THE EFFECTIVENESS OF SOCIAL SUPPORT MECHANISMS PROVIDED TO HIV AND AIDS ORPHANS: THE CASE OF TEMBISA CHILD AND FAMILY WELFARE SOCIETY, GAUTENG

By

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DECLARATION

In accordance with the rules of the University of Fort Hare, I hereby declare that this dissertation is my own work and has not previously been submitted to any other university or for any other qualification.

SIGNATURE:

DATE:
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ABSTRACT

The study was aimed at investigating the effectiveness of social support mechanisms provided to HIV and AIDS orphans in Tembisa, Gauteng Province. An interview guide was designed and it guided the in-depth interviews with HIV and AIDS affected and infected orphans. In addition, a focus group was run with the social workers and the children’s caregivers. Empirical findings gathered were based on the qualitative information from the participants. The findings indicated that social support systems were effective although there were various challenges facing their smooth running. Firstly social support provided to orphans is mainly provided by caregivers, social workers, schools and the government. Secondly for some, the support is not entirely enough to help them cope with life. The minority of the orphans indicated that they were not even aware that they were orphaned. The study therefore recommends that social workers and caregivers be trained on how to be effective social support systems for HIV and AIDS orphans. Furthermore psycho-social support groups need to be more informational and inclusive of HIV and AIDS orphans.

KEY WORDS: HIV and AIDS, orphans, poverty, caregivers, social workers, psycho-social support
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CHAPTER ONE
GENERAL OVERVIEW OF THE STUDY

1.1 Introduction

This chapter presents the general orientation of the study. It provides the background of the study and highlights the initial interest in conducting the study. The research problem and main questions of the study are also stated here. Further, this chapter defines the primary terms employed in the study and demonstrates how the research contributes to the society at large. The outline of the ensuing chapters is also presented.

1.2 Background to the study

HIV and AIDS is one of the major public health challenges and it is now a pandemic worldwide. According to the Human Development Report (2010) several countries worldwide showed a decline in human development due to the AIDS pandemic and there were increased economic and political mismanagements. In most African nations the fact of the matter is that the burden of parental death from AIDS is the greatest with 12.3 million children under the age of fifteen having lost one or both parents to AIDS (Bio Med Centre Public health, 2006: 2).

According to Statistics South Africa (2011) the population of the country was estimated to total 50.59 million by mid-2011 of whom approximately 48% are male and 52% are female. The HIV prevalence rate is estimated to be approximately 10.6% and the number of people living with HIV is estimated to be approximately 5.38 million. It is further estimated that 16.6% of the adult population between the
ages of 15-49 years are HIV positive (Stats SA, 2011). It is further said that the number of HIV infections for 2011 for the population aged 15 years and older is estimated at 316,900 and an estimation of 63,600 new HIV infections will be among children aged 0-14 years. Even with the expansion of antiretroviral treatment access, it is estimated that by 2015, the number of orphaned children will still be overwhelmingly high (Avert Organization, 2011).

South Africa is a signatory to the Declaration of Commitment of the United Nations General Assembly Special Session on Children held in 2002 (UNGASS). One of the articles of the Declaration states that:

By 2003 develop, and by 2005 implement national policies and strategies to: Build and strengthen governmental family and community capacities to provide supportive environments for orphans and boys and girls infected and affected by HIV and AIDS including by providing appropriate counselling and psycho-social support, ensuring their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children, to protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance. (Article 65)

The Sowetan (2012) reported that, the Social Development Minister Bathabile Dlamini, in Gugulethu had highlighted that caregivers were reported to be misusing social grants. It was said that after the replacement of the state maintenance grant the number of people receiving grants rose from 70,000 in 1998 to about 15 million to date (Sowetan, 2012). According to the government these social assistance grants are to assist caregivers give orphans (in this case HIV and AIDS orphans) a better life and a chance to being respectable members of community.

In the State of the Nation Address of February 10 2011, President Jacob Zuma announced that social grants would be linked to economic activity and community
development so as to enable short-term beneficiaries to become self-supporting (Gostelow 2011: 200). The Department of Social Development provides care and support to orphans and vulnerable children and their caregivers and these include childcare forums, community based drop-ins, Home-based care Centres, Early Childhood Development Programmes, amongst others.

The rate of population growth in South Africa is 1.07% per annum and is significantly lower than that of the rest of sub-Saharan Africa. In the past few years of the post-apartheid regime, profound political and social changes have been seen in South Africa, with the government taking the lead in introducing significant social welfare policy changes (September and Dinbabo, 2008: 90). Major objectives of social welfare policies in South Africa are alleviating poverty and enabling the previously disadvantaged communities to have access to basic social services (White Paper of 1997 extract in the Department of Social Development’s Strategic Plan for 2011-2014: 13). A number of studies carried out so far have indicated that child poverty is still exceedingly high (Barnes et al., 2009; Coetzee & Streak, 2004; Noble et al., 2007; UNICEF South Africa, 2005; Wright et al., 2009). A 2006 empirical study on the level of child poverty clearly indicated that poverty was deepening in various parts of South Africa.

Meintjes and Hall (2009: 46) noted that the General Household Survey in 2007 identified approximately 3.7 million orphans (children without both parents) living in South Africa. The General Household Survey also indicated that the number of children who had lost both parents had increased over the previous five years (2002-
2006) and of further interest was that during 2006 77% of all orphans were of school-going age – seven years and above.

September and Dinbabo (2008: 105) argued that poverty and unemployment are key concerns that impact on a family’s capacity to care for their children. September and Dinbabo (2006: 98) noted that previous inequalities in education, health care and basic infrastructure have also contributed to the backlog in present services. The vulnerability of children, especially those living in poor areas, is compounded by HIV and AIDS.

A number of researchers (Haacker, 2002; Kirby, Laris, and Rolleri, 2007, UNAIDS, 2008) have indicated that the HIV and AIDS pandemic is one of the greatest threats to the realisation of child rights in South Africa and sub-Saharan Africa. Research by the Children’s Institute (2009) demonstrates some of the multiple vulnerabilities faced by children before the death of caregivers. Children often take on the responsibility of caring for sick adults and are unable to attend school or study because of the difficulties at home. In short, children’s experiences of orphanhood and its compounded vulnerabilities begin long before the death of a significant adult. It is not surprising that many of the subsequent experiences of children who have been orphaned are poverty-related – such as an inability to afford school fees and school uniforms, prolonged experiences of hunger, inadequate housing and poor access to water (Children’s Institute, 2009). On the other hand, Meintjes et al. (2008: 57) reported that although the government and civil society have expressed concern about the growing number of children living in child-headed households although there is little evidence to support this fear.
The factors mentioned above show that when it comes to social welfare policy implementation and provisions of support mechanisms, many challenges still face the legislators, the judiciary, the executive branches of the government and the South African society as a whole. For the purpose of this study support mechanisms refer to all social support given to HIV and AIDS orphans in Tembisa Child and Family Welfare Society Organization. This assistance might be from social workers, care workers or givers and other members of society offering support to orphans affected and infected with HIV and AIDS. The need for continuing social welfare policy reform processes and providing support mechanisms for responding to orphans and vulnerable children in South Africa are critical for policy makers. This research therefore evaluated the social support provided to HIV and AIDS orphans in Tembisa, Gauteng.

1.3 Problem Statement

The AIDS epidemic has affected a lot of children in South Africa leaving them either affected or infected (Bradshaw et al 2006: 9). These children are left behind with the greatest challenge of all which is figuring out how to survive, they are left with responsibilities way beyond their capacities, and they lack financial, emotional, physical, mental and material support to care for themselves. In addition they are left under the care of people who are financially, emotionally, physically or mentally incapable to care for them (Twine, Collinson, Polzer and Kahn, 2007: 120). The government has put forward means to assist these children to cope with the difficulties of life but regardless of these there is still a need to determine how effective the measures put forward are assisting.
The majority of orphans and vulnerable children in South Africa are left in the care of old and weak women or sickly caregivers. The government has made recommendable success in combating abject poverty and hunger through Social Assistance Programme (Kaseke, 2010: 161). Even after such, issues like fraud still hover around and most caregivers and orphans are still battling with meeting challenges of day-to-day living. However Kaseke (2010) continues to argue that the high prevalence of HIV and AIDS among caregivers has worsened the challenges of child poverty. The government in 2005 enacted the Children’s Act 38 of 2005 which provided under Section 155 and 156 for orphans of whatever nature to be assisted with foster care grants. The grant was to assist foster parents put the orphaned children through school, clothe them and shelter them. Due to the backlogs in many organizations assisting with the application of these grants and the misuse of such grants by some foster parents, the survival of HIV and AIDS orphans is still a struggle far from being won.

The previous inequalities in education, healthcare and basic infrastructure have highly contributed in caregivers being unable to care for orphans and orphaned children (Kaseke, 2010: 160). Social support systems and the welfare services provided to aid orphans were a great vehicle for the research study to explore whether or not they are being helpful as there are reports that organization backlogs and high staff turnovers for Non Profit Organizations are slowing service provision to the orphans (Temin, 2008: 13). The researcher embarked on this research project with the goal of evaluating the effectiveness of these support systems offered to HIV and AIDS orphans.
1.4 Research Aims and Objectives

The general aim of the study was to examine the effectiveness of social support systems provided to HIV and AIDS orphans by Tembisa Child and Family Welfare. The following specific objectives guided this study:

- To explore the challenges faced by HIV and AIDS orphans in Tembisa.
- To investigate the types of social support provided to HIV and AIDS orphans.
- To examine the effectiveness of social support provided to HIV and AIDS orphans.
- To examine the challenges faced by social workers in Tembisa Child and Family Welfare Society in the provision of social support to HIV and AIDS orphans.

1.5 Research Questions

The following research questions guided the process of the study:

- What challenges are faced by HIV and AIDS orphans in Tembisa?
- What forms of social support are provided to HIV and AIDS orphans?
- How effective is the social support provided by professional social workers to these orphans?
- What are the challenges faced by social workers in the provision of social support to HIV and AIDS orphans?

