

**The perceptions of Social Auxiliary Workers on their
role and competencies in addressing biopsychosocial
needs of children living with HIV at drop-in-centres**

By

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**A mini-dissertation submitted in partial fulfilment of the
requirements for the degree**

**Master of Social Work in Health Care
(MSW Health Care)**

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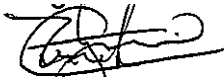
**UNIVERSITY OF PRETORIA
FACULTY OF HUMANITIES**

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October 2016

DECLARATION

I hereby declare that: “The perceptions of Social Auxiliary Workers on their role and competencies in addressing biopsychosocial needs of children living with HIV at drop-in-centres” is my own work, that all the sources used or quoted have been indicated and acknowledged by means of complete references, and that this dissertation was not previously submitted by me for a degree at another University.

Signature: 

Date: *13 October 2016*

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To my son and daughter, Terrence and Tisha, this was done in part to help you appreciate the significance of hard work and perseverance!

To my late father, I dedicate this to you! Thank you for your belief, enthusiasm and sacrifices towards my education – “I am proudly the son of my father.”

ABSTRACT

The perceptions of Social Auxiliary Workers on their role and competencies in addressing biopsychosocial needs of children living with HIV at drop-in-centres

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South Africa bears the largest burden of children living with HIV in Sub-Saharan Africa, with 450 000 of the continent's over 3 million children living with HIV estimated to be in the country (UNAIDS, 2013:87). Children living with HIV have various intrinsic biopsychosocial needs, and the meeting of these needs within drop-in-centres is primarily the responsibility of Social Auxiliary Workers, a "frontline" category of social welfare workforce whose roles are viewed as critical in enabling the identification and facilitation of provision of health and other services. The study was informed by a concern that, in spite of their envisaged roles, Social Auxiliary Workers have very limited paediatric HIV knowledge, skills and experience.

The goal of the study was to explore the perceptions of Social Auxiliary Workers on their role and competencies in addressing biopsychosocial needs of children living with HIV at drop-in-centres. The researcher conducted this study from a qualitative approach. The study was applied in a natural setting and a collective case study design was utilised. The work experiences of a purposive sample of participants that was randomly sampled were gathered by means of semi-structured one-on-one interviews. **A total sample of 10 participants was drawn from a pool of 40 Social Auxiliary Workers who were employed in 18 drop-in-centres that are in Sedibeng District Municipality.**

The study's findings indicate that children living with HIV had many complex biological, psychological and social needs that were exacerbated by stigma, discrimination and non-disclosure of the children's HIV status by parents. This created underlying debilitating barriers for Social Auxiliary Workers to efficiently identify, and get children into treatment, care and social support services. The findings also revealed that Social Auxiliary Workers had limited, non-standardised and highly imperceptible HIV knowledge and skills to competently work with children living with HIV. Furthermore, findings showed that Social Auxiliary Workers face institutional and resource challenges that stem from poverty, insufficient financial resources within drop-in-centres and lack of structured large scale programmes to mobilise and educate communities on children and HIV.

The study concluded that many of the biopsychosocial needs that children living with HIV face are not being comprehensively and sustainably addressed as Social Auxiliary Workers are not effective in their role, amongst other things, due to lack of skills and knowledge on how to address factors that contribute to the exclusion; and consequently, disproportionate low access of services by children living with HIV.

The study proposes the training and capacitation of Social Auxiliary Workers on paediatric HIV so as to increase the depth and breadth of services rendered to children living with HIV. It is also important that regular and on-going supervision and debriefing opportunities for Social Auxiliary Workers should be strengthened to promote optimal consolidation of skills and knowledge. The provision of simplified practice guidelines and procedures should also be prioritised in order to ensure consistency in understanding amongst Social Auxiliary Workers of their role and obligations. Furthermore, it is recommended that Government and the Department of Social Development should consider scaling-up funding for drop-in-centres as well as implementation of HIV-related stigma and discrimination mitigation programmes in communities.



KEY WORDS

Drop-in-centre

Department of Social Development

Social Auxiliary Worker

Biopsychosocial perspective

HIV and AIDS

Children living with HIV

Stigma and discrimination

Disclosure and non-disclosure

Role and Competencies

Psychosocial care and support

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ACRONYMS

AIDS – Acquired Immune Deficiency Syndrome

AGYW – Adolescent Girls and Young Women

ART – Anti Retroviral Therapy

ARVs – Anti-retrovirals

CBOs – Community Based Organizations

DoH – Department of Health

DSD – Department of Social Development

FBOs – Faith Based Organizations

HIV – Human Immunodeficiency Virus

NGOs – Non-Governmental Organizations

NSP – National Strategic Plan on HIV, STIs and TB 2012-2016

OVC – Orphaned and Vulnerable Children

PHC – Primary Health Care

PMTCT – Prevention of Mother To Child Transimission

SACSSP – South African Council for Social Service Professions

TB – Tuberculosis

UNAIDS – United Nations Programme on HIV/AIDS

UNICEF – United Nations Children’s Emergency Fund

WHO – World Health Organization

CHAPTER 1

GENERAL INTRODUCTION AND ORIENTATION OF THE STUDY

1.1 INTRODUCTION

South Africa's Human Immuno-deficiency Virus (HIV) and Acquired Immuno-deficiency Syndrome (AIDS) epidemic has had a devastating effect on children. The United Nations Programme on HIV/AIDS (UNAIDS) (2013:87) notes that, of Sub-Saharan Africa's over 3 million children under the age of 15 years who are living with HIV, South Africa bears the largest burden of an estimated 450 000 children living with the virus. Children living with HIV have various intrinsic biopsychosocial needs, and the meeting of these needs largely depend on the role and competencies of "frontline" staff, such as Social Auxiliary Workers, that interact with the children on a regular basis.

Responding to the dire needs of children living with HIV and other vulnerable children in South African communities, Non-Governmental Organisations (NGOs) and Community Based Organisations (CBOs), with the support and supervision of the government, through the Department of Social Development (hereafter referred to as DSD), set up drop-in-centres to meet the various needs of vulnerable children. The actual rendering of services in drop-in-centres is primarily the responsibility of Social Auxiliary Workers, a category of social welfare workforce regarded as a supportive service to Social Work.

Amzel, Toska, Lovich, Widyono, Patel, Foti, Dziuban, Phelps, Sugandhi, Mark, and Altschuler (2013:147) remark that, Social Auxiliary Workers like other categories of community care-giving staff have very limited HIV knowledge, and lack skills and exposure in working with HIV positive children. The aforementioned factors have an influence on the role and competencies of Social Auxiliary Workers; and consequently, they have an influence on the ability of children living with HIV to access comprehensive, responsive and supportive health services. There are other authors such as Pharaoh (2005:3), who note that the majority of staff in community based facilities caring for children living with HIV, have received limited guidance and

skills training in HIV programming, which consequently compromises the responsiveness of activities aimed at tackling the complex biopsychosocial needs faced by these children. In the context of health, the significant biopsychosocial needs encountered by children living with HIV include a combination of factors that could be classified as being either psychological (thoughts, emotions, and behaviors), social (relationships and socio-economic), environmental (school attendance, and access to services) and biological factors (physical symptoms, impact of disease and medication) (Amzel et al, 2013:147).

The researcher argues that, in spite of the envisaged critical role that Social Auxiliary Workers can play in enabling and facilitating the provision of health services to children living with HIV, the non-standardised and highly imperceptible HIV knowledge that this cadre possesses greatly impinges on their role and competencies in working with children living with HIV. The study under investigation therefore sought to explore and understand the perceptions of Social Auxiliary Workers regarding their role (functions, tasks and responsibilities) and competencies (capabilities, skills, knowledge, expertise, proficiency) and the effect thereof on their abilities to address health needs of children living with HIV at drop-in-centres.

This study was conducted with Social Auxiliary Workers working at drop-in-centres that are operating in Sedibeng District Municipality, in Gauteng province. Sedibeng District Municipality consists of three local municipalities, namely Lesedi, Midvaal and Emfuleni. According to Statistics South Africa (2012:79), as of 2011 the district's population was estimated at approximately 916 484. It is noted that, due to its lower rentals and close proximity to Johannesburg, Sedibeng District Municipality is residence to people who migrate from different places to search for economic opportunities in greater Johannesburg (Statistics South Africa, 2012:79). In this respect, Sedibeng is host to several development challenges, which inversely affects the district municipality's ability to render health services to its residents and vulnerable populations.

The key concepts for the study are as follows:

- **Drop-in-centres**

Section 213 of The Children's Act No. 38 of 2005 (as amended), define drop-in-centres as community-based facilities, registered and regulated by the Department of Social Development, aimed at providing basic services that meet the emotional, physical and social development of vulnerable children. Amongst some the appropriate programmes that drop-in-centres are expected to provide, is the provision of primary health care, in collaboration with local health clinics. Drop-in-centres are also expected to be proactive by rendering prevention and early intervention programmes, according to the Department of Social Development's Norms and Standards for drop-in-centres (2008:144).

- **Social Auxiliary Work**

The South African Council for Social Service Professions (SACSSP), states that Social Auxiliary Work is registered and regulated as a social service profession in terms of Section 18 of the Social Service Professions Act 110 of 1978 (as amended), as well as the Social Work Amendment Act 102 of 1998. In the Supervision Framework for the Social Work Profession in South Africa, jointly authored by DSD and SACSSP (2012:34), Social Auxiliary Work is defined as "a supportive service to social work, rendered by a Social Auxiliary Worker under the supervision of a Social Worker to further the aims of social work." In the context of this study, focus will be on Social Auxiliary Workers that are employed within drop-in-centres to contribute towards the caring and protection of vulnerable children, specifically children living with HIV.

- **HIV and AIDS**

Although the terms HIV and AIDS are sometimes used interchangeably as if they refer to the same condition, it is very critical to understand the distinction between the two terms. Barnett and Whiteside (2006:30) assert that, HIV is an abbreviation for Human Immunodeficiency Virus, the virus that causes AIDS. The authors explain that for HIV infection to occur, the virus has to enter the body and attach itself to host cells in the human immune system, known as

CD4 cells. A person is said to be HIV positive when HIV antibodies are detected in their blood. Jackson (2002:38) explains that, having a positive reaction on a test for HIV does not mean that one has developed AIDS as individuals infected with HIV can survive for many years provided that they have adequate care and treatment.

AIDS on the other hand, is an acronym for Acquired Immune Deficiency Syndrome, a disorder of the immune system that is described by Ross and Deverell (2010:91) as the final stage of HIV infection when the virus would have seriously weakened the body's defences against diseases. In the AIDS stage opportunistic infections increase in frequency, severity and duration until the person dies (Barnett & Whiteside, 2006:32).

The focus in this study will be on children who are infected and are living with HIV as opposed to those who have developed AIDS, the final stage of HIV infection that often leaves one requiring hospitalisation and end-of-life care. It is noted by Barnett and Whiteside (2006:39) that the most important cause of HIV infection among children is mother-to-child transmission through prenatal (at the time of delivery) or post-natal (through breastfeeding).

- **Children living with HIV**

For the purposes of this study, the child living with HIV is regarded as a vulnerable child. Although the exact statistics of children that are living with HIV and are accessing services from drop-in-centres are not known, Stover, Hallett, Wu, Warren and Gopalappa (2014:27) point out that, due to high prevalence of HIV in South African communities, there is a great number of children living with HIV that are accessing services from drop-in-centres.

Although defining the term "vulnerable children" is normative, complex and value laden, there is some consensus amongst some authors that vulnerable children are those children who find themselves in precarious situations where their essential needs are not met and their rights are unfulfilled (Skinner, Tsheko, Mtero-Munyati, Segwabe, Chibatamoto, Mfecane, Chandiwana, Nkomo, Tlou and Chitiyo, 2006:621). In section 150 of the Children's Act No. 38 of 2005 (as amended), vulnerable children are also referred to as children in

need of care and protection. The Act states that these are children below the ages of 18 years who are either orphaned or are vulnerable or both and are living in circumstances with high risks and their prospects for continued growth and development are seriously threatened. This includes children who are living with HIV, abused children, working children, destitute children, abandoned and neglected children, children living on the streets or children with chronically ill parents. It is important to point out that, the teenage years of 13-18 may be considered adolescence in some cultures globally (UNICEF, 2013:35), so in this study the adolescent will be used to denote to a teenage child who may be having reproductive health needs and/or is engaging in sexual behaviors (UNICEF, 2013:35).

- **Biopsychosocial needs**

Frankel, Quill and McDaniel (2004:73) define biopsychosocial needs as the different biological, psychological, and social factors that influence health, and/or could be a result of ill-health. In concurrence with the aforementioned authors, Borrell-Carrió, Suchman and Epstein (2004:579) remark that, biopsychosocial needs should not be seen narrowly but should rather be considered widely in their fullest context as conditions or factors that impinges on patients' understanding of their health conditions; and consequently impacts on ways by which patients deal with disease processes. In the context of this study, children living with HIV are affected by many biopsychosocial needs which might be physical (bio), psychological (anxiety, depression, emotional, cognitive and behavioural), social (relationship problems), and environmental (limited access to education and healthcare) (Mothi, Karpagam, Swamy, Lala Mamatha & Sarvode, 2011:913). The above identified biopsychosocial needs interact in a complex manner that worsens the vulnerability of children living with HIV.

- **Role and competencies**

A role can be defined as the functions, activities or tasks performed by Social Auxiliary Workers in the realm of their occupation (De Kock, 1999:41). Competency is regarded as the ability of the person to perform his or her

specific occupational role according to certain standards or requirements (Hyland, 1994 in De Kock, 1999:41).

1.2 THEORETICAL FRAMEWORK

The biopsychosocial perspective that stems from the social systems theoretical framework was used to understand and interpret the philosophical assumptions of this research study. Borrell-Carrió et al. (2004:03) note that the biopsychosocial perspective emerged in the late 1970s from the work of George Engel and John Romano as a reaction to the narrow medical (biomedical) model on illness which had its primary focus on biological factors. Engel and Romano argued that patients' needs can only be holistically understood and adequately addressed if clinicians simultaneously attend to the biological, psychological, and social dimensions of illness (Cohen & Brown, 2010:24). The biopsychosocial perspective thus became popular for systematically considering the complex interactions between biological, psychological, and social factors in understanding illness and health care delivery (Borrell-Carrió et al., 2004:04).

Cohen et al. (2010:24) note that the biopsychosocial perspective and the social systems theory are closely interlinked. Bertalanffy is considered the founding father of the social systems theory through his work that advocated for trans-disciplinary studies in understanding the interdependent, transacting and mutually interacting parts influencing phenomena (Midgley, 2003:112). The social systems theory and the biological perspective are famed for being compatible with the foundations of modern social work practice through their emphasis to practitioners to view every aspect of human life in a holistic manner; and to structure interventions that are sensitive to the multiple systems in which individuals function (Greene, 2000:36).

This study was centred on the phenomenon of HIV and AIDS, an epidemic that has been noted to owe its complexity to various biological, psychological, and social factors. To achieve an objective exploration of the perceptions of Social Auxiliary Workers on their role and competencies in meeting biopsychosocial needs of children living with HIV, it was important for the researcher to move away from a linearity way of thinking and adopt a holistic way of thinking that allowed

understanding of the various complex but mutually interdependent factors affecting children living with HIV on different levels.

The literature used in this section was preferred for its relevance and simplicity in the manner it juxtaposes and discusses the origins, tenets and interconnectedness of both the biopsychosocial perspective and the social systems theory. Germain (1991:67) observes that there is a very close allied relationship between the social systems theory and the biopsychosocial perspective. Whereas the social systems theory is pre-occupied with transactional and reciprocal exchanges between entities or elements, the principles of the biopsychosocial perspective could be argued to “borrow” from the social systems theory by being concerned with the relations between entities (individuals) and biological, psychological and social processes in given contexts (Greene, 2000:36; Germain, 1991:68). The biopsychosocial perspective and social systems theory were useful in putting across that, children living with HIV exist in a social system that functions at different levels namely the micro-system (individual, group or family), mezzo-system (children immediate social network) and macro-system (society on a large scale) (Greene, 2000:37).

In this study, it was noted that natural interaction between Social Auxiliary Workers and children living with HIV existed in the context of (and was potentially determined by) structures and systems that existed within community establishments, thereby highlighting the principle of mutual influence or reciprocal causality (Germain, 1991:68). In a study of this nature, it was important to understand complex interdependent relationships so as to effectively interpret problems and develop balanced intervention strategies. Thus, as pointed out by Dale, Smith, Chess and Norlin (2006:13), it was important for this researcher to determine the “linkages and interplays” between various systems to enable formulation of meaningful strategies and guidelines on supporting and improving the role and competencies of Social Auxiliary Workers working with children living with HIV.

Critiquing the relevance of social systems theory and biopsychosocial perspective in social work practice, Greene (2000:36) remarks that, the two are practice tools to link clients to effective and humane systems that provide them with resources, services and opportunities. In the context of this study this implied that, as the researcher

explored ways of strengthening the role and competencies of Social Auxiliary Workers, programmatic interventions that have potential to mainstream the health needs of children living with HIV were also explored.

In conclusion, it can thus be said that, the biopsychosocial perspective that stems from the social systems theory was deemed appropriate for this study as it challenged the researcher to adopt a holistic conceptual framework that focused on the cause-and-effect relationship between various factors as well as the interrelatedness that exists between persons (study participants) and various biological, psychological, social processes (Midgley, 2003:112). In line with the assertion of Dale et al., (2006:13) that social work theories and perspectives should assist researchers to adopt solution-oriented stances and suggest appropriate remedial interventions for research problems, the holistic focus of the biopsychosocial perspective was vital in assisting the researcher when interpreting data of Social Auxiliary Workers' perspectives on their role and competencies in addressing the health needs of children living with HIV at drop-in-centres; and in drawing appropriate recommendations to address identified challenges.

1.3 RATIONALE AND PROBLEM STATEMENT

Social Auxiliary Workers are a vital cog in the care of children living with HIV within community based facilities however; their role and competencies related to addressing the health needs of children living with HIV are not well understood as there are no formal studies that have been done on the subject. In the context of drop-in-centres, children living with HIV are a "hidden" population as there are no structured strategies to identify, enumerate and support them in spite of the observations that there are numerous such children accessing services from the drop-in-centres (Stover et al., 2014:27). This study aims to promote the best interest of children as it makes recommendations for the establishment of guidelines and systemic procedures for identification and support given to children living with HIV in the context of drop-in-centres with specific reference to Social Auxiliary Work.

The researcher observed from his field of work as well as from existing scholarly literature which includes the studies and writings of Mofenson and Cotton (2013:04),

that children living with HIV face a host of new and unfamiliar multifactorial health challenges that requires social service professionals to be knowledgeable, skilled and competent when rendering services. Harber (1999) and Smart (2002) note that, being at the forefront of the battle to provide effective care and support to children living with HIV, there is need to develop “new interventions” that equip social service professionals with necessary skills and knowledge.

It is therefore this researcher’s opinion that, exploration of perceptions on the role and competencies of Social Auxiliary Workers did not only result in gaps identification on services being rendered, but also laid a foundation for coming up with practical guidelines for improvement of support mechanisms directed towards Social Auxiliary Workers so as to improve their competency and responsiveness in providing early, timely and appropriate health interventions to children living with HIV. It could also thus be said, there was need to identify and understand the competency challenges encountered by Social Auxiliary Workers in discharging their role in their work with children living with HIV. The guiding primary research question for this study was as follows: ***What are the perceptions of Social Auxiliary Workers on their role and competencies in addressing the biopsychosocial needs of children living with HIV at drop-in-centres?***

In line with the observations of Maree and Van der Westhuizen (2007:25-26) that sub-questions are useful in assisting the researcher to unpack and answer the primary question, the sub-questions that underpinned this proposed study were as follows:

- *What are Social Auxiliary Workers perceptions regarding the biopsychosocial needs of children living with HIV at drop-in-centres?*
- *What challenges do Social Auxiliary Workers experience regarding their work with children living with HIV at drop-in-centres?*
- *To what extent do the challenges impact on the role and competencies of Social Auxiliary Workers to address the biopsychosocial needs of children living with HIV at drop-in-centres?*

1.4 GOAL AND OBJECTIVES

The research goal and objectives of the study were as follows:

1.4.1 Goal of the study

The goal of this study was to explore the perceptions of Social Auxiliary Workers on their role and competencies in addressing biopsychosocial needs of children living with HIV at drop-in-centres in order to recommend guidelines for more effective service rendering.

1.4.2 Objectives

The specific research objectives of this study were as follows:

- To obtain a sample of Social Auxiliary Workers within drop-in-centres working with children living HIV.
- ◆ To explore and describe the perceptions of Social Auxiliary Workers on their role in working with children living with HIV at drop-in-centres.
- ◆ To explore and describe the perceptions of Social Auxiliary Workers on their competencies in working with children living with HIV at drop-in-centres.
- ◆ To identify the challenges that Social Auxiliary Workers are experiencing in working with children living with HIV at drop-in-centres.
- ◆ To suggest strategies to improve Social Auxiliary Workers' role and competencies in working with children living with HIV at drop-in-centres.

1.5 RESEARCH DESIGN AND METHODOLOGY

A detailed description of the research methodology including the research approach, type of research, research design, methodology, and the measures that were taken to ensure the trustworthiness of the data, as well as the ethical considerations of the study, will be presented in Chapter Three. The following discussion is a brief overview of the research methodology utilised for the study.

The study adopted a qualitative approach. A qualitative approach is more concerned with “what” questions, which was exactly what the study sought answers for (Fouché & De Vos, 2011:95). The qualitative approach enabled the researcher to obtain an in-depth understanding of the perceptions of Social Auxiliary Workers on their role and competencies in addressing the biopsychosocial needs of children living with HIV at drop-in-centres (Fouché & De Vos, 2011:95).

The research was exploratory in nature. More specifically, it was an applied research study, as it sought to make recommendations that Social Auxiliary Workers might use to improve the responsiveness and effectiveness of their interventions targeted at addressing the biopsychosocial needs of children living with HIV within drop-in-centres (Neuman, 2000:23).

A qualitative research design, more specifically the collective case study design, was utilised in the study (Rubin & Babbie, 2011:442). A collective case study enabled the researcher to gain insight and an understanding into the perceptions of Social Auxiliary Workers regarding their role and competencies in addressing the biopsychosocial needs of children living with HIV at drop-in-centres (Struwig & Stead, 2001:7).

The research population for this study included all the Social Auxiliary Workers who are employed in the 18 drop-in-centres that are funded by the Department of Social Development in Sedibeng District Municipality. The researcher used non-probability purposive sampling as well as simple random sampling procedure of probability sampling, respectively, to select a representative sample for this study. The use of the two sampling strategies allowed a sample of “relevant” and “information rich participants” to be selected (Struwig & Stead, 2001:122; Bryman, 2008:458).

The researcher made use of semi-structured one-on-one interviews to collect data, since it allowed the researcher to “uncover the lived world” and to gain in-depth understanding and knowledge on the perceptions of Social Auxiliary Workers regarding their role and competencies in addressing the biopsychosocial needs of children living with HIV within drop-in-centres (Greeff, 2011:349).

1.6 LIMITATIONS OF THE STUDY

Although the study reached its aims, there were some unavoidable limitations. The sensitivity of the topic could have influenced the participants' responses and hence influenced the findings of the study. However, the selection of Social Auxiliary Workers with a minimum of at least a year's experience working in a drop-in-centre minimised this as this group was more likely to give responses based on experience and the desire to have their practice challenges addressed. Finally, the findings of this study will probably not be generalised to the whole country, as it was carried out in one district. However, when conducting human scientific research and viewing the findings of an explorative study through a case study, it is important to note that every Social Auxiliary Worker's perception regarding their role and competencies in addressing the biopsychosocial needs of children living with HIV within drop-in-centres is important and relevant (Fouché & Schurink, 2011:311).

1.7 DIVISION OF THE RESEARCH REPORT

The research report consists of four chapters namely:

Chapter One is the introduction and general orientation to the study, including a broad introduction of the research topic, the theoretical framework, rationale and problem statement, goal and objectives, a brief overview of the research methodology and the limitations of the study and thus placing the total investigation in context

Chapter Two contextualises the needs of children living with HIV from a biopsychosocial perspective, citing other relevant studies that have been done on children and HIV within community based programmes. It also includes an in-depth discussion on the policy and the legislative framework for children living with HIV. Finally, key issues relating to the origins, practice, and the impact that the role and competencies of Social Auxiliary Workers have on the circumstances of children living with HIV at drop-in-centres are discussed.

Chapter Three outlines the research methodology used for the study. A detailed explanation of the research approach, type of research, research design, study population, sampling, data collection, data analysis, pilot study and ethical issues is

included. This chapter also presents and discusses the empirical findings of the study.

Chapter Four outlines the conclusions and recommendations of the study. Furthermore, the researcher indicates how the goal and objectives of the study have been achieved. The key research findings are highlighted from which conclusions were drawn and in turn, recommendations are made.

In the following chapter, literature on children living with HIV is reviewed; and the role that Social Auxiliary Workers play in addressing the biopsychosocial needs of the children is also discussed.

CHAPTER 2

SOCIAL AUXILIARY WORK PRACTICE AND CHILDREN LIVING WITH HIV: A LITERATURE REVIEW

2.1 INTRODUCTION

The focus of this chapter is on reviewing literature on the origins and history behind the practice of Social Auxiliary Work in South Africa. The role and competencies of Social Auxiliary Workers and the challenges they encounter in addressing the needs of children living with HIV at drop-in-centres will be explored. On this subject, other issues that would be deliberated on include the extent of HIV knowledge that Social Auxiliary Workers possess to effectively address the biopsychosocial needs of children living with HIV at drop-in-centres.

