Rensburg, H.C.J. (Ed.) *Health and health care in South Africa*. 2nd ed. Pretoria: Van Schaik Publishers.

Hick, S. 2006. *Social Work in Canada*. 2nd ed. Toronto: Thompson Education Publishing Inc.

Hinckley, C. 2007. Exploring the use of television for guidance to expectant fathers. University of Pretoria. In Maree, K. (Ed.) *First steps in research*. Pretoria: Van Schaik Publishers.

Holloway, I. & Wheeler, S. 1996. *Qualitative research for nurses*. Oxford: Blackwell Scientific Publications.

Human Sciences Research Council (HSRC). 2014. *South African National HIV Prevalence, Incidence and Behaviour Survey 2012*. Cape Town: HSRC Press.

International Federation of Social Workers. 2012. *Statement of ethical principles*. Available: <http://www.ifsw.org/policies/statement-of-ethical-princ> (Accessed 2014/05/02).

Jansen, J.D. 2007. The Research Question. In Maree, K. (Ed.) *First steps in research*. Pretoria: Van Schaik Publishers.

Jo'Burg Child Welfare. 2013. *Foster Care Manual*. Available: <http://www.jhbchildwelfare.org.za> (Accessed 2013/03/08).

Johnson, K. 2004. Social Services Information System Mentor Meeting: Federal Definitions. Available: <http://www.dhs.state.mn.us/main/idcplg?IdcService> (Accessed 2014/04/14).

Kganyago, L.N. 2006. *Description of risk factors in foster care failure*. Johannesburg: University of Johannesburg. (MA Mini-Dissertation).

Kiragu, K. & Pulerwitz, J. 1999. Application of behaviour change theory to HIV programs: Lessons learned from operations research at Horizons. Available: <http://www.popcouncil.org/Horizons/ORToolkit/AIDSQuest/cmnbehvrtheo/indvsocchn.html> (Accessed 2014/02/10).

Leedy, P.D. & Ormrod, J.E. 2005. *Practical Research: Planning and Design*. New Jersey: Pearson Prentis Hall.

Lietz, C.A, Langer, C.L. & Furman, R. 2006. Establishing trustworthiness in qualitative research in social work: Implications from a study regarding spirituality. *Qualitative Social Work*, 5(4):441-458.

Mandikonza, S. 2013. Personal interview with Ms. Susan Mandikonza, Designated social worker, Jo'Burg Child Welfare. 11 January 2013. Johannesburg.

Manukuza, K.B. 2013. *Legal placement of orphaned children in related foster care: The perspectives of social workers*. Johannesburg: University of the Witwatersrand. (MA Mini-Dissertation).

Maree, K. & Van der Westhuizen, C. 2007. Planning a research proposal. In Maree, K. (Ed.) *First in steps research*. Pretoria: Van Schaik Publishers.

Mawere, N. 2009. *"When Home is Haven": Challenges and opportunities perceived by foster parents within the cluster foster care scheme*. Johannesburg: University of the Witwatersrand. (BSW Research Project).

Medical Dictionary for the Health Professions and Nursing. 2012. Huntingdon Valley: Farlex.

Miller-Keane Encyclopaedia and Dictionary of Medicine, Nursing, and Allied Health. 2003. 7th ed. Philadelphia: Saunders.

Muperi, W. 2015. HIV positive but not beaten. *Daily News*, 22 February: 6.

Mutupo, P. 2014. Heroes of our time: HIV+ Paida Mutupo. *New Zimbabwe*, 10 November: 1.

National Association of Social Workers. 2008. *Code of ethics*. Washington, DC: NASW Press.

Neuman, W.L. 2006. *Social Research Methods: Qualitative and Quantitative approaches*. 6th ed. Boston: Pearson Education, Inc.

Nieuwenhuis, J. 2007. Introducing Qualitative Research. In Maree, K. (Ed.) *First steps in research*. Pretoria: Van Schaik Publishers.

