

**THE EXPERIENCES AND CHALLENGES OF WOMEN LIVING WITH  
HIV IN THE PIETERMARITZBURG REGION, KWAZULU-NATAL  
PROVINCE: PERSPECTIVES OF SOCIAL WORKERS**

**by**

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I declare that **The experiences and challenges of women living with HIV in the Pietermaritzburg region, KwaZulu-Natal Province: perspectives of social workers** is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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DATE

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## **ABSTRACT**

A qualitative study was undertaken in Pietermaritzburg to unveil the experiences and challenges of WLWHIV as perceived by social workers as well as to explore and describe the experiences of social workers in rendering services to these women. Explorative, descriptive and contextual research designs were employed for the research process. Purposive and snowball sampling techniques were utilised to recruit participants who met the set criteria. Face-to-face semi-structured interviews were conducted with thirteen participants. Data obtained were transcribed and analysed applying Tesch's eight steps (Creswell, 2009). Data verification was guided by Guba's model (Krefting, 1991).

The findings revealed the existence of strained relationships between WLWHIV and their partners and ineffective delivery of social work services to WLWHIV. Based on the findings, it is recommended that specialised training for social workers on issues related to death and dying and services for children of WLWHIV be incorporated in the guidelines for social work practice.

## **KEY CONCEPTS**

Social work, social worker, women living with HIV, psychosocial support.

## LIST OF ACCRONYMS

AIDS	Acquired immune deficiency syndrome
ART	Anti-retroviral treatment
BSW	Bachelor of Social Work
CBOs	Community based organisations
CCGs	Community care givers
CPD	Continuous professional development
DM	District municipality
DSD	Department of Social Development
HCT	HIV counselling and testing
HIV	Human immune virus
HRH	Human resources for health
PLWHA	People living with HIV
SASSA	South African Social Security Agency
SACSSP	South African Council for Social Services
UNAIDS	Joint United Nations Program on AIDS
UNICEF	United Nations' Children Fund
WHO	World Health Organisation
WLWHIV	Women living with HIV

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## CHAPTER ONE

### GENERAL ORIENTATION TO THE STUDY

#### 1.1 GENERAL INTRODUCTION, PROBLEM FORMULATION AND MOTIVATION FOR THE STUDY

HIV and AIDS and Sexually Transmitted Infections plan for South Africa 2007-2011 state that an estimated 39.5 million people were living with HIV worldwide in 2006, and that more than 63% are from sub-Saharan Africa. About 5.54 million people are estimated to be living with HIV in South Africa in 2005, with 18.8% of the adult population (15-49) affected (Department of Health, 2007:9). Women are disproportionately affected; accounting for approximately 55% of HIV positive people. Women in the age group 25-29 are the worst affected with prevalence rates of up to 40%. Some provinces are more severely affected than others, with the highest antenatal prevalence in 2005 being in KwaZulu-Natal (39.1%) and the lowest in the Western Cape (15.7%) (Department of Health, 2007:27). Issues related to gender inequality and poverty are regarded as drivers of the HIV and AIDs epidemic (Shisana, Rice, Zungu, Zuma, 2010:39).

The human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) remain an incurable, communicable and stigmatised disease (Lennon-Dearing, 2008:28). It is argued that this is a “multigenerational family disease”, meaning that it can affect multiple members of the same (extended) family, and sometimes even friends (Owens, 2003:164). However, unlike the historical perspective which claimed that this pandemic is affecting mostly and particularly, the homosexual white males in the urban areas (Yoon, 2005:255), the situation has changed, and it is asserted that the rate of infection is now alarmingly high amongst women in the rural areas (Catz, Gore-Felton & McClure, 2002:53; Joseph & Bhatti, 2004:31; Kaplan, Tomaszewski & Gorin, 2004:153; The 2012 National Antenatal Sentinel HIV & Herpes Simplex Type-2 Prevalence Survey in South Africa). In the case of the United States, for instance, the minority women are especially vulnerable to HIV (Catz, Gore-Felton & McClure,

2002:53). Likewise, Hodge and Roby (2010:27) state that in sub-Saharan Africa, 61 per cent of those infected with the virus are women.

Amongst these women, the most affected are those of childbearing age of whom most are primary caregivers for their children (Lichtenstein, Sturdevant & Mujumdar, 2010:131). It is common knowledge that women, despite their HIV infection, continue to play a caregiver role to their husbands and children, whilst on the other hand, they cannot receive the same treatment as men (Joseph & Bhatti, 2004:39). They pursue this task without sufficient information, medication or support (Amuyunzu-nyamongo, Okengo, Wagura & Mwenzwa, 2007:S25).