After discussing HIV prevalence and trends in children, the biopsychosocial perspective will be applied to look at the major issues affecting children living with HIV. It is the opinion of the researcher that, besides shortage of Social Auxiliary Workers within drop-in-centres in South Africa, there are many institutional obstacles and system barriers that contributes to the biological, psychological and social needs of children living with HIV being unmet. In constructing this chapter, the researcher will give due consideration to current debates and studies on the effectiveness of the role and competencies of social service paraprofessionals, such as Social Auxiliary Workers, in addressing biopsychosocial needs of children living with HIV.

To provide structure to this chapter the discussions will be laid out as follows: conceptualisation of Social Auxiliary Work; Social Auxiliary Workers' role and competencies; Social Auxiliary Work practice in drop-in-centres; HIV and AIDS global summary; HIV and children - prevalence and trends; the hidden problem – HIV infected children; and biopsychosocial needs of children living with HIV.

2.2 CONCEPTUALISATION OF SOCIAL AUXILIARY WORK

Literature on Social Auxiliary Workers in South Africa is very limited. Most of the few sources that are available are more than ten years old and mainly discuss the history and training of Social Auxiliary Work. Schultz (2015:26) and De Kock (1999:29),

assert that the concept of Social Auxiliary Work in South Africa came into effect in November 1991, after an investigation into social work by the Auret Commission of 1976, which revealed that there was a need for the establishment of a category of people to render support services to Social Workers. Schultz (2015:26) points out that, after a series of discussions and legislative processes, it was the promulgation of the Social and Associated Workers Act (Act 110 of 1978) that led to the recognition of Social Auxiliary Workers, who were previously then called “associated workers”.

Commenting on the development of Social Auxiliary Work on the international stage Kadushin (as cited in Schultz, 2015:26) similarly asserts that, as the social work profession grew, some of the demands that were being exerted on “high-level” professionals (Social Workers) could easily be bridged or addressed by removing “low-level functions” to Social Auxiliary Workers who would play the roles of “case-aides” or “social work assistants”. Schultz (2015:26) notes that the term “auxiliary worker” was accepted by the United Nations as far back as 1958 when it was described as someone who has been trained in a particular field “... with less than professional qualifications and who assists and is supervised by a professional worker”.

The Department of Social Welfare’s White Paper for Social Welfare, from its draft format in the early 1990s to its publication in 1997, is noted to have hugely influenced the development of Social Auxiliary Work in South Africa. The White Paper’s call for the establishment of a developmental welfare perspective in social services in South Africa led to the realisation that there were other tasks that did not necessarily need the attention of a Social Worker with sophisticated four-year training. Social Auxiliary Work was therefore deemed essential as an occupation that was to help Social Workers in the execution of their duties without being directly involved in social work functions (De Kock, 1999:31).

De Kock (1999:31) further states that, the White Paper for Social Welfare indicated that, Social Auxiliary Workers could be important paraprofessionals in helping achieving the objectives of developmental social welfare by complementing the work of Social Workers in enacting a comprehensive social service system, programmes

and social security systems to promote social development as an approach to social welfare. The author further states that, like Social Workers, Social Auxiliary Workers were equally expected to be active in ensuring the wellbeing of the people by linking them to health and economic development programmes. Put in other words, Social Auxiliary Workers were thus expected to be vital in addressing the causes and effects of vulnerability amongst marginalised population sectors by delivering “integrated services to communities, children, families, and individuals affected by social problems” (De Kock, 1999:31).

The importance of Social Auxiliary Work in modern day South Africa is emphasised Schultz (2015:26) who notes that, “Although the involvement of social auxiliary workers is a historic fact, the need for their services has grown significantly over the past few years, especially after the new Children’s Act came into being.” The Department of Social Development (DSD) (2015:01) and Schultz (2015:26) concur that, there is currently an escalation in the successful involvement of Social Auxiliary Workers in the Non-Governmental Organization sector as well as the public sector, particularly within the Department of Social Development.

Based on increasing demand, the training of Social Auxiliary Work has expanded every year (Schultz, 2015:27). The promulgation of the South African Qualifications Authority (SAQA) Act in 1995 has seen Social Auxiliary Work being trained as a one year Further Education and Training Certificate (FETC) that is officially registered by SAQA on the National Qualifications Framework (NQF) as a level 5 higher education qualification. Like Social Work, the registration, education, training and practice of Social Auxiliary Work is guided, regulated and registered with the SACSSP.

2.3 SOCIAL AUXILIARY WORKERS’ ROLE AND COMPETENCIES

In the context of this study, a role can be defined as functions, activities or tasks performed by Social Auxiliary Workers in the realm of their occupation (De Kock, 1999:41). As already alluded to, working under the guidance and supervision of Social Workers, all functions and activities of Social Auxiliary Workers are geared towards achieving the aims of social work. The role of Social Auxiliary Workers with individuals, families, groups and communities is particularly tailored towards primary social care. The commonly discussed role of Social Auxiliary Workers by the

Department of Social Development (DSD) (2008:46) include the provision of prevention services, identifying, tracing and channeling clients to Social Workers, referring clients to resources and conveying information, offering psychosocial care and support services, conducting educational and prevention groups, recruiting, supervising and guiding volunteers or caregivers and carrying out home visits.

DSD's Norms and Standards for Home and Community Based Care Programmes (2009:19), identify the duties of Social Auxiliary Workers as being to offer basic counseling services, facilitating referrals to social workers, administration, undertaking supervision sessions with child care givers, preparation for statutory intervention, coming up with child headed and vulnerable children interventions, running support groups and offering debriefing to all volunteers or caregivers.

For the purposes of this study, the concept of competency is defined to mean the acquisition of various skills, knowledge and understanding that an individual in an occupation can effectively apply within their work contexts. Jansson (2014:47) notes that, competency in itself denotes one's ability, capacity; expertise; aptitude; and mastery to be able to do something successfully or efficiently. In the social services sector, professional competence is outlined as the capability of one to demonstrate the ability to put all their relevant educational and experiential acquisitions into practice by evaluating social problems and developing and implementing response strategies (Jansson, 2014:47). A person is thus deemed competent in their practice or profession when they are able to discharge their specified occupational role and satisfy certain basic requirements and/or standards. In the context of Social Auxiliary Work practice it could be said a competent Social Auxiliary Worker is one who feels comfortable and confident that their education and training has adequately prepared them to be effective in their work (De Kock, 1999:41).

2.4 DROP-IN-CENTRES

Lundy Foundation (2008:32) indicates that, although drop-in-centres are talked so much about as effective safety nets for Orphaned and Vulnerable Children (OVC), their usefulness remain inadequately described and poorly understood owing to limited studies that have been conducted to identify their components, define their mechanisms and evaluate their effectiveness. Similar views are shared by Thurman,

Kidman and Taylor (2013:04) who add that, although there is limited evidence to improve understanding of the impact of drop-in-centres, they are becoming a commonly used strategy for OVC support hence government, through the Department of Social Development, continue to make substantial investments to support the work of drop-in-centres in South African communities. Thurman et al., (2013:04) goes further to note that drop-in-centres are now a major component of the family-centred programme approaches in which care workers and Social Auxiliary Workers provide a range of support services during regular visits to OVC's homes as well as when OVC come to drop-in-centres for services.

Foster (2005:23) notes that, although there is enormous variation in how drop-in-centre programmes are implemented, the concept of drop-in-centres is now common for “providing the major share of effective and accepted assistance given to OVC and other poorer members of society in sub-Saharan Africa”. The author notes that in some instances drop-in-centres may be manned by trained professionals such as Social Workers and Psychologists, but on the other end of the spectrum, which is usually the case in resource constrained settings, they rely entirely on paraprofessionals such as Social Auxiliary Workers, Child and Youth Care Workers, and lay volunteers, “a set of social services cadres with arguably limited training and capacity to make sustainable impact in the scope and intensity of services rendered to OVC (Foster, 2005:26). Thus, gaps remain in service outcomes on aspects such as OVC psychological health, emotional support, child protection and HIV prevention or risk mitigation in those drop-in-centres that are manned by paraprofessionals (Foster, 2005:26).

The development of modern day drop-in-centres is described by Foster (2005:23) to have its origins in “olden days traditional OVC community based care which was done informally, voluntarily and indigenously” by extended family, kinship and community members in most African cultures. The traditional OVC community based care responses initiated and strengthened mutual aid opportunities and social support by creating a sense of solidarity amongst people living together as they encouraged the participation of everyone in caring for orphaned children and families in need, in the spirit of “ubuntu”, the essence of helping others, which enabled OVC to reach their full potential as human beings (Foster, 2005:24). Similar views are also

shared by Mutangadura (2000:12) who adds that, back in the days, kinship ties, community members, and neighbours became “social security” for OVC by virtue of being sources and resources that strived to improve the livelihoods of OVC, enabling them to access economic, social, psychological and emotional support in times of need.

In modern days, drop-in-centres are found located in Non-Governmental Organisations (NGOs), Faith Based Organisations (FBOs), and Community Based Organisations (CBOs) and have grown to represent formal safety nets for OVC care as they also rely on funding and expert input from governments (Mutangadura, 2000:12). Foster (2005:25) notes that, depending on their service model, drop-in-centres usually strive to provide appropriate service responses to meet the diverse needs of their clientele. In the case of those drop-in-centres targeting children, the services rendered have often been broad to meet the complex and diverse needs of children and have largely included home visits to provide relief in the form of psychosocial support, and material assistance that might include food, clothing, and payment of school fees for some children (Foster, 2005:25).

Thurman et al., (2013:04) observe that, if well serviced drop-in-centres have the potential strengths to run successful home visiting programmes that can promote children and families’ linkages to needed social services. The authors note that, by being part of communities drop-in-centres can make a difference in helping families and children obtain various lower and higher level needs, which can be demonstrated by significant increases in families’ access to social grants as well as the fulfillment of children’s material needs.

In the context of this study, the drop-in-centres that were focused on are those that serve OVC and are cited by Section 213 of the Children’s Act No. 38 of 2005 (as amended), as community-based facilities, registered and regulated by the Department of Social Development. Section 213 of the Children’s Act No. 38 of 2005 (as amended) further states that drop-in-centres should aim to provide prevention and early intervention programmes that meet the emotional, physical and social development needs of vulnerable children.

2.5 HIV AND THE BIOPSYCHOSOCIAL PERSPECTIVE

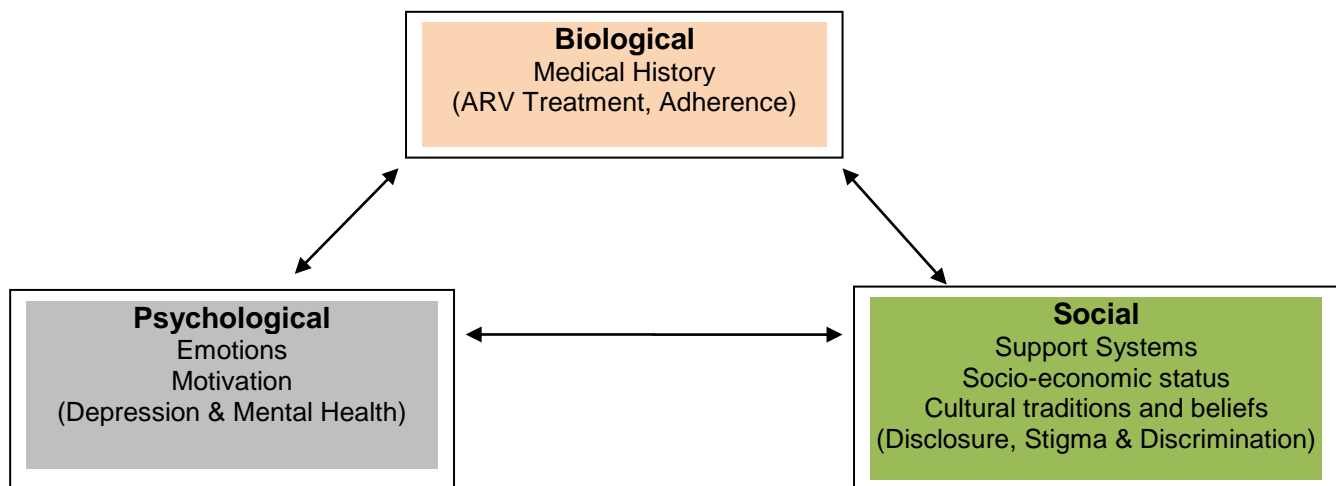
Cowles (2000:12) asserts that, the underlying theoretical perspective of social work in the health field has been that physical, psychological and social environmental conditions tend to influence one another and must be taken into account in order to understand and help clients and their families in health settings. Thus, both the biopsychosocial perspective and the general systems theory which view a person's health status as reflecting the interdependency of physical, psychological and social environmental systems; and advances that a change in one affects change in the others, were utilised to understand the interpretations behind this study (Cowles, 2000:12).

In the context of this study, it is important for Social Auxiliary Workers not to deal with children living with HIV in a fragmented manner. Every child living with HIV, who seeks services from a drop-in-centre, must be assessed and assisted in the context of three components, namely biological, psychological and social dimensions, which are in constant and continuous interaction with each other and are unique to each child. In this study, the biopsychosocial perspective was used to recognise the interaction between the medical, social and psychological dimensions of HIV. The researcher also made use of the biopsychosocial perspective to exhort Social Auxiliary Workers to provide children living with HIV with services that are responsive to their needs.

Engel (1980:535) asserts that the biopsychosocial model is based on the systems approach. Brannon and Fiest (1992:11) clarifies that, although the systems approach is not necessarily a component of the biopsychosocial model, by emphasising the mutual dependence of each system within the whole and suggesting that a change in one system will produce changes in the others, the systems approach thus helps one to understand the interaction among the biological, psychological and social components of disease and wellness (HIV in this case).

The researcher would also like to acknowledge the view by Gatchel (2005:593) that, by offering a broadened integrated approach to human disease, the biopsychosocial perspective clarifies and simplifies understanding of "complex diseases," such as HIV, which is not just a medical disease but a social one as well (Kellerman,

Sugandhi, Luo, McClure & Yogev, 2013:136). Similarly, Dogar (2006:11) asserts that, the biopsychosocial perspective offered a response to the shortfalls of the biomedical model which based its interaction with human disease and behavior only on pure scientific aspects of medicine. Figure 2.1 below illustrates the interaction between biological, psychological and social factors to affect one's health.



Source: Dogar (2006:12).

Figure 2.1: Biopsychosocial perspective

Succinctly summarised, the biopsychosocial perspective therefore, represents an attempt to integrate the psychological (psycho) and the environmental (social) factors into the already established biomedical (bio) model of health (Ogden, 2004:25). The figure above illustrated that biological, psychological and social factors influence the prevention, causes, presentation, management and outcome of the disease “as each of the factors continuously interact with the others; and together they constitute the unique state of any disease” (Dogar, 2006:12).

The rationale of the biopsychosocial perspective for this study is that Social Auxiliary Workers working with children living with HIV within drop-in-centres are expected to possess insight and skills to practice “integrated HIV care”, according to Soto, Bell and Pillen (2004:44). For effective implementation of any HIV services in community based care and health facilities, it is pertinent for all levels of service providers to understand the interacting biological, psychological and social needs of individuals

living with HIV “and the importance of addressing them simultaneously rather than as independent, isolated elements” (Soto et al., 2004:46).

The applicability of the biopsychosocial perspective in disease interpretation and management is also expanded on by Novack, Cameron, Epel, Ader, Waldstein, Levenstein, Antoni, and Wainer (2007:389) who remark that, even at a basic level within communities, at Social Auxiliary Workers level in the context of this study, there should be comprehensive understanding of the biological elements, psychological and social aspects of HIV. An illustrative example is given by Novack et al., (2007:393) that aspects such as stigma and social isolation are (social factors) that people living with HIV are prone to experience and they might affect their emotional and mental well-being (psychological factors) as stigma and social isolation is often associated with less social support from family and friends (social factors). Consequently, higher levels of stigma and lack of support for people living with HIV have been found to contribute to limited access to treatment and care services as well as lower levels of adherence thereby bringing complications to the medical, pathological, or physiological (biological factors) processes that are needed to be followed to manage HIV (Novack et al., (2007:400).

The fact that the biopsychosocial perspective is founded in on the social systems theory means that the fundamental assumption of this perspective “is that systems exist within systems” (Sheridan & Radmacher, 1992:62). A system is viewed as a dynamic entity that is comprised of components that are continuously interrelated. In the context of this study, children living with HIV are consequently viewed as being a system in itself, as well as part of other systems, such as their families, community facilities (drop-in-centres, schools and health care centres), and society in which they live (Dogar, 2006:12). These systems all affect and are affected by each other (Sarafino, 2002:72). As underpinned by both the biopsychosocial perspective and the social systems theory, Social Auxiliary Workers are encouraged to develop a global view of their work, as it should be noted that the provision of interventions (or lack thereof) to children living with HIV at one level of a system can often lead to unanticipated outcomes at other levels (Sheridan & Radmacher, 1992:62).

It is acknowledged that the HIV epidemic has created a multidimensional crisis that requires integrated approaches for all professionals or paraprofessionals that work

with children living with HIV. In the context of this study the biopsychosocial perspective and the social systems theory thus, dares policy makers, programme implementers, health providers, educators, researchers and professionals and paraprofessionals to equip themselves with knowledge and skills and to develop effective strategies for responding and addressing the biological, psychological and social needs of children living with HIV.

2.6 SOCIAL AUXILIARY WORK PRACTICE IN DROP-IN-CENTRES

In South Africa, the majority of drop-in-centres are manned by Social Auxiliary Workers. The Children's Act no 38 of 2005, Section 213, is explicit that, drop-in-centres should implement health, nutrition, educational, parenting, recreational, household economic strengthening and psychosocial care and support programmes that protect and lead to the realisation of improved well-being and better health outcomes for children. Thus the scope of practice of Social Auxiliary Work within drop-in-centres is expected to include the implementation of programmes and activities that contribute to provision of basic and developmental care of children contributing to meeting their physical, emotional, spiritual, cognitive and social needs. Although Social Auxiliary Workers in drop-in-centres are expected to work under the supervision, instructions and control of trained Social Workers, in practice they work with very limited supervision due to shortage of social workers in South Africa (Chakras Consulting, 2012:18; Gray, 2006:59).

Children living with HIV are among the category of vulnerable children that are found within drop-in-centres. It is this researcher's observation that, in spite of the envisaged critical role that Social Auxiliary Workers can play in enabling and facilitating the provision of biopsychosocial services to children living with HIV, the non-standardised and highly imperceptible HIV knowledge that Social Auxiliary Workers possesses, affects the role and greatly compromises the competencies of this cadre to offer effective services that address the health needs of children living with HIV within drop-in-centres. Harber (1999) argued that, the lack of HIV knowledge amongst some social service professions lead to HIV positive children being regarded as akin to other children in need of care and protection in spite of clear evidence that these children have unique and special needs.

It is also important to point out that, despite the availability of a lot of information and research on HIV and AIDS, when it comes to children, the information and research are mainly on the “affected” children rather than “infected” children. Put in other words, the focus of many authors and researchers has been on children orphaned by HIV and AIDS rather than those that are infected by HIV. There is clear information and research gaps on children living with HIV and their dilemma in accessing health care services (Kellerman et al., 2013:135).

The researcher could not find any direct studies that have been done on the relationship between Social Auxiliary Work practice and its influence on access to biopsychosocial services by children living with HIV within drop-in-centres, but there are common observations and concerns from the literature that was reviewed that, the limited knowledge on HIV programming that Social Auxiliary Workers have hindered their ability to identify children living with HIV and afford them an opportunity to access responsive health services that are appropriate, effective, efficient and adequate (Amzel et al., 2013:147). It is the opinion of this researcher that access to, and provision of biopsychosocial services for children living with HIV hugely depend on the competence, knowledge and skills of the workforce that the infected children are in regular contact with. This proposed research is therefore intended to address a dearth of information through the gathering of data on the role and competencies of Social Auxiliary Workers in effectively addressing the biopsychosocial needs of children living with HIV.

The importance of having a capacitated care giving workforce that competently responds to the health needs of children living with HIV in community based facilities, such as drop-in-centres is also discussed by Kellerman et al. (2013:135) who remark that, pediatric HIV is in danger of becoming a neglected disease despite the expansion of new approaches and advancements in the treatment of the disease. Kellerman et al. (2013:135) explain that, some primary community-based interventions have inadvertently perpetuated poor access to treatment for infected children due to their failure to pursue new ideas that are needed to propel programming that diagnoses, links, provides optimal support and retains infected children in care and treatment services.

A further assertion is made by Kellerman et al. (2013:136) that HIV is not just a medical disease but a social one, and as such community based care programmes designed for children living with HIV should provide comprehensive and integrated activities that are aligned with broader child health services, such as immunisation and nutritional assessments. It is for the aforementioned observations that the researcher will focus on Social Auxiliary Workers, as critical personnel in driving programmes in community based drop-in-centres, and seek to understand their perceptions and experiences on how their role and competencies impact on access to, and provision of health services to children living with HIV.

Budlender, Pendlebury and Jamieson (2008:32) note that despite their potential to be central in South Africa's responses to HIV and AIDS and other matters affecting Orphans and Vulnerable Children (OVC), for various reasons Social Auxiliary Workers still remain an under-utilised and under-recognised category of social welfare workforce. Looking at the arguments discussed so far, one can concur with the assertion of Heunis, Wouters and Kigozi (2012:347-348) that, limited knowledge and skills on paediatric HIV by certain sects of the social welfare workforce does not only debilitate and limit access to health services for children living with HIV, but it also provides a backdrop for the emergence of other unique sets of health challenges that have potential to erode South Africa's overall progress in reversing the scourge of HIV and AIDS. To help unpack the above statement the researcher will, in the following section, discuss the biopsychosocial needs of children living with HIV.

The Sedibeng drop-in-centres where this study took place are described by DSD (DSD, 2005b:20) as "important development actors in their own right with huge potential in responding to HIV and AIDS". The drop-in-centres were mostly established in communities with HIV high prevalence as a strategy to promote community-based responses that strengthens the participation and involvement of families and communities in addressing the scourge of the HIV epidemic in the face of limited health care resources (DSD, 2005b:21). With very limited budgets, averaging R1 200 000 per year, the major funder of most of the drop-in-centres is DSD. Although traditionally one of the key functions of drop-in-centres in South Africa has been to provide hot meals to OVC, in recent years the services that drop-

in-centres provide have expanded to include dealing with other socio-economic issues that affect not only children living with HIV, but also their families and community members at large.

Social Auxiliary Workers are the highest category of “skilled paraprofessional” found in most of the drop-in-centres. On average each drop-in-centre has two Social Auxiliary Workers. The workload or clientele of drop-in-centres ranges between 150 to 300 OVC and is dependent on infrastructure, catchment area and total funding received. The major roles of Social Auxiliary Workers working in drop-in-centres, as expected by DSD (2005b:23), include marshaling prevention, education and development programmes through organising and running life skills and economic empowerment education; accessing and establishing resources (educating communities about how to access and use available resources); and practical support for OVC and their families by facilitating and/or rendering material support, emotional support, practical arrangements, and after school care services).

In regards to health care, Social Auxiliary Workers are expected “to monitor the health of OVC and refer them to local clinics when appropriate, and follow up to ensure OVC receive services from providers”. In regards to child protection, DSD (2005b:24) explains that Social Auxiliary Workers, working together with caregivers, should create awareness, identify, report and assist Social Workers in addressing issues of abused children. Education Support through the provision for homework assistance as well as psychosocial support to cater for the emotional and psychological well-being of OVC, are some of the huge components of the work that is expected of Social Auxiliary Workers (DSD, 2005b:24).

2.7 HIV AND AIDS GLOBAL SUMMARY

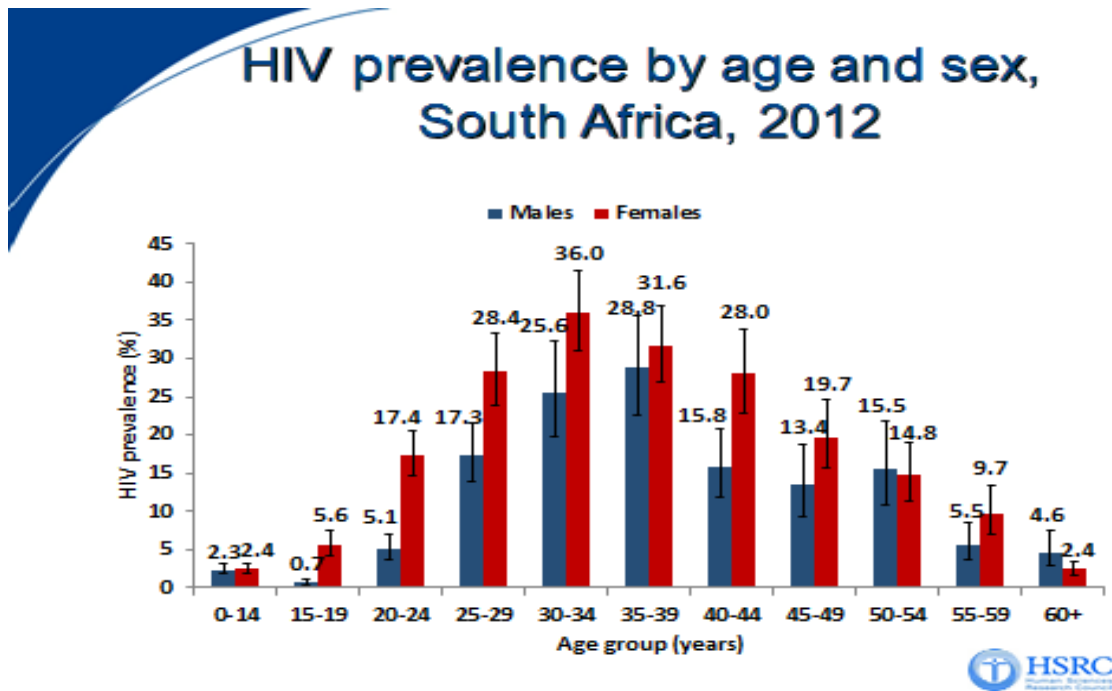
WHO (2015:12) states that, HIV continues to be a major global public health issue, with an estimated 36.9 million people living with HIV at the end of 2014, globally. It is further estimated by WHO (2015:12) that globally, 1.9 – 2.2 million people became newly infected with HIV in 2014. The following table gives a global summary of the HIV (and AIDS) epidemic, according to WHO (2015:14).