Nieuwenhuis, J. 2007. Qualitative research designs and data gathering techniques. In Maree, K. (Ed.) *First steps in research*. Pretoria: Van Schaik Publishers.

Obono, O.M., Ajuwon, A.J., Arowojolu, A.O., Ogundipe, G.A.T., Yakubu, J.A. & Falusi, A.G. 2006. Ethics in Research. In Olayinka, A.I., Taiwo, V.O., Raji-Oyelade, A. & Farai, I.P. (Eds.) *Methodology of Basic and Applied Research*. 2nd ed. Ibadan: The Post Graduate School University of Ibadan.

Organisation of African Unity (OAU). 1999. *African Charter on the Rights and Welfare of the Child*. Available: http://www.au.int/en/sites/default/files/Charter_En_A (Accessed 2014/09/26).

Page, N. & Czuba, C.E. 1999. Empowerment: What is it? *Journal of Extension*. Available: <http://www.joe.org/1999october/comm1.php> (Accessed 2014/05/04).

Payne, M. 2005. *Modern Social Work Theory*. 3rd ed. Chicago, Illinois: Lyceum Book Inc.

Ramaphosa, C. 2014. Speech delivered at the Commemoration of World AIDS Day, 1 December. Johannesburg.

Ross, E. & Deverell, A. 2010. *Health, illness and disability: Psychosocial approaches*. 2nd ed. Pretoria: Van Schaik Publishers.

Rungani, J. 2013. Personal interview with Ms. Judith Rungani, Designated social worker, Jo'Burg Child Welfare. 11 January. Johannesburg.

Sadan, E. 1997. *Empowerment and community planning: Theory and practice of people-focused social solutions*. Tel Aviv: Hakibbutz Hameuchad Publishers (in Hebrew).

SAPA. 2012. Shortage of Social workers. *Sowetan*. 14 August: 5.

Schurink, W., Fouché, C.B. & De Vos, A.S. (Ed.) 2011. Qualitative data analysis and interpretation. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delpont, C.S.L. *Research at grass roots for the social sciences and human service professions*. Pretoria: Van Schaik Publishers.

Sebba, J. 2012. *Why do people become foster carers: An international literature review on the motivation to foster*. Oxford: Oxford University.

Shenton, A.K. 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22(2004):63-75.

Sibanda, S. 2014. *Challenges faced by social workers working in child protection services in implementing the Children's Act 38 of 2005*. Pretoria: University of Pretoria (MSW Mini-Dissertation).

Skelton, A. 2012. Foster care crisis: Kinship grant a solution? Available: <http://www.children.pan.org.za/>. (Accessed 2014/05/13).

Smart, R. 2003. Planning for orphans and HIV/AIDS affected children. In Uys, L. & Cameron, S. (Eds.) *Home-based HIV/AIDS care*. Cape Town: Oxford University Press.

Statistics South Africa. 2007. *Greater Johannesburg Metropolitan Community Survey 2007*. Available: <http://www.statssa.gov.za/communitynew/content.asp> (Accessed 2014/04/29).

Strydom, H. 2011. Ethical Aspects of research in the social sciences and human service professions. In De Vos, A.S. (Ed.), Strydom, H., Fouché, C.B. & Delpont, C.S.L. *Research at grass roots for the social sciences and human service professions*. Pretoria: Van Schaik Publishers.

Strydom, H. & Delpont, C.S.L. 2011. Sampling and pilot study in qualitative research. In De Vos, A.S. (Ed.), Strydom, H. Fouché, C.B. & Delpont, C.S.L. *Research at grass roots for the social sciences and human service professions*. Pretoria: Van Schaik Publishers.

Swanepoel, J.M. 1999. *Experiences of kinship foster parents*. Rhodes University (MSoc Dissertation). Available: <http://www.eprints.ru.ac.za/2531/1/SWANEPOEL-MSoc-99-97.pdf>. (Accessed 2014/04/14).