By virtue of their identity as caring beings, women have little or no time to themselves (Lafrance, 2009:39). For instance, in areas such as Umzimkhulu in Kwa-Zulu Natal, women, regardless of their economic position, whether they are breadwinners, educated, and sometimes wealthy, play multiple roles such as caring for the family members, cooking, doing laundry for their husbands and children, fetching firewood, fetching water, rearing children and showing respect to their husbands. Many women in this area are educators and their husbands are either working far from home or are unemployed. Therefore, these women have to carry the additional burden of managing the household and providing in the family's needs. In some instances, when a house has to be built with mud bricks, the same women have to mould the bricks themselves. It has also been observed that many widows have lost their husbands as a result of the opportunistic diseases related to AIDS. Since a family is a system making demands on its members, some of the widows who are HIV-positive are expected to care for their elderly parents-in-law even when they are not living together with them. Such responsibilities place a severe burden on women living with HIV (WLWHIV).

Being diagnosed with HIV immediately interferes negatively with the woman's way of life in terms of identity and relationships with others (Lennon-Dearing, 2008:28). This usually constitutes the beginning of a long road of challenging life events and extraordinary personal changes from which, even a well- balanced individual cannot easily escape (Joseph & Bhatti, 2004:30).

The first critical challenge that women infected with HIV encounter, is what Owens (2003:164) terms the “triple burden”, which means, combined factors of gender, race, and socio-economic status. This simply indicates that women infected with the virus are more adversely affected than their partners, particularly when looking at the psychosocial factors (Catz, Gore-Felton & McClure, 2002:54). Peterson (2010:470) points out that WLWHIV exhibits higher levels of depression, lower levels of well-being and functioning, as well as lower quality of life than men in a similar situation. For example, being traumatised with their new health status, women get secondary traumatisation as they are sometimes blamed for infecting their husbands and unborn children, being called by names such as ‘vectors’, ‘diseased’, and ‘prostitutes’ (Ndinda, Chimbwete, McGrath & Pool, 2007:93). In this regard, it was found that women in the United States are said to be three times more suicidal than men, and this is said to be more common in their first three months of diagnosis with HIV, which is not surprising (Cooperman & Simoni, 2005:149).

When men are unfaithful to their wives in uMzimkhulu, where the researcher is working, they are viewed as ‘real men’ and extramarital relationships are regarded as being “normal” and “socially acceptable”. However, this is not unique to this area as some authors also wrote about the issue in the South African context (Mfecane, 2008; Shefer & Foster, 2009). Unfortunately, the men’s promiscuity puts their wives at risk of contracting HIV. In addition, in uMzimkhulu, there are women who are severely depressed to such an extent that some end up in the mental hospital. The researcher has observed that some of the women who are admitted to the uMzimkhulu Mental Hospital are HIV-positive. Several studies have confirmed the relationship between psychiatric diagnoses among WLWHIV (Olley, Seedat, Nei & Stein, 2004; Bansil, Jamieson, Posner & Kourtis, 2009)

No one can shy away from the fact that the distribution of HIV-infection is influenced more by gender and/or social beliefs, customs and practices that define masculine and feminine attributes (Amuyunzu-nyamongo et al., 2007:S25). Hence, more cases of HIV and AIDS are associated with sexual contact (Perry, Davis-Maye, & Onolemhemen, 2007:40). Chakrapani, Newman, Shunmugam and Dubrow (2010:49) concur with this

idea, stating that women acquire HIV from their husbands and/or partners who in turn, acquire it from multiple sexual relations. Amuyunzu-nyamongo et al. (2007:S25) point out that, men, whether married or not, hold the most of the decision-making powers in a relationship. Unfortunately, this power men have in decision-making has led to many women being unable to negotiate for safe sex with their partners and ended up being infected with HIV. Amuyunzu-nyamongo et al. (2007:S25) point out that, men, whether married or not, hold the most of the decision-making powers in a relationship. Unfortunately, this power men have in decision-making has led to many women being unable to negotiate for safe sex with their partners and ended up being infected with HIV. Unreasonably so, in this scenario, women are generally expected to be faithful, chaste and morally upright as against their partners (Ndinda et al., 2007:94).

In addition, more often than not, women infected with the virus are living in low-income households with inadequate housing and social support (Lichtenstein et al., 2010:132; Catz et al., 2002:53). These women would then easily subordinate their own health care needs for those of their children (Greene, Tucker, Rourke, Monette, Koornstra, Sobata, Byers, Hwang, Dunn, Guenter, Ahlualia & Watson, 2010:224).

This then suggests that the normal functioning of women infected with the virus changes drastically after having been diagnosed, as they are now forced to do more health related work than focusing on their future (Joseph & Bhatti, 2004:40). Mueller, Martel, Le, Tolman, Geiken and Ka'opua (2009:1169) assert that highly active ART yields some very good results amongst HIV-positive women, in that those taking this treatment are less likely to develop AIDS and are less likely to contemplate having and bringing up children. The social work services offered by social workers to women living with HIV are therefore of critical importance, as these women would be able to acquire relevant and important information that would enable them to make informed decisions about their situation.