Table 2.1: Global summary of the HIV (and AIDS) epidemic, 2014

Number of people living with HIV in 2014	Total 36.9 million [34.3 million – 41.4 million] Adults 34.3 million [31.8 million – 38.5 million] Women 17.4 million [16.1 million – 20.0 million] Children(<15 years) [2.6 million – 2.8 million]
People newly infected with HIV in 2014	Total 2.0 million [1.9 million – 2.2 million] Adults 1.8 million [1.7 million – 2.0 million] Children(<15 years) 220 000 [190 000 – 260 000]
AIDS death in 2014	Total 1.2 million [980 000 – 1.6 million] Adults 1.0 million [890 000 – 1.3 million] Children(<15 years) 150 000 [140 000 – 170 000]

Source: WHO (2015:14)

UNICERF (2014:34) and WHO (2015:14) concur that Sub-Saharan Africa is the most affected region by HIV, accounting for almost 70% of the global total of new HIV infections and having an estimated 25.8 million people living with HIV in 2014. Whilst pointing out that South Africa ranks first in HIV incidence in the world, Shisana, Rehle, Simbayi, Zuma, Jooste, Zungu, Labadarios, Onoya, et al. (2014:35) explain that the main findings of The South African National HIV Prevalence, Incidence and Behaviour Survey of 2012, estimated that of South Africa's estimated 52.3 million population, 6.4 million people were living with HIV/AIDS in 2012; with over 400 000 new HIV infections occurring in the same year. When the total population figures are taken into context, it is estimated that South Africa has an HIV prevalence of 12.2%, an increase from the 10.6% prevalence of 2008 (Shisana et al., 2014:36). The following figure shows South Africa's HIV prevalence as disaggregated according to age and gender.

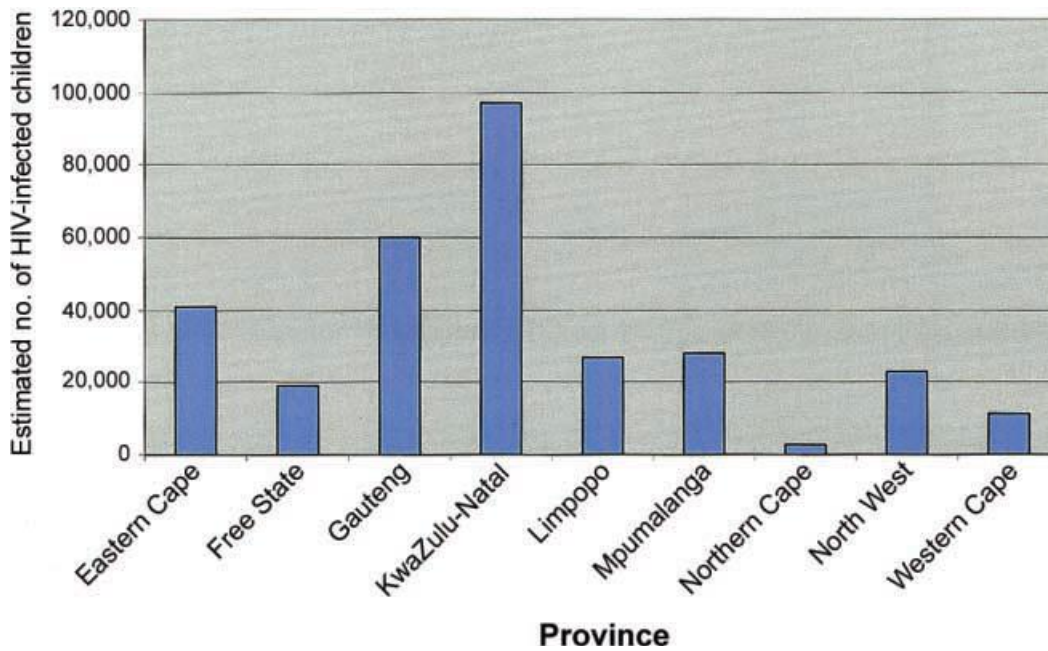


Source: Shisana et al. (2014:40)

Figure 2.2: South Africa's HIV prevalence

2.7.1 HIV and children (prevalence and trends)

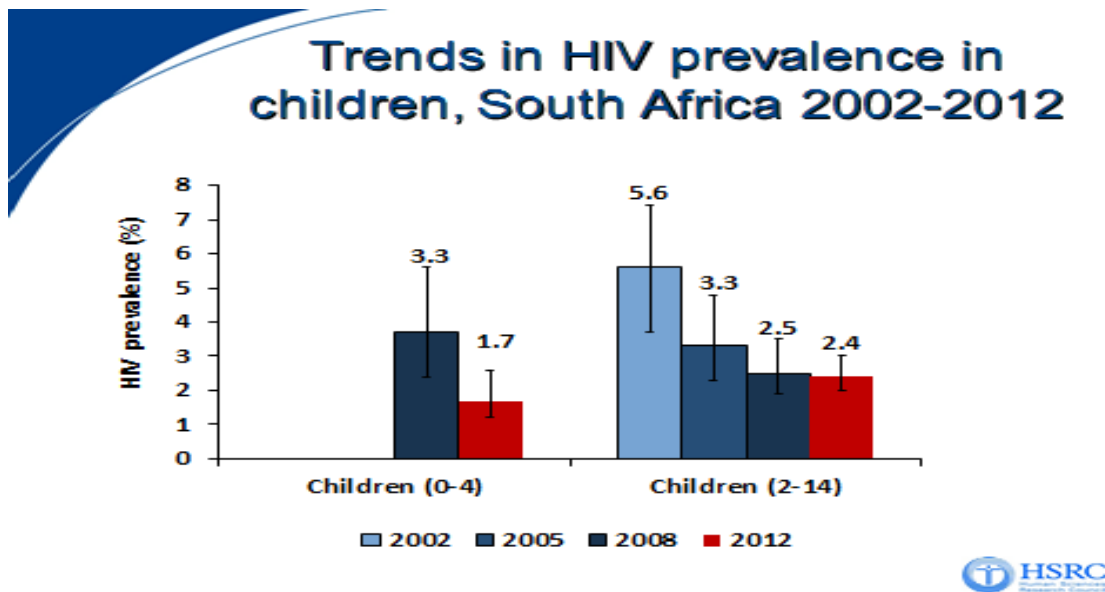
UNAIDS (2015:41) states that, globally there is limited availability of data on children mainly because “most of HIV infections are acquired early in life and are probably undiagnosed”. The aforementioned views are shared by Augusto (2012:667) who remarks that, despite a successful adult scale-up of testing and treating, the situation of children infected by HIV in South Africa is more concerning as very little is known about them. Barring the above observations, the number of children living with HIV in South Africa has been increasing steadily over the years. Meyers, Moultrie, Naidoo, Cotton, Eley, and Sherman (2007:475), note that by mid-2006 data from the Actuarial Society of South Africa AIDS and Demographic Model as well as the South African Demographic and Health Survey, estimated that almost 300,000 children in South Africa aged 15 years and below had HIV infection. Figure 2.3 below shows the estimated numbers of HIV-infected children in each province by mid- 2006.



Source: Meyers et al. (2007:475)

Figure 2.3: Estimated number of HIV-infected children in South Africa

The observations that the number of children infected by HIV has been increasing steadily over the years is authenticated by the recent statistics provided by UNAIDS (2015:43) which reveal that, in South Africa an estimated 410 000 [370,000-450,000] children were living with HIV infection in year 2012. Data from Shisana et al. (2014:37) estimates the prevalence of HIV in children aged 2–14 years to be 4.1% as depicted in the figure below.



Source: Shisana et al. (2014:56)

Figure 2.4: Prevalence of HIV in children

2.7.2 The hidden problem – HIV infected children

As previously alluded to, although HIV infection amongst children is a problem in southern Africa, it is one that is poorly described for various reasons. According to Gray (2009:11), there are no clearly defined “case detection and testing mechanisms” for children, thereby perpetuating the extent of the “hidden HIV paediatric population”. Whilst acknowledging the successes of Prevention of Mother to Child Transmission (PMTCT) programmes in many African countries, UNAIDS (2015:51) points out that the gains of PMTCT programmes could be reversed as the focus of HIV programmes, locally and internationally is shifting to HIV prevention in other high risk populations such as Adolescent Girls and Young Women (AGYW), sex workers, migrant populations and Men who have Sex with other Men (MSM).

Commenting on PMTCT, Ramirez-Avila, Noubary, Pansegrouw, Sithole, Giddy, Losina, Walensky and Bassett (2013:28) observe that in spite of the current successes, interventions at the start of PMTCT rollout in 2002 in South Africa were significantly less successful in preventing HIV transmission to infants than current practices. Furthermore, HIV testing was not rigorously implemented for children until recent years, “which raises concerns that there are high numbers of undiagnosed HIV infected children likely to only present to care once ill and immune-

compromised, if no strong interventions to diagnose these children are put in place” (Ramirez-Avila et al., 2013:29). It is noted that there are now loud calls for swift action to “establish the extent of the hidden pediatric HIV-infected population” so as to ensure that this population has access to appropriate HIV care through improved case detection, referrals, testing, initiation on ART and retention in care, using both community and facility-based approaches. (Ramirez-Avila et al., 2013:29).

Pegurri, Konings, Selassie, Crandall, Matinhure, Naamara and Assefa (2015:07), share similar views with the above authors as they add that, although there was improved coverage and effectiveness of prevention of PMTCT programmes, which managed to reduce new HIV infections among children under 15 years old by 40 per cent globally between 2009 and 2013, there were still about 3.2 million children under 15 years of age worldwide living with HIV in 2013, comprising 9.1% of all people living with HIV, with the vast majority residing in Sub-Saharan Africa.

In a study that was conducted in rural and urban Mozambique to identify motivators and barriers to accessing HIV prevention, care and treatment services for HIV-infected, De Schacht, Lucas, Mboa, Gill, Macasse, Dimande, Bobrow and Guay (2014:04) observed that there are still many women who are delivered by traditional birth attendants and are not tested for HIV during pregnancy, a practice that “increases the likelihood that a child’s infection remains unnoticed as the child may only be tested after becoming clinically ill or after the loss of one or both parents”. De Schacht (2014:04) further observe that in communities where there is little HIV education, “traditional birth practices” hinders postnatal care follow-up activities for children infected by HIV. The findings of the above study are similar to observations made UNAIDS (2015:46) that, failure to diagnose HIV in pregnancy, to provide PMTCT services, and to follow up on HIV exposed children “represent missed chances for prevention of HIV transmission”.

UNAIDS (2015:51) observes that, due to significant challenges that remain in reaching children living with HIV, treatment gaps remains disproportionately high for these children due to significant challenges that exists in reaching these children with treatment and care services. UNAIDS (2015:15) further provides a disheartening statistic that “three of four children living with HIV or 76% are not receiving HIV

treatment”, as depicted in figure 2.5 below. In 2013, while 38% of adults living with HIV worldwide received antiretroviral therapy, only 24% of children living with HIV obtained HIV treatment (UNAIDS, 2015:53).

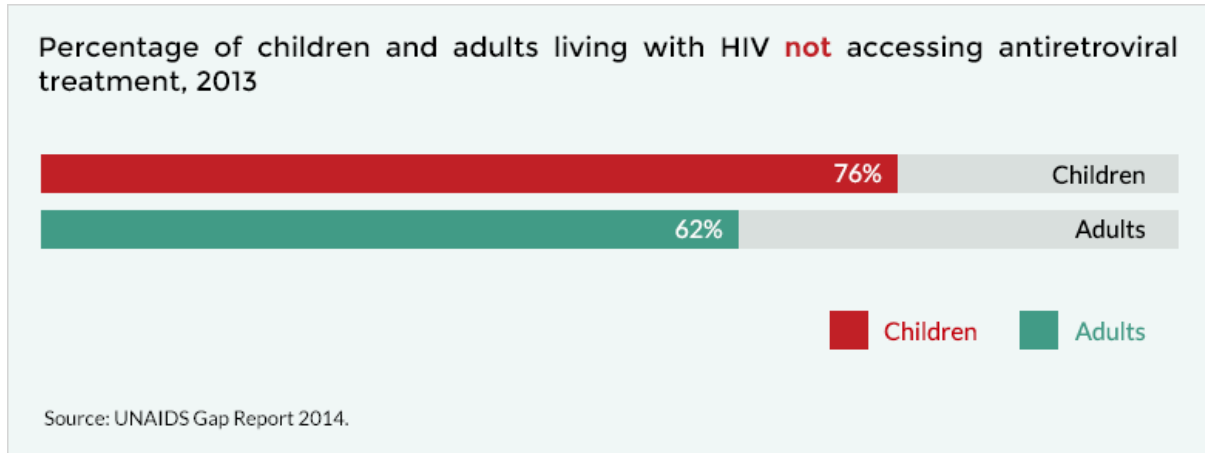
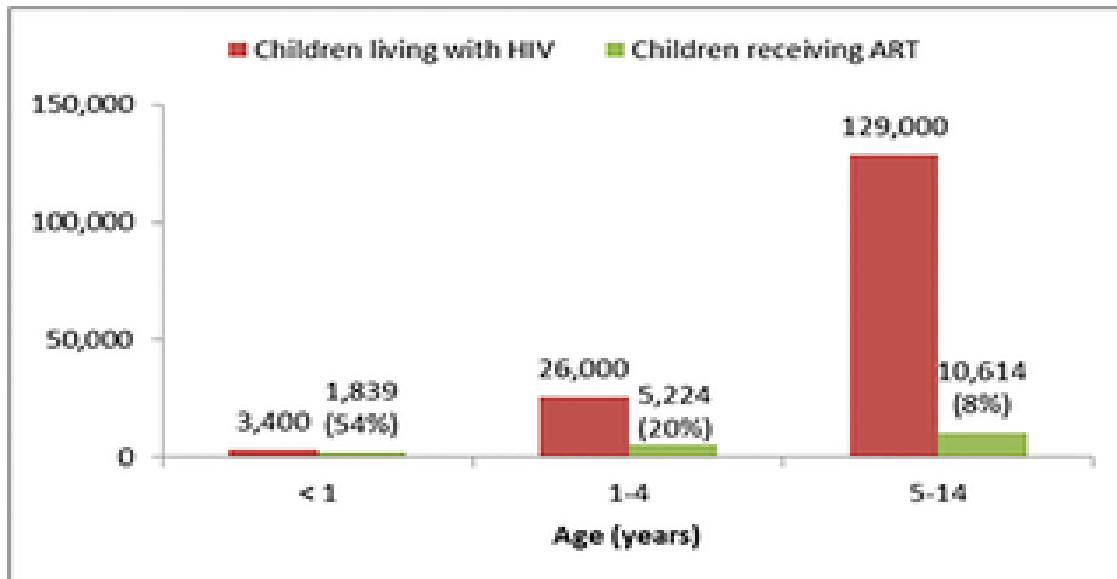


Figure 2.5: Children living with HIV not accessing ART

In a study that was undertaken in Ethiopia to understand the prevalence and burden of HIV in children, Pegurri et al. (2015:03) found out that generally there was scarcity of data on Ethiopian children infected by HIV, which in turn consequently contributed to these children being neglected in national treatment and care programmes. The large population of children living with HIV in Ethiopia is noted to have been vertically infected and to have never been identified. Pegurri et al. (2015:03) note that, of the estimated population of 160, 000 HIV positive children under 15 years, only 12% were included in ART coverage in 2013. The following below highlights the estimated number of children younger than 15 years living with HIV and receiving ART, by age, in Ethiopia, by 2013.



Source: Pegurri et al. (2015:03)

Figure 2.6: Children living with HIV and receiving ART in Ethiopia, 2013

Writing in the District Health Barometer (DHB), a document that provides an annual overview of primary health care (PHC) in the public health sector across the provinces and districts in South Africa, Massyn, Day, Peer, Padarath, Barron and English (2014:121) notes that by year 2012/2013 there was an estimated 410 000 children under the age of 15 living with HIV in South Africa, of which only 148 342 were on ART. The above statistics are supported by the observation by UNAIDS (2015:27) which points out that, besides the fact that South Africa is implementing the largest ART programme in the world with over 2 million people on treatment, only 30-50% of South African HIV infected children who require ART are receiving it, pointing to larger gaps that exists in identifying, treating and supporting children living with HIV.

In a study aimed to assess factors related to barriers and the timing of initiation of treatment in Uganda for HIV-infected children, Boender, Sigaloff, Kayiwa, Musiime, Calis, Hamers, Nakatudde, Khauda, Mukuye, Ditai, Geelen, Mugenyi, de Wit and Kityo (2012:03), found that a lot of health and community based care workers in community facilities are not skilled to do case detection/identification of HIV infected children. The authors further espouse that, although many government policies and efforts by international donors seek to make treatment of HIV freely available to children through national ART programmes, there are specific “human skills

barriers” amongst health and community based care workers that hold back scale-up of pediatric ART in Africa.

2.8 THE LEGISLATIVE ENVIRONMENT AND CHILDREN LIVING WITH HIV

It is noted by many authors that, on attaining independence in the post-1994 period, South Africa engaged in a thorough process to transform its health system. The African National Congress (ANC) (1994:07) note that, on attaining independence the government spearhead a complete transformation of national health care delivery systems, institutions and legislation so as to put in place comprehensive, effective, efficient, compassionate, equitable, accessible and responsive health programmes that addressed structural, functional, racial and geographical inequalities and disparities in the country. The ANC (1994:08) further notes that the government sought to ensure that health care practices were in line with international norms, ethics and standards, and that “emphasis was on health and not only on medical care”. van Rensburg and Engelbrecht (2012:122) asserts that by putting an “emphasis on health and not only on medical care” it meant that the new health structure and service had to be re-oriented to be preventive, primary, holistic and integrative to community participation approaches.

van Rensburg et al. (2012:125) observe that to date, the structuring and dispensation of health services to all sectors of the population in South Africa is marked by promulgation of necessary laws, that is, policies and legislation to guide implementation of health services. Some of the notable legislative documents that have had profound effect on the re-structuring of health systems include the Constitution of the Republic of South Africa, which is argued by van Rensburg et al. (2012:127) to be “the overall framework for all policies and legislation ... applying to the domain of health”. By espousing the values of social justice, equality, respect for human rights, the constitution laid a foundation for both a liberal and egalitarian health care system (van Rensburg et al., 2012:127).

Although there have been a host of significant health policies, plans and programmes that have been churned out in the health sector domain in an effort to promote the values of the constitution, as spelt above, the most significant ones for children living with HIV are the National Strategic Plan on HIV, STIs and TB 2012-

2016 (NSP), HIV Counselling and Testing (HCT) Policy Guidelines, Integrated Service Delivery Model, the Primary Health Care (PHC) re-engineering approach; National Action Plan For Orphans, Other Children and Youth made Vulnerable by HIV and TB 2012 – 2016 (NAP) and the Children’s Act No. 38 of 2005 (as amended). The researcher will now argue that in spite of the existence of relevant HIV legislative framework, there are glaring shortcomings in the proposed policies, plans, guidelines and programmes which makes it difficult for health and community based structures, such as drop-in-centres, to identify and render services to HIV infected children.

Commenting on the contribution of South Africa’s legislative environment in “hiding” the problem of HIV infected children, Goga, Dinh and Jackson (2012:09) explain that although South Africa has the National Strategic Plan on HIV, STIs and TB 2012-2016 (NSP), a framework to guide the activities of all partners whose work is relevant to HIV, sexually transmitted infections (STIs) and TB with the goal to prevent new HIV infections through a combination of interventions so as to achieve “Zero new HIV and TB infections” in South Africa; the NSP is criticised for lacking “specificity” in advancing interventions that need to be pursued to identify, commence and increase retention of HIV infected children in care programmes. It could be argued that the NSP tends to focus mainly on adults and PMTCT (in relation to infants only); and is therefore not vocal on “older” children living with vertically acquired HIV, who appear all but forgotten in national HIV programmes. Put in other words, the magnitude of the population of older HIV-positive children infected through vertical transmission is insufficiently recognized in the NSP.

Section 130 of the Children’s Act No. 38 of 2005 (as amended) states that a child may be tested for HIV if testing is in the best interests of the child and consent is given by the child or the child’s parent or caregiver. The Department of Health (DoH)’s HIV Counselling and Testing (HCT) Policy Guidelines (2010:11) shares the similar position that an HIV test should only be undertaken “if it will be in the best interests of the child and if it is clear that the test will provide access to the continuum of care and promote a child’s physical and emotional welfare”. Goga et al. (2012:10) points out that this provision is problematic by its very nature as some parents and/or caregivers in some communities might not possess sufficient

information and might not be mature enough to understand the benefits, risks and health implications of an HIV test for their children, consequently leading to denial of consent. Goga et al. (2012:10) also point out that the provision in the Children's Act that if the child is over 12 years then the child can give consent without his or her parent's knowledge, could be proved to be a barrier in traditional African settings where children are generally regarded as incapable of making independent decisions irrespective of their age, knowledge and views.

National Action Plan For Orphans, Other Children and Youth made Vulnerable by HIV and TB 2012 – 2016 (NAP), as put together by DSD, is described as a national strategic and operational framework that should guide national, provincial, district and community-level efforts aimed at mitigating the impact of HIV on children. DSD (2012:18) points out that the proposed strategic interventions in the NAP 2012-2016 are designed to create an enabling environment within which community based structures and sector government departments can operate efficiently and effectively in strengthening the capacity of households to provide protection, care and support to children living with HIV. DSD (2012:18) is explicit that one of the specific objectives of NAP is sustaining health and wellness of children living with HIV by ensuring that they have access to treatment and adherence support. NAP also advocates for the creation of a supportive environment that will increase the resilience of children living with HIV. In the case of drop-in-centres, NAP is specific that as community based care structures, drop-in-centres should provide comprehensive quality health and social services in order to promote, restore and maintain maximal level of comfort, social functioning and health for children living with HIV (DSD, 2012:19).

In regards to Social Auxiliary Workers and Community Caregivers, NAP notes that they are the first line of support between the community and various health and social development services and should therefore play a vital role in helping parents and guardians make informed choices about the health and psychosocial well-being of their children infected and affected by HIV. Given the nature of the challenges posed by HIV and the services required for improving the quality of life infected children, NAP admonishes Social Auxiliary Workers to adopt multi-sectoral

approaches that cut across socio-economic, health, educational and spiritual functions of human society (DSD, 2012:19).

It has been observed by Goga et al. (2012:12) that although NAP and other legislative frameworks are rooted in the South African Constitution (which calls for the inalienable rights of children, section 28), exist to guide the work of professionals and institutions working with children infected or put at risk by HIV, there have been lack of orientation and training for caregiving staff such as Social Auxiliary Workers on these legislative frameworks thereby making it impossible to achieve implementation of a standardised and co-ordinated approach to address the needs of children living with HIV. Goga et al. (2012:12) sums that, the objectives of the legislative frameworks to achieve delivery of a comprehensive package of essential services in the provision of education, health, nutrition and social protection services for children living with HIV are not being met due to lack of understanding and poor coordination within community based facilities, such as drop-in-centres.

2.9 BIOPSYCHOSOCIAL CHALLENGES FACED BY CHILDREN LIVING WITH HIV

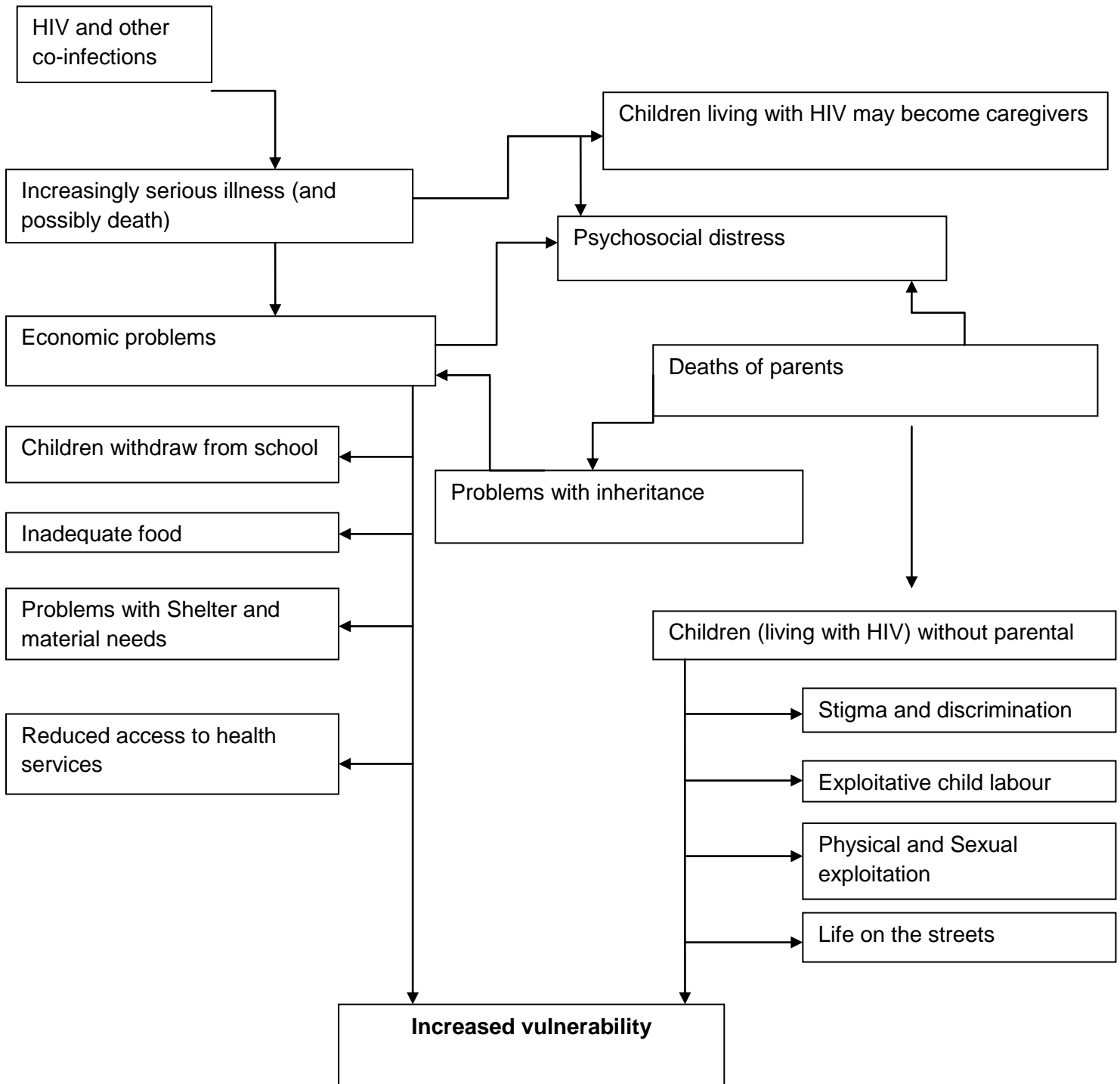
In line with the biopsychosocial perspective that was used to guide interpretations in this study, “bio” refers to the clinical/medical and biological aspects of HIV infection, including the course and trends of the virus and the impact they have on the provision of treatment and care services to children that are living with HIV (Frankel et al., 2004:73). On the other hand, the term “psychosocial” will refer to an examination of both the personal, psychological aspects of the lived experiences children that are living with HIV, and the external social implications of the virus on the health and well-being of the children (Mothi et al., 2011).