The American Heritage Medical Dictionary. 2007. Houghton: Mifflin Company.
Treatment Action Campaign. 2013. *HIV and support groups*. Available: <http://www.tac.org.za/documents/literacy/wshpdfs/66-73.pdf> (Accessed 2015/02/15).

Tyebjee, T. 2003. Attitude, interest, and motivation for adoption and foster care. *Child Welfare League of America*, LXXXII(6):685-706.

United Nations Programme on HIV/AIDS (UNAIDS). 2001. *Investing in our future: Psychosocial support for children affected by HIV/AIDS. A case study in Zimbabwe and the United Republic of Tanzania*. Available: <http://www.unaids.org/publications/IRC-pub02/JC606> (Accessed 2014/11/24).

United Nations Programme on HIV/AIDS (UNAIDS). 2012. *Global report: UNAIDS report on the global AIDS epidemic*. Available: <http://www.avert.org/worldwide-hiv-aids-statistics.htm> (Accessed 2014/12/03).

Van Dyk, A. 2012. *HIV and AIDS education, care and counselling*. 4th ed. Cape Town: Pearson Education South Africa Pty Ltd.

Vranda, M.N. & Mothi, S.N. 2013. Psychosocial issues of children infected with HIV/AIDS. *Indian Journal of Psychological Medicine*, 35(1):19-22.

Warwick, J.K. 2013. *An explorative study of the experiences and needs of foster carers of HIV positive children in the Western Cape, South Africa*. Cape Town: University of Cape Town (MSocSc Mini-Dissertation).

World Bank. 2011. *Empowerment and poverty reduction: A source book*. Available: <http://www.go.worldbank.org> (Accessed 2014/05/02).

World Bank. 2013. *Social inclusion*. Available: <http://www.go.worldbank.org> (Accessed 2014/05/02).

APPENDIX 1: ETHICAL CLEARANCE LETTER



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

29 August 2014

Dear Prof Lombard

Project: Challenges in placing children living with HIV in foster care in Johannesburg
Researcher: B Muchanyerei
Supervisor: Nontembeko Joyce Bila
Department: Social Work and Criminology
Reference numbers: 13274181

Thank you for the application that was submitted for ethical consideration.

I am pleased to inform you that the above application was **approved** by the **Research Ethics Committee** on 28 August 2014. 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 approval and ethical clearance.

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

We wish you success with the project.

Sincerely

Prof Karen Harris
Acting Chair: Research Ethics Committee
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: Karen.harris@up.ac.za

Research Ethics Committee Members: Dr L Blokland; Prof Prof M-H Coetzee; Dr JEH Grobler; Prof KL Harris (Acting Chair); Ms H Klopper; Dr C Panebianco-Warrens; Dr Charles Puttergill; Prof GM Spies; Dr Y Spies; Prof E Taljard; Dr P Wood



APPENDIX 2

Faculty of Humanities
Department of Social Work & Criminology

LETTER OF INFORMED CONSENT FOR THE RESEARCHER'S ASSISTANT

Date: 08.08.2014
Researcher: Babbot Muchanyerei
Student Number: 13274181
Cell: 073 560 7910/ 084 329 1039
Email: babbotm@webmail.co.za

Title of the study: Challenges in placing children living with HIV in foster care in Johannesburg

Goal of the study: The goal of the study is to investigate the challenges in placing children living with HIV in foster care in Johannesburg.

Procedures: I understand that I will be invited to act as research assistant in focus group discussions to investigate the challenges in placing children living with HIV in foster care in Johannesburg. The duration of each session will be approximately 60 minutes. I am aware that I should attend at least one session with each group of the participants and that I will be advised of the time and venue of the meeting. I give full consent to the researcher to audio-tape the focus group discussions. I take note that the study is scheduled for August to October 2014.

Risks and discomforts: I take note that there are no foreseen risks and discomfort involved in participating in the study. However, I understand that this research will remind me of the practical realities and challenges in placing children living with HIV in foster care in Johannesburg.