1.6 Significance of the study

The significance of the study lies in the development of a better understanding of the life of children who are orphaned by HIV and AIDS in South Africa (Tembisa). It is hoped that the results will give room to improve the lives of orphans through policy
formulations or the assistance of important role players like the Department of Social Development, NGOs and Social Workers in Tembisa and South Africa as a whole. The study will contribute in the knowledge base of HIV and AIDS and the reality of its effects especially on the poor communities of South Africa. It could also provide information for the Department of Health and Social Services on how to ensure that the current measures put forward to assist orphans actually work.

1.7 Delimitations and scope of the study
The research was conducted specifically in Tembisa. One organization in particular was targeted that is Tembisa Child and Family Welfare Society; the study focused on the two offices (Phomolong and Kopanong) and drew its participants from their clientele.

Tembisa Township is situated to the north of Kempton Park on the East Rand of the province of Gauteng, South Africa. It was established in 1957 when Africans were resettled from Alexandra and other areas in Edenvale, Kempton Park, Midrand, Germiston, Irene, Olifantsfontein and Verwoerdburg. The name Tembisa comes from the Zulu word “Thembisa” which means “Give Hope”. It came about when black people and their families were evicted. When the township was created it is said to have been a beacon of hope for those who were suddenly homeless. They were accommodated in shacks. The first sections were Ecaleni, Sedibeng, Mqantsa and Mashemong. Later on Sethokga hostel was established next to Thafeni section. There were two schools at Thafeni and Ecaleni and one shop at Ecaleni that also served as a post office.
In 1962/63 the first four-roomed house was built in Sedibeng section and residents were called to inspect it. It was then called the “sample house” and the approval of residents was sought. The municipality started building the four-roomed houses and administration offices at Sekelo section and a two roomed clinic at Mqantsa clinic. In 1983 the township was granted municipal status by means of election. 14% of the residents voted and in 1984 the town council was replaced by seven Black administrators and a White chairperson. Civic Associations emerged and questioned the imbalances in the township. Street committees were formed after a meeting with the working committee was held. Mandates were taken from communities leading to consumer boycotts in 1985 and also an imposed withdrawal of the army and police from the township.

In 1986 the entire leadership of the township (Tembisa Residents Association) was detained at Moderbee Prison. In 1987 the Council collapsed after accruing rent arrears totalling R12 million. The township was intended to house single people with most sections having hostels for single men. These sections included Makhulong, Temong, Jiyane, Vusumuzi, Ethafeni, Mlonjaneni and Lerale. Presently most people have taken these houses and turned them into family houses.

The township was founded after the Afrikaner dominated National Party gained power in 1948 and began to implement apartheid, the pace of forced removals and the creation of townships outside legally designated white areas. The Johannesburg council established new townships for black Africans evicted from the city’s freehold areas. According to the Wikipedia in 1956 townships were laid out for particular ethnic groups. This was done as part of the state’s strategy to sift black Africans into
groupings that would later form the buildings that would later form the building blocks of the so called “independent homelands”. Tembisa is known as the second largest township in Gauteng province after Soweto.

In 2011 the population of Tembisa was estimated to be between 250 000 and 500 000 (Collins map, 2011). Currently the population is estimated to be around 511 671. The township is located 27 km outside north of Johannesburg town.

1.8 Chapter Outlines

Chapter 1: General Overview of the study

The chapter introduces the study and outlines its background, aims, objectives, problem statement and its significance. It also operationalizes the concepts used in the study. Chapter outlines are also presented in this chapter.

Chapter 2: Literature review

The chapter evaluates previous studies and the literature related to the study. It also describes the theoretical frameworks used in the study. Furthermore the chapter reveals gaps in literature and shows that this study fits into current debate.

Chapter 3: Research Methodology

This part of the chapter explains the methods that were used in the research. It clearly explains the research design, methods of sampling and data collection, the instruments, ethics and data analysis.

Chapter 4: Presentation of data and analysis

This chapter examines and analyses the data that were collected. The findings of the study are also presented in this chapter.

Chapter 5: Summary of findings, conclusions and recommendations
In this chapter the findings of the study are summarised and conclusions drawn. Also the chapter focuses on recommendations drawn from the findings. Suggestions for further studies as well as the limitations are also outlined in this last chapter.

1.9 Conclusion

This chapter provided an introduction and a brief background to the area of the study focusing on the problem statement, the purpose, the research design and research methodology. In the next chapter a more detailed discussion on the key concepts are clarified and literature related to the study discussed in detail.
CHAPTER TWO
SOCIAL SUPPORT MECHANISMS FOR HIV and AIDS ORPHANS

2.1 Introduction

The literature review chapter evaluates previous studies related to social support mechanisms provided to HIV and AIDS orphans. This is in relation to the main objective of the study which is to investigate the challenges faced by HIV and AIDS orphans in South Africa and critically evaluate the support mechanisms available to them. It also describes the two theoretical frameworks that were used in the study, the strengths perspectives and the buffering perspective.

2.2 Theoretical Framework

This study made use of two theories, the strengths and the feminist perspectives. The two perspectives helped to clear the angle the research is taken from and also explain why the two perspectives are relevant in this study.

2.2.1 Strengths Perspective

The strengths perspective emphasizes the individuals’ capacities, talents, competencies, possibilities, visions and hopes (Saleeby, 2005). Key concepts include empowerment, resilience and membership to a viable group or community. Important sources of strength are cultural and personal stories, narratives and lore. An individual's or group's response to traumatic situations is determined by risk, "protective" and "generative" factors, which are influenced by membership to a particular community (Saleeby, 1997). Emotions, beliefs, health realization and community empowerment play important roles in maintaining health and wellness.
However, the strengths approach is criticized as being positive thinking in a different guise, reframing clients’ deficits and misery, ignoring how manipulative and dangerous or destructive some clients can be, and ignoring or downplaying real problems (Saleeby, 2002).

The strengths perspective in working with HIV and AIDS orphans is more applicable when used to tap the resilience of families caring for the orphans (Early and Glenmaye, 2000). It is every state’s wish that social workers place an importance in redesigning welfare systems that build on family strengths and work in partnership with families and community based organizations (Bernard, 2004). Research on resilience has shown that most children and young people who have grown up in highly stressed families and resource deprived communities do “somehow” manage to become not only successful by societal indicators but to develop social, emotional, intellectual, moral and spiritual strengths. Resilience gives practitioners a scare commodity these days and that is hope. It helps families, though in risk, develop a protective and nurturing environment that is very necessary for HIV and AIDS orphans.

A resilient family according to Bernard (2004) is bound to form caring relationships and these are shown by a conveying of loving support. It emphasizes on a respectful relationship, one characterized by kindness, trust, availability and value for importance. Caregivers convey a sense of compassion and non-judgemental love. They understand that no matter how negative a person’s behaviour they still deserve to be given the best so as to view the world in a positive way. This in relation to most HIV and AIDS orphans can be understandable as most of them tend to convey
troubled behaviours, sadness and pain which caregivers need to learn to deal with. This is due to the fact that for most HIV and AIDS orphans, orphanhood begins with the illness of the parents, not death (UNICEF, 2006). Forming caring relationships can be one way to deal with orphans portraying behavioural problems. Most of the orphans just need to be listened to and taken seriously. It is important to let them know that they are important people and hence shape a positive perception of themselves.

2.2.2 Buffering hypothesis

The buffering hypothesis stems from the belief that social support is mostly beneficial during stressful moments (Martin and Mushett, 2011). Buffering to dictionary.com is anything that shields and protects against annoyance, harm or hostile forces or something that lessens the impact of shock. The notion predicted by the hypothesis is that people are shielded from bad effects of stressful events in life by social support systems. Akert et al (2007) explain buffering as a theory that states that people only need social support when under stress as it protects them from its damaging effects.

Buffering is said to be helpful in two ways, to interpret an event in a less stressful way than we otherwise would and to help people cope. There are however numerous classifications of support functions which consist of three basic functions: emotional, instrumental and informational support (Helgeson, 2002). Emotional support means having people to listen to one and sympathize and make them feel loved and valued. Instrumental/tangible assistance involves help with household
chores, lending money and running errands. Finally informational support according to Helgeson (2002) involves the provision of information or guidance.

HIV and AIDS has increased the number of orphans enormously to the extent that the United Nations now defines an orphan as a child who has lost one parent, since when the disease kills one the next one follows within a short period of time. The death of both parents leads the child to be called a double orphan (UNAIDS, 2000). As the number of orphans continues to escalate the numbers of economically active adults, particularly childbearing, women are also shrinking. The Convention of the Rights of the Child (CRC) (Article 5) and the African Charter on the Rights and Welfare of the Child (AC) (Articles 9(3) and 18) are international instruments that place primary responsibility of the welfare of children on parents or guardians and extended families. The African norms and values just like these instruments, articulate such child welfare values. In many African traditions the extended family was part and parcel of child rearing with the villagers and community members playing a role as the child was viewed as belonging to everyone. The AIDS pandemic defies the concept of the analogy “it takes a village to raise a child” as many communities can no longer cope with those in need of care. This leads to children either to find themselves without care givers or in alternative care such as adoption, non-relative-care or institutionalization which violates family totems. Helgeson (2002) believes that resources for social support are needed from people within the environment if the stress levels are low. Also he believes that the type of support is determined by the severity of the stressor (in the case of this study loss of parents to HIV and AIDS). The study will focus more on the female caregivers as
they form the bulk of Tembisa Child and Family Welfare Society’s caseloads and the HIV and AIDS orphans in their care.

2.3 Conceptualizing HIV and AIDS orphans, care givers and support systems

The impact of HIV and AIDS on children and families is a product of many interrelated factors requiring responses that vary by family, community and country (Williamson et al., 2004). This section will give working definitions for the terms HIV and AIDS orphans, care givers and support systems as they are used in the process of the study. In addition the terms are discussed at length and their relevance to the study conceptualized.

2.3.1 HIV and AIDS Orphans

UNICEF and global partners (UNICEF, 2005) define an orphan as a child who has lost one or both parents. According to the definition children who lost both parents and children who have lost a mother and have a father or lost a father and have a mother are considered orphans. UNICEF (2005) noted that there were over 132 million children in Sub Saharan Africa, Asia, Latin America and the Caribbean classified as orphans. Of this number only 13 million had lost both parents. Evidence clearly showed that the vast majority of orphans are living with a surviving parent, grandparent, or other family member.