Richter, Beyrer, Kippax and Heidari (2010:29) observe that, amidst a host of challenges that include poverty, unemployment and global economic recession, South Africa is one of the sub-Saharan countries that are struggling with mitigating the “vulnerable children crisis.” The situation is noted to be complex for children who are living with HIV, whose health needs remain unmet while communities’ capacity to effectively respond is severely constrained. Hall, Woolard, Lake, and Smith (2012:79) thus acknowledge that there are “bigger and broader” global and societal

socio-economic challenges and barriers that mitigate against the provision of health, social, physical, cultural, legal, and economic services children made vulnerable by HIV.

Although HIV is a global threat of significance to children, emerging as a biological, psychological and social problem (Vranda & Mothi, 2013:19), there is limited structured research that has been performed to profile the specific challenges and barriers that are encountered by children living with HIV (Boender et al., 2012:03). Both Vranda et al. (2013:19) and Boender et al. (2012:03) concur that, children living with HIV battle with many multifactorial challenges in their lives, which include illness, lack of resources, social isolation, lack of access to appropriate HIV services and care and need for psychological and social services. Mothi et al. (2011:914) add that some of the dominant challenges include poor health, poor nutrition, and lack of basic care (survival vulnerability); leaving school due to poor (academic vulnerability); and anxiety and depression (psycho-social vulnerability).

Figure 2.7 below is an adaptation from Breuer et al. (2011:10) and illustrates problems that are experienced by children living with HIV and their families.



Source: Breuer et al. (2011:10)

Figure 2.7: Problems among children and families affected by HIV and AIDS

In the sub-sections below the researcher will therefore discuss the “woefully daunting and inescapable” biopsychosocial challenges that children living with HIV face, particularly in resource limited countries where several barriers determine access and utilisation of health services (Boender et al., 2012:03). The biopsychosocial needs or challenges experienced by children living with HIV will be explained and expanded on separately as biological, psychological and social challenges although overlaps in the discussions will be unavoidable due to the inter-relatedness of the constructs.

2.10 BIOLOGICAL NEEDS

Bharathi, Pai and Nayak (2014:75) observe that HIV develops very rapidly and is especially fatal among children as children living with HIV are very prone to get opportunistic infections because of their weak immune systems. In the case of children living with HIV who might be on treatment, Bharathi et al. (2014:77) comment that, with advances in medical treatment, HIV has been transformed from an acute illness with a vastly foreshortened life span to a condition with many characteristics of a serious chronic illness, hence caring for children infected with HIV poses significant challenges to families and health professionals.

De Schacht (2014:04) explains that children that are living with HIV are susceptible to medical complications or conditions, such as malnutrition, pneumonia, and tuberculosis, especially if they are not on treatment. Vranda and Mothi (2013:22) share similar views and add that, neurological, neuropsychological, and developmental manifestations of HIV disease are the earliest and most devastating markers of infection in children. Vranda et al. (2013:22) cite some studies of the Central Nervous System that were done on children that are infected by HIV in India. The studies observed serious signs of 8-13% of neurodevelopment delays in HIV infected children. Delayed developmental milestones, poor expressive and receptive language development and motor development skills were noted to be some of the direct impact of HIV on neuro-developmental of children that are infected (Vranda et al., 2013:22).

De Schacht (2014:04) notes that, most HIV infected children are malnourished as 30 – 50% of children that get hospitalized with severe acute malnutrition are HIV positive. The author explains that mortality of children with HIV and severe acute malnutrition is four times higher than that of those with severe acute malnutrition alone (30% versus 80%). Severe pneumonia and severe acute malnutrition are also cited as high risk factors for death in hospitalised children with HIV. In regards to tuberculosis, De Schacht (2014:05) points out that, it is very common to experience incidences of tuberculosis disease and HIV co-infection in children living with HIV. It is also observed that it is more difficult to diagnose tuberculosis in HIV co-infected children and that there are higher chances of experiencing acute side effects due to interaction of anti- tuberculosis medication and ARVs for infected children who gets commenced on treatment (De Schacht, 2014:07).

2.10.1 Lack of access to medical treatment, care and support services

Mothi et al. (2011:913) identify some of the challenges faced by children living with HIV as including delayed diagnosis, lack of appropriate pediatric formulations and a general lack of skilled personnel to efficiently respond to enormous biological, psychosocial, mental and cognitive problems that these children face.

Many authors concur that although the advantages of early infant HIV diagnosis and treatment initiation are well established, children living with HIV are often taken to clinics or health facilities only after being recurrently unwell. Boender et al. (2012:03) cite a study that was done to examine factors influencing the timing of ART initiation among children attending HIV clinics in Uganda. The study established that even though ART is now free and widely available in Uganda, 72% of the children in the study presented with advanced HIV disease at their initial visit. In a similar study that was conducted in 2012 by the Elizabeth Glaser Pediatric AIDS Foundation in Lesotho, Malawi and Swaziland which sought to understand gaps in the treatment of HIV positive children it was established that, despite the notable availability of HIV treatment in public health facilities, only 23% of the 2.02 million children in need of ART received it in 2010, compared with 51% of adults in the same year. The Elizabeth Glaser Pediatric AIDS Foundation (2012:01) noted that HIV in children goes undiagnosed, and therefore untreated due to gaps that exist in service delivery.

The study also observed that, in the cases where children living with HIV are eventually initiated on antiretroviral therapy (ART); regular monitoring for adherence and other vigilant or supportive services varies from one service point to another, depending on the role and competencies of care-giving staff.

Observations that are similar to the conclusions of the above cited studies are made Yeapa, Hamilton, Charalambous, Dwadwa, Churchyard, Geisslera, and Granta (2010:06) who comment that, treatment of pediatric HIV infection in many African countries is often significantly delayed, resulting in excess mortality. Yeapa et al (2010:06) explain further that, without treatment, over 50% of HIV-infected children are estimated to die much earlier before the age of ten as HIV infected children have much higher rates of disease progression, if not on treatment.

2.11 PSYCHOLOGICAL NEEDS

Bharathi et al. (2014:55) assert that, due to complexities of their illness and treatment (or lack of treatment), children with chronic illness in general, and HIV in particular, are found to be at greater risk for psychiatric problems, including depression, anxiety, feelings of isolation, emotional and behavioural problems. Grover, Pensi and Banerjee (2007:215) who studied emotional, behavioral disorder and the impact on the mental health of children infected with HIV in India note that children living with HIV scored high for emotional, behavioral, and psychiatric disorder when compared to children that were not infected by HIV. Grover et al. (2007:216) explain that the most common disorders that were found in children living with HIV were “anxiety disorders, followed by attention-deficit hyperactivity disorders, conduct disorders, oppositional defiant disorders, and mood disorders”. Higher behavioral problems, such as rule breaking behavior, was found to be higher among those children who found out about their positive HIV status on their own and those children who were discriminated by other children due to their HIV status (Grover et al., 2007:216).

The observations above are corroborated by findings of a study that was done in Kwa-Zulu Natal, Gauteng and the Eastern Cape by Thurman and Kidman (2011:34) to determine the type of services that are needed to support the social, educational and psychological wellbeing of orphans and children living in HIV affected

households. The study indicated that there is increasing evidence from South Africa that children living with HIV experience negative health, social and developmental outcomes. Children living with HIV showed higher levels of mental health problems, and they were more likely to miss school and have difficulty concentrating due to stress and worry (Thurman et al., 2011:35).

2.12 SOCIAL NEEDS

The basic social and economic needs of children living with HIV are not different from those of other children even though it could be ascertained that their needs are more intensified due to the vulnerabilities that they encounter (Kay, 2001:116). The socio-economic needs of children living with HIV include physical care, that is, to be assured of warmth, shelter, food and other material needs. Emotional security, love, affection, respect and support are also categorised as key socio-economic assets (Kay, 2001:116). Uys and Cameron (2003:182) caution that in order for parents to meet the basic socio-economic needs of children infected by HIV, they need to provide them with access, at the very least, to functioning health education and social services.

2.12.1 Unmet basic social and economic needs

Expanding on the above, Breuer et al. (2011:109) explain that children living with HIV may not have their basic needs such as food, shelter, health care and education met as their parents might be too ill to work and provide for the children. The absence of parents in the lives of some children living with HIV is noted to have drastic consequences on their socio-economic and psychosocial wellbeing “as it often translates into losing emotional support, being poorer than other children, having less to eat, financial hardships and disruption of schooling opportunities” (Thurman & Kidman, 2011:37). Similar views are shared by Cluver et al., (2011:341) who assert that, children living with HIV are four to six times more likely to be exposed to emotional and physical abuse than uninfected children in healthy families. It is also noted that children who lose their parents early due to HIV and AIDS are more likely to be with no access to social assistance due to lack of birth registration certificates, and might as a result, experience challenges inheriting their deceased parents’ estates (Breuer et al., 2011:11).

2.12.2 Stigma and non-disclosure

Vranda et al. (2013:20) assert that, a major factor that distinguishes HIV from other chronic or terminal illnesses is the stigma, which too often leads to HIV infected children and their families living in a “conspiracy of silence” and shame associated with the illness. One of the disturbing consequences of “conspiracy silence” is that the families of children living with HIV may be withdrawn, become socially isolated and become emotionally cut off from traditional support systems (Vranda & Mothi, 2013:20). Arun, Singh, Lodha and Kabra (2009:806) studied the perception of parents and guardians on disclosure of diagnosis of HIV infection to children in the Indian context. The study revealed that only 7 out of the 50 children (14%) were aware of their HIV status while 43 out of the 50 (86%) were unaware. Fear of stigmatisation was cited by the parents and guardians as the major reason for non-disclosure to children. Breuer, Myer, Struthers and Joska (2011:109) corroborate that, children living with HIV, particularly in impoverished settings, are most likely to experience higher levels of poverty as well as extreme high levels of stigmatisation and bullying.

Grover et al. (2014:217) assert that stigma breeds fear, anger, remorse, psychological pain and blame which leads to denial and non-disclosure by parents, “even in cases where illness is evident in their children infected by HIV”. Self-imposed secrecy and reactions to social stigma preclude families from procuring necessary treatment, obtaining much needed social support and seeking assistance with permanency planning for infected children (Grover et al., 2014:217).

In concurrence with the discussions above, Mothi et al. (2011:914) note that, non-disclosure, stigma, and fear are major issues playing a role in the biopsychosocial continuum of children living with HIV. It is noted that in some communities HIV stigma and discrimination is still rife and as a result, some parents do not find it appropriate to disclose the HIV status of their children. This is a critical point in the case of drop-in-centres where the status of children living with HIV will remain unknown to Social Auxiliary Workers; which means the Social Auxiliary Workers will therefore not be able to render any particular support that improves the biopsychosocial outcomes of infected children. Urassa, Walraven and Boerma

(1997:340) note that, the inability by some community based facilities care-giving staff to “identify” and render “health services” to children living with HIV has resulted in some literature labeling children living with HIV as “the invisible and forgotten children.”

2.12.3 Children transitioning into adolescence

The stage of adolescence is described by Louw and Louw (2007:278) as a time of both physiological and social transition to adulthood, during which children develop secondary sexual characteristics, and take on increasing levels of independence and responsibility. Louw et al., (2007:279) perceive adolescence as a period of biological, social, emotional and cognitive development which, if not negotiated satisfactorily, can lead to emotional and behavioral problems in adult life. Age-wise adolescence is said to begin at 11-13 years of age (early stage) and move to 15-18 years (middle stage) and 19-22 years of age (late stage). In this study, the term adolescence is used loosely to refer to children that are developing sexual characteristics and the capacity for reproduction (puberty) and are in the age group of 11-18 years.

The transition of children living with HIV into adolescence has received different reviews from various authors. Vranda et al. (2013:21) point out that, for HIV infected children who live to adolescence, the normal developmental challenges of this stage, including puberty, sexuality and the desire to “fit” or be “normal” are seriously complicated by the HIV disease. The authors postulate that, as HIV infected children move through adolescence and become sexually active, they encounter significant challenges in managing the complex issues of integrating healthy sexual development with their HIV infection. In instances where the adolescent children would not have been informed of their diagnosis or status, it is difficult for them to make informed decisions regarding their sexual actions and related life choices (Vranda et al., 2013:21).

Commenting on a cross-sectional study that was done in Uganda to examine the transitioning of HIV infected pediatrics into adolescence, Mofenson and Cotton (2013:03) noted that, poor health programming for children living with HIV had an impact on their adulthood health outcomes thereby posing a new set of cumulative health and developmental challenges that put a strain on already over-burdened

health systems. The argument here is that, failure to address the HIV-related biopsychosocial vulnerabilities of children living with HIV has dire future consequences for the children themselves, as well as societal systems. Pegurri et al. (2015:07) argue that, failure by community organisations to identify, engage and bring children living with HIV to treatment, care and support has potential “to impact on the children’s social, health, and economic assets”. There is emerging evidence that is showing that, if children living with HIV do not receive adequate counselling and guidance they are more likely to engage in early sexually debuts, unprotected sex, transactional sex, intergenerational sex, sexual and gender-based violence, substance abuse and other risks (Pegurri et al., 2015:07). For those children living with HIV that might be on ARVs, they are likely to “rebel” and not adhere to their medical regimes (Pegurri et al., 2015:07).

2.12.4 Lack of skilled personnel

Sint, Lovich, Hammond, Kim, Melillo, Lu, Ching, Marcy, Rollins, Koumans, Heap, and Brewinski-Isaacs (2013:170) observe that, a combination of lack of skills and knowledge amongst program implementers create a poor enabling environment for children living with HIV to realize better health outcomes. Sint et al. (2013:170) suggest that staff that associate with children living with HIV in community facilities should be competent enough to provide acceptable counselling and supportive services to infected children and their families; as well as consistent and timely referrals if optimal health care for children living with HIV is to be realized. Mothi et al. (2011:914) add that, if the care-giving staff caring for children living with HIV is adequately trained on HIV, it increases the chances of initiating infected children on ART at an early age, which consequently decreases morbidity and mortality.

2.12.5 Terminal illness and death

Although the focus of this study is on children living with HIV and not on children with AIDS, it should be mentioned that, as the disease progress, children living with HIV may confront the physical and mental decline associated with AIDS. The “twin” issues of death and bereavement are real for children living with HIV (Brown & Powell-Cope, 1992:49). Vranda et al. (2013:21) comment that, facing and understanding their own possible death are major challenges faced by children with

AIDS particularly in cases where families would not have communicated the HIV prognosis to the child in the first place. It is noted that, more than coping with their own mortality; children living with HIV may have to cope with mortality of their loved ones with HIV and AIDS. Cluver, Orkin, Boyes, Gardner and Meinck (2011:337) cite some in-depth longitudinal studies that were done in South Africa that revealed that children living with HIV could be “dually-affected” as it is very common for them to have an AIDS-sick parent or caregiver.

2.13 SUMMARY

In conclusion, the discussions outlined in this chapter reveal that children living with HIV have a myriad of biopsychosocial needs and challenges that put a strain on their opportunities to access health services and other related social services. It was discussed that Social Auxiliary Workers are responsible for driving programmes and rendering services to children living with HIV within drop-in-centres. It is not clear whether Social Auxiliary Workers are adequately trained and capacitated to be addressing the biopsychosocial needs of children living with HIV. It is thus, the opinion of this researcher that an empirical exploration of the views of Social Auxiliary Workers on their role and competencies in meeting the biopsychosocial needs of children living with HIV will be a step in the right direction in coming up strategies that might lead to improvement in health programming for children living with HIV. The researcher is hopeful that this study will shed light on the state of Social Auxiliary Work practice within drop-in-centres that deliver services to children living with HIV.

The research methodology, ethical aspects, empirical findings and the summary will be presented in the next chapter.

CHAPTER THREE

RESEARCH METHODOLOGY AND EMPIRICAL STUDY

3.1 INTRODUCTION

This chapter will provide a comprehensive description of the research approach, type and design, the research methodology and the ethical aspects relevant to the study. Furthermore, the chapter will present and discuss the empirical findings of the study. The goal of the study was to explore the perceptions of Social Auxiliary Workers on their role and competencies in addressing biopsychosocial needs of children living with HIV at drop-in-centres. The objectives were as follows:

- To obtain a sample of Social Auxiliary Workers within drop-in-centres working with children living HIV.
- To explore and describe the perceptions of Social Auxiliary Workers on their role in working with children living with HIV at drop-in-centres.
- To explore and describe the perceptions of Social Auxiliary Workers on their competencies in working with children living with HIV at drop-in-centres.
- To identify the challenges that Social Auxiliary Workers are experiencing in working with children living with HIV at drop-in-centres.
- To suggest strategies, based on the research findings, to improve Social Auxiliary Workers' role and competencies in working with children living with HIV at drop-in-centres.

3.2 RESEARCH METHODOLOGY

Qualitative research is defined by Babbie (2007:378) as the “non-numeric examination and interpretation of observations and data, for the purpose of discovering underlying meanings and patterns of relationships.” Creswell (2009:35-41) adds that qualitative research draws on an inductive process in which themes and categories emerge through analysis of data collected by such techniques as interviews, observations, video tape, and case studies. The researcher chose qualitative research for the advantages that are stated by Creswell (2009:35-41) that

it has flexibility; it provides room for in-depth analysis, and the potential to observe a variety of aspects of a social situation.

The research methodology is organised under the following headings: the research approach, type of research, research design and methods, feasibility of the study, and ethical aspects.

3.2.1 Research approach

The researcher employed a qualitative approach which entailed a systematic and subjective approach to assess and give significance to the perceptions of Social Auxiliary Workers on their role and competencies in addressing biopsychosocial needs of children living with HIV at drop-in-centres (Burns & Grove, 2009:51). The qualitative approach aims to understand, observe, explore and obtain a realistic and descriptive perspective from respondents who have direct experience of what is being researched (Fouché & Schurink, 2011:308; Babbie, 2011:26). The topic under study required an in-depth exploration as there is no significant information on the experiences or challenges faced by Social Auxiliary Workers working with children living with HIV at drop-in-centres. Therefore, a qualitative approach was the most suitable approach for the study as it allowed for a broader description of the experiences of Social Auxiliary Workers within their natural context (Burns et al., 2009:53). In addition, Yates (2004:138) notes that “qualitative research explores how individuals or group members give meaning to and express their understanding of themselves; their experiences and/or their words.”

3.2.2 Research question of the study

The research question in this study was: **What are the perceptions of Social Auxiliary Workers on their role and competencies in addressing the biopsychosocial needs of children living with HIV at drop-in-centres?** Bryman (2008:9) defines a research question as a question that provides an explicit statement of what it is the researcher wants to know about. Welman, Kruger and Mitchell (2005:52) corroborate that, a research question stems from the research topic, makes the theoretical assumptions in the framework more explicit, and indicates what the researcher wants to know first and foremost. In a similar vein, Fouché and De Vos (2011:80) point out that a research question should clarify the

intention of the research, should provide the researcher with a good platform from which to conduct the investigation and should allow readers to evaluate the research by providing benchmarks against which to judge not only what the project aimed to achieve, but also what it did not set out to do. In regards to literature search for the literature review, Fouché and De Vos (2011:80) remark that, the research question is both a signpost and a set of boundary marker as it sets the researcher on a specific path and defines the territory to be explored.

In line with the observations of Maree and Van der Westhuizen (2007:25-26) that sub-questions are useful in assisting the researcher to unpack and answer the primary research question, the sub-questions that underpinned this study were as follows:

- What are Social Auxiliary Workers perceptions regarding the biopsychosocial needs of children living with HIV at drop-in-centres?
- What challenges do Social Auxiliary Workers experience regarding their work with children living with HIV at drop-in-centres?
- To what extent do the challenges impact on the role and competencies of Social Auxiliary Workers to address the biopsychosocial needs of children living with HIV at drop-in-centres?

3.2.3 Type of research

In line with the recommendation of Monette, Sullivan and DeJong (2010:04) that outcomes of research should be able to benefit a group or society, applied research was followed in this study because the research goal was to explore the perceptions of Social Auxiliary Workers on their role and competencies in addressing biopsychosocial needs of children living with HIV at drop-in-centres in order to recommend guidelines for more effective service rendering (Fouché & De Vos, 2011:94). Applied research often tries to solve practice and policy problems so as to help the social welfare workforce accomplish tasks (Neuman, 2000:24). The study thus makes suggestion of recommendations and practice guidelines that might be used to improve the responsiveness and effectiveness of Social Auxiliary Workers' interventions targeted at addressing the biopsychosocial needs of children living with HIV within drop-in-centres.

3.2.4 Research design and methods

This section will elaborate on the research design and methodology used in the study.

3.2.4.1 Research design

Hagan (2000:68) defines a research design as a plan or blueprint for answering the who, what, where, when, why, and how questions of any study investigation. A qualitative research design, more specifically, the collective case study was utilised in the study (Neuman, 2000:37; Smith, 2000:113; Rubin & Babbie, 2011:442). The collective case study design was selected as the most appropriate for this study for the reasons that are stated by Crowe, Cresswell, Robertson, Huby, Avery and Sheikh (2011:01) that it allows in-depth, multi-faceted explorations of complex issues in their real-life settings. Fouché and Schurink (2011:320) assert that a case study allows for interaction, holistic understanding and thorough analysis of, amongst other things, persons, groups, episodes, processes, communities, societies or any other unit of social life.

The researcher was enabled to gather “detailed and rich-in-context information” of Social Auxiliary Workers’ perceptions regarding their role and competencies in addressing biopsychosocial needs of children living with HIV at drop-in-centres (Fouché & Schurink, 2011:321). In line with the views of Cresswell (2013:99) and Padgett (2008:33) that a collective case study research design allows for meaningful interpretation of multiple perspectives in a study, the interest of the researcher was not on individual perceptions of participants, but rather on their collective perspectives as Social Auxiliary Workers delivering services to children living with HIV within drop-in-centres. This was supported by the views of Nieuwenhuis (2007:75) who notes that “case studies offer a broad 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”. Crowe et al. (2011:02) add that this approach helps “to generate a broader appreciation of a particular issue.”

The case study design, as with all other research designs, is not without its limitations. Critics have argued that the case study design is lacking in scientific

rigour and it provides little basis for generalisation. In this study the researcher mitigated the aforementioned concerns by adopting suggestions by Crowe et al. (2011:07) and Bryman (2008:54-55), to focus data collection in line with research questions; use of theoretical sampling (drawing a sampling framework); respondent validation (getting the views of participants on the accuracy of emerging findings); and practicing transparency (justifying all choices made throughout the research process with the view of eliminating biased interpretations).

3.2.4.2 Research population, sample and sample method

3.2.4.2.1 Population

Strydom and Delport (2011:392) state that the term sample always implies the simultaneous existence of a population of which a sample is a smaller section, or a set of individuals selected from a population. Conversely, a population is a totality of persons, events, organisation units, case records, or other sampling units with which the research problem is concerned (Bryman, 2008:418).

In line with the assertion of Strydom (2011a:223,224) that, population is a term that sets boundaries on the study units as it refers to individuals in the universe with specific characteristics or attributes in which the researcher is interested, the population of this study were all the forty (40) Social Auxiliary Workers who are employed in the 18 drop-in-centres that are in Sedibeng District Municipality and are funded and supported by the Department of Social Development. The study was conducted at the 18 drop-in-centres (see Appendix 2 for permission letter).