Benefits: I understand that apart from transport costs and refreshments to be served during the focus group discussion, the researcher will not offer me any incentives for being involved in the study. The findings of the study are however hoped to assist in addressing the challenges in placing children living with HIV in foster care in South Africa.

Confidentiality: Information shared during the focus group discussions will be treated with the strictest confidentiality. I will not divulge information from the focus group discussion to anybody else and I will, to the best of my ability prevent inadvertent disclosure of confidential information.

By signing this letter of consent, I confirm that I have read and clearly understood its contents. I do not give up my legal right by signing this letter of informed consent.

Researcher's assistant (Print name) Researcher assistant's signature Date

Researcher (Print name) Researcher's signature Date



APPENDIX 3

Faculty of Humanities
Department of Social Work & Criminology

LETTER OF INFORMED CONSENT FOR PARTICIPANTS (SOCIAL WORKERS)

Date: 08.08.2014
Researcher: Babbot Muchanyerei
Student Number: 13274181
Cell: 073 560 7910/ 084 329 1039
Email: babbotm@webmail.co.za

Title of the study: Challenges in placing children living with HIV in foster care in Johannesburg

Goal of the study: The goal of the study is to investigate the challenges in placing children living with HIV in foster care in Johannesburg.

Procedures: I understand that I will be invited to participate in a focus group discussion to investigate the challenges in placing children living with HIV in foster care in Johannesburg. The duration of the session will be approximately 60 minutes. I am aware that I will be advised of the time and venue of the meeting. I give full consent to the researcher to audio-tape the focus group discussion. I take note that the study is scheduled for August to October 2014.

Risks and discomforts: I take note that there are no foreseen risks and discomfort involved in participating in the study. However, I understand that this research will remind me of the practical realities and challenges in placing children living with HIV in foster care in Johannesburg.

Benefits: I understand that the researcher will not offer me any incentives for being involved in the study. The findings of the study are however hoped to assist in addressing the challenges in placing children living with HIV in foster care in South Africa.

Participants' rights: I am fully aware that participation in this study is voluntary and that I may withdraw my participation from the study at any time if I so wish, without negative consequences.

Confidentiality: Information shared during the focus group discussion will be treated with the strictest confidentiality. I will not divulge information from the interview to anybody else and I will, to the best of my ability prevent inadvertent disclosure of confidential information.

Dissemination of research results: I also understand that the researcher will compile a research report to be submitted to the University of Pretoria for academic purposes and that the research findings will be submitted for publication to a scientific journal. However, I take note that the researcher will ensure that no information that would identify me (my name and surname, in particular) would be included in the transcriptions, research report and any other further publication. Other than the researcher, I am aware that the researcher's supervisor will have access to the research data and she will treat it as confidential. I am also aware that raw data will be securely stored for a minimum of 15 years, according to the University of Pretoria's stipulations. I take note that the research data and transcripts will not be used by the researcher or any other researcher without my informed consent.

By signing this letter of consent, I confirm that I have read and clearly understood its contents. I do not give up my legal right by signing this letter of informed consent.

| | | |
|--------------------------|-------------------------|-------|
| _____ | _____ | _____ |
| Participant (Print name) | Participant's signature | Date |
| _____ | _____ | _____ |
| Researcher (Print name) | Researcher's signature | Date |



APPENDIX 4

LETTER OF INFORMED CONSENT FOR PARTICIPANTS (FOSTER PARENTS)

Date: 08.08.2014
Researcher: Babbot Muchanyerei
Student Number: 13274181
Cell: 073 560 7910/ 084 329 1039
Email: babbotm@webmail.co.za

Title of the study: Challenges in placing children living with HIV in foster care in Johannesburg

Goal of the study: The goal of the study is to investigate the challenges in placing children living with HIV in foster care in Johannesburg.

Procedures: I understand that I will be invited to participate in a focus group discussion to investigate the challenges in placing children living with HIV in foster care in Johannesburg. The duration of the session will be approximately 60 minutes. I am aware that I will be advised of the time and venue of the meeting. I give full consent to the researcher to audio-tape the focus group discussion. I take note that the study is scheduled for August to October 2014.