This definition contrasts with concepts of orphan in many industrialized countries, where a child must have lost both parents to qualify as an orphan. UNICEF and other organizations adopted the broader definition of orphan in the mid-1990s as the
AIDS pandemic began leading to the death of millions of parents worldwide, leaving an ever increasing number of children growing up without one or more parents. Therefore, the term of a ‘single orphan’ referring to the loss of one parent and a ‘double orphan’ referring to the loss of both parents was born to convey this growing crisis (UNICEF, 2008). For the purpose of the study the definition given by UNICEF will be used.

2.3.2 Care givers

The strength and resilience of this country is dependent on the health and well-being of its children (Bojer et al, 2007). The HIV and AIDS crisis, complemented by other social factors, is contributing towards a complex situation where an overwhelming number of children need care and support. A caregiver is most commonly seen or described as a child’s mother or father who is the ‘sole’ carer of them (UNAIDS, 2000). It is also described as the particular child care worker assigned to plan, observe and care for that child during child care.

Attachment is one specific and circumscribed aspect of the relationship between a child and caregiver that is involved with making the child feel safe, secure and protected. The purpose of attachment is not to play with or entertain the child. The child uses the caregiver as a secure base from which to explore and, when necessary, as a haven of safety and a source of comfort.

2.3.3 Support systems

In South Africa the HIV and AIDS pandemic has resulted in an increasing number of orphans resulting from a rise in the number of AIDS related deaths among adults. In
most AIDS affected households it is very common for children to be sent away to be taken care of by members of the extended family (Kawewe, 2006). It is however argued that the apartheid legacy and the migrant labour system in South Africa weakened the family structures, more especially those of extended families.

The Draft Children’s Bill (2002) chapter 13 b; stated an expected increase of child headed households in South Africa due to the then rising of numbers of HIV and AIDS related deaths. Many argued that child-headed households were not a sign that the support systems of the extended families were inefficient. Instead they saw them as a sign of coping in traditional support systems of the extended family and the community. In a study carried out by Foster (1997) in Diana van Dijk (Cindi Organization, 2012) most child-headed households were receiving regular supportive visits and material support from extended families.

In the case of Tembisa where most children were born and raised in informal settlements with little or no knowledge as to whom their extended families are, it is a challenge for orphans to attain such support. Most community members are willing to assist for a month or two after the passing away of the primary care giver and afterwards they throw in the towel.

The Department of Social Department (DSD) Gauteng came up with a Strategic Plan that was informed by the Ten Point Plan which represents the priorities to be addressed by the social development sector during the period of 2000 to 2005. These priorities were an outcome of an intensive process of consultation with some
stakeholders in October 1999 and were launched by the Minister of Social Development in January 2000. The Ten Point Plan includes:

- Rebuilding of family, community and social relations
- Integrated poverty eradication strategy
- Comprehensive social security system
- Combating violence against women and children, older persons and other vulnerable groups
- HIV and AIDS
- Youth development
- Accessibility of social welfare services
- Services to people with disabilities
- Commitment to co-operative governance
- Train, educate, re-deploy and employ a new category of workers in social development

All the strategic plans stated above have an effect on orphans in the case being studied, HIV and AIDS orphans. Most importantly a plan was set aside for HIV and AIDS programs. The DSD has since the implementation of this plan provided subsidies for the running of and facilitation of services to support community-based care and assistance for people affected and infected by HIV and AIDS. The plan on the ground especially in Child Welfares works to assist care givers of HIV and AIDS orphans care for the children by providing support groups and material assistance.

Social workers in South Africa according to the state’s policies put up since 1997 have been encouraged to implement a developmental social service policy towards social work service delivery. This means that in rendering services to clients, prevention must always form the bulk of the service before intervention and statutory
services are offered. There have been a number of challenges faced by service deliverers in living up to these standards including a lack of qualified social workers in the field, (Dawes, 2011).

Family preservation services according to Strydom in Sun Scholar Research (2005) are short-term family based services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. These services developed in response to the over-reliance on out-of-home care that characterized services in the 1970s in the United States. The services grew out of the recognition that children need a safe and stable family and that separating children from their families is traumatic for them, often leaving lasting negative effects. It builds upon the conviction that many children can be safely protected and treated within their own homes when parents are provided with services and support and are empowered to change their lives. It’s a strategy that is based on the belief that children and young people need a family in which to develop (Bernard, 2004). It promotes the perspective that the best way of achieving permanency in the lives of children is to allow them to be with their families and to work with the family to try to prevent the placement of children outside of family care as well as the philosophy which discourages the removal of children from their families. HIV and AIDS orphans are often in need of such services according to the South African Family Practitioners (2009).

The most important aspect in selecting the right families to consider for the service is to engage with families should there be a risk of children being removed from their families. This is based on the conviction, as stated in the preamble of the United
Nations Convention on the Rights of the Child, that the family, as the fundamental group of society and the natural environment for the growth and well-being of its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community. Child-headed families and teenage parents fit the category of families in need of family preservation services, (Meintjes et al, 2004). In the case of Tembisa Child and Family Welfare Society families with children subjected to abuse and neglect are susceptible to receiving the service. Families with unemployed caregivers residing in not so good environments attain family preservation services. The goal is to preserve the family while ensuring that the children are safe, (Meintjes and Van Niekerk, 2005). In the process the family is equipped with the necessary skills to remain together successfully.

According to DSD reports the National Policy Frameworks for Families (April 2001) stated the following components of family preservation:

i) **Intensive family support**

The aspect of family preservation services implies delivering intensive services to families with the aim and objective of preventing removal of children from their homes. The first pilot study on family preservation project carried out in Inanda, Durban by Ravestijn (2001) sought to address the risk factors within the family by strengthening families and developing support networks within the neighbourhood. Families were therefore viewed as an integral part of the neighbourhood and the project attempted to place the responsibility of children, first with the family and with the community. It embodied the principle of Ubuntu (caring for others’ well-being within an attitude of mutual support) where every member of the neighbourhood has
a responsibility towards others, with children and families being embraced by the interconnected rings of caring and support.

The specific goals of family preservation include:

- To improve the well-being of children within their families and communities
- To let families remain the primary caregivers of children
- To support the strengths of families
- To re-unify families
- To decrease the placement rate as well as the placement shifting (drift) of children.

ii) Family Reunification

Family reunification services as a goal of family preservation refers to those services aimed at systematically reuniting children within Residential Care or Foster Care with their families and communities. Family reunification aims at helping each child and family to achieve and maintain, at any given time, their optimal level of re-connection to full re-entry of the child into the family system, which affirms the child as part of the family (Grey, 2011). The family reunification model recognises that family reunification requires collaborative multi-sectorial work which should be offered as long as needed to maintain the reconnection.

In Tembisa Child and Family Welfare Society family reunification services are often offered to children committed to the two children’s homes attached to the organization. Many at times families are ready to reunite with children placed at the Crisis Home as most of the children are healthy. Adoptions and unrelated foster cares are also the order of the day. But for the Care Centre housing HIV and AIDS
infected children the number of reunifications, adoptions, and unrelated foster care placements are very minimal.

**iii) Community Conferencing**

Community conferencing is one of the Family Preservation Strategies that has been designed to bring forth community efforts in addressing the needs of children, young people and families (Jeeley et al, 2004). As a family preservation strategy, it goes hand in hand with efforts aimed at providing intensive family support, family reunification, as well as youth mentor services. It is an approach used to engage diverse individuals, groups, service providers, community leaders, professionals, para-professionals and volunteers in community-based organizations for children, youth and families to create a community-based comprehensive response to issues affecting children, young people and their families (Gostelow, 2011).

Some of the goals for community conferencing are:

1. To bring about a re-orientation in community values that contributes to child protection, development, youth support and development and family support.

2. To improve access to services for children, youth and families at different levels of the community.

3. To help communities to form a vision for improving conditions for children, youth and families in the communities.

4. To create safe communities for children and supportive communities for families.

5. To prevent and reduce the removal of children from their families and communities.
6. To assist communities to build community resources that address the needs of children, young people and families.

As an organization, Tembisa Child and Family Welfare Society is working with the community in engaging it to be more prepared for assimilating HIV and AIDS orphans into its care. It facilitates a group for foster parents taking care of HIV and AIDS orphans and gives them support and courage to face the challenges they go through every day. Most of the foster parents are also affected by the disease and need the programme for their own coping more than that of coping with the orphaned children.

The increasing orphan population in South Africa is perhaps the most tragic and long-term legacy of the HIV and AIDS pandemic. In 2006 South Africa had over 1,5 million maternal orphans under the age of 18 and of these 66% of these children were orphaned as a result of HIV and AIDS, (SA Fam. Pract., 2009). In a study conducted in North West Province of South Africa it was found that caregivers of HIV and AIDS orphans who were mostly grandmothers experienced a lack of welfare and family/emotional support in their care of HIV and AIDS orphans. It was found that most of the caregivers were not aware of their rights or those of the orphans concerned. They were not aware of social grants put in place by the state to support these orphans whilst others did not have the necessary documents to apply for the state grants (Meintjes et al, 2005). In addition they had no knowledge of how to acquire these documents, leading to a great distress on the caregivers.
2.4 Social assistance grants

According to Hall and Proudlock (2011) between 2010/11 the government of South Africa spent about R89 billion in social grants. This is despite the ever increasing unemployment rate and the impact of 2009’s recession. Grant expenditures seemingly increased from 3.2% of the gross domestic product to 3.5%. The government’s most successful strategy in combating abject poverty and hunger was its Social Assistance Programme. The majority beneficiaries of the Programme are children receiving Child Support Grants. Mothers are usually the recipients of the grants although anyone acting as a child’s primary caregiver can be a recipient (Rosa and Meintjes, 2004). This was put in place because many children are cared for by relatives as a result of the impact of HIV and AIDS. In 2010 the age restriction for the grant was increased from ending with 16 year olds to 18 year olds (Hall and Proudlock, 2011).

The Child Support Grant was first introduced in 1998, and over the past fourteen years South Africa’s social grant has evolved into one of the most comprehensive social protection systems in the developing world. It has managed to reach over 10 million South African children every month. The expansion to its criteria for eligibility over the fourteen years has included an increase in the limit from seven to eighteen years old (Hall and Proudlock, 2011). Also there have been adjustments to the income threshold to take inflation into account and improve equity.