3.2.4.2.2 Research sample and sampling method

The researcher used non-probability purposive sampling as well as simple random sampling procedure of probability sampling, respectively, to select a sample of 10 Social Auxiliary Workers for the study. Purposive sampling was preferred for the reason that it allowed a sample of “relevant” and “information rich participants” to be selected (Struwig & Stead, 2001:122; Bryman, 2008:458). Nieuwenhuis (2007:79) corroborate that, “participants are selected because of some defining characteristics that make them the holders of the data needed for the study.” In line with the above assertions, the researcher firstly employed criterion sampling (as part of purposive

sampling technique), which entailed that the researcher decided at the design stage the typical characteristics of participants that were to be included in the study (Nieuwenhuis, 2007:80). The main typical characteristics of Social Auxiliary Workers that were included in the study were that:

- They had to be registered with SACSSP.
- They had to be working directly with children that are living with HIV within drop-in-centres.
- They had to have at least a year's experience working in a drop-in-centre.
- They had to be willing to participate in the study.
- They had to be available for the study.
- Both females and males were selected.

After selecting the names of Social Auxiliary Workers who met the main typical characteristics specified above from the list of 40 Social Auxiliary Workers, the researcher placed their names into a box. Only 10 were subsequently selected randomly to participate in the study. A contingent plan was put in place that, should any of the selected Social Auxiliary Workers had been unwilling to participate or withdrew from the study, the researcher would have continued with random selection from the names in the box until he had gotten the 10 Social Auxiliary Workers to participate in the study.

3.2.5 Data collection method

For its predominance and numerous advantages in qualitative research, this study made use of semi-structured one-on-one interview schedule as means of data collection (see Appendix 3). Semi-structured one-on-one interviews are used to gain a detailed picture of a participant's beliefs about, or perceptions of, a particular topic (Greeff, 2011:342). Through these interviews, the researcher "uncovered the lived world" and gained in-depth understanding and knowledge on the perceptions of Social Auxiliary Workers regarding their role and competencies in addressing the biopsychosocial needs of children living with HIV at drop-in-centres (Greeff, 2011:349).

The semi-structured one-on-one interviews constituted three kinds of questions, main questions, probes and follow-up open-ended questions which allowed greater

interaction between the researcher and the Social Auxiliary Workers. This was in line with the observation of Bryman (2008:196) and Greeff (2011:349) that, semi-structured interviews allow for considerable flexibility in scope and depth as they provide some latitude to ask further questions in response to what is seen as significant replies. The semi-structured interviews were therefore, a powerful way of exposing reality and helped the researcher to understand the everyday experiences of the participants (Greeff, 2011:362). An interview schedule was used to guide the semi-structured interviews. Greeff (2011:352) defines an interview schedule as “a set of predetermined questions” that are used to guide interviews. In line with the recommendation of Greeff (2011:352), the researcher compiled a schedule that had a broad range of themes covered in the semi-structured interviews, focusing on the perceptions of Social Auxiliary Workers in regards to their role and competencies in addressing the biopsychosocial needs of children living with HIV at drop-in-centres.

The semi-structured one-on-one interviews were conducted at the drop-in-centres where Social Auxiliary Workers are employed. The researcher took notes and utilised a digital recorder to record the interviews. The researcher transcribed the tape recordings after the interviews. While the semi-structured one-on-one interviews allowed for in-depth information to be gathered (Greeff, 2011:352), the method had the disadvantage of generating voluminous information that made analysis of findings a tedious time consuming activity (Rubin & Babbie, 2011:488). The researcher counteracted this by meticulously adhering to the process of qualitative data analysis.

3.2.6 Data analysis

Data analysis is a process of interpreting collected data so as to convert it into organised information “for the purpose of discovering underlying meanings and patterns of relationships” (Babbie, 2007:378). In the study data analysis was guided by Creswell’s (2009) model of data analysis, which suggests that, data analysis is “an on-going process that routinely starts prior to the first interview” (Creswell, 2009:184). The researcher chose Creswell’s (2009) model, also known as data analysis spiral, for its flexibility (Schurink, Fouché & De Vos, 2011:403; Bryman (2008:551). The following stages were followed in the process (Creswell, 2009:126-129):

- ***Managing data***

Data was recorded using a tape recorder. The advantage of doing this was that it ensured verbatim recording and, at the same time enabled the researcher to communicate, listen and probe participants attentively (Rubin & Babbie, 2011:468).

After the interviews, the researcher created computer files for the tape recorded data and labeled them appropriately. This process was then followed by the researcher attentively listening to the interviews and transcribing them accurately into a word package.

- ***Reading and writing memos***

After the organisation and conversion of the data had been done, the researcher read the transcripts in their entirety and made notes on key concepts that occurred. This processes involved generating categories, key themes and salient themes that appeared and reappeared from the participants' responses (Schurink, Fouché & De Vos, 2011:410; Greeff, 2011:373). In analysing data, the researcher considered the words, the context, consistency, frequency of comments, extensiveness of comments, specificity of comments, and what was not said, as well as finding the "big idea" (Greeff, 2011:373).

- ***Describing, drawing patterns, themes and coding***

After categories of themes were identified, the researcher started with the process of identifying and classifying sub themes that were internally consistent but distinct from one another. This was done to make the data more manageable and it enhanced trustworthiness and easy retrieval of information (Rubin & Babbie, 2011:448). Using an open code system, the researcher highlighted all similar categories and patterns using one colour (Rubin & Babbie, 2011:480). Then, the researcher interpreted the data accordingly and in the process sought for other plausible explanations for these data and linkages among them.

- ***Representing and visualising***

The researcher then presented the data in a table format that depicts the themes accordingly. The themes will be discussed and substantiated by verbatim quotations in section 3.5 of this chapter

3.2.7 Trustworthiness of qualitative data

The following measures were taken to enhance trustworthiness of the data:

- ***Credibility***

To ensure credibility the researcher accurately identified and described the population (Schurink, Fouché & De Vos, 2011:386). The selection of Social Auxiliary Workers who participated in this study was achieved by utilising participant eligibility (inclusion and exclusion) criteria (see 3.2.4.2.2). Miles and Huberman (1994:34) emphasise the need for data collection and data analysis procedures to be derived from those that have been successfully utilized before in comparative studies. The data collection and analysis procedures utilized in the study are widely used in qualitative studies and have been applied as prescribed thereby ensuring credibility of the study.

Data credibility and trustworthiness was also enhanced through prolonged interview sessions that were punctuated by probing until data saturation occurred (Creswell, 2009:192; Rubin & Babbie, 2011:448). The researcher would also read interview transcripts numerous times until he was in a position to capture accurate descriptions of perceptions and experiences as reported by Social Auxiliary Workers. “Sufficient scrutiny, reflection, and interrogation” of study data was applied (Shenton, 2003:64).

- ***Member checking***

Participant validation was the most critical technique for establishing credibility. This entailed interpreting the information and then checking with the participants if the interpretation and thematic analysis was consistent, correct, and congruent with their experiences (Creswell, 2009:191; Greeff, 2011:372). Besides enhancing credibility this was also essential in ensuring that information was not subjectively interpreted (Rubin & Babbie, 2011:447). In line with the recommendation of Lietz et al. (2006:453), member checking was done “on the spot”, at the end of interview

sessions with each participant “in order to check with the source the trustworthiness of what was found”.

- ***Conformability***

The concept of conformability demands that the researcher takes steps “to help ensure as far as possible that the research’s findings are the result of the experiences and ideas of the participants, rather than the characteristics and preferences of the researcher” (Shenton, 2004:72). The researcher has earlier in the chapter (see 3.2) provided a detailed description of the methodological process that was followed in the study. Schurink, Fouché & De Vos, (2011:421) contend that, also critical to conformability is the “audit trail”, a process which allows any observer to trace the course of the research step-by-step and understand the descriptions made on methodological processes and procedures. The researcher has kept all research documents for the reasons cited above (Lietz et al., 2006:450; Bryman, 2008:32).

- ***Reflexivity***

In this strategy the researcher reflected on his own experience and knowledge (Lietz et al., 2006:448). The researcher employed data neutrality as a way of safeguarding against attaching preconceived ideas or own perceptions on the experiences of Social Auxiliary Workers (Creswell, 2009:192). This was achieved through maintaining neutrality, avoiding being judgemental and being mindful while becoming closely involved with the Social Auxiliary Workers’ experiences.

- ***Peer debriefing***

Lastly, trustworthiness was ensured through the use of peer debriefing and external audit as the researcher engaged with fellow researchers and other experienced colleagues, such as the study supervisor, in reviewing data and interpretation thereof (Crowe et al. 2011:08). This was useful in detecting gaps in the collected data (Lietz et al., 2006:448).

- ***Transferability***

To ensure transferability the researcher made use of the biopsychosocial perspective since the study was undertaken in the realm of the social systems

theoretical framework. Data was collected using a semi-structured interview schedule and was analysed using Creswell's (2009) model, thus any research that will be conducted in the same parameters will produce the same results as the study (Schurink, Fouché & De Vos, 2011:423). The researcher also strived to provide rich and thorough information regarding the description of the research setting or context and observed transactions and processes, and in-depth discussions of findings and themes as a way of ensuring rigor and transferability of data to other settings (Rubin & Babbie, 2011:450).

3.2.8 Pilot study

The researcher conducted a pilot study to determine whether relevant data can be obtained from the participants (Delpont & Strydom, 2011:395). These authors note that, "Researchers should never start the main inquiry unless they are confident the chosen procedures are suitable, valid, reliable, effective and free from problems and errors, or at least that they have taken all possible precautions to avoid any problems and errors that might arise during the study" (Delpont & Strydom, 2011:395). Using the same criteria for recruiting participants for the study, the researcher did a pilot test of the semi-structured one-on-one interview schedule on 2 Social Auxiliary Workers. The information obtained from participants used in the pilot test was not used in the main study.

Doing a pilot was advantageous in that it gave the researcher a taste and feel of what the real study was going to be like. Moreover, it enlightened the researcher on the feasibility of the study in terms of financial resources, time and willingness of participants to participate in the study (Strydom & Delpont, 2011:395). The semi-structured one-on-one interview guide appeared to be suitable during pilot study. As such, it was not necessary to consider another procedure of collecting data (Strydom, 2011a:243). The participants in the pilot study signed informed consent letters.

3.3 ETHICAL CONSIDERATIONS

The researcher adhered to the ethical guidelines required for a study of this nature as an obligation to the University of Pretoria, the research participants and the social work profession. The researcher obtained permission to conduct the study from the University of Pretoria (see Appendix 1). The researcher was also granted permission by the Department of Social Development to conduct the study. In line with the remarks of Farrimond (2013:03) that successful researchers are those who identify key ethical principles that can impact on their study and incorporate them into their entire research process, from design to data collection and analysis to the publication of findings, this study paid due attention to the following ethical issues:

3.3.1 Informed consent and voluntary participation

It is a foundational principle of social research to never coerce anyone into participation; participation must be voluntary (Strydom, 2011c:117). The researcher adhered to the principle of informed consent by providing adequate and all possible information to Social Auxiliary Workers selected for the study, the procedures to be followed, the possible advantages and disadvantages of the study as well as credibility of the researcher. Sharing all the above information with the Social Auxiliary Workers helped put them in a position to choose to participate or not to participate in the study (Taylor, 2000:07). The researcher did not coerce Social Auxiliary Worker to participate in the study, but rather adhered to the principle of voluntary participation (Babbie, 2001:470). Besides requesting participants to sign consent letter prior to participating in the study, the researcher explained to participants that they could withdraw anytime from the study should they feel uncomfortable to continue. Informed consent to record the interviews and to securely store data for a minimum of 15 years at the University of Pretoria was also obtained from all participants.

3.3.2 Deception of participants

Avoidance of deception of participants in this study was done by clearly communicating the goals and procedures of the study. There was no misrepresentation of facts, which could have violated the respect of participants

(Strydom, 2011c:115). In other words, the research was not represented as something other than what it was (Bryman, 2012:143). No information was withheld from participants and the researcher was forthright in informing participants that they will not receive any payment for participating in the interviews.

3.3.3 Confidentiality, privacy and anonymity

The researcher ensured confidentiality, privacy and anonymity for all participants in every step of the research (Strydom, 2011c:119). Firstly, the researcher informed and got permission from the participants to use a tape recorder and field notes to record data. Secondly, participants were informed that the researcher will compile a research report to be submitted to the University of Pretoria for academic purposes. However, participants were assured that no information that directly identified their names, surnames or contact numbers will be disclosed in the study report; instead pseudonyms will be used where necessary. Lastly, it was also indicated to the participants, through the informed consent letter, that raw data, transcriptions and informed consent letters will be securely stored for a minimum of 15 years, according to the University of Pretoria's stipulations.

3.3.4 Avoidance of harm

Strydom (2011c:115) observes that, harm to participants in the social sciences is mainly emotional in nature. The goal of the study was to explore the perceptions of Social Auxiliary Workers on their role and competencies in addressing biopsychosocial needs of children living with HIV at drop-in-centres. This involved discussing issues around HIV and AIDS, which could have had potential to trigger suppressed or repressed emotions of some participants that might have been affected by the pandemic in their lives. The researcher informed the participants about the potential impact of the study and offered them the opportunity to withdraw from the study if they so wished without any negative consequences (Strydom, 2011b:115).

The researcher also explained fully the purpose of the study and had the participants sign informed consent forms as part of minimising harm. Lastly, in instances where emotions were stirred, participants were referred for counselling with a professional

and experienced Social Worker, working for the Department of Social Development in Sedibeng Region.

3.3.5 Debriefing of participants

The “member checking” activities and the debriefing of participants that happened at the end of interview sessions afforded participants a reflective opportunity to work through their experiences and thereby minimise “possible harm which may have been done in spite of all precautions” (Strydom, 2011c:115). Through debriefing, problems generated by the research experience were corrected as the researcher answered participants’ questions and removed misconceptions. (Taylor, 2000:09; Strydom, 2011b:122). Participants expressed appreciation of the research experience for affording them an opportunity to reflect on their work experiences. Thus, the researcher did not experience any situation where the participants needed therapy or counselling.

3.3.6 Actions and competence of researcher

Addressing the assertion by Strydom (2011c:123) that a researcher is ethically obliged to ensure that he is competent and adequately skilled to undertake a proposed study, this researcher is a qualified social worker who has undertaken research on various social issues in his work. In addition, the researcher successfully completed a research project for his post graduate studies in Masters in Development Studies with the University of the Free State. The researcher has sound communication skills and has experience in interviewing processes (Greeff, 2011:368). The researcher also possesses a fairly developed understanding of the phenomenon he wished to study which aided in the research process Strydom (2011c:115)

3.3.7 Publication of findings

The researcher compiled a report as accurately and objectively as possible. The researcher ensured this by not manipulating the results (Strydom, 2011b:126). The researcher also mentioned the shortcomings and limitations of the study (Rubin & Babbie, 2011:84). The findings were also revealed to participants and Department of Social Development Sedibeng District management as a form of recognition and

gratitude, and to maintain future good relationships with the community (Strydom, 2011b:126). The researcher also acknowledged the work of others which he consulted and correctly referenced to avoid plagiarism (Strydom, 2011b:126). Study participants were also informed of the researcher's intentions to publish a paper emanating from the findings of the study.

3.4 SECTION 1: EMPIRICAL FINDINGS

The purpose of this section is to present and interpret the qualitative data obtained from the interviews with the participants in the study; that is, Social Auxiliary Workers working with children living with HIV within drop-in-centres. As data was being processed and analysed, there were recurrent themes and sub-themes that were raised by the participants and specific trends and patterns emerged. The empirical findings of the study will therefore be presented in two main sections; first the biographical information of the participants and, second, the themes and sub-themes from the data that was obtained during the interviews. Findings will be supported and substantiated by direct quotes in order to give voice to the views of the participants. The key findings will also be highlighted and substantiated with literature in the final discussion of the chapter. A total of 10 Social Auxiliary Workers participated in the study.

3.4.1 Biographical profile of participants

The biographical profile of the 10 participants is displayed below. Their profile includes the following variables: gender, age, years of qualification as a Social Auxiliary Worker and years of experience working in a drop-in centre.

3.4.1.1 Gender composition of participants

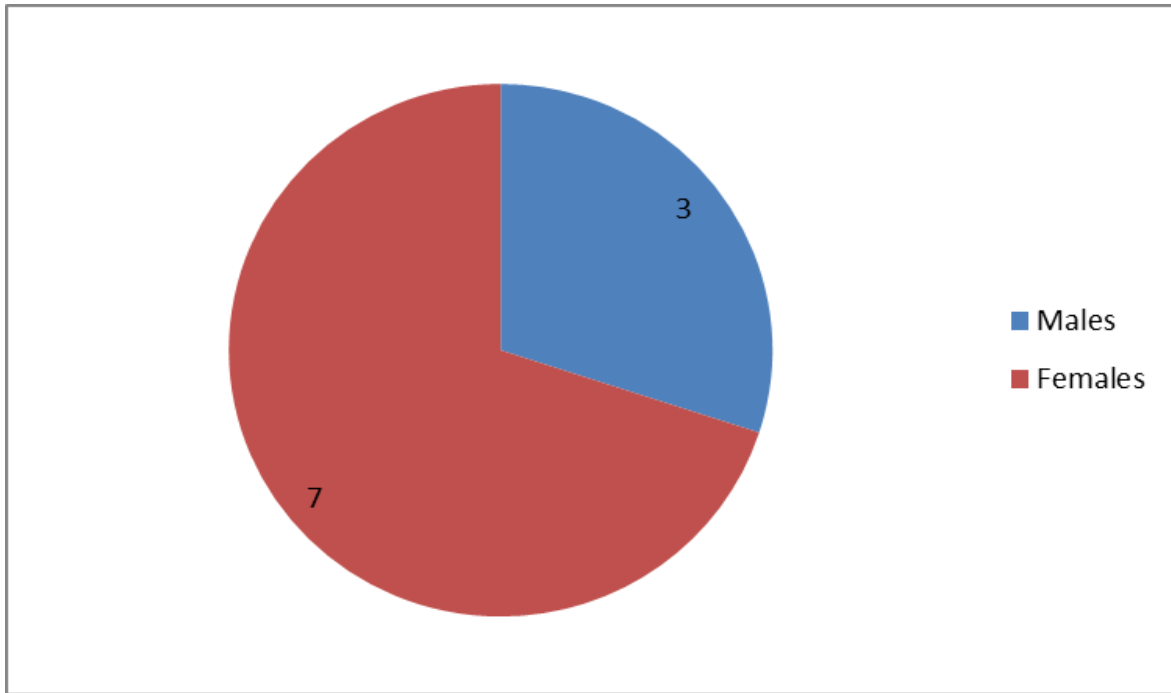


Figure 3.1: Gender composition of participants

Figure 3.1 above illustrates that, out of the 10 participants 7 were female and only 3 were male. This was expected because females currently dominate the social welfare sector (Fischl, 2013). Men typically consider social welfare professions, such as Social Auxiliary Work, to be feminine occupations as much of the jobs involves addressing insecurities and hidden issues, which contradicts backgrounds of many men, who on growing up, were taught to mask their emotions and discouraged to talk about their feelings and insecurities (Fischl, 2013).

3.4.1.2 Age distribution of participants

Of the 10 participants, none were between the ages of 38 to 42 and 43 years and above. Of the participants, 5 were between the ages of 26 to 31; 4 were between the ages of 32 to 37. There was only one participant who was between the ages of 20 to 25. The ages of participants are visually presented in the bar-graph below.

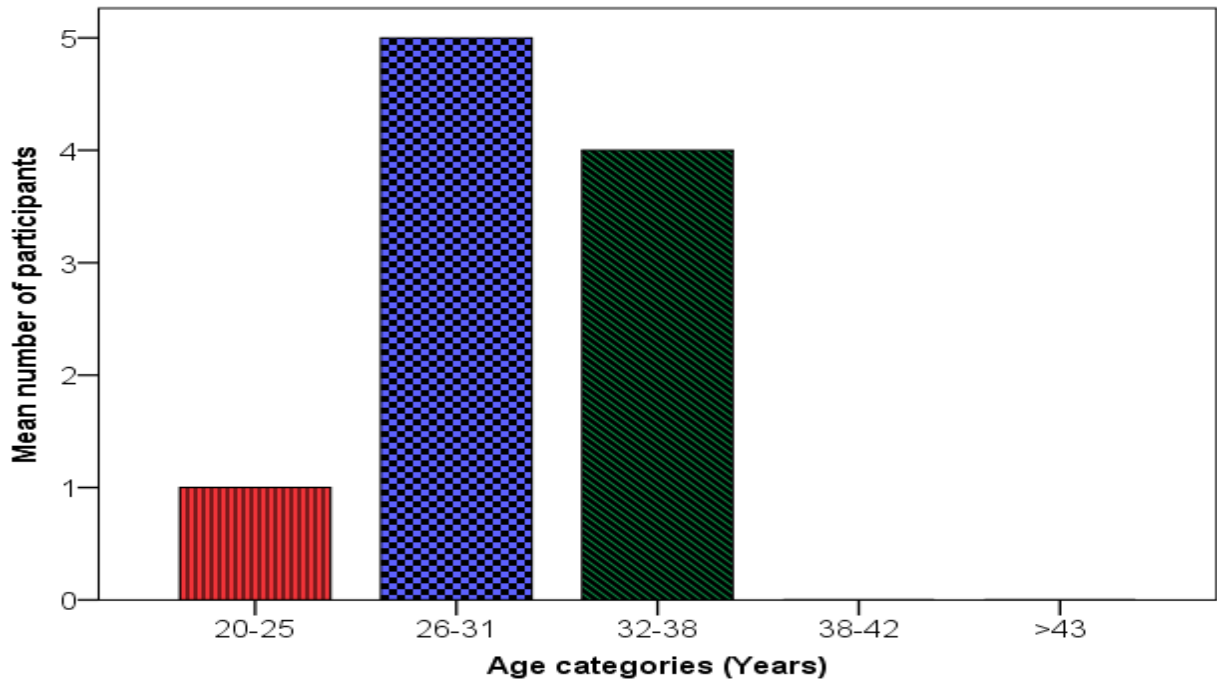


Figure 3.2: Age distribution of participant

The absence of participants between the ages of 38 to 43 years and above may be because Social Auxiliary Workers in this age group are more likely to have branched to occupying more senior and/or different roles in government departments or other related social welfare sectors.

3.4.1.3 Year of qualification as Social Auxiliary Worker

Of the 10 participants, 4 qualified as Social Auxiliary Worker in the year 2008, 3 in year 2009, 1 in year 2010 and 2 qualified in year 2013. The year of qualification and age of participants are visually presented in the clustered bar chart below.

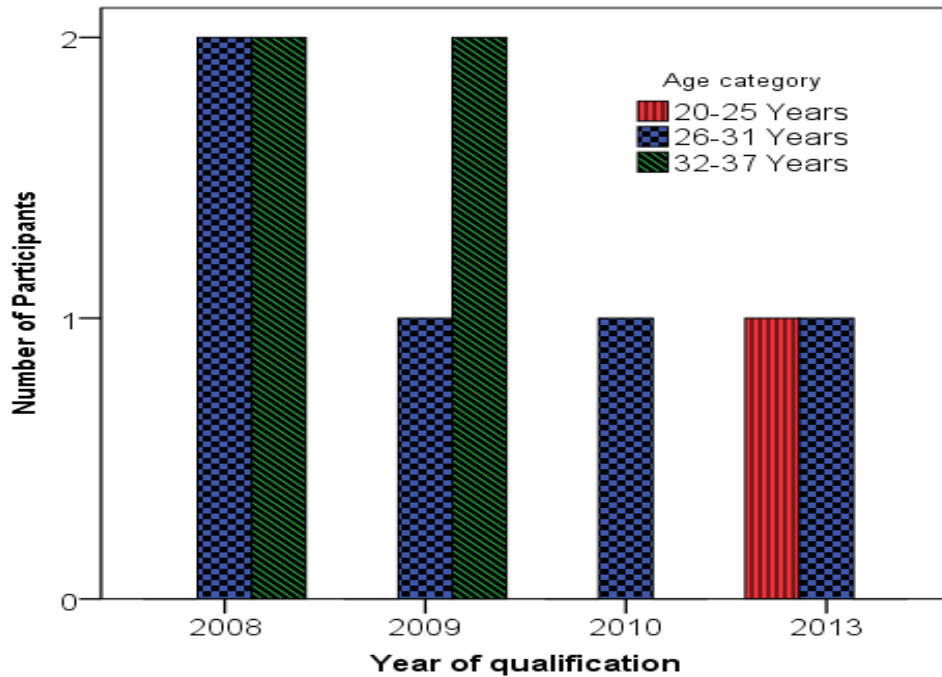


Figure 3.3: Year of qualification and age of participants

3.4.1.4 Years of employment in a drop-in-centre

In the context of years of employment in a drop-in-centre, 5 of the participants had been employed for six years; whilst 2 participants had been employed for five years; 2 had been employed for two years; and there was only 1 participant who had been employed for four years. The researcher viewed the cause of these results being that one of the criteria for participant selection was that participants had to have been employed for at one year in a drop-in-centre. The participants' years of employment in a drop-in-centre are visually presented in the table below.

Table 3.1: Participants' years of employment in a drop-in-centre

Years of employment in a drop-in-centre	Number of participants
6	5
5	2
2	2
4	1

3.5 SECTION 2: EMPIRICAL FINDINGS

Main themes and sub-themes were identified during data analysis and are presented in this section. The themes and sub-themes are summarised in Table 3.2 below. The themes provide answers to the research question for the study, which was: What are the perceptions of Social Auxiliary Workers on their role and competencies in addressing the biopsychosocial needs of children living with HIV at drop-in-centres? These findings will be supported and substantiated by direct quotes in order to give voice to the views of the participants. The key findings will be highlighted and substantiated with literature in the final discussion of the chapter.

The researcher identified the following themes and sub-themes from the transcripts:

Table 3.2: Summary of identified themes and sub-themes

Themes	Sub-themes
Theme 1 Biological needs of children living with HIV	1.1 Limited access to medication. 1.2 Poor nutrition. 1.3 Opportunistic infections.
Theme 2 Psychological needs of children living with HIV	2.1 Mental health, anxiety and depression.
Theme 3 Social needs of children living with HIV	3.1 Non-disclosure by parents. 3.2 Stigma and discrimination. 3.3 Education and schooling needs. 3.4 Health facilities challenges.
Theme 4 Economic needs of children living with HIV	4.1 Poverty and unmet material needs.