Risks and discomforts: I take note that there are no foreseen risks and discomfort involved in participating in the study. However, I understand that this research will remind me of the practical realities and challenges in placing children living with HIV in foster care in Johannesburg.

Benefits: I understand that apart from transport costs and refreshments to be served during the focus group discussion, the researcher will not offer me any incentives for being involved in the study. The findings of the study are however hoped to assist in

addressing the challenges in placing children living with HIV in foster care in South Africa.

Participants' rights: I am fully aware that participation in this study is voluntary and that I may withdraw my participation from the study at any time if I so wish, without negative consequences.

Confidentiality: Information shared during the focus group discussion will be treated with the strictest confidentiality. I will not divulge information from the focus group discussion to anybody else and I will, to the best of my ability prevent inadvertent disclosure of confidential information.

Dissemination of research results: I also understand that the researcher will compile a research report to be submitted to the University of Pretoria for academic purposes and that the research findings will be submitted for publication to a scientific journal. However, I take note that the researcher will ensure that no information that would identify me (my name and surname, in particular) would be included in the transcriptions, research report and any other further publication. Other than the researcher, I am aware that the researcher's assistant and supervisor will have access to the research data and they will treat it as confidential. I am also aware that raw data will be securely stored for a minimum of 15 years, according to the University of Pretoria's stipulations. I take note that the research data and transcripts will not be used by the researcher or any other researcher without my informed consent.

By signing this letter of consent, I confirm that I have read and clearly understood its contents. I do not give up my legal right by signing this letter of informed consent.

| | | |
|--------------------------|-------------------------|-------|
| _____ | _____ | _____ |
| Participant (Print name) | Participant's signature | Date |

| | | |
|-------------------------|------------------------|-------|
| _____ | _____ | _____ |
| Researcher (Print name) | Researcher's signature | Date |

APPENDIX 5: PERMISSION LETTER TO CONDUCT RESEARCH



26 June 2014

Mr Babbot Muchanyerei
Flat 5 Astor Court
8 King Street
Germiston
1401

Dear Mr Muchanyerei

RE: Request to conduct research in Jo'burg Child Welfare – CFU Department

This served to confirm that your request to conduct the research on the **Challenges in placing children living with HIV in foster care in Johannesburg** in our Department has been approved.

We will be looking forward to seeing your findings on the topic once you have completed.

Wishing you all the best with your research

Thanking you

Nomvuyo Shabangu
Manager; Child and Family Unit and Adoptions

Postal Address: P O Box 62606, Marshalltown, 2107-Address: 1st Floor, Edura House, 41 Fox Street, Johannesburg. Tel: 011 298 8500
Fax: 011 298 8590 ·E-mail: director@jhbchildwelfare.org.za·funds@jhbchildwelfare.org.za·Website:www.jhbchildwelfare.org.za
Registered in terms of the Non-Profit Organisations ACT 71 of 1997 – Registration No.: 000-566

APPENDIX 6

INTERVIEW GUIDE FOR SOCIAL WORKERS

Title of the study: Challenges in placing children living with HIV in foster care in Johannesburg

Goal of the study: To investigate the challenges in placing children living with HIV in foster care in Johannesburg.

SECTION A: DEMOGRAPHIC INFORMATION OF PARTICIPANTS

1. Participant code

| | |
|--|--|
| | |
|--|--|

2. Gender

| |
|---|
| M |
|---|

| |
|---|
| F |
|---|

3. Age in years (*Tick appropriate box*)

| | | | |
|-------|-------|-------|-----|
| 20-30 | 31-40 | 41-50 | 51+ |
|-------|-------|-------|-----|

4. Race

| | | | |
|---------|-------|----------|--------|
| African | White | Coloured | Indian |
|---------|-------|----------|--------|

5. Qualification

| | | |
|------------|-----|--------------|
| SW Diploma | BSW | Postgraduate |
|------------|-----|--------------|

6. Years of experience as a social worker

| | | | |
|-----|------|-------|-----|
| 3-5 | 6-10 | 11-15 | 15+ |
|-----|------|-------|-----|

SECTION B: KNOWLEDGE AND EXPERIENCE OF PLACING CHILDREN IN FOSTER CARE

1. For how long have you been working as a social worker in this organisation?
2. How has been your experience with the placing in foster care of children in need of care and protection in general?