Prior to the Child Support Grant the government provided a limited State Maintenance Grant where applicants needed to prove that they were the sole provider and caregiver for a child below the age of 17 (Meintjes et al, 2004).
Divorced and widowed parents together with single parents and those who had their spouses in jail were ineligible to receiving the grant. In a household survey held in 1990 to analyze the impact of this grant it was found that 0.2% of African children were in receipt of the grant whilst 1.5 % of white children, 4% of Indian children and 4.8% of Coloured children received the grant. Receipt of the grant was more eased by one’s location and children living in rural areas were often excluded due to lack of knowledge regarding the grant, an inability to travel to application sites and other administrative problems.

In December 1995 the government of South Africa (post-apartheid error) established the Lund Committee to evaluate the then social protection system and come up with ways of improving it. It was the committee that recommended a Child Support Grant that would reach a greater number of children and families. Its main aim according to Hall and Proudlock (2011) was to provide for the poorest of families and benefit their children. Over the years the application and means test has been modified over and over again to suit the needs of vulnerable children.

Since the year 2002 there have been a diverse set of problems associated with the use of the foster care system to provide financial assistance to the country’s increasing number of orphans, (Children’s Institute, 2011). There has been evidence that the social worker and court based foster care system is not coping with the demand for foster care orders. In May 2011 the North Gauteng High Court ordered the Department of Social Development to design a comprehensive legal solution to the foster care crisis by 2014 (Proudlock et al, 2011). This was due to the fact that a large number of Foster care grants had lapsed by 2009 leaving vulnerable children
without assistance while social workers were unable to provide quality services to abused children due to higher foster care case loads. At the same time caregivers and children had to wait an unreasonably long time for their grants to be processed. Van Dijk wrote that:

The idea of a social worker is that they do some case work, some group work, and some community work. But our social workers are bogged down in foster care case work and so for example, therapeutic interventions are very minimal unfortunately

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In a Children’s court case held in January 2011 child X lived with his mother and his grandmother for the first two years of his life in Eastern Cape. After the death of his grandmother his mother could not afford to take care of him and took him to his aunt and uncle. It was not until the death of his mother eight years later that the aunt and uncle could apply for the Foster Care grant in respect of the child. The question raised was “are orphaned children who are already in the care of relatives without visible means of support and therefore entitled to the Foster Care Grant?” The court felt the family only wanted the foster care order to alleviate its financial position and that the foster care system was now being used as an income maintenance system. This judgment was appealed and if the High Court overrules the judgment then all orphans will clearly be eligible to Foster care Grants (single and double orphans), (Hall and Proudlock, 2011).

The current Foster Care Grant system demands that the applicant produces both parent’s death certificates, and affidavit stating who they are in relation to the child and why they are applying for the grant. It is with no reasonable doubt that some orphans are left in the care of extended relatives and grandmothers who have no clue who the fathers or sometimes mothers of the children are. Most of the orphaned
children are left without birth registrations and caregivers face problems when trying to register the births of the children. While the access to the Child Support Grants has increased substantially over the years the Foster Care Grant remains a favourable option for those who can access it because it is more than three times the amount of Child Support Grants (Jacobs et al, 2005).

Research by the Children’s Institute demonstrates that the extension of the Child Support Grants to all children can play a critical role in supporting children through the AIDS pandemic in South Africa, (Avert Organization, 2004). It argued that the current financial assistance offered by government to orphans (namely the Foster Care Grant) is inappropriate and inadequate in the face of HIV and AIDS because the number of foster care cases in many parts of South Africa already exceeds the capacity of social workers and courts. As a result a lot of orphans are unable to access Foster Care Grants. This is the case as Tembisa Child and family Welfare Society where families have to wait a year or two before their applications are processed. At the time of processing some children are already deceased or the prospective foster parents themselves. In other cases the children end up moving to other areas as the prospective foster parents cannot afford to provide for them.

Even after the government has allowed for extension orders for foster care to be extended until the child turns eighteen and not every two years there is still a lot social workers and courts are facing in the bid to make foster care applications a lot faster for clients (Grey, 2011). The continued use of the administratively complex foster care system for the provision of basic financial support for orphans brings the
child protection system to its knees rendering it even less able to provide protection to children who really need it.

The Children’s Institute (2011) further noted that the poverty of children is neither synonymous with nor exclusive to orphanhood. According to them a social security system which provides grants to orphans under the age of 18 without providing adequate support to many other impoverished children whose parents are alive is simply discriminatory. In other words it fails to make provisions for the multitude of other children growing up in vulnerability due to HIV and AIDS. There are many South African children growing in the care of HIV and AIDS infected mothers or fathers and receive no social support from the state (Rosa and Meintjes, 2004). Their vulnerability is therefore not taken into consideration because one of the parents is still alive.

2.5 Experiences of Orphans

Children orphaned by HIV and AIDS tend to suffer many ailments from the time their parents are ill till their death. It is no surprise why most would tend to explain their orphanhood as beginning during the illness of their parent (Kawewe, 2006). Although there have been reports of hope and resilience, there have been recent studies providing a foray into the life experiences marked by significant difficulties and unsuspected life changes, emotional pain, fears about the future, stigma and losses. In most cases children report having to grow-up assuming grown up duties because of the emotional and care duties placed on them. For adolescent children who are mostly unaware of the nature of their parents’ illness and its nature find the need to be aware of its cause and the death. In most communities in Zimbabwe according to
a study held by UNICEF (2006) the importance of silence as a virtuous way of coping was very hard emotionally especially on older siblings who had to assume responsibility for the younger ones. It is said that most of the children found comfort and a sense of distraction if they had the ability to attend school.

In the case of Tembisa where most children were born in the township with little or no knowledge of their extended families outside Gauteng, orphaned children are mostly left at the mercy of communities. Often in such cases within a month or two of losing a parent community members would have grown weary of taking care of the children and they are brought to the hands of the organization. The children at that stage are usually in a state of loss.

Many children now belong to no one as they are left in homes without anyone to raise them (Bojer et al, 2007). In addition to this children suffer from the mythology and stigma attached to being orphaned by HIV and AIDS which deters relatives from assuming custody and care for them. In other situations poverty and financial resources at all levels of society make the economic burden of caring for orphans almost impossible. For most nations like South Africa the option for caring for these children is to place them in institutions despite the well-documented short and long-term adverse effects and limitations to human development and social functioning for children growing up in such settings.

Marcus and Harper (2000) assert that orphans engaged in parental roles lose out on their schooling and childhood. According to them a reinforcement of poverty and HIV and AIDS denies a lot of orphans the right to education. A lot of studies have shown
that African orphans were less likely to be at school than non-orphans and double orphans were the most severely affected. In Uganda, Kampala it was found that an establishment of a relationship between poverty and HIV and AIDS, abject deprivation increases in orphanhood as children become vulnerable to extremes of starvation and hunger, sexual exploitation and abuse, including child labour as farm and domestic workers.

2.6 Conclusion

The phenomenon of HIV and AIDS and orphans is very overwhelming as the pandemic is often damaging to children. It affects children directly with some being left infected by the virus and leaves some affected by the experience of watching a care giver suffer and die from the disease. Communities are failing to provide these orphans with the care and support they deserve. The overwhelming rate at which children are orphaned leaves the government and many social service professionals with no choice but to ‘warehouse’ these children in institutions. A large number of caregivers to HIV and AIDS orphans are made up of females. Though social services are doing all they can to promote resilience to survivors through the strengths perspective and the buffering perspective, the pandemic keeps deepening and resources to enable people to cope are limited. The strain and hardships of coping are felt by caregivers and the orphans themselves. Social assistance put in place to assist caregivers seems to be making some difference for some children although there are still issues arising from the projects. This chapter explored the information outline above.
CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

Research methodology according to Williams (2011) refers to a clear cut idea on what the researcher is carrying out his research on. It creates the right platform for the researcher to map out the research in relevance to make solid plans. According to Williams (2011) the research methodology drives the researcher in the right track. The entire research plan is based on the concept of right methodology. This chapter therefore discusses the methodology that was used in this study for the purpose of collecting data required to evaluate the support mechanisms provided to HIV and AIDS orphans. It describes and justifies the qualitative research design that was used to provide answers to the research questions. It also looks at issues of access and entry to the research site, Tembisa Child and Family Welfare Society. Further, it describes how data was collected from the HIV and AIDS orphans, their caregivers and the social workers working with them. Finally, it outlines the data analysis procedures that were employed in this study. This chapter therefore includes research design, research instruments, data collection procedures, data analysis and ethical considerations.

3.2 Research design

Creswell (2008) believes that once the researcher has developed an understanding of the rationale behind the choice of engaging in any form of research (either qualitative or quantitative) he designs the study. Denzin and Lincoln (2000) define research design as a set of guidelines and instructions to be followed in addressing
research problems. Research design is the procedure or strategy that the researcher uses or adopts to do or approach the research process. Fouche (2005) acknowledges the ambiguity that rests in the definitions of the term research design. However, for the purpose of this study, research design refers to ‘all the plans, steps and decisions the researcher makes to conduct the research’ De Vos et al (2005). Creswell (1998:2) as quoted by Fouche (2005) extends this definition and defines a research design as an ‘entire process of research from conceptualising a problem to writing a narrative’.

A qualitative research design was used in this study. Qualitative research according to Shank (2002) involves ‘a form of systematic empirical inquiry into meaning’. Systematic means ‘planned, ordered and public’ which explains the process in which data is collected. By empirical Shank (2002) meant that this type of research inquiry is grounded and based on the experiences of the world. Denzin and Lincoln (2000) believe that qualitative research involves an interpretive and naturalistic approach. This means that qualitative researchers study things in their natural environments and attempt to make sense of, or interpret phenomena in terms of meanings people put to them.

Creswell (2002) further defines qualitative research as an approach useful for exploring and understanding a central phenomenon. The goal of this method was to learn about the phenomenon. The researcher asked participants broad general questions, collected the detailed views of participants in the form of words and then analysed the information for description and themes. From this data the researcher
interpreted the meaning of the information drawing on personal reflections and past research, (Creswell, 2008).