Theme 5 Transitioning into adolescence	
Theme 6 Roles and competencies of Social Auxiliary Workers	<ul style="list-style-type: none">6.1 Preventive interventions to contribute to the maintenance of health and the prevention of diseases.6.2 Psychosocial care and support.6.3 Counselling.6.4 Treatment support and Running support groups.6.5 Provision of basic material needs.6.6 School attendance and homework support.6.7 Life skills development.6.8 Facilitating referral of clients to resource systems.
Theme 7 Strategies regarding improvement of Social Auxiliary Work services to children living with HIV	<ul style="list-style-type: none">7.1 Training on HIV for all Social Auxiliary Workers working with children living with HIV.7.2 Strengthened supervision and debriefing sessions.7.3 Community mobilisation and education to address stigma and discrimination.7.4 Increased funding for Drop-in-centres.

Seven main themes, each with a number of sub-themes, were identified from the data. The first five main themes focused mainly on the biopsychosocial needs of children living with HIV and the impact they have on the well-being of the children if they are unmet. Theme six focussed on the roles, knowledge and skills of Social

Auxiliary Workers, their experiences and perceived effectiveness and challenges in addressing the biopsychosocial needs of children living with HIV. The last main theme, theme seven, focused on strategies and changes required to effectively support children living with HIV within drop-in-centres.

3.5.1 Theme 1: Biological needs of children living with HIV

From the participants' responses with regards to biological needs of children living with HIV, three main ideas emerged from this theme, namely limited access to medication, poor nutrition and susceptibility to other diseases. These will be presented below in the next section as sub-themes.

Sub-theme 1.1: Limited access to medication

All the participants indicated that the society that they live in is not tailor-made for “inclusion” and “integration” of children living with HIV, which consequently creates barriers for children to access ARVs and related care and support medical services. The following quotes demonstrate the sentiments of the participants regarding limited access to medication services for children living with HIV:

- *“Most such children that I suspect are HIV positive are not on treatment because they have not been tested. Some of them their parents have died from the disease.*
- *“... Many of these children look ill and are very frail because they are not on treatment.”*
- *“We have seen the health of some children who are infected by HIV deteriorate to critical levels as they will not be on any treatment to help them fight HIV.”*

The findings revealed that there were many children that were living with HIV that were known to participants and were not receiving any medication as there was a disconnect between the views of parents and the health needs of children, a situation which ultimately resulted in children not being tested for HIV so that they get on ART treatment. The findings merge well with the global picture that has been shared by UNAIDS (2013:63) and UNICEF (2013:42) that, for various reasons, many children that are HIV positive are not accessing treatment resulting in a treatment

gap where 1.9 million children globally qualify for HIV drug treatment, but only 650,000 are receiving it.

The researcher found the following statement that was shared by one of the participant to be relatively representative of the views of many participants who had children in their care who were living with HIV but were not on any treatment:

- *“Because children lack information on their status, it is not even possible for them to know where to start in seeking for medical attention, and the parents of these children are not cooperative with us when we seek to intervene as they would not have disclosed to the children.”*

The above response has been shared by many authors such as Meyers et al. (2007:476), who have asserted that, there are many children in South Africa who are infected with HIV who are not receiving ART and are not entering HIV care and support services due to “none or late diagnosis”. The authors share similar sentiments with those of the participants in this study that, lack of knowledge and cooperation by some parents and guardians make it difficult for children living with HIV to be identified and referred into appropriate services.

In tandem with the biopsychosocial perspective, the researcher observed that the lack of information on HIV by many parents creates barriers for identification and diagnosis of HIV amongst children. This in turn, makes HIV a medical crisis of unparalleled proportion for the majority of the children living with HIV within drop-in-centres.

Sub-theme 1.2: Poor nutrition

Seven participants pointed out that children living with HIV struggled with accessing adequate nutrition, which is best achieved through consumption of a balanced healthy diet. The participants explained that, in most instances the growth and development of children living with HIV was very poor as their nutritional requirements were not being met. Participants described these situations as follows:

- *“Children with HIV do not eat well and their growth is very poor, especially here in Sedibeng where the socioeconomic circumstance of many parents is terrible due to unemployment.”*

- *“Children infected by HIV have special nutritional needs which parents cannot afford because they are poor and do not work.”*
- *“Lack of nutritious food for children with HIV is very common in our community because of poverty.”*

In line with the premise of the biopsychosocial theoretical framework that, one missing dimension in a patient’s circumstances can affect their overall health trajectory, it is clear from the above findings that participants view nutrition as playing a decisive role in the overall health and well-being of children living with HIV. The important relationship between HIV, nutrition, growth and survival of children living with HIV is emphasised by WHO (2009:07) which recommend that, nutritional assessment and support should be an integral part of the care plan of an HIV-infected child as failure to address nutritional concerns might lead to children failing to attain typical developmental milestones or developing behavioral abnormalities such as loss of concentration and memory.

The relevance of the interplay between HIV, poverty and nutrition that was cited by participants is explained by WHO (2009:07) as being very common in “resource-poor settings and a major contributor to growth faltering among HIV infected children”. Although poor socioeconomic circumstances are responsible for poor provision of food which contributes to malnutrition, growth failure, failure to thrive, or wasting in children living with HIV, WHO (2009:07) asserts that opportunistic infections can also affect food intake, absorption and metabolism and lead to weight loss and poor growth for children living with HIV. The interaction between HIV and opportunistic infections or diseases is discussed in the next sub-theme.

Sub-theme 1.3: Opportunistic infections

Four participants indicated that children living with HIV suffer from opportunistic infections that come about as a result of being infected with HIV. The participants described the situation as follows:

- *“...one of our children always suffered from one disease to another before we knew she was HIV positive. At one time she was diagnosed with tuberculosis; it was not good at all.”*

- *“Infected children are at risk of easily contracting other illnesses such as flue, tuberculosis and coughing ...”*
- *“.. positive children have diseases which makes them not to grow well like other children that are not infected with the virus”*

The above quotes are in tandem with the assertions of De Schacht et al. (2014:04) who allude to the fact that, children living with HIV are prone to other medical conditions such as pneumonia, and tuberculosis, especially if they are not on treatment. In some instances, opportunistic diseases are the earliest and most devastating markers of infection in children (Vranda & Mothi, 2013:22). In line with the arguments of the biopsychosocial perspective that ill health can only be holistically addressed if all dimensions of a disease are adequately understood (Cohen & Brown, 2010:24), the researcher observed that, as much as the study participants appreciated the need to address opportunistic infections, they also acknowledged that this should not be done in isolation, treating HIV itself should be a priority as HIV is the host and precursor to opportunistic infections (De Schacht et al., 2014:04).

3.5.2 Theme 2: Psychological needs of children living with HIV

HIV was noted to pose a direct threat to the psychological health, functioning, and well-being of children living with HIV, particularly given the burden of stigma, poverty, and stressors related to consequences of living with HIV.

Sub-theme 2.1: Mental health, anxiety and depression

Four participants indicated that it is common for children that are living with HIV to experience mental, emotional, anxiety and depression disorders that are as a result of the struggles they go through in their lives. Participants mentioned that the mental health disorders that children face are directly related to the social determinants of health (such as stigma, poverty and orphanhood) and psychosocial stressors related to living with HIV. One participant mentioned the following:

- *“The three children that I know to be HIV positive in our drop-in-centre do not listen or pay attention to details when we are having our activities. They always look distracted and they are very sad and distant; it is as if they have some mental problems”*

Another participant, who caters for a child living with HIV who is attending school explained that she learnt about most of the mental health problems of the child through the class teacher who expressed concern that:

- *“The child was emotional and expressed many behavioral problems, and was always anxious and socially withdrawn from other children in her class”*

The above experiences that were described by participants are in line with the observations of an HIV and Child Mental Health Case-Control Study that was done in Rwanda by Betancourt, Scorza, Kanyanganzi, Fawzi, Sezibera, Cyamatare, Beardslee, Stulac, Bizimana, Stevenson and Kayiteshonga (2014:467) that concluded that, “HIV positive children have higher levels of depression, mental disorders, anxiety, conduct problems, and functional impairment compared with HIV unaffected children”. In tandem with the principle of “complex interactions” between biological, psychological, and social factors as proposed by the biopsychosocial theoretical framework (Borrell-Carrió et al. 2004:04), it should be noted that HIV, especially when untreated, is likely to have an impact on both the brain and the central nervous system, which could be a sequelae to mental disorders. The researcher supports the idea that clinician and caregiving staff should always systematically consider this principle when exploring factors that contribute to mental disorders that are experienced by children living with HIV.

3.5.3 Theme 3: Social needs of children living with HIV

The participants recognised that most of the social problems faced by children living with HIV are exacerbated by the fact that parents and families are not doing well enough when it comes to disclosing HIV diagnosis to children, thereby creating platforms that breed stigma and discrimination for children living with HIV. The challenges posed by non-disclosure, stigma and discrimination are presented the following sub-themes.

Sub-theme 3.1: Non-disclosure by parents

All participants cited issues of non-disclosure of children’s HIV positive status by parents as the most difficult challenge that the children have to put up with as it impacts not only on children’s understanding of their HIV status; but access to health

services and adherence to medication for those children that might be on ART. Some of the responses that were obtained from participants are as follows:

- *“Parents do not tell their children that they have HIV and this makes it difficult for us and other community members to help the children to deal with their status.”*
- *“It is not fair that parents are not disclosing the HIV status of their children ...”*
- *“Many of the parents abuse and misunderstand the concept of confidentiality, when we try to intervene and help the children they can threaten you with legal action as they want the HIV status of their children to remain a secret.”*
- *“There are lots of misconceptions about HIV on the part of parents and caregivers which lead to secrecy and non-disclosure, which in turn puts infected children at risk of not being able to access treatment.”*

The responses indicated above are confirmed by Bikaako-Kajura, Luyirika, Parcell, Downing, Kaharuza, Mermin, Malamba and Bunnell (2006:86) that engaged in a study that sought to assess “Disclosure of HIV status and adherence to daily drug regimens among HIV-infected children in Uganda”. The study revealed that, lack of disclosure create interpersonal and intrapersonal conflict as it does not allow for open conversations about living with HIV between parent and child, thereby blocking avenues for children to access medication and social support. As mentioned by some participants above, not discussing HIV and disclosing a child’s positive status can create a context of secrecy, mistrust, and confusion and put the child at risk for negative health outcomes (Rwemisisi, Wolff, Coutinho, Grosskurth & Whitworth, 2008:37). Besides refusal to take medication, for those children that might be on ART, some of the adverse outcomes of non-disclosure that parents might need to contend with include, decreased trust between child and parent, and feelings of fear, anxiety, and resentment towards both the medication and the parent by the child (Bikaako-Kajura et al., 2006:87)

It was also interesting to note that two participants particularly raised the principle of confidentiality as being an inadvertent excuse that many parents are using to avoid disclosing their children’s status. Kyaddondo, Wanyenze, Kinsman and Hardon (2013:39) assert that, many parents may be reluctant to disclose their own HIV status due to fears of “losing face” in the community and their children’s eyes, and

they would rather “keep the secret” private even if it is at the risk of creating negative health outcomes for their children.

The following response that the researcher got from one of the participants must receive some further attention:

- “... *Because of non-disclosure some children rebel against their parents by choosing not to take their medication, which exposes their bodies to ART resistance.*”

It is clear from the response above that children need disclosure of their HIV status in order to help them understand their illness, and to mold them to be active and informed participants in their own care (Biadgilign, Deribew, Amberbir, Escudero and Deribe, 2011:02). This finding is also supported by Kyaddondo et al. (2013:41) who notes that, children who are uninformed about their HIV-positive status and who are on ART may refuse to continue taking their medication until they are told what disease they have, and why they are taking the medication they are on.

The present researcher observes that the findings substantiate the biopsychosocial perspective principle of mutual influence and reciprocal causality (Germain, 1991:68), as it is evident that not only does non-disclosure affect the relationships between parents and their children; but it also inadvertently impacts on children’s willingness and commitment to adhere to their HIV treatment.

Kyaddondo et al. (2013:41) recommends the building of strong and trusting relationships between parents and their children as a way to help to support ART adherence for children. Lack of open disclosure of HIV status to children can create confusing and distrustful social conditions for children as some parents often resort to threats, bribery, and verbal or physical abuse to force their children to take medication, tactics which may have further negative impacts on their health outcomes of children (Kyaddondo et al., 2013:41).

Overall, the findings above show that disclosure is advantageous in improving children’s access to health services and ART adherence as children are bound to be more proactive and motivated to take responsibility on issues of their own health if they are told early of their diagnosis. It is better for children to know their status early,

preferably before age 10, as knowing their status will help them protect themselves and others (Biadgilign et al., 2011:03).

Sub-theme 3.2: Stigma and discrimination

There were an overwhelming number of participants who cited stigma and discrimination as the biggest enemy that children living with HIV encounter in their daily lives. The seriousness of stigma, isolation and discrimination on children living with HIV are summarised in the following quotes:

- *“In our community, some community members do not want their children to mix with children suspected of having HIV ... they even tell their children not to play with those children.”*
- *“... Children with HIV do not have friends, they are isolated and stigmatised.”*
- *“As Social Auxiliary Workers we are also afraid that they can get hurt during playtime and infect other children.”*
- *“Discrimination is a reality for children that have HIV especially in schools where teachers and other pupils do not know how to relate to them.”*

The responses in this study confirm views that have been shared by numerous authors that, children living with HIV often experience stigma, isolation and are ostracised by their communities and in some instances, by close relatives who are supposed to protect them (Campbell, Foulis, Maimane & Sibiyi, 2005:809). The fact that some community members do not want their children to mix with children suspected of having HIV, illustrates not only that there is still a lot of inaccurate information about how HIV is transmitted, but also that HIV is perceived to be a life threatening disease. The researcher found it even more concerning that one Social Auxiliary Worker was not sure whether she should allow children living with HIV to freely mix and play with other children as she feared that they “can get hurt during playtime and infect other children.”

The following responses that were obtained from two of the participants demand further analysis:

- *“Stigma from communities and non-understanding of HIV forces parents to lie about the condition of their children who are HIV positive. I remember one scenario when we had to go with children to a camp and we had to sleep over*

for two days. One parent brought some medication and said we must give it to her child every day at seven o'clock in the evening. She emphasised that her child had a problem of "falling", meaning the child had epilepsy. However when I looked at the medication I knew they were ARVs as my nephew who has HIV is taking the exact medication. It was clear that the mother did not want us to know that her child was HIV positive, and would rather prefer her child had any other disease besides HIV."

- *"Stigma is a big issue within families; parents hide the medication that the children take as they do not want anyone outside the family to know of the children status."*

In line with the suggestion of the biopsychosocial perspective to understand the complex interdependency and interplay between variables (Dale et al., 2006:13), the researcher observed that stigma and discrimination were probably the most important factors that participants used to interpret and delineate social needs for children living with HIV. The responses that were obtained from participants illustrate that for children living with HIV, stigma and discrimination is a double-edged knife as the children do not only have to experience stigma and isolation at the level of society (institutional stigma), but they also have to contend with stigma and discrimination that exists at the family level that is as a result of fear and ignorance of the disease. This finding is in line with the assertion made by Whyte, Alber and van der Geest (2008:12) that, within many social contexts in Africa, HIV stigma still persists amongst children living with HIV within families as HIV is regarded as a "sexual disease", and as such; "it is not culturally acceptable to talk about sexual matters between family generations, especially to children".

Similar views are shared by Kyaddondo et al. (2013:43) who assert that, for parents who have children that are infected with HIV; matters are complicated by the fact that in African communities HIV is continuously represented as an illness which is a stigmatised punishment for deviant sexual behaviours. Many parents are therefore reluctant to disclose their children's HIV status due to fears of having to explain one's own past personal sexual actions, which may be judged and seen as being immoral or promiscuous (Whyte et al., 2008:12). The aforementioned point is crucial in highlighting the fear of social censure and the psychological internalisation of shame,

guilt, and sadness that is brought about by the complex but mutually reinforcing inter-linkages between HIV stigma and non-disclosure. This is also in tandem with the statement by the United Nations Secretary-General, Ban Ki Moon (2008) that, "Stigma remains the single most important barrier to public action ... it helps make AIDS the silent" (UNAIDS, 2013:67). Given these serious consequences, further research into the relationship between stigma and non-disclosure is recommended as they remain as significant inhibitors of HIV care and service access for children.

Sub-theme 3.3: Education and schooling needs

Most of the participants viewed HIV as a factor that hinders children from effectively accessing and participating in educational and schooling activities. The participants commented that children living with HIV are faced with challenges such as absenteeism from school, school dropout, illness and stigmatisation. The following are some of the responses that were given:

- *"Schools lack support systems. For example, teachers at school do not know how to handle or support children that are living with HIV."*
- *"Positive children have educational needs due to poverty ... parents are not resourced to buy school uniforms, scholastic material and equipment needed for educational purposes."*
- *"Children infected by HIV miss many days of schooling due to illness."*
- *"Children living with HIV drop out of school because they are constantly ill."*

In line with the biopsychosocial perspective's principle of "cause-and-effect", the research responses indicate the intricate relationship between children's HIV status, poverty and educational systems (Midgley, 2003:112). Participants noted that, not only do children living with HIV have to battle with illnesses related to their status, but they also performed poorly in school because their teachers are not knowledgeable on how to assist them. The researcher observed that the vulnerability of children living with HIV is further increased by the fact that they come from poor families who cannot afford to provide them with basic educational resources or materials.

The responses therefore confirms observations by Gicharu, Mwaniki, Kibui, Gichuhi, and Kahiga (2015:17) that came out of a study in Kenya that investigated the effects of HIV and AIDS on academic performance of children; which indicated that there

was an increase in the number of pupils dropping out of school and there was a dip in school attendance due to various HIV related phenomena that affected infected children such as personal illness, discrimination, stigma and declining financial support from parents. Gicharu et al. (2015:19) also affirm that “lack of essential learning resources and conscientised teachers” in poor settings contributes to poor performance of pupils infected by HIV and overall “put a strain on their educational rights”.

Sub-theme 3.4: Health facilities challenges

One of the participants mentioned that some people in her community always complain that the health care staff (nurses) at their local clinic has a negative attitude towards patients. The participant suggested that this could be a factor that is contributing to non-disclosure and lack of co-operation from parents of children that are living with HIV. The following quote demonstrate the sentiment of the participant:

- *“People complain of the poor quality of care and the negative staff attitudes by clinic staff which makes it difficult for them to go to the clinic and openly discuss their children’s issues with us.”*

Holzemer, Makoae, Greeff, Dlamini, Kohi, Chirwa, Naidoo, Cuca, Uys, and Durheim (2009:62) suggest that, it is possible that dealing with HIV patients places high work-related demands and strain among staff in health care facilities (nurses), which may contribute to the nurses experiencing physical, emotional and/or mental exhaustion (burnout), which could consequently be experienced by patients as poor service. In the context of HIV this could alienate patients and communities further from health services Holzemer et al. (2009:63).

In the context of the biopsychosocial theoretical framework, the responses above bring out the trans-interdependency and transacting nature between various professions or disciplines and how they mutually influence the HIV phenomenon (Midgley, 2003:112). Although the factors being raised in the findings are outside the scope of this study, the researcher recommends that separate studies be done to figure out how challenges experienced by people at health care facilities could be addressed so as to improve the uptake of HIV treatment and care services for children living with HIV.

3.5.4 Theme 4: Economic needs of children living with HIV

Poverty was also seen as a key challenge that inhibits children living with HIV from attaining basic physiological needs. Hazell and Haddad (2001) define poverty as the, “inability of individuals to meet or achieve their basic material and physiological needs which can be measured either as a lack of income, which limits access to food and to education, health, housing, water and sanitation services or by the failure to achieve desired outcomes, such as a high quality diet rich in micronutrients, health status, educational attainment and the quality of health, water and sanitation services received.” The impact of poverty on the economic well-being of children living with HIV is discussed in the sub-theme below.

Sub-theme 4.1: Poverty and unmet material needs

Six participants noted that most children living with HIV in their communities tend to come from poorer households where their parents and guardians are not employed. The following responses from the participants indicate how poverty reinforces and aggravates many of the vulnerabilities that children living with HIV encounter in their lives:

- *“There is very high unemployment in our community which makes it easy for children in our communities to experience hunger on a daily basis and suffer from malnutrition.”*
- *“Some of the parents of HIV positive children are themselves ill and they cannot work to provide food and clothing to their children.”*
- *“The conditions in the shacks where some families live are not hygienic for children that have illnesses such as HIV.”*
- *“Here in Sedibeng many families live in poverty and they cannot afford adequate food for their children. Unfortunately those children that are on anti-retroviral treatment should eat a lot of food, food that is not available in their homes.”*

The responses are in line with observations that have been made by various researches that, poverty exacerbates the disintegration of the socioeconomic situation of children living with HIV by weakening their potential social and economic support systems (Hall, 2012:86). The fact that more than half of the participants in this study cited poverty to be a major threat to the health and well-being of children

living with HIV, authenticates the assertion by Mokgatle and Madiba (2015:02) that, the majority of children that are infected by HIV in South Africa are from provinces and districts that are characterized by unemployment and poverty. Poverty, unemployment and underemployment in households can result in children living with HIV experiencing poor levels of nutrition, food insecurity and malnutrition (Mokgatle & Madiba., 2015:04). Compared to employed parents, unemployed parents cannot provide the basic needs such as health care, basic food, clothing, shelter and education needed for the good health and development of their children (Hall, 2012:87).

In agreement with the guidelines of biopsychosocial perspective for researchers to systematically comprehend the complex interactions between various factors if the they are to competently interpret research phenomena, the researcher observed that poverty and unemployment of parents were presented as decisive factors that, generally, determine socio-economic circumstances of communities and families, and more specifically, define the overall health and wellbeing of children living with HIV.

3.5.5 Theme 5: Transitioning into adolescence

Related to the above sub-theme, six participants noted that children who were born with HIV and were transitioning into adolescence presented the most difficult circumstances for them to work with. At one drop-in-centre the participant noted that she was aware of five adolescents that were living with HIV, two were not on medication, and the three that were on medication had not been disclosed to by their parents; meaning to say they found out on their own that the medication they were taking was for HIV. The participant expressed concern that the adolescents were now expressing various behavioural problems that they did not know how to deal with such as substance abuse, bunking school, criminal activity and, for those that were on treatment, defaulting from medication. The participants explained that the adolescents were being difficult as a way of “revolting” against their parents whom they blamed and resented for passing the HIV virus to them. Some of the statements that came from participants that illustrate the points above are as follows:

- *“Because of non-disclosure some children getting into teenage hood rebel against their parents by choosing not to take their medication, which exposes their bodies to ART resistance.”*
- *“Rebellion against treatment, conflicts with parents and substance abuse is common, especially when the children turn into teenagers ...”*

The responses that children living with HIV had higher chances of presenting various behavioural problems when they transition into adolescence, especially when they have not been engaged on their HIV status, are supported by Tassiopoulos, Moscicki, Mellins, Kacanek, Malee, Allison, Hazra, Siberry, Smith, Paul, Van Dyke, and Seage (2012:284) who allude to the fact that, sexual risk behaviour among adolescence or teenagers with perinatal HIV infection was very high, especially where parents lacked skills and knowledge on engaging the adolescent children. Engaging in early sexual intercourse that is not protected, ARV non-adherence, non-disclosure of HIV status to sexual partners; thereby placing their partners at risk for HIV infection with drug-resistant virus, are argued to be some of the presenting sexual risk behaviours amongst adolescence with perinatal HIV infection (Tassiopoulos et al. (2012:286).

The following statements were obtained from one of the participants:

- *“Children that are reaching puberty stage are the most problematic as they have tendencies to isolate themselves, rebel and present a lot of behavioural problems because they view themselves as different from others.”*
- *“Some of the older children that have HIV do not listen to our advice as they are falling pregnant, which means they are having unprotected sex. They are passing the disease to others.”*

The responses above that adolescents that are HIV positive have tendencies to isolate themselves and present a lot of behavioural problems because they view themselves as different from others are in line with the observations of Louw and Louw, (2007:279) that, if adolescents are HIV positive and are not on antiretroviral treatment, their physical development may be delayed, and they may look different from their peers, a factor which may adversely affect their peer attachment and bonding. Battles and Weiner (2002:165) also back the responses by noting that,

while the period of adolescence transition can be challenging for all young people, the issues are particularly complex for those who have are living with HIV. In addition to the established physical, developmental and cognitive difficulties that can result from living with HIV, adolescents can confront anxieties related to fitting in with their peers, disclosing their status to others, particularly to potential sexual partners, and negotiating the use of protection to prevent transmission to others or re-infection to themselves. Put simply, the responses above highlight that as children living with HIV transition into adolescence, they struggle particularly with making decisions about their romantic relationships, reproductive health and sexual activities.

In line with the encouragement of the biopsychosocial perspective for researchers to come up with “solution-focussed philosophical assumptions”, the researcher encourages the Department of Social Development to consider systematically running specialised trainings on adolescence for Social Auxiliary Workers (Borrell-Carrió et al., 2004:04). It is the researcher’s assumption that such trainings will equip Social Auxiliary Workers with skills to competently handle the complexities posed by the adolescence stage and the impact that the complexities exert on the abilities of adolescents to access health care services.

3.5.6 Theme 6: Role and competencies of Social Auxiliary Workers in working with children living with HIV at drop-in-centres

From the participants’ responses with regards to their role and competencies, the researcher identified eight roles that characterises the work of Social Auxiliary Workers that are working with children living with HIV at drop-in-centres. The eight roles are: preventive interventions to contribute to the maintenance of health and the prevention of diseases, psychosocial care and support, provision of basic material needs, facilitating referral of clients to resource systems, life skills development, school attendance and homework support, treatment support and running support groups. The perceptions of the Social Auxiliary Workers in regards to their competencies in performing their identified role are discussed below as sub-themes.