SECTION C: CHALLENGES IN PLACING CHILDREN LIVING WITH HIV IN FOSTER CARE

1. Are you dealing with many cases of children who are living with HIV?
2. What are the challenges that you are facing as a designated social worker in placing these children in foster care?
3. What do you think are the causes of these challenges?

SECTION D: RECOMMENDATIONS

1. In your opinion, how do you think these challenges may be addressed and what are your recommendations regarding the placement of children living with HIV in South Africa.

APPENDIX 7

INTERVIEW GUIDE FOR FOSTER PARENTS

Title of the study: Challenges in placing children living with HIV in foster care in Johannesburg

Goal of the study: To investigate the challenges in placing children living with HIV in foster care in Johannesburg.

SECTION A: DEMOGRAPHIC INFORMATION OF PARTICIPANTS

1. Participant code

| | |
|--|--|
| | |
|--|--|

2. Gender

| |
|---|
| M |
|---|

| |
|---|
| F |
|---|

3. Age in years (*Tick appropriate box*)

| | | | | |
|----------|-------|-------|-------|-----|
| Below 30 | 31-40 | 41-50 | 51-60 | 61+ |
|----------|-------|-------|-------|-----|

4. Marital status

| | | | | |
|--------|---------|----------|---------|---------------------|
| Single | Married | Divorced | Widowed | Living with partner |
|--------|---------|----------|---------|---------------------|

5. Race

| | | | |
|---------|-------|----------|--------|
| African | White | Coloured | Indian |
|---------|-------|----------|--------|

SECTION B: KNOWLEDGE AND EXPERIENCE OF FOSTERING CHILDREN

1. For how long have you been a foster parent (in general and with Jo'Burg Child Welfare)?
2. How has been your experience with the fostering of children in need of care and protection in general?

SECTION C: CHALLENGES IN FOSTERING CHILDREN LIVING WITH HIV

1. What are your views about caring for a child/ren living with HIV?
2. Do you have any child living with HIV in your foster care?
3. What is your experience in caring for a child/ren living with HIV?
4. What are the challenges that you face in caring for the child/ren?

SECTION D: RECOMMENDATIONS

1. What are your recommendations regarding the placement and care of children living with HIV in South Africa?

APPENDIX 8: EDITOR'S LETTER



Online Editorial Services

7 MAY 2015

TO WHOM IT MAY CONCERN

I have over 8 years free-lance experience of editing academic theses for post-graduate students and work-related reports.

I confirm that I edited this thesis, '*Challenges in placing children living with HIV in foster care in Johannesburg*' by Babbot Muchanyerei.

1. I checked compliance with the guidelines which the author provided:
Font: Arial, 12 point
Spacing: 1.5
Language: South Africa English

Thus, the grammar, spellings were checked and corrected according to the South African English dictionary in Microsoft Word. Punctuation anomalies were corrected. Suggestions for correction of long and wordy sentences were made as 'comments'. It is the author's discretion to accept or reject those editorial suggestions.

2. I also checked compliance with the Harvard Reference style for in-text and the Reference List. I used the guidelines from the University of Johannesburg and the University of Stellenbosch to correct the referencing inconsistencies which were detected.
3. I also checked the 'flow' in the document, paying particular attention to the sequencing of the sections in each chapter. Thus, chapters 1 and 3 were re-structured, and a second re-structured version of the report was submitted to the author for his consideration.
4. For the document layout, white spaces in the entire report were removed. The section headings were defined in order to generate an automatic Table of Contents.

Kind regards,

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