3.3 Justification of the use of qualitative research method

A qualitative research approach was suitable for this study because the researcher sought to understand the social support mechanisms available to HIV and AIDS orphans. Qualitative research was chosen because the researcher wanted to evaluate the social support mechanisms provided to HIV and AIDS orphans in Tembisa. Furthermore the researcher hoped to understand the challenges orphans face in their everyday lives and how they cope with them. Understanding this information would require the researcher to find out also how the caregivers view the situation of the orphans in their care and also how the professional social workers working with this group of children cope with the challenges they meet in service provision.

The researcher heard from the orphans themselves, their caregivers and the professional service providers what challenges they face with the social support systems currently in place for the HIV and AIDS orphans. Through this method of research the researcher was able to study the phenomenon in its natural setting and attempt to make sense of or to interpret it in terms of the meanings people bring to it (Denzin and Lincoln, 2000).

Qualitative research was advantageous to this study because it aims to comprehend phenomena of support mechanisms offered to HIV and AIDS orphans. This research was more suitable rather than the quantitative research methodology because it
derives the interpretation from the perspectives of those working directly with the orphans (social workers and their caregivers) and the orphans themselves. Unlike quantitative researchers who seek to quantify the problem and understand its prevalence by looking for projectable results to a larger population, qualitative researchers seek instead to explore a phenomenon in which one has no prior knowledge of what to expect (Surveygizmo, 2010). Qualitative research according to De Vos et al (2005:269) differs from the quantitative research design in that it does not usually provide the researcher with a step-by-step plan or a fixed recipe flow. A qualitative research method was significant for evaluating the social support mechanisms for HIV and AIDS orphans as it concentrates on the everyday lives of orphans and how they are coping through life (De Vos et al, 2005) which is intentional and creative, easily explained and not predicted.

3.4 Population

Powers et al. (1985) in De Vos et al (2005: 193), define a population as a set of entities in which all the measurements of interest to the researcher are represented. Seaberg (1988) also in De Vos et al (2005) define a population as the total set from which the individuals or units of the study are chosen. From these definitions it is clear that population generally refers to a large collection of individuals or objects that is the main focus of a scientific inquiry (Castillo, 2009). It is a well-defined collection of individuals or objects within a certain population usually having a common binding characteristic or trait. In the case of this study every individual who is a resident of Tembisa Township made up the population of the study. The researcher found it difficult to interview every member of the studied population; hence the researcher selected a sample. For the purpose of this study the population
was constituted of all female caregivers, social workers and HIV and AIDS orphans being serviced by Tembisa Child and Family Welfare Society.

3.5 Sample

A sample, to quote Arkava and Lane in De Vos et al (2005:194), comprises elements of the population considered for actual inclusion in the study or simply a subset of measurements drawn from a population in which one is interested in. It is useful in explaining some facet of the population. The Oxford Dictionary (2003) defines the sample size as the units to be included in the sample. The units of analysis or sample size include individuals or groups from whom research study responses will be elicited. Strydom H. (2005) defines a sample as ‘elements of the population considered for actual inclusion in the study’. This study was only limited to HIV and AIDS orphans being serviced by Tembisa Child and Family Welfare Society and also residing there. Furthermore the study also targeted the caregivers to the orphans and the social workers who are servicing them. This research made use of 13 caregivers and 2 social workers. The number of orphans used was determined by the information the researcher collected. Since the research made use of qualitative research methods, the sample was kept at a minimum so as to avoid having to analyse bulky information that might lead to biased findings. The choice for the sample size was mainly based on the need for accuracy required by the researcher and the need to explore, understand and evaluate the phenomenon under study (Shank, 2002).
3.6 Sampling procedure

According to De Vos et al (2005) there are two major groups of sampling procedures, probability and non-probability sampling. The former being based on randomization whilst the latter is done without randomization. For the purpose of this study the non-probability procedure was utilised. Sampling is necessary due to the fact that getting data from all population elements is close to impossible and can also be very expensive to do. This study utilised a purposive non-probability sampling procedure. Purposive sampling is based on the ‘judgement of the researcher that a sample has typical elements which contain the most typical attributes of the population’ (Singleton et al, 1988 in De Vos et al, 2005). According to Social Research Methods a purposive sample is a non-representative subset of some larger population and is constructed to serve a very specific need or purpose.

Purposive sampling procedures were used for the purpose of drawing a sample. Therefore one sampled with a purpose in mind. An advantage of purposive sampling is that the researcher can reach a targeted sample quicker especially where sampling for proportionality is not a primary concern. A limitation of purposive sampling is that since it is the responsibility of the researcher to choose participants, there is a possibility of bias or a likelihood of overweighing subgroups in the population that is more readily accessible (William, 2006). For the purpose of this research the samples were drawn from the caseloads of social workers in Tembisa Child and Family Welfare Society. Participants comprised of female caregivers to HIV and AIDS orphans in the caseloads.
3.7 Data collection Instruments and Administration

Data collection is the process of gathering and measuring information on variables of interest, in an established systematic fashion that enables one to answer stated research questions and evaluate outcomes. This study employed an interpretive approach which assisted the researcher to make reasonable evaluation of the information gathered. This approach is mostly concerned with interpreting meaningful human and social action (Nkomo, 2006). Semi-structured interviews were used to provide the researcher with more detailed information about the participants’ personal experiences, views and challenges. It also allowed the researcher to probe for more information. Focus groups were also used as means of collecting data. The researcher asked questions, listened attentively, learnt and understood what was meaningful to the research participants through their eyes and perspectives (Creswell, 2008).

3.7.1 Interview guide

The study used semi-structured interviews with the aid of interviewing guides targeting the HIV and AIDS orphans. The interview guide consisted of non-directive unstructured questions. The interview guides were written in English but the interviews were conducted in English and Zulu. The questions on the research guide were meant to guide the participants and the researcher to keep to the objectives of the study. The interviews conducted were recorded with an audio recorder to make it easy to analyse the data and also to avoid misquoting the participants.
Interviews are face to face meetings between the interviewer and the interviewee and according to De Vos et al (2005) they are a predominant mode of data collection in qualitative research. For the purpose of this research semi-structured interviews were used. These are defined as organized around areas of particular interest while allowing flexibility in scope and depth (Morse in De Vos et al, 2005). This allowed the researcher to probe, creating the flexibility that is so significant for exploring unanticipated issues. The purpose was to understand as much as possible the experience and views of the participants concerning the objectives of the study so as to allow the researcher to draw suitable conclusions. Interviews gave the researcher a platform to ask for elaboration or redefinition if a response appeared to be incomplete or ambiguous. Face to face interviews were ideal for this study as they allowed the researcher to probe more and understand what the participants thought about the support systems that are available for HIV and AIDS orphans.

The interviewing strategy was conducted at a relatively modest cost and in relatively brief time. An interview was advantageous as it exposed the researcher to the participant's world views and permitted considerable probing. It allowed participants to react and build upon their responses as they influenced and interacted with each other. It provided speedy results.

3.7.2 Focus group

Focus groups were used as a method of collecting data and they targeted Tembisa community members, care workers and social workers from Tembisa Child and Family Welfare Society. Focus groups are a means of understanding how people feel or think about an issue (De Vos et al, 2005: 299) and can help understand how
people feel about the issue being studied. Participants in the group were allowed to share their perceptions, points of views, experiences and wishes without any pressure. The worker created an environment tolerant and non-threatening to all participants. The group involved fifteen participants.

3.8 Data analysis

De Vos et al (2005: 333) explain data analysis as the process of bringing order, structure and meaning to a mass of data collected. Zimmerman (1992) in De Vos et al (2005:84) refers to data analysis as a search for pattern in recurrent behaviours or objects of body knowledge. Creswell (2002:99) defines it as a process of bringing order, structure and interpretation to the mass of data collected. Once the research reached a point of saturation (Gambril, 2010: 318) the data collection process was concluded.

Qualitative data analysis was used. This according to De Vos et al (2005), qualitative analysis is a search for general statements about relationships in different categories of data. The researcher went through the transcripts of the collected data with the use of a translator. Data analysis was done through the process of data coding. Through reading the transcripts the researcher came up with the underlying meanings of the information gathered. This process was repeated until a list of topics was acquired. Topics were then clustered together into baskets and were labelled as ‘major topics’, ‘unique topics’ and ‘left overs’. Data were then categorised into themes after finding the most descriptive wording for the topics as correctly stated by De Vos et al (2005: 319).
3.9 Ethical Considerations

In line with the ethical requirements of research, the researcher consulted with relevant authorities to gain access to research components. In order to gain access to the participants the researcher gained permission from the University in the form of a clearance letter and from Tembisa Child and Family Welfare Society’s management. With regard to ethics in research, the following ethical considerations were exercised:

3.9.1 Informed consent

According to De Vos et al (2005), obtaining informed consent implies that all possible information on the goal of the investigation, the procedures, advantages, disadvantages, dangers and the credibility of the researcher will be rendered to potential subjects or their legal representatives. The involved participants were informed of the nature and purpose of the research, its risks and benefits and consented to participate without coercion. The participants were given a consent form to sign (adults) and they werelegible to withdraw from the research when they felt like it. Children were asked to verbally consent although their caregivers had to sign consent forms of acknowledging that they knew their children were participating in the research.

3.9.2 Anonymity and Confidentiality

To observe the principle of confidentiality and anonymity means handling information about subjects in a confidential manner. It places a strong obligation on the researcher to guard jealously against information that he/she is confided in by the participants (Strydom M., 2005). The researcher assured the participants that the
information they shared would not be disclosed to anyone but that it would be shared with the institution to which the researcher is studying under. Sustaining confidentially eliminates the risk of harm and embarrassment to those studied.

3.9.3 Debriefing of participants

Participants were debriefed after every session so as to eliminate any problems that might have arisen during the research. Emotional harm to participants is not easy to detect and therefore a debriefing session allowed the researcher to discuss the feelings of the participants and explain the basic intent of the study (De Vos et al, 2005). Debriefing allowed the researcher to rectify any misperceptions that might have risen in the minds of the participants.

3.10 Limitations

Due to the purpose of the research, participants might have overemphasized their situation in a hope that the researcher might bring quality services in due course. On the other hand the participants might have given socially acceptable answers in order to hide their situation and thereby distorting the data that was being collected. Also the fact that the researcher is part of the Tembisa Child and Family Welfare Society’s social workers might have influenced some responses to be biased. The time frame of the research was also a limitation.