Sub-theme 6.1: Preventive interventions to contribute to the maintenance of health and the prevention of diseases

A total of eight research participants acknowledged that, when it comes to children living with HIV they had a “preventive” role that they were playing in order to contribute to the maintenance of health and the prevention of diseases in the lives of children. The Social Auxiliary Workers variedly described “preventive” role but all of them seemed to suggest that these were treatment adherence and access to health services support activities that were meant to “prevent” children known to be living with HIV from sliding further into attack or infection by other diseases by ensuring they adhere to their medication. The following participants’ views capture this theme as follows:

- *“For the two children that are HIV positive that I work with, I make sure I do regular home visits to check if the children are taking their medication so that they stay strong and don’t get attacked by other opportunistic diseases.”*
- *I help HIV infected children by doing health monitoring of their adherence, especially those children that are living with grannies.”*
- *My role include following up with the family to take the children for scheduled check-ups at the clinic.”*

The responses indicate that, in cases where Social Auxiliary Workers know the status of children and there is open communication with the parents or guardians of the children, supportive home visits are done by the the Social Auxiliary Workers to ensure the children are taking their medication and they are not missing their clinic visits. The responses are supported by Jamieson and Berry (2012:26) who state that preventive interventions rendered by drop-in centres should be in the context of the Primary Health Care Policy (Department of Health, 1997) which states that the services of drop-in centres staff should be to strengthen health outcomes for children living with HIV by ensuring they have access to health, counselling, treatment and rehabilitation services.

On being asked their opinion on how effective they were in their “preventive” role, the Social Auxiliary Workers had the following to say:

- *“Our support services to HIV infected children only work when their families are welcoming to us, unfortunately some family members do not want to*

welcome us in their homes due to stigma issues and we cannot force ourselves on them.”

- *“It is a struggle to support children living with HIV since most of them do not know that they have HIV as their parents have not told them, and we do not know how to handle such situations.”*

The responses show that effectiveness of Social Auxiliary Workers to provide supportive and “preventive” health services to children living with HIV is constrained by the unwillingness of some parents to disclose the condition to the children; and refusing to have the Social Auxiliary Workers visit the children. This is in contradiction to the Children’s Act, Section 144(1), that prescribes that prevention and early intervention programmes should be aimed at strengthening and supporting families with children in difficult circumstances so that problems can be prevented from escalating (Jamieson & and Berry, 2012:26).

Participants noted that, as Social Auxiliary Workers they did not think they have the skills to deal with most parents that tend to be protective and resist disclosure to their children, a situation that makes it impossible for them to support children living with HIV. This is reflected by the following quotes:

- *“I do not know how to handle parents of HIV positive children who do not cooperate with us in our efforts to help their children.”*
- *“I have not been trained on how to equip parents with skills to look after HIV infected children and prevent further suffering for these children.”*

The above quotes provide insights into conditions that impact on the ability of Social Auxiliary Workers to render good quality care to Children living with HIV. Social Auxiliary Workers who participated in the study felt that they are unsupported in their practice and quest to provide preventive interventions to Children living with HIV as they do not have knowledge and skills to handle issues of disclosure and social effects of stigma in interventions targeted at families that have children living with HIV. The researcher observed that the call to adopt or implement “holistic conceptual frameworks” as advocated for by the biopsychosocial theoretical framework that was used to interpret the findings of this study, was not put into practice by Social Auxiliary Workers as they lacked pre-requisite knowledge and skills to make

significant contributions in preventing ill-health, particularly in the sphere of HIV (Midgley, 2003:112).

The above responses are also supported by Yeap et al. (2010:1102) who assert that, despite research which advocates for a well trained staff, which can then facilitate improved HIV service delivery and care to children, there is a dire lack of HIV-specific skills training and knowledge, which compromises effectiveness of the day-to-day activities that community based staff have to undertake for families and children infected and affected by HIV. It can also thus be said, there is a significant discrepancy between the type of “preventive” role that the Children’s Act, Section 144(1) expects caregiving staff, such as Social Auxiliary Workers, to perform and the level of HIV knowledge and skills that they possess.

Sub-theme 6.2: Psychosocial care and support

All participants pointed out that they do psychosocial care and support programmes to address the needs of children living with HIV. The activities of what constitutes psychosocial care and support roles differed amongst participants. The following quotes demonstrate this:

- *“We offer emotional, spiritual and social support by doing home visits to the homes of children infected by HIV.”*
- *“By talking and listening to the concerns of HIV positive children, it can be said we are supporting them psychologically as well as emotionally.”*
- *“Children come to our centre to eat cooked food and get food parcels, and this is an important element of fulfilling our psychosocial care and support role as a drop-in-centre.”*
- *“I do counselling with HIV positive children as part of our psychosocial care and support programmes. We also give them food parcels and clothes and school material that we get as donations from supermarkets.”*

The responses above indicate that, the definition and understanding of psychosocial care and support amongst Social Auxiliary workers working with children living with HIV within drop-in-centres is varied and not standardised. Participants cited giving cooked meals and food parcels, doing home visits, assisting with school homework, giving clothes and other material assistance; as well as “talking” to children as key

activities that, when provided either individually or collectively, comprise psychosocial care and support. The fact that there was not one clear uniform and objective view of defining psychosocial care and support amongst the study participants displays the “social complexity” that is also attached to measuring the effectiveness (competencies) of Social Auxiliary Workers rendering psychosocial services within drop-in-centres as views were different depending on one’s own experience and meaning.

The above responses confirm the views of Yeap et al. (2010:1105) who note that, as much as there is a desire amongst drop-in-centres to holistically design and implement multi-initiatives that address dynamic social complexities affecting children, the lack of boundaries and common definition of “Psychosocial care and support” creates a problem situation for caregiving staff, who would not know what to focus on, and how to measure their effectiveness (competency) in identified aspects.

Utilising the biopsychosocial theoretical framework, the researcher observed that as much as there is need to juxtapose factors so as to establish their interconnectedness, when it comes to practice there is need to simplify the delineation of the factors. This is very important particularly for lower level paraprofessionals, such as Social auxiliary Workers, who might not have received adequate trainings in high level concepts such as psychosocial care and support, but are still expected to deliver comprehensive services to their clientele.

Sub-theme 6.3: Counselling

A total of eight participants stated that counselling children living with HIV was one of their major roles. Participants mentioned the following:

- *“I do basic counselling with the children to support them emotionally and socially.”*
- *“I go to do home visits and talk with children and parents as part of counselling.”*
- *“I give support to families with positive children. This support has been mostly counselling and moral...”*
- *“I encourage the children and stand by them as part of spiritual and emotional support and counselling ...”*

The responses show that “Counselling” as a concept was understood differently by participants. The responses are in line with the observations of Igumbor, Scheepers, Ebrahim, Jason and Grimwood (2011:233) that, delivery of HIV counselling services for children remains an uphill task for many child caregiving workers in HIV endemic countries because of definitional challenges, and the situation is made all the more difficult because of the myriad of uses and activities for which the term “counselling” is applied. In this study the researcher equally noted that the term “counselling” is used loosely by Social Auxiliary Workers to refer to basic-lay-counselling and practical emotional support and care services given to children; as opposed to the professional and therapeutic counselling services that are supposed to be done, say by Psychologists or Social Workers. In South Africa counselling is not deemed a domain in the realm of Social Auxiliary Work practice as DSD and SACSSP (2012:34) clearly state that “the Social Auxiliary Worker does not provide therapeutic services, but provides supportive services.”

Commenting on their effectiveness in the counselling role, some participants had the following to say:

- *“I have not received any training in counselling children that have HIV ...”*
- *“I have never received any training in communicating and counselling children with HIV, so I don’t know how to reach out to them and establish connection to their problems.”*
- *Counselling children is very difficult as one needs some special skills which we do not have as Social Auxiliary Workers.”*
- *My knowledge on HIV and children is limited, so I just speak to them in general terms.”*

The above views are confirmed by Igumbor et al. (2011:235) who emphasise that, there is lack of counselling skills resulting in poor pediatric HIV service delivery and care in South African communities because many community caregiving staff, such as Social Auxiliary Workers, have very limited HIV knowledge and skills to benefit them in terms of their day-to-day practice. Participants highlighted that if they are to improve their services for children living with HIV they would need training in child-HIV-counselling skills, especially in the issues of facilitating disclosure, adherence support, addressing stigma, adolescence, sexuality, as well as in addressing fears

related to death and an uncertain future, in order to improve. The views of some of the participants on the above issues are captured as follows:

- *“Counselling children is emotionally moving, especially when the parents do not want to disclose the HIV status.”*
- *“Some children refuse to take their treatment and it is difficult to assist them as I don’t have information on HIV drugs.”*
- *“Teenagers who know they are HIV positive, ask questions about sexuality, whether they will marry and have children of their own It is difficult for me to answer their questions.”*
- *“Because of stigma and discrimination in our society some adolescents just don’t care; they do not adhere to medication as they say they will fall ill and die anyway It is difficult to work with them.”*

Responses show that there are various complex scenarios, which strain Social Auxiliary Workers' capacities to effectively counsel children. The issues of parental disclosure of HIV status to children was perceived by participants as delicate and complicated matter, that is worsened by the fact that the participants do not have any training to encourage appropriate disclosure practices amongst parents and family members who have children that are living with HIV. It was also highlighted by some participants that they fear negative consequences that can be brought forward by their efforts to try and dispel fear, stigma, and discrimination in families and communities as they lack professional skills and capabilities to effectively do so.

The fact that some participants reported difficulties in “counselling” children living with HIV transitioning into adolescents, particularly those who are sexually active, was equally not surprising given the fact that, in the first place, the participants had mentioned that they have not undergone any formal training in HIV counselling and care. The responses are in line with the observations of Vranda and Mothi (2013:23) who comment that, notwithstanding the fact disclosure of HIV status to children who are infected perinatally or early in their life remains difficult and controversial, many families and providers do not realize that non-disclosure over a long time can lead to severe emotional and social consequences for HIV-infected adolescents that parents or guardians are often unaware of the consequences. Vranda and Mothi (2013:23) exhort families and health care providers to realise that a child's knowledge of his or

her own HIV infection status is associated with delayed HIV disease progression, which therefore means that disclosure is a positive event for both children and their families.

In agreement with the biopsychosocial theoretical framework, the researcher observed that the findings further show the need to understand the relevance of the transactional and reciprocal relationship between counselling skills and their influence on HIV service delivery for children (Greene, 2000:36; Germain, 1991:68). To improve the capabilities of Social Auxiliary Workers to handle “the complex issues” of children living with HIV, Igumbor et al. (2011:235) advocate for universal provision of “paediatric HIV/AIDS training to address the lack of confidence and skills” that Social Auxiliary Workers have, but most importantly, to increase their professional expertise in integrating children’s issues in HIV management.

Sub-theme 6.4: Treatment support and running support groups

Five participants mentioned that they ran HIV support group as a way to educate and support treatment for children that are living with HIV and their parents. Participants mentioned that the support groups are aimed at bringing together HIV infected and affected children to talk about HIV. Some participants explained that, as support systems to children that are living with HIV, they play a vital role in the support groups by providing ongoing care, support and empowerment to the children to make informed choices about their health and psychosocial well-being. The following quotes demonstrate the experiences of participants in discharging their role in treatment support and running support groups:

- *“Although we have room to run support groups in most cases they are poorly attended as children do not want to talk about HIV due to stigma ... so we end up not having groups that focus only on HIV positive children but rather, general groups.”*
- *“The support groups are not structured so we do not have any curricula that we follow, children can just decide any topic that they want us to discuss.”*
- *“I have not received any training in running support groups, so I just use any material that I come across. Sometimes I use my phone to look from the internet.”*

The responses above show that, whereas the participants viewed support groups as a suitable platform that they could use to render HIV education, emotional and related psycho-social support activities to children that are living with HIV, they could not regard their role in running the support groups as effective as they noted that the support groups were not structured, lacked a curricula, attendance was poor due to stigma attached to them, and that themselves as Social Auxiliary Workers, had not received any training in convening and running HIV support groups with children.

The researcher observed that the concept of support groups itself is an attempt to align with the proposition that is made by the biopsychosocial theoretical framework that, patient adherence to treatment regimens can be easily supported by enrolling them in psychosocial support programmes that are holistic and responsive to their needs (Boender et al., 2012:03). It could thus be said, support groups could be essential in enhancing adherence amongst children that are already on ART (Boender et al., 2012:03).

In the context of this study, the researcher noted that Social Auxiliary Workers are not effective in their support group activities as they conduct support groups in an ad-hoc manner that is not in line with guidelines provided by DSD (2010:10) which states that, support groups should be purposeful, structured and formally organised if they are to help people with common concerns and needs to achieve their set goals. It is also noted that the establishment, management and sustainability of support groups will need to be premised on a well-trained cadre of Social Auxiliary Work (DSD, 2010:10).

Sub-theme 6.5: Provision of meals and material needs

A total of five participants noted that chief amongst roles was to fulfill DSD expectation that drop-in-centres are to provide meals, food parcels, clothing, scholastic and other material items to all needy children that come to the centres. Participants mentioned the following:

- *“As part of nutritional support I make sure all children receive cooked meals.”*
- *“We provide some material support in the form of school uniforms, shoes and writing exercise books in the case where families cannot afford.”*

Although drop-in-centres are funded by the Department of Social Development and other sources, the participants referred to a lack of funds or resources as an important factor hampering the provision of meals and material needs to children living with HIV. Participants mentioned the following:

- *“I think finance is one of the main problems that we have because what we have is not enough to adequately feed and address all material challenges of children.”*
- *“The money that we get from Social Development is not enough to buy school uniforms and shoes for those children that do not have ... We have to do fundraising but donors are difficult these days.”*

In line with the proposition of the biopsychosocial perspective and social systems theory that, children living with HIV exist in a social system that functions at different levels (Greene, 2000:37), the responses in this section are vital in illustrating the importance of roles that are played by macro-systems in the creation of circumstances or environments that either aid or hinder the addressing of the needs of children living with HIV. Although participants appreciated the support from Department of Social Development, they seemed to assert that the funding that the drop-in-centres was getting from the Department of Social Development was not sufficient to address food and material requirements of all children living with HIV. The above sentiments are supported by remarks made by Budlender and Proudlock (2011:41) that, the subsidies provided by the Department of Social Development to drop-in-centres and non-governmental organizations do not cover the full cost or scope of the social welfare services that need to be rendered and this seems to be the biggest hurdle in proper service delivery.

It can be argued that, the reality of being underfunded compromised, limited and undermined the delivery and quality of provision of meals and material assistance to children living with HIV by Social Auxiliary Workers within drop-in-centres. Budlender and Proudlock (2011:41) encourage the Department of Social Development and government to increase the funding for drop-in-centres so that the staff can be able to effectively respond to the welfare needs of children. These authors further assert that the Department of Social Development and government have the primary

responsibility to fund and establish favourable conditions within drop-in-centres so that programme staff (such as Social Auxiliary Workers) can institute effective, comprehensive poverty-reduction programmes and social services that are inclusive of poor and marginalised children, families and communities.

In concurrence with the biopsychosocial perspective, the researcher contends that the macro-system (Department of Social Development) should strengthen its funding responsibilities so as to sufficiently address the needs of the micro-system (individual children) and their mezzo-system (their families) (Greene, 2000:37). This premise of the biopsychosocial perspective is supported by the dictates of the Children's Act that enforces the provision of food as a service by drop-in-centres. Adequate government funding will thus be vital in ensuring that drop-in-centres comply with this provision (Budlender & Proudlock, 2011:41).

Sub-theme 6.6: School attendance and homework support

Six participants identified helping with school attendance and homework support as one of the role they play in working with children living with HIV. Generally, the views shared by participants insinuated that school attendance and homework support were activities that were done to ensure that children stay in school and improve their academic achievements in the face of potential barriers. Participants mentioned the following:

- *“We do homework assistance with children, which involves us helping children that are living with HIV to read and write, but also to do their school homework.”*
- *“I run after-school activities which involve life skills ... I talk in general with all children and I give them general knowledge on health and well-being, the importance of exercising and eating health food.”*
- *“I support the children to stay in school by being in constant contact with the school teachers. The teachers phone us to track the children when they miss school.”*

The responses show that the participants' role in supporting School attendance and homework completion by children after schooling hours was helpful in providing children with supervision during a time when many might be exposed to, and engage

in anti-social and destructive behaviors. This view is supported by support Schwartz (1996:21) who asserts that, children left unsupervised after school often fall prey to deviant behaviors that are harmful to them, to their schools, and to their communities.

Commenting on their effectiveness in their school attendance and homework support counselling role, some participants had the following to say:

- *“The after-school activities we do are good at broadening children’s perspectives and improving their socialisation.”*
- *“We can be effective in homework assistance if we get trainings from teachers on the current curriculum that children are learning in schools. This can perhaps help us to guide children so that they improve their academic performance.”*

In line with the views of Schwartz (1996:23) that all “after school care and homework assistance activities should be structured”, the participants’ responses above illustrate that as much as the participants perceived their role to be somewhat effective in assisting children with school attendance, they still felt that they could do more to improve academic outcomes if only they could receive “formal” trainings on current curriculum from school teachers. The researcher noted that this request could have been necessitated by the fact that many of the participants left primary and secondary school many years back and the curriculum has evolved since then. In line with the systems-orientation approach of the biopsychosocial perspective, it could also be said that the above findings highlight the importance of mutual support and co-ordination between systems (agents) that are providing services to children living with HIV.

Sub-theme 6.7: Life skills development

Three participants stated that their work with children living with HIV involved building their life skills (life skills development). The views of the participants in this regard are captured as follows:

- *“Our life skills development activities are done during homework support, we teach children to speak and to be confident in what they do.”*

- *“There is need to give HIV infected children life skills so that they can face life challenges ... although this is expected of us we do not have any training on it so we just do what we think is best.”*
- *“I also want the Department of Social Development to teach us more on life skills development so that our activities can address this when we do services with children.”*

The responses show that “Life skills development” as a concept is overly simplified by participants, who tended to view the homework assistance services that they give to children as being synonymous with life skills development. The oversimplification of the life skills development concept by participants is evident when one takes into context the definitions of life skill that are given by WHO as well as DSD. DSD (2013:36) specifies that, life skills development is based on empowering children by harnessing their own strengths, abilities, beliefs, accomplishments, values, interests and resources to be deal effectively with the demands and challenges of everyday. Examples of a core set of life skills that are at the heart of skills-based development initiatives for the promotion of health and well-being for children that are include problem solving, critical thinking, and communication/collaboration/cooperation skills (WHO, 2010:02).

The quotes above from study participants indicate that they are currently not effective in their life skills development role as they have not received any training or tools to use in performing relevant activities. The responses are confirmed by the assertions that are made by WHO (2010:03) that, life skills development activities should be focused and offered in the ambit of a curricula (framework). WHO advocates for a life skills development activities to be marshaled by staff that would have been trained on the curricula.

It is the observation of the researcher that running life skills development activities has the potential to offer Social Auxiliary Workers opportunities to address underlying psychological and social factors that might influence the abilities of children to be resilient in the face of HIV. This is in line with the premise of the biopsychosocial perspective, which affirms that people’s inner cognitive and

psychological strengths should be taken into account in order to help them to understand and adjust to their settings (Cowles, 2000:12).

Sub-theme 6.8: Facilitating referral of clients to resource systems

Seven participants mentioned that facilitating referral of children living with HIV to resource systems was a major role that was expected of them. The participants mentioned the following:

- *“HIV positive children, like other children, have many needs so we refer them to Home Affairs, SAPS (South African Police), Clinics, and SASA (South Africa Social Security Agency). These services are very far away from our community so many children and families that we refer do not go as they don’t have transport fare.”*
- *“Some children’s situations are difficult and I do a referral form and refer to psychologist. The psychologist is in private practice so some many families don’t go because they can’t afford. Only our Social Worker at DSD sometimes helps.”*
- *“We network with other CBOs for things like food and referrals ... We have churches, supermarkets and private sponsors that help us with the funding when we refer our children.”*

From the responses, it is clear that, by virtue of the nature of their profession and the type and amount of resources that are found in drop-in-centres, Social Auxiliary Workers are not able to meet all the needs of children hence they have to do referral. This is in line with the dictates of the Social Work Act, 1978 (Act 110 of 1978) which specifies that, Social Auxiliary Work is a supporting service, which implicitly imply that Social Auxiliary Workers should assist and support individuals and families to access services by facilitating referrals to resource systems, a role which involves informing, educating and enabling clients to access and utilise resources.

The participants’ responses in the above quotes also reflect on the perception held by Martin (2010:21) that, the role of facilitating referrals that Social Auxiliary Workers do has systematic limitations that are grounded in the absence of essential service providers within local communities, and in some instances where these service providers are available the referral systems that they employ are poorly defined,

which translates into poor coordination and impacts negatively on the provision and access of effective and comprehensive services to needy children and families.

In the context of the biopsychosocial model, which is based on the systems approach (Engel, 1980:535), the researcher asserts that, it is important for government departments, NGOs, CBOs and the private sector not to render services to children living with HIV in a fragmented manner. Rather, each stakeholder must have clearly defined systems that continuously interact and support the work of others (Martin, 2010:21). The researcher notes that this is also essential if duplication of services is to be avoided and referral networks are to be strengthened.

3.5.7 Theme 7: Strategies for improvement of Social Auxiliary Work services to children living with HIV

The responses that were presented in the previous themes provide evidence of the challenges that Social Auxiliary Workers encounter in working with children that are living with HIV within drop-in-centres. The challenges have effects on the role and competencies of Social Auxiliary Workers. The participants were asked to provide suggestions on strategies to improve their work in this regard. The suggestions made by the participants are discussed as the sub-themes in this section.

Sub-theme 7.1: Training on HIV for all Social Auxiliary Workers working with children living with HIV

In order to efficiently address the challenges that Social Auxiliary Workers are facing in working with children living with HIV, all participants stated that they should receive adequate training on all HIV aspects so that they become equipped to interpret, understand and handle challenges that come up with working with children that are living with HIV. The views of participants on the need to train all Social Auxiliary Workers on HIV were presented as follows:

- *“I think that all Social Auxiliary Workers should be trained on HIV so that we can effectively support children.”*
- *“We need the trainings very much and then maybe we will properly handle issues affecting children.”*

The above suggestions are supported by social welfare workers who participated in a study conducted by September and Dinbabo (2008:117). They suggested that in order to ensure proper implementation provision of services to children, there is a need for social welfare worker (Social Auxiliary Workers included) to be trained; this entails in-service training with frequent professional supervision (September & Dinbabo, 2008:117).

The suggestions are also in line with the biopsychosocial perspective's underlying theoretical assumption that, everyone who works with clients in the health field should understand how biological, psychological and social conditions influence one another. This is important to understand and interpret clients' health needs (Cowles, 2000:12). The researcher concurs with study participants that training is the best avenue that can be used to equip Social Auxiliary workers with the skills and knowledge to understand the interplays between biological, psychological and social factors in the context of children living with HIV. The need for frequent professional supervision is elaborated on in the sub-theme below.

Sub-theme 7.2: Strengthened supervision and debriefing sessions

Four participants mentioned their experiences of the supervision that they receive from their designated DSD Social Workers as having a direct bearing on their role and competencies in working with children living with HIV. Their supervision experiences are summed in the quotes below:

- *“We receive irregular supervision from Social Workers from the Department of Social Development ... the supervision is not intense and in most cases it is held offsite, and also the supervision does not focus on working with children that are infected by HIV.”*
- *“As people that work with infected children we need debriefing sessions ourselves, some experiences we share with the HIV positive children are quite traumatic.”*

The above quotes highlight that, although Social Auxiliary Workers have been discussed as being of critical importance in the provision of services to children living with HIV within drop-in-centres, the “unpredictable, non-routine, non-standardised and highly imperceptible supervision” that they receive greatly compromises their

effectiveness (Gray, 2006:57). This responses also corresponds with the assertion of Munson (2002:92) that, despite the Social Service Professions emphasis of the critical importance and value of conducting effective supervision, Social Auxiliary Workers within drop-in-centres continue to receive “unstructured, faulty and weak” supervision, subsequently leading to poor service provision (Munson, 2002:93).

In tandem with the applicability of the biopsychosocial perspective, Social Auxiliary Worker can only be effective in their work when they have received sufficient capacitation, through comprehensive supervision, abilities to interpret and manage HIV case scenarios (Novack et al., 2007:389).

In the following two sub-themes participants suggested strategies to address “other broader” factors (institutional barriers) that have an impact on their role and competencies. The researcher observed that this was in line with the underlying theoretical assumptions that underpinned this study as it validated the person-environment-systems interdependency that is advanced by the biopsychosocial model and the general systems theory (Cowles, 2000:12).

Sub-theme 7.3: Community mobilisation and education to address stigma and discrimination

Two participants noted that bigger government initiatives were needed to address the structural factors and health system barriers that entrench stigma and discrimination and inhibit children’s access to HIV care services rendered by community care workers (Cowles, 2000:11). The following quotes bring out the recommendations to address structural and institutional barriers as perceived by participants:

- *“The government should start programmes that targets and involve communities in explaining and fighting stigma and discrimination ... if this was happening it could make our work with HIV infected children easier.”*
- *“Government departments should help us to run big events in our communities to educate parents about HIV and AIDS.”*

The recommendations made by the participants affirm the assertions made by Holzemer et al. (2009:79) that, community mobilisation and education against stigma and other cultural practices that disenfranchise people infected by HIV should be

done at a bigger scale and should be spearheaded by government. The authors explain that, it is difficult to effectively disseminate HIV education in “hard-to-reach” communities due to the dwindling effectiveness of traditional communication strategies such as print and radio. Government led and supported HIV communication and programmes has potential to lead to improved service provision and uptake of HIV services (Holzemer et al., 2009:79).