Social support in the form of interacting with others, addressing emotional concerns, receiving instrumental aid, information, or appraisal, is another inherent element of coping with HIV (Peterson, 2010:471). This therefore suggests that treatment and social support to women living with HIV plays a vital role in harmonising the situation,

particularly among friends and family members (Hodge & Roby, 2010:31). To this effect, Yoon (2005:258) states that meaningful relationships are essential to psychological and physiological health, hence support groups still appear as offering many benefits to people with chronic or stigmatised illnesses, such as emotional support, help with coping and information (Lennon-Dearing, 2008:28). The underlying principle in support groups is empowerment, that is, combining the expertise of a professional leader with the experiential knowledge of members, both of which are considered to be extremely valuable (Lennon-Dearing, 2008:28).

Current studies imply that psychological variables, inclusive of loneliness, affect the functioning of the immune system, thereby weakening the body's capacity to fight diseases (Yoon, 2005:256). Again, it is suggested that homelessness contributes a great deal in the transmission trends of the virus (Greene et al., 2010:224). This means that housing is fundamental to the health and wellbeing of individuals, as it provides a safe and sheltered space (Greene et al., 2010:224).

The psychological challenges that women infected with HIV usually face are, according to Joseph and Bhatti (2004:36-37) the following:

- **Finances:** These women are experiencing financial difficulties due to the loss of income of the deceased husband or their own, due to their health situation.
- **Children:** They have a feeling of not actually fulfilling the role of a mother and nurturer. They have a fear of passing the virus to their children through non-sexual contact and this unwittingly leads to decreased interaction with their children.
- **Marital relationships:** Many of them lose their husbands due to AIDS-related diseases and sometimes getting separated as a result of the confirmation of their HIV-status.
- **Disclosure and social support:** Sometimes they face a situation where one would even be excluded from family gatherings, particularly after disclosure. In fact women become selective in disclosing their HIV-status to their families.

- **Caregiving and receiving:** As they are caring for others they eventually forget about themselves.
- **Quality of life:** It becomes difficult for them to lead a normal life with the daily life activities as they tend to concentrate more on health related functions.

HIV-positive women get stigmatised, discriminated against, face the break-up of their marriages, are disinherited after the death of their husbands and sometimes lose employment (Ndinda et al., 2007:93). In some instances, these women are even unable to concentrate on the education of their children, and at times a gap naturally emerges between them, as mothers, and their children, while they are looking after their husbands who are dying from AIDS related illnesses (Joseph & Bhatti, 2004:36). It is consequently no surprise, that HIV-positive mothers perceive having children as an additional burden, describing it as stressful and worrisome (Mueller, Martel, Le, Tolman, Geiken & Ka'opua, 2009:1169).

Other studies have shown more interest in the health side of HIV in women, and this is based on the belief that HIV manifests itself differently in women than in men (Cowdery & Pesa, 2002:236). The following six health areas were identified by Cowdery and Pesa (2002:236) in this regard:

- **Physical functioning** relates to the extent to which illness interferes with a variety of physical activities.
- **Role functioning** relates to the extent to which illness interferes with one's usual daily activities.
- **Social functioning** relates to the extent to which illness interferes with normal social activities such as, visiting friends or engaging in group activities.
- **Mental health** relates to the general mood or affect, including anxiety, depression, and psychological wellbeing.
- **Health perceptions** relate to one's overall rating of one's current health status.
- **Pain** relates to the intensity of bodily pain.

A person's emotional, social, mental and spiritual needs are the essential elements of positive human development and can only be met through psychosocial support

(International Federation of Red Cross and Red Crescent Societies, 2010). This form of service as stipulated by the UNAIDS (2009:6) is meant to:

- strengthen comprehensive care;
- increase the use of health care provisions;
- promote primary and secondary prevention and the links with HIV-counselling and testing (HCT);
- reduce the number of drop out patients;
- enhance adherence to care;
- establish and maintain better communication between care providers and the beneficiaries; and
- optimise therapeutic alliances to prevent failure and non-compliance.

The common factor for both psychological and health factors in the effect of HIV on women, is the social support received (Cowdery & Pesa, 2002:242). However, Peterson (2010:473) highlights another critical point that seeking support is not easy, as one would at times try and balance the need for support with the concern of overburdening the family. The question of disclosure is viewed as another heavy burden, since many of those who do, may risk the breaking up of marriages or relationships, neglect and rejection by family and friends, and sometimes experience physical or sexual abuse as a result of it (Peterson, 2010:470).

Stigma remains a critical challenge to HIV-positive women, and failure to deal with it may result in negative and self-destructive behaviours such as engagement in sexual risk taking and the use of substance by women (Clum, Chung, Ellen & The Adolescent Medicine Trials Network for HIV/AIDS interventions, 2009:1455). Stigma is loosely defined as: the social expression of negative attitudes and beliefs contributing to the process of rejection, isolation, marginalisation and harm to others, which is totally against the notion of human rights and equality (Ndinda et al., 2007:93-94).

Stigma is associated with low self-esteem, depression, anxiety, loneliness, suicidal ideation (thoughts about suicide) and poor treatment adherence, particularly by those who are already sick (Lashley & Durham, 2010:451). Nyanzi-Wakholi, Lara, Watera,

Munderi, Gilks and Grosskurth (2009:905) perceive stigma in three categories. They state that