3.11 Conclusion

This chapter reflected on the research methodology that was used for the purpose of this study. The data gathering methods employed in the research were also discussed. The data analysis and procedures were also explained and discussed.
Ethical considerations, limitations and delimitations were also discussed. In the next chapter the findings of the research study and a comparison with the recent literature will be provided.
4.1 Introduction

This chapter presents the findings obtained from semi-structured interviews conducted with HIV and AIDS orphans and also the focus group discussion conducted with social workers and child care givers selected from the data base of Tembisa Child and Family Welfare Society. Furthermore, in this chapter, the findings are discussed in a narrative and exploratory format. These are supported by appropriate quotations from the transcribed interviews. Subsequently the findings are compared to and supported by the relevant literature. A qualitative investigation was undertaken to find out the perceptions of the orphans, with regard to the social support systems supporting HIV and AIDS orphans in the area. This section provides the findings according to the themes that emerged.

4.2 Biological characteristics of participants

Interviews were held with 12 orphans within the age range of 10-18 (both affected and/ infected with HIV and AIDS). These children consisted of 6 boys and 6 girls and they were selected purposively from the data base of HIV and AIDS orphans receiving services from Tembisa Child and Family Welfare Society. The idea was to involve children who have knowledge regarding the subject topic so as to acquire the correct information. Stigmatization and labelling were avoided.

A total number of 8 children interviewed were both affected and infected with HIV and AIDS and 4 indicated that they were affected only. Seven of the orphans were
maternal orphans with unknown fathers, 2 were paternal orphans with unknown mothers and 3 of them were double orphans. Issues of HIV and AIDS orphans and children still continue to affect people of all ages, nations and living conditions. The population of orphaned children in Tembisa is very high with Tembisa Child and Family Welfare Society recording a number of more than 3000 families every year. The average dependency ratio in most of these families is 1:3. In all cases reported to the organization of very ten, eight are of orphans affected or infected by HIV and AIDS.

Of the children 5 reported to be residing in either shacks or as tenants in outside rooms. Four interviewees reported to be staying in their parental homes and three reported that they lived in the homes of extended family members and that their parents never owned houses of their own. Child D stated that:

I live with my three siblings at my grandmother’s house. My mother used to live with us before she fell sick and passed away. Luckily for us we are the only family my grandmother has now...

For most of these children though the case is quite different and Child H highlighted that:

My aunt has four children of her own and they are girls. She and my mother stayed together in our shack from the time I was born. The shack is two roomed and had one bedroom which my aunt and cousins sleep in. Two of my cousins now have children... there is hardly any space...

A focus group was done and 15 participants were involved. Amongst these participants were two social workers attached to Tembisa Child and Family Welfare Society, three child care workers and ten members of the community (foster parents and significant others). All of the participants were black South African. Amongst the participants 10 lived with HIV and AIDS orphans, 5 were also infected with HIV and
AIDS. The participants’ ages ranged from the age of twenty one (21) to sixty five (65) years.

4.3 Challenges faced by HIV and AIDS orphans

The study aimed at investigating the challenges that are being faced by HIV and AIDS orphans and the results of these are highlighted in this section.

4.3.1 The state of health of Orphans

HIV and AIDS has in the past presented a continuum of complex health issues that ranged from protecting personal health to ensuring that societies have adequate supplies of health care. In Tembisa the main hospital (Tembisa Hospital) has a facility specifically for children infected with HIV and AIDS. All the children participating in the study that are on Anti Retro Viral medication or Immune Boosters claimed to attend check-ups at the hospital (Masakhane clinic).

Child F stated:

I started taking Anti Retro Viral treatment at the age of 5 (now 15 years old). It has been a routine for me and they are now like a part of me. My aunt usually takes me to the clinic for my check-up but when she is not available to do so I go on my own...

Caregivers reported to understand the need to keep the children under constant monitoring to ensure that they do not default on their medication. It was however an agreement to most of the participants in the focus group that keeping track of what the children ate and did during school hours was difficult. They reported that because these are children and they like to experiment, they eat most of the things that they are told not to eat at the hospital. They eat these things behind the caregivers’ backs. Such defaults only come to light when the children’s viral loads spiral after hospital check-ups.
4.3.2 Food insecurity

Health and nutrition statuses tend to decline as less money is often available to properly feed the household. One community member reported that the greatest challenge they have with caring for the orphans is that having an extra mouth to feed is not easy with the present day economy. Community member 1 stated:

I have five children of my own and when my brother died his three children came to stay with me as his wife died too and I am the only family left. Two of his children are attending school and the youngest is at crèche... my salary was not enough to feed and clothe my children...

Through the organization’s Family Preservation programme many community children find a source of food security from the food parcels handed out every month. Normally family preservation is meant to work with a family for at least six months and discharge afterwards. One social worker stated this:

Some of our clients are placed on family preservation as a temporary measure whilst we work on processing their foster care applications which normally take longer than a year...

Tembisa is not an agrarian region hence farming for food is not an option for many care givers. None of the community members in the focus groups reported to have a backyard garden in their homes as they claimed that space is taken up by outside rooms which they use as a source of income.

4.3.3 Poor Education

The loss of a parent due to any disease is not easy on a child. Losing a parent to HIV and AIDS is not easy for most children as they suffer from psycho-social effects and often lose concentration at school. Seven of the children interviewed were aware that their parents died of HIV and AIDS and two of these witnessed the illness and death of their parents. Child B reported:
I was twelve and the eldest. I would help to wash and dress my mother. She was very sick but did not want to go to the hospital until it was too late... She passed away at home in my presence (sobs)...

The child reported that during the time her mother was sick she went to school occasionally so as to help look after her. Her performance at school dropped a lot that she had to repeat some grades. Four years later she still remembers the death of her mother like it was yesterday.

In all the interviews the participants indicated that HIV and AIDS related sicknesses affecting their deceased parents affected them in their school performances. Others (four) suffered through absenteeism at school and hence missed out on some lessons and important tests. Others (six) had to drop out from school after the death of their parents and re-start at a later stage in a new school with present care givers. Some (two) because of family circumstances were forced to enter into the system and be institutionalised hence resulting in stigmatization by other learners at school. These and other factors have resulted in low performance by most HIV and AIDS orphans as well as the overburden placed on care givers to address their needs.

4.3.4 Poverty

Poverty is still a big challenge for many orphans of HIV and AIDS. According to Nyawasha (2006) the death of a parent signifies the disruption of the basic pattern of a child’s life. With death comes the challenge of meeting the child’s basic needs and basic food requirements. Child B reported that she and her siblings stayed with their parents in the rural areas of Limpopo where life was simple and much cheaper. After the death of their mother they had to move to Tembisa to stay with their maternal aunt as she is the only surviving family they know. She describes life in Gauteng
(Tembisa to be precise) as very expensive as their aunt has to put food on their table every day, clothe them, pay bills and school fees. When asked how they survive Community member 4 said that, “We wait a long time to have foster care grants paid out and most of us are unemployed and survive on part time jobs that give us less than R500.00 a month…”

Another community member also highlighted that, “...if it were not for the outside rooms I built from a loan I got from the bank last year life would be very hard for us... Rental money from tenants helps us…” For most orphans though the loss of parents means no more income in the house. The death of a parent can leave the children unable to maintain their home. Saifaids (2004) in Nyawasha (2006) states that increasing poverty can cause a degradation of the immediate family environment and increases health risks whilst reducing its ability to obtain health services.

4.4 Social support given to orphans
Social support according to Martin and Mushett (2011) is the perception and actuality that one is cared for, has assistance available from other people, and that one is part of a supportive social network. Although all the orphans claimed to have social support (emotional, tangible, informational and companionship) from one place or the other they were all adamant that more could be done.

4.4.1 Emotional support
Emotional support is explained as support which offers empathy, love, trust, acceptance, encouragement or caring according to Martin and Mushette (2011). It is often referred to as esteem or appraisal support and builds on one’s self esteem.
Children whose parents are living with HIV experience many negative changes in their lives (Avert Organization, 2012). Every child interviewed reported that they valued emotional support as it made them feel valued and part of the families they belonged to. Most responses reflected that this sort of support emanates mostly from home than any other source. Child A was quoted saying, “My mother (referring to foster parent) is very loving of me and my siblings (referring to the foster parent’s children)”.

From the statement above it is clear that the child sees himself as part of the family and has a strong sense of identity to his foster family. Although the child lost his parents the emotional support given by the present caregiver and her family is helping to cover that gap. However a minority of the orphans (two) expressed that they have been discriminated against by friends at school who knew that their parents were very sick with HIV/AIDS. The researcher noted shyness and a form of isolation from such children. Child E stated that, “My friends no longer want to ‘hang out’ with me because they think I will also get sick like my mother”. The child stated that she never gets an opportunity to talk about this with her aunt as she gets home very late and tired from work. It is clear from the findings above that most children lack emotional support from their caregivers as they have busy schedules during the day. Most caregivers agreed that they do not get to spend enough time with the children so as to talk to them and understand what they are going through. One caregiver reported that the child under her care was unaware that they were HIV positive for quite a long time. She reported that the child was devastated and angry at the parent for not telling them sooner. Caregivers agreed that it was very difficult for them to open up and tell the children about their statuses. One social worker
indicated that, “as much as it is not easy to tell these children their statuses it usually works better if they knew possibly from a very young age...” In agreement with this Caregiver 6 shared how she helped her grandson accept his situation. She said,

I told my grandson when he was only five years old about his condition. His teachers and friends knew and whenever he would get hurt playing he made sure his friends did not touch his blood... He carried his medical kit to school and always insisted they call me...