The responses above show the validity of the suggestion made by the biopsychosocial model that, for effective implementation of any community health programme, it is pertinent for all “systems to be simultaneously engaged” as the whole is greater than the sum of its parts (Soto et al., 2004:46). In the context of this study this simply means that, HIV programmes for children living with HIV should not isolate community members but should rather enlist them as key partners whose involvement is vital in redefining acceptance and inclusion into treatment and care of children living with HIV.

Sub-theme 7.4: Increased funding for Drop-in-centres

Three participants expressed that there is a need to increase the funding of drop-in-centres by government. The participants noted the greatest needs of children living with HIV were material in nature and therefore an increase in funding would see Social Auxiliary Workers being able to facilitate adequate provision for the needs. The following quotations highlight their suggestions:

- *“Department of Social Development should increase funding to drop-in-centres to enable us to address all needs of children.”*
- *“More funding for drop-in-centres so that we try to help children to have warmer clothes and to stay in better places.”*

Lombard (2005:225) supports this by stating that the greatest challenge for Non Profit Organizations is inadequate funding, which results in weakened service provision for clients. As underpinned by both the biopsychosocial perspective and the social systems theory that “systems exist within systems” (Sheridan & Radmacher, 1992:62), the researcher encourages drop-in-centres to develop a global view of their work and to consider expanding their capabilities to approach

private funders and institutions that are not necessarily related to government departments.

3.6 SUMMARY

Chapter Three focused on the research methodology and the ethical considerations that were followed during the research study. The empirical findings of the study were subsequently presented and discussed. The study was embedded within the biopsychosocial perspective which is based on the systems approach and recognises the interaction between the biological (medical), social and psychological factors; and their impact in the provision of comprehensive services by Social Auxiliary Workers to children that are living with HIV within drop-in-centres.

Seven themes emerged and these were: biological needs; psychological needs; social needs; economic needs and transitioning into adolescence of children living with HIV; the role and competencies of Social Auxiliary Workers; strategies regarding improvement of Social Auxiliary Work services to children living with HIV and addressing institutional barriers that impact on the work of Social Auxiliary Workers. Themes and sub-themes that emerged from the transcripts acknowledged and represented the voices and perspectives of participants in the study. These were substantiated through direct quotations with integration of literature where applicable.

The key findings of the study will be discussed in Chapter Four. The chapter will also contain the conclusions and recommendations that are based on the key findings.

CHAPTER FOUR: CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

This chapter seeks to explain how the researcher achieved the goal and objectives of the study. The researcher will explain how the objectives were achieved by highlighting the main findings of the study. Conclusions will be drawn from the study and recommendations will be made on the key findings of the study.

4.2 GOAL AND OBJECTIVES OF THE STUDY

The goal of the study was to explore the perceptions of Social Auxiliary Workers on their role and competencies in addressing biopsychosocial needs of children living with HIV at drop-in-centres. Below is the research question on which the study was based:

What are the perceptions of Social Auxiliary Workers on their role and competencies in addressing the biopsychosocial needs of children living with HIV at drop-in-centres?

The goal was achieved through the attainment of the following objectives:

- **Objective 1:** To obtain a sample of Social Auxiliary Workers within drop-in-centres working with children living HIV.

This objective was achieved in Chapter Three, especially section 3.6.1 where the researcher detailed the research design and methods methodology that was used in the study. In sub section 3.6.1.1.1 the researcher described, how using an inclusion and exclusion criteria, the non-probability purposive sampling as well as simple random sampling procedure of probability sampling, respectively, were applied to select a sample of 10 Social Auxiliary Workers who participated in the study.

- **Objective 2:** To explore and describe the perceptions of Social Auxiliary Workers on their role in working with children living with HIV at drop-in-centres.

This objective was addressed in the empirical study in Chapter Three, especially section 3.5.6. Participants' perceptions and understanding of what constitute specific roles in working with children living with HIV at drop-in-centres were varied and not standardised. Major differences in perceptions were on the roles psychosocial care and support, counselling and preventive interventions to contribute to the maintenance of health and the prevention of diseases. The "loose" and myriad translations that are attached to the aforementioned roles make it impossible for Social Auxiliary Workers to provide standardised services to children living with HIV within drop-in-centres.

- **Objective 3:** To explore and describe the perceptions of Social Auxiliary Workers on their competencies in working with children living with HIV at drop-in-centres.

The objective was achieved through a literature review in Chapter Two (see sub-sections 2.1, 2.3, 2.6 and 2.12.4) which emphasised that limited HIV knowledge, and lack of skills and exposure in HIV work were the biggest hindrances impacting on the competencies of Social Auxiliary Workers delivering services to children living with HIV. The empirical study in Chapter 3 (see sub-section 3.5.6) confirmed that Social Auxiliary Workers did not think they can effectively work with children living with HIV as they do not have the skills to deal with stigma, discrimination, non-disclosure; issues that are of paramount importance in determining access and provision of services to children.

- **Objective 4:** To identify the challenges that Social Auxiliary Workers are experiencing in working with children living with HIV at drop-in-centres.

This objective was addressed in Chapter 2 (sub-sections 2.5, 2.6, 2.7, 2.8, 2.9, 2.11 and 2.12), where it became evident that the work of Social Auxiliary

Workers with children living with HIV within drop-in-centres is to a larger extent undermined by institutional and infrastructural barriers. These barriers were indicated as being multi-dimensional, multi-sectoral and multi-faceted and they led to Social Auxiliary Workers addressing the biological, psychological and social factors of HIV as independent and isolated elements as opposed to adopting “integrated HIV care”. The common denominators that were discussed as underlining the institutional and infrastructural barriers are unavailability of resources, poor coordination and operationalisation of HIV legislative frameworks and limited supervision and guidance opportunities given to Social Auxiliary Workers due to shortage of Social Workers in South Africa.

In addition, this particular objective of the study was accomplished in the presentation of empirical study findings in Chapter 3 (sub-section 3.5), which indicates that some of the study participants identified lack of structured referral systems and limited funding for drop-in-centres as barriers. The lack of government initiated strategies to address and educate families and communities on HIV stigma and disclosure was also identified as posing a challenge to the work of participants.

- **Objective 5:** To suggest strategies, based on the research findings, related to improving Social Auxiliary Workers’ role and competencies in working with children living with HIV at drop-in-centres.

This objective was met in the empirical study in Chapter Three and Chapter Four. The participants proposed a number of strategies to improve the role and competencies of Social Auxiliary Workers in addressing biopsychosocial needs of children living with HIV at drop-in-centres. The main strategies suggested are as follows:

- Training on HIV for all Social Auxiliary Workers working with children living with HIV.
- Strengthened supervision and debriefing sessions.
- Community mobilisation and education to address stigma and discrimination

- Increasing funding for Drop-in-centres.

4.3 KEY FINDINGS OF THE STUDY

The researcher will present key findings and conclusions in this section in a sequential manner.

- The findings indicate that children living with HIV have many different health, psychological and social (biopsychosocial) needs that interact in a complex manner and were understood differently by Social Auxiliary Workers; consequently impacting on the expected roles of Social Auxiliary Workers and children's access to comprehensive and responsive services.
- Findings have established that Social Auxiliary Workers that are employed within drop-in-centres are mandated by DSD to perform roles that holistically address the biopsychosocial needs of children living with HIV, but the Social Auxiliary Workers are not empowered or equipped to competently apply the biopsychosocial approach in their work as they have not received practical and/or theoretical training on the approach. It can thus be said, the barriers in delivering services to children living with HIV are rooted on that Social Auxiliary Workers have a vague understanding of the biopsychosocial approach.
- The findings indicate that drop-in-centres are important institutions in which government, through DSD, expects Social Auxiliary Workers to provide a range of services that are meant to address the complex and diverse needs children living with HIV and other OVC in poor communities.
- The findings revealed that Social Auxiliary Workers had limited, non-standardised and highly imperceptible HIV knowledge and skills; which greatly compromised their competencies in offering effective services to children living with HIV within drop-in-centres.
- Findings have established that the exact numbers of children living with HIV within drop-in-centres are not known as Social Auxiliary Workers do not know

how to do “case-finding” of the children. The study indicated that, in spite of the availability of HIV frameworks, policies and legislation in the country, there are no “simplified” practical and systematic guidelines and procedures that Social Auxiliary Workers can use to work with children living with HIV.

- The findings revealed that that Social Auxiliary Workers faced major challenges in working with children who were born with HIV and were transitioning into adolescence. The study indicated that these children exhibited challenging behaviours that Social Auxiliary Workers did not know how to handle.
- Findings have established that stigma and discrimination is still rampant in communities and is associated with parents and caregiver non-disclosure of HIV status to their children, thereby limiting access to treatment and care services for the children.
- The findings indicated that Social Auxiliary Workers in drop-in-centres are working with very minimal supervision due to limited numbers of Social Workers that are employed by DSD. Furthermore, the findings indicated that when supervision happens, it is often off-site and not specific to HIV work.
- The findings indicate that the funding that drop-in-centres receive from government through DSD is insufficient for Social Auxiliary Workers to make a difference in the lives of children living with HIV, whose majority of the biopsychosocial needs is grounded in poverty.
- The findings revealed that that Social Auxiliary Workers face institutional challenges in working with children living with HIV. Findings indicated that the institutional barriers stem from lack of government initiated and co-ordinated community mobilisation and education activities to address stigma and discrimination in communities.

In summary, the biopsychosocial perspective and the general systems theory which the researcher employed proved very useful in interpreting the transacting linkages and complex interdependencies that came out in a lot of the findings of the study.

Stigma, discrimination and non-disclosure were the most important factors that participants used to define and delineate the biological, psychological, social and economic needs of children living with HIV within drop-in-centres. The same factors were also viewed as having a direct negative “cause-and-effect” relationship on the roles and competencies of participants.

Participants viewed stigma, discrimination and non-disclosure as creating barriers in accessing and helping children enrolled in HIV treatment and care programmes. The study confirms the findings of UNAIDS (2013:63); UNICEF (2013:42) and Bikaako-Kajura et al. (2006:86) that, stigma, discrimination and non-disclosure are debilitating factors that block avenues for children to access medication and social support. The findings of the study also suggest that, poverty and insufficient resources within drop-in-centres; as well as lack of large scale state-driven efforts to mobilise and educate communities on children and HIV, were also perceived as factors that exerted strain on Social Auxiliary Workers’ roles and competencies.

The dearth lack of HIV knowledge and skills training for Social Auxiliary Workers to handle the delicate and complex issues of children living with HIV were also perceived by study participants as compromising the effectiveness of their work.

In agreement with the guidelines of biopsychosocial perspective for caregiving staff to systematically grasp the mutual but complex interactions between biological, psychological, social and economic factors if they are to competently serve their clientele, the researcher concurs with the recommendations of Igumbor et al. (2011:235) that, universal paediatric HIV/AIDS training should be made available to all community based care giving staff in order to improve their understanding and expertise in integrating HIV issues in their daily work with children, families and communities. It is thus important for the government to increase funding for drop-in-centres and also to do more in mobilising and educating communities on children and HIV (Holzemer et al., 2009:79).

4.4 CONCLUSIONS

The following conclusions were derived from the literature review and empirical research findings of the study:

- It can be concluded that children living with HIV have many distinct biological (health), psychological and social needs that impact on their well-being. The study therefore concludes that, the biopsychosocial approach should be adopted to allow for comprehensive, integrated, inclusive, multi-sectoral and high quality HIV treatment, care and social support programmes for children living with HIV to be sustainably and holistically implemented.
- The researcher concluded that Social Auxiliary Workers are not effective in their roles targeted at addressing the biopsychosocial needs of children living with HIV because they do not have any specific training on working with children living with HIV. As concluded in this study, the lack of training contributes to the disproportionate low access to HIV treatment and care children living with HIV.
- The researcher concluded that by virtue of being based in the communities, drop-in-centres and Social Auxiliary Workers have potential to do more in as far in as far as addressing the unique needs of children living with HIV is concerned.
- The researcher concluded that there are no mechanisms, activities or programmes aimed at identifying children living with HIV within drop-in-centres, an aspect which complicates the integration of the biopsychosocial needs of children living with HIV into other services rendered within drop-in-centres.
- The researcher concluded that Social Auxiliary Workers particularly struggle to work with children living with HIV who will be transitioning into adolescence.
- The researcher concluded that stigma and discrimination within communities prevents many parents and guardians from disclosing HIV status to their children.

- The researcher concluded that non-disclosure of positive HIV status to children by parents and guardians isolates children living with HIV and acts as a barrier for the children to access appropriate treatment, care and other social support services.
- The researcher concluded that there is limited and irregular supervision being rendered to Social Auxiliary Workers by the Department of Social Development, this aspect deprives the Social Auxiliary Workers of opportunities to get to guidance and debriefing opportunities.
- The researcher concluded that the funding that drop-in-centres receive from government through DSD is inadequate for Social Auxiliary Workers to sufficiently address the biopsychosocial needs of children living with HIV. As concluded in this study, some of the biopsychosocial needs of children living with HIV are material in nature due to poverty and unemployment of their parents. The study therefore concludes that DSD should consider increasing funding for drop-in-centres as this will enable Social Auxiliary Workers to provide for the biopsychosocial needs of children that require financial or material resources.
- The researcher concluded that the integration of the currently fragmented community mobilisation, education and awareness raising activities on paediatric HIV could go a long way in addressing stigma, discrimination and non-disclosure issues within communities. The study therefore concludes that where there is no stigma and discrimination, there will be strengthened possibilities to create opportunities for children living with HIV to access services in more efficient, structured and holistic manner.

It can be concluded that physical, psychological and social environmental conditions define; and consequently determine the services that children living with HIV should be given. The biopsychosocial perspective and the general systems theory are ideal in working children living with HIV as they are useful in understanding and interpreting the interdependency of physical, psychological and social factors.

As mentioned in Chapter One, Social Auxiliary Workers are “frontline” and their role and level of competencies are essential in addressing the intrinsic biopsychosocial needs of children living with HIV. However, the study has illustrated that Social Auxiliary Workers’ competencies in their role is compromised due to limited skills and knowledge that they have on paediatric HIV. While the reality of the complications that are brought about by poverty; community stigma and discrimination; as well as non-disclosure of HIV status to children by parents should not be ignored, it should be noted that the capacitation of Social Auxiliary Workers with HIV skills and knowledge will go a long way in tackling most of the critical challenges that impinges on efforts targeted at addressing biopsychosocial needs of children that are infected. Accordingly, it is also crucial that the government, through the Department of Social Development, takes collective responsibility in addressing economic, environmental, legislative and other social barriers that mitigates Social Auxiliary Workers from realising their full potential in their work.

4.5 RECOMMENDATIONS

Based on the key findings and conclusions of the study, the following recommendations were respectfully made:

➤ **Training of Social Auxiliary Workers on paediatric HIV**

The Department of Social Development must train Social Auxiliary Workers on paediatric HIV to address the insufficient knowledge and skills that they have. Findings indicated the limited knowledge, skills and experience that Social Auxiliary Workers have on pediatric HIV significantly lowers the effectiveness of their work. Thus the training and capacitation of Social Auxiliary Workers in pediatric HIV could contribute to an increase in the depth and breadth of HIV services that children living with HIV will ultimately receive. The researcher also suggest that, besides making Social Auxiliary Workers more effective by upgrading their HIV knowledge, skills training on pediatric HIV could enable the Social Auxiliary Workers to understand and appreciate the emotional difficulties involved with working with children living with HIV.

➤ **Training of Social Auxiliary Workers in the biopsychosocial approach**

There is a need to educate Social Auxiliary Workers in the practical application of a biopsychosocial approach in rendering services to children living with HIV. This would ensure that Social Auxiliary Workers understand the interconnectedness of the biological, psychological and social needs of children living with HIV and they are able to address them in an organised and integrated manner.

➤ **Provision of simplified and standardised tools**

The Department of Social Development should provide Social Auxiliary Workers with simplified and standardised tools that they can use in their daily work with children living with HIV. This would solve most problems that Social Auxiliary Workers encounter in understanding, interpreting and applying HIV policy and legislative frameworks in the context of their work with children living with HIV. The study findings revealed that there is no uniform understanding of roles such as counselling and psychosocial care and support. Thus, the provision of simplified practice tools will ensure that there is consistent understanding amongst Social Auxiliary Workers of their roles and obligations. Moreover, this would increase uniformity, comprehensiveness, and efficiency of services given to with children living with HIV by Social Auxiliary Workers.

➤ **Strengthened supervision of Social Auxiliary Workers**

There is need to strengthen and re-structure the current supervision models and opportunities that are accorded to Social Auxiliary Workers in order to promote optimal performance and improve standards of service provision to children living with HIV by Social Auxiliary Workers. It was noted in the study that some of the cases that Social Auxiliary Workers are confronted with are complex and beyond their scope. Regular, on-going and on-site supervision from skilled Social Workers could be vital in guiding and increasing the experiences of Social Auxiliary Workers in working with children living with HIV. The researcher recognises that frequent supervision sessions could also be essential in providing debriefing opportunities as working with children living with HIV can be a heavy burden that may lead to stress, depression, and isolation. Another reason that was cited in the study as contributing to

weakened supervision systems for Social Auxiliary Workers is the shortage of Social Workers employed by the Department of Social Development. The Department of Social Development thus need to employ more Social Workers in order to strengthen supervision of Social Auxiliary Workers and also to achieve the SACSSP's recommendations that Social Auxiliary Workers should work under the supervision of a Social Worker.

➤ **Scaling up community mobilisation interventions to address HIV stigma and discrimination**

Identifying and addressing HIV-related stigma and discrimination in communities is paramount importance if children living with HIV are to receive services that meet all their needs. Children living with HIV are not known to Social Auxiliary Workers as their parents and guardians prefer to keep both their HIV positive status and that of their children secret for fear of stigma and discrimination from fellow community members. The researcher views stigma and discrimination as limiting and disempowering factors that provide rationale to parents and guardians not to disclose HIV status to children and Social Auxiliary Workers. Community sensitisation and education programmes targeted at HIV-related stigma and discrimination will therefore be vital in demystifying stigma and discrimination and this could help in addressing other factors, such as non-disclosure, which disenfranchise children living with HIV from accessing services.

➤ **Increasing funding for drop-in-centres**

The available financial and material resources that are allocated to drop-in-centres by DSD are not in proportion to the growing needs of children living with HIV, consequently posing constraints to the quality of services given to the children. There is therefore need for government and the Department of Social Development to consider scaling-up funding to ensure that Social Auxiliary Workers within drop-in-centres can sustain their responses and improve the quality of services that they render to children living with HIV. It is also the recommendation of the researcher that the Department of Social Development should work on creating economic opportunities by facilitating linkages of drop-in-centres to other potential funding institutions or donors.

➤ **Further research**

Further research is needed to develop strategies and programme activities that promote the identification, integration and inclusion of children living with HIV into treatment, care and other social support services. Furthermore, in-depth research is needed to establish ways of capacitating Social Auxiliary Workers to render effective services to children living with HIV.

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Ethics letter from the University of Pretoria



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

31 August 2015

Dear Prof Lombard

Project: The perception of social auxiliary workers in their role and competencies in addressing biopsychosocial needs of children living with HIV at drop-in-centres
Researcher: E Zibengwa
Supervisor: Ms N Bila
Department: Social Work and Criminology
Reference number: 14263442 (GW20150805HS)

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 27 August 2015. 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

Kindly note that your original signed approval certificate will be sent to your supervisor via the Head of Department. Please liaise with your supervisor.

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

Permission Letter from the Department of Social Development



GAUTENG PROVINCE
SOCIAL DEVELOPMENT
REPUBLIC OF SOUTH AFRICA

Enquiries: Nokuthula Vilakazi
Social Work Supervisor
HIV/AIDS Sub- Programme
Sedibeng Region
(016) 930 2129/ 071 492 1059

13 May 2015

Attention: Mr. Enock Zibengwa

RE: PERMISSION TO CONDUCT A RESEARCH STUDY

Following your request, I am pleased to inform you on behalf of the Sedibeng District Management Committee that you have been granted permission to undertake your study within the Sedibeng DSD registered and supported drop-in-centres by means of interviewing Social Auxiliary Workers. We understand that the goal of your proposed study is to explore the perceptions of Social Auxiliary Workers on their role and competencies in addressing biopsychosocial needs of children living with HIV at drop-in-centres.

We take note that each selected Social Auxiliary Workers will be interviewed for approximately 60 minutes. We further acknowledge that drop-in-centres and selected Social Auxiliary Workers will not receive any monetary or material benefits for participating in the study.

We hope that your study will add value to the work that Social Auxiliary Workers in drop-in-centres are doing in addressing the needs of children living with HIV.

Yours Sincerely,

Nokuthula Vilakazi
Social Work Supervisor

Semi-structured Interview Schedule

Goal of this study

To explore the perceptions of Social Auxiliary Workers on their role and competencies in addressing biopsychosocial needs of children living with HIV at drop-in-centres.

SECTION A: BIOGRAPHICAL DETAILS OF THE PARTICIPANTS

1. Gender

Male		Female	
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2. Age distribution

20-25 yrs		26-31 yrs		32-37 yrs		38-42 yrs		43+ yrs	
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3. Year qualified as a Social Auxiliary Worker?

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4. Years of employment in a drop-in-centre?

How many years have you been working as a Social Auxiliary Worker in a drop-in-centre?

1yr		2yrs		3yrs		4yrs		5yrs		6yr+	
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SECTION B: BIOPSYCHOSOCIAL NEEDS OF CHILDREN LIVING WITH HIV

1. What are the major biopsychosocial needs of children living with HIV in your drop-in-centre?
2. How serious are these biopsychosocial needs? Explain in your own views.

SECTION C: NATURE OF SOCIAL AUXILIARY WORK SERVICES (ROLE)

1. What is the nature of services you render as a Social Auxiliary Worker in regards to children that are living with HIV?
2. In your own opinion, how effective are the services that you are rendering?
3. What do you think must be done differently in order to improve the services that you are rendering?

SECTION D: KNOWLEDGE AND SKILLS OF SOCIAL AUXILIARY WORKERS (COMPETENCIES)

1. Have you undergone any training or in service training on the biopsychosocial needs of children living with HIV?
2. In your own view, do you have an understanding of working with children living with HIV?
3. What kind of support (supervision) do you get in your work with children living with HIV?
4. What are your needs or aspects that you would like improvement on if you are to provide better services to children living with HIV?

SECTION E: CHALLENGES EXPERIENCED WHEN PROVIDING HIV HEALTH CARE SERVICES

1. What challenges do you experience in working with children living with HIV?
2. How do you deal with these challenges?

SECTION F: RECOMMENDATIONS

1. What are your recommendations regarding improvement of Social Auxiliary Work services to children living with HIV?

Informed Consent Letter for Participants



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Social Work & Criminology

Date: 12/05/2015

INFORMED CONSENT FORM FOR SOCIAL AUXILIARY WORKERS

Researcher: Enock Zibengwa

Contact details: 0789945455/0114941900

Title of the study:

The perceptions of Social Auxiliary Workers on their role and competencies in addressing biopsychosocial needs of children living with HIV at drop-in-centres

Purpose of the study:

Is to explore the perceptions of Social Auxiliary Workers on their role and competencies in addressing biopsychosocial needs of children living with HIV at drop-in-centres

Procedures:

I understand that I will be invited to participate in a semi-structured one on one interview to discuss perceptions on my role and competencies in addressing biopsychosocial needs of children living with HIV at drop-in-centres. I give permission that an audio recorder can be used for this purpose. I am aware the duration of the interview will be approximately sixty (60) minutes.

Risks and Discomfort:

I take note that there is no foreseeable risk and discomfort involved in participating in the study. However, I understand that this study will remind me of the practical realities and challenges involved in working with children living with HIV. I also understand that, should there be need, I will be referred to an experienced professional for counselling and debriefing.

Benefits:

I understand that the researcher will not offer me any incentives for being involved in the study.

Participant's Rights:

I am fully aware that participation in the study is voluntary and that I may withdraw my participation at any time if I so wish without any consequences. Upon my withdrawal, the information I provided for the study will be destroyed.

Confidentiality:

I understand that the data obtained from the study will be treated with utmost confidentiality. Other than the researcher, I am also aware that the researcher's supervisor will have access to the information. I understand that the researcher will compile a research report to be submitted to the University of Pretoria; however my name will not be mentioned in the report. I am aware that where necessary the researcher will use pseudonyms to enhance anonymity.

Data storage:

I am aware that the collected data will be stored for 15 years at the Department of Social Work and Criminology according to the policy of the University of Pretoria and when necessary may be used for future research.

I, understand my rights as a research participant, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being conducted.

Participant: -----

Date: -----

Signature: -----

Researcher: -----

Date: -----

Signature: -----

Letter from the editor

EDITOR'S STATEMENT

11 June 2016

To Whom it May Concern

I hereby confirm that I have proof read the mini-thesis entitled **The perceptions of Social Auxiliary Workers on their role and competencies in addressing biopsychosocial needs of children living with HIV at drop-in-centres** by Enock Zibengwa, for language and editorial errors.

I suggested relevant changes, where I saw fit, using the "Track Changes" function in windows MSWord; the student could thus either accept or reject my suggestions at his own discretion. The edit entailed correcting spelling and grammar where necessary, and checking for consistencies in style and reference method used. I have not helped to write this document or altered the student's work in any significant way.

It was not my responsibility to check for any instances of plagiarism and I will not be held accountable should the student commit plagiarism. I did not check the validity of the student's statement/research/arguments.

I trust this is in order,



Tavakunda Marembo (Mr)

072 0757 436

tmarembo@gmail.com



Education is the key!