Emotional support therefore becomes easier when caregivers become more open to the children. It was further discovered that some of the orphans were unaware that their parents were deceased. They believed that their caregivers are their parents. Literature however reveals that most children begin to experience material and physical loss long before they are orphaned (Avert Organization, 2012). It is stated that most parents become unable to work and support their children and hardly have the time to talk and connect with the children. According to the Family Health International (2002) usually the neglect is not intentional but is caused by the situation parents find themselves in. Young children whose parents are infected with HIV may also suffer emotionally as they have to watch their parents succumbing to the disease and eventually experience deaths, causing further emotional trauma. Therefore HIV and AIDS are most likely to constitute chronic stressors in the lives of many South African children. Not only do they have to live without being with the familiar care of their parents, they also have to bear to learn living with new caregivers. Children grieve differently and literature has shown that they grieve longer. Harden (2006) believes that this grieving often has long term effects on the behaviour of the children and also on their active participation in society. It is clear from the findings above that most children lack emotional support from their caregivers as they have busy schedules during the day.
4.4.2 Tangible/instrumental support

This is a function of support that involves the provision of financial assistance, material goods and services (Helgeson, 2002). It encompasses the direct ways people assist others. Most of the community members in the focus group agreed that the support group for HIV and AIDS affected and infected caregivers being run by Tembisa Child and Family Welfare Society has been helpful support to them. Through the group people living with HIV and AIDS receive psychosocial support from social workers. They are taught on the way of raising the children and of coping with the daily stress and burden that comes with it.

Four of the community members involved in the focus group were foster parents who are fostering children affected and infected with HIV and AIDS. They reported that the government has been very helpful with the foster care grant that is paid towards meeting the basic needs of every orphan. However they all shared the same sentiments that they felt urgency had to be placed on applicants with children infected with HIV and AIDS. Community member 5 highlighted that, “Applying for the foster care grant takes a long process... infected children must receive first preference and not made to wait long...”

The Children’s Act 38 of 2005 allows for orphaned children both affected and infected to receive a foster care grant which is currently worth R770.00 per month per child. This comes after a qualified social worker conducts investigations concerning the child’s background, current placement and schooling progress. A Section 155 report is compiled, canalized by a senior supervisor and sent to the Presiding officer of the Children’s Court for finalization. Due to many people
scamming the government by claiming that the parents of the children are deceased when they are not, before finalization the child’s story must be published on the local paper under foster care applications. After publication the child waits for a month before their report can be finalized by the Children’s Court. The waiting kills the foster parents who often claim that the Child Support Grant of R280.00 is not enough to provide for the needs of the children. Community member D stated that:

It is difficult to maintain a healthy balanced nutrition for the children, provide for their educational needs and most importantly their health needs with the Child Support Grant... I spent a year before I could get the Foster Care grant paid out...

Due to organizational backlogs social workers reported that they are having a difficult time processing foster care grants speedily. However Tembisa Child and Family Welfare Society run a social support group for affected and infected caregivers. The group runs with members of about 40. The group offers emotional as well as instrumental support to its members by visiting them in trying times, attending to bereavements within the group and most importantly the provision of food parcels and medical kits. The beneficiaries to the support group expressed that through the support of the group most of them have been assisted to get birth registrations for the children in their care enabling them to access government grants. There was a concern though that the moneys received from the Child Support and Foster Care grant respectively were just not enough to meet the needs of the children.

Most caregivers claimed that life used to be easier when they could register for both the foster care grant and the disability grant as most of them are of old age and can no longer afford to get employed. They explained that nowadays accessing the disability grant because of being HIV infected is a huge struggle. One caregiver reported that her doctor had qualified her for the disability grant but the doctor
appointed by the state at the South African Social Security Agency (SASSA) felt she was undeserving of it. Most applications are said to be rejected in this manner and participants claimed that this was causing a great challenge for them. Social workers reported that though most of their clients reported to them that the food parcels they received on a monthly basis were very helpful they still felt it was very little especially for families surviving on the Child Support Grant.

4.4.3 Informational support
This function of social support entails the provision of guidance, advice or useful information to someone. It has the potential to assist others solve problems. In the case studied it was found that the majority of informational support was received from social workers and support group members. One worker stated that: “...we talk to our children concerning HIV and AIDS and how to live with themselves after being affected and infected with it...” However it was the agreement of all members of the focus group that though information is being offered to the children there is still a high number of orphans mostly infected who are getting pregnant. This raised a concern for the group as it meant that the children were being reckless despite some of them actually knowing their statuses. One child was quoted saying, “Sometimes we just want to experience a normal life without boundaries like any other children...” Children interviewed stated that they most often felt like they lived in bottles and were not free to explore the world like other children their ages. They expressed that instead of going to the movies and parties their caregivers insisted on keeping a close eye on them so that they don’t eat the wrong foods, forget to take their medications or for some end up being infected like their late parents were. Instead of taking the information given to them as information to save their lives they felt that it
impinged on their freedom of expressing self and constantly reminded them of their conditions.

Social workers claimed that they offer talks to children at schools but feel that most of the children are either taking the information they receive for granted or others are simply victims of external pressures. One worker was quoted however saying:

Most schools are not cooperative when we try to initiate talks on HIV and AIDS to their children as they claim their children know everything as they are teaching them...

The sad part noted by the social workers and most caregivers was that when they do finally talk to the children concerning these things they always find that they are not as informed as the educators paint them to be.

4.4.4 Companionship support

This is the type of support that gives one a sense of social belonging and is seen as the presence of companions to engage in social activities with. The National Institutes of Health (2009) reported that families form the most fundamental and lifelong support systems for children. However from the moment children affected and infected by HIV and AIDS came into the spotlight they have been portrayed as abandoned and alone (Meintjies, 2006). With respect to these children people have gone too far as we only tend to see the figure, the child, but no ground. We seldom see their caregivers and families despite their great need for assistance. We forget that it is the aunts, uncles, grandparents or older siblings, who take the children to the clinics, feed, care and clothe them (National Institute of Health, 2009). Tembisa Child and Family Welfare Society in its psycho-social support for caregivers of HIV and AIDS orphans incorporate companionship. As a means of assisting caregivers to
unburden them once at the end of each year an outing is made for them where they go out and have fun away from the hustles of parenthood. The caregivers in the focus group stated that most of the time they feel overwhelmed with caring for the children that they hardly have time for themselves. One caregiver indicated that, “Having people to talk to who are going through the same things you are going through makes life much easier…”

One of the social workers stated that the outing is a form of self-care for the caregivers. The fact that most caregivers are old and hardly have time to treat themselves gave the organization the idea to create this opportunity for them.

4.5 Roles played by social workers and the challenges they face
In the provision of social support to the orphans the study noted that there were several roles that came into play for the social workers involved.

4.5.1 Organisers
The major role played by most social workers dealing with HIV and AIDS orphans is that of organisers. Apart from organizing for meetings and activities for the child support groups they run they also organize for talks and other community development plans. The workers explained that they get to organize for members of the group to meet, plan sessions accordingly and collect information necessary for the groups to benefit from.
4.5.2 Educators
Most of the participants both from the focus groups and the interviews agreed that the social workers played the roles of educators as most of the information that has helped them cope with their conditions emanated from them. Social workers are often involved in teaching about resources and ways of developing skills like efficient budgeting and communication, the prevention of violent acts, amongst other things.

4.5.3 Facilitators
In this role social workers are involved in gathering groups of people together for a variety of purposes that include community development. They are involved in group therapies and task groups. The greatest challenge with facilitating task groups that the research picked up was that most group members failed to participate in tasks given claiming they were too old and could not manage. Social workers stated that the programme of support groups would be even more efficient if the orphans themselves had a group too instead of just the caregivers.

4.5.4 Case managers
Case managers are involved in locating services and assisting their clients to access those services. For vulnerable children like orphans social workers stated that they often deal with cases were grandparents are left with children who have different surnames from one mother but without birth registrations. At times the caregivers themselves do not have Identity Books. This role allows the social worker to assist such clients and liaise with the Home Affairs offices to register them so that they can acquire the help they need. With birth registration, children can access grants, be registered in schools and enjoy other benefits meant for South African children. One
worker however stated that: “The Children’s Act limits some services to South African citizens only leading us to end up providing food parcels only to the foreign national...” In the case of Tembisa where some residents are from Zimbabwe, Mozambique, Lesotho and Swaziland, the roles of the social workers are limited in assisting caregivers and orphans as they usually do not have the right documentation to be in South Africa.

4.5.5 Brokers

Social workers work as brokers in making referrals to link families or persons to needed resources. In the case of Tembisa Child and Family Welfare Society one worker in particular is responsible for the running of the HIV and AIDS psycho-social support groups. Other workers when they pick up needy families in their caseloads make the necessary referral to the group. If the family does not fit the criteria for the group they are referred to the Family Preservation group that is also run by one worker.

4.6 Effectiveness of the social support systems currently being used

From the study carried out there is evidence that the current social support systems that have been put in place are making a difference in the lives of other HIV and AIDS orphans. A large number of the orphans are being assisted by the Foster Care grant which most care givers are using to benefit the children educationally as well as providing for other basic needs. For those orphans whose care givers are not entirely surviving on the grant, a brighter future is being curved for them as their care givers are putting aside money for them from their grants.
The government’s decision to have Foster care orders lapse when the children turn eighteen years of age has helped ease backlogs for social workers. This therefore means that they can now focus on supervising the grants and to ensure that the money is used for the benefit of the orphans. Moreover this also gives social workers a chance to be more hands on in dealing with issues that care givers and HIV and AIDS orphans run into on a daily basis. Therefore social workers can now provide the four types of social support as mentioned earlier in this document.

4.7 Conclusion

This chapter presented the results of the study which established that social support systems were effective although there were various challenges facing their smooth running. Social support provided to orphans is mainly provided by caregivers, social workers, schools and the government. Further, the support is not entirely enough to help them cope with life. The minority of the orphans indicated that they were not even aware that they were orphaned and the findings of the study have highlighted the challenges they face.
CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

In the previous chapter, the findings of the focus group and unstructured one on one interview analysis were presented and discussed. This chapter therefore provides a summary of major findings and derive conclusions from these findings. Recommendations for social support systems are presented as well suggestions for future research studies.

5.2 Summary of findings

For this end a qualitative data collection approach was used so as to gain an understanding of the perceptions of HIV and AIDS orphans in Tembisa, their social workers and caregivers. Their perceptions towards the effectiveness of social support mechanisms offered to HIV and AIDS orphans were explored as well as the challenges that they met.

In terms of the first objective of the research which was to explore the challenges faced by HIV and AIDS orphans in Tembisa, it was found that the data derived from the study aligned with the related literature which portrays orphan related challenges as impacting on the daily lives of the affected and infected orphans. These challenges are severely activated by poverty, geographical locations, educational needs, food security and health related issues.
The findings further suggest that though the government has placed certain supports like social assistance grants, their misuse and sometimes inaccessibility makes it hard for caregivers to support HIV and AIDS orphans. In the case of infected children, their health is determined by the nutrition they get and getting access to their treatments at the right times. Lack of proper finances were found to be a big challenge as most caregivers were either unemployed or at the age of pension.

The findings of the study strongly support the available literature that argues that children orphaned by HIV and AIDS depend mainly on their extended families to meet their basic needs. Social support also emanates from social workers attached to Tembisa Child and Family Welfare Society. These people act as the support systems of these children and are struggling to maintain and provide for these children’s basic needs. Emotional distress, old age, backlogs, financial lack and time constraints were cited as some of the main causes of social support systems overburdened.

The findings show that most of the caregivers are affected by HIV and AIDS and others are actually infected themselves. They showed that the caregivers themselves were not immune to the disease and were suffering at a personal and emotional level.

The findings indicated that it was difficult for the caregivers to openly talk about HIV related issues with the orphans. This can be attributed to the still existing non-acceptance of HIV and AIDS by other members of the community. Also stigmatization and discrimination towards HIV and AIDS sufferers still seems to be
continuing. Caregivers agreed that their roles have changed from just parenting children to being counsellors, nurses, teachers and social workers. They all agreed that they could not always rely on the fact that their children were learning and getting all the support they need from school as it was usually not the case.

It was the agreement of most of them that the support they receive from the Child Welfare Society had eased some stress in their parental roles. However the fact that the psycho-social support group was only for the parents made them feel like their children are not being given enough attention.

The findings of the study revealed that social workers as part of the social support systems of HIV and AIDS orphans are also impacted by HIV. It was their view that they could do more for the orphans and that they are currently not giving them the support they would love to. The greatest challenge they agreed to face was burnout from huge caseloads that they handle on a daily basis apart from the HIV and AIDS orphans cases. They seemed to agree that the time they spend on other statutory cases took up most of their energy that could be channelled into supporting the orphans.

The social workers also felt that there was a need for special training on how to run HIV and AIDS support groups that targeted all social workers in the organization. They felt that the training would improve their attitudes and knowledge with regard to addressing HIV and AIDS related issues. The idea was that although the Social Work programme lately trains generic social workers, none of them have specific training on handling HIV and AIDS related issues. Therefore this led to only one
worker focusing on the project and the rest strictly focusing on foster care cases and backlogs.

The social workers further felt that all children, irrespective of where they originated from deserved to receive the same services. They felt that government assistance needs to be uniform for all HIV and AIDS orphans and that it was not enough for others to survive on material support only whilst others are receiving social assistance. They felt that they received less support from the Government and their superiors to initiate and run support groups properly.

The non-availability of a working relationship between educators and the social workers was also raised as a contentious point as they felt that the reason they were fighting a losing battle with most of the orphans was that they were not well informed of their conditions.

5.3 Conclusions

From the findings above it is safe to conclude that HIV and AIDS orphans in Tembisa still need a lot of resources especially when it comes to social support systems. The study revealed that there are a lot of orphans and very little labour power (social workers) to handle their needs. This therefore leads to orphans having little support from organizations in terms of social support groups and the likes.

The findings also show that caregivers themselves are struggling with dealing with the HIV and AIDS pandemic as they themselves are carriers who also have to deal with the loss of their children or parents, and are left with the burden of caring for
orphans. The burden becomes unbearable because most of the caregivers are unemployed and those that are employed make a low income and have other dependants to care for. Accessing state assistance is sometimes a major problem as some orphans are left without birth registrations. Those that do get the assistance are either finding it too small or misusing it.

Also it can be concluded that social workers as support systems need more support from the organizations they work in so as not to suffer from burn-outs. Only one social worker in the organization is responsible for running psycho-social support groups in the organization. The number of HIV and AIDS affected and infected children and families grows every year. The workers are not coping with the group and also other statutory work requirements they need to fulfil. At the end of the day they do not have time to fully focus their strengths and ideas into improving the lives of HIV and AIDS orphans and their caregivers.

State funding for programs like HIV and AIDS psycho-social support groups must always be punctual and ready for Non-Profit-Making organizations. This will ensure that organizations are able to buy food parcels and medical kits on time and also allow them to budget and plan for events for the groups. Therefore the conclusion drawn from this study is that social workers, caregivers and the state need to work together to better the social support that is already available for the orphans and also to come up with more support for the future.
5.4 Recommendations

Given the realities, it becomes apparent that the South African government must take urgent actions in grooming available social support systems. There is a need to provide for ongoing support systems for HIV and AIDS orphans. Not only do effective social support systems groom self esteemed youth but they also groom a responsible and well informed population. HIV and AIDS orphans need to know that HIV is no longer a death sentence but a condition that can be handled when one has the right support.

1. **Policy makers should actively be educated about the importance of social support systems for orphans.**

This can be done by:

- Advocating for HIV and AIDS social support modules to be introduced for all practicing social workers.
- Putting programs in place for all affected and infected orphans and caregivers to access.

2. **Through the involvement of the community at large, in the fight against stigmatization and alienation of orphans due to their health statuses.**

- Actively involve community members in programs dealing with HIV and AIDS.
- Community education
- Educate all those named as role players in providing social support to orphans (grandparents, aunts, uncles, siblings).

3. **Health education with special emphasis on reproductive health to improve the orphans’ knowledge of the dangers they put themselves in when they do not leave a healthy lifestyle.**
If HIV and AIDS infected children are taught how to live healthy lifestyles the re-
ocurrence of orphan hood due to HIV and AIDS could be stopped. The emotional
stress and depression that the orphans themselves went through when they lost their
own parents could be avoided. Furthermore a healthy lifestyle means a longer a
fruitful life hence caregivers do not have to go through the pain of losing the children
like they did the parents of the children.

5.5 Implications for social work practice
The Canadian Association of Social Workers (CACW, 2012) defines social work as a
profession that is concerned with helping individuals and collective groups and
communities to enhance their individual and collective well-being. It aims to develop
their skills and ability to use their own resources and those of the community to
resolve problems. In this study social workers have been observed to be facing a
challenge of burn out in their jobs. A single worker has a caseload of an average of
100 cases (foster care). These are cases that have already been finalized before the
Presiding Commissioner of the Children’s Court. The same worker has a caseload of
+/−30 new cases that still have to be investigated and finalized for foster care.
Tembisa Child Welfare is the only Welfare servicing the community of Tembisa
therefore all crisis cases are brought here. All workers alternate attending crisis
cases. At the end of the day there is little time for workers to concentrate their efforts
and time to assisting HIV and AIDS orphans.

The social work profession is about assisting individuals in the community develop
their skills and be able to stand for themselves in the future. With the majority of
caregivers being old grandmothers it is difficult for workers to implement projects that
will be able to sustain the community members without them having to lean on the organization at all time. This leads to workers being forced to issue out food parcels for a very long period of time to clients even those who are on the Family Preservation caseload.

Psycho-social support groups lack sustainability due to the fact that only one person runs and manages the groups and if that person is not there, there is no group. Social work as a generic profession needs to provide extensive training that will allow all social workers on the field to be able to diversify their skills into other departments without the fear of doing things wrong.

Social workers need some independence in practising their work. At times workers are limited by organizational rules and policies which make it difficult for them to follow up clients and to initiate social support systems that they feel might work better for their clients. They lack autonomy in their jobs. It is important for all state agents working with children to work in support of each other. The biggest challenge that social workers were found to experience in this study was that most of their referral systems were not as helpful to their clients as they are supposed to be. This causes clients to doubt the state system’s ability to assist them in solving their problems and makes many doubt the assistance of social workers.

5.6 Suggestions for future studies

It is suggested that for future research the population of the study should be widened to include other areas from other provinces so as to gain the perspectives of other social support systems with regard to HIV and AIDS orphans.
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dilemma for international social workers”. *Women in Welfare Education


APPENDIX 1: FOCUS GROUP DISCUSSION

Selection Criteria: 10 community members, 2 social workers and 3 child care workers were selected with attention to their involvement with HIV and AIDS orphans in Tembisa and their involvement with Tembisa Child and Family Welfare Society.

Purpose: The collection of information regarding the support given to HIV and AIDS orphans in Tembisa by care givers, care workers and the social workers in the organization. As part of evaluation and also collected information regarding their roles in offering support, their feelings towards it and recommendations for better service.

Process: The facilitator encouraged discussion among participants, ensuring that everyone talked and participated. The facilitator also prompted with questions and clarifications as needed and helped participants by writing down notes on the flipchart as needed.

Materials: Flipchart, markers note pads.

Information collected: social support mechanisms provided to HIV and AIDS orphans

Facilitation

What are the challenges that HIV and AIDS orphans in their care face?

Ask participants to identify the social support systems available in their community for HIV and AIDS orphans, the ones they have used and what they would love the mechanisms to provide for them.

Rank their challenges according to the importance they place in them.

Discuss the services they receive from Tembisa Child and Family Welfare Society and how they have contributed to raising HIV and AIDS orphans (foster care, institutionalization, family preservation, support groups). Probe for examples.
What are the experiences social workers have had in helping HIV and AIDS orphans and what challenges have they met? Probe for examples

Probe for the experiences they have received from other service providers outside Tembisa Child Welfare.

Preparation of a summary of the workshop for data analysis:

1. Date and location of workshop

2. Facilitator

3. Brief description of participants (total number of participants, approximate ages, activities performed).

4. Comments from participants (describe process followed and note insightful comments from participants, summarize discussion of topics covered).

5. General comments about workshop.
APPENDIX 2: INTERVIEW GUIDE

1. Based on your experience what social support mechanisms are available for orphans in Tembisa. How helpful have these mechanisms been?

2. Who are the main beneficiaries? What do you think they are benefiting and using the benefits for?

3. What are the main strengths and weaknesses, threats and opportunities faced by orphans, caregivers and their support systems? How do they contribute to the lives of HIV and AIDS orphans? What challenges do the orphans face on a day to day basis?

4. What is the future of the social support systems available for the South African orphans as a whole? Where is the service provision going? How can it be strengthened?

5. Closing remark

(The interview guide was meant for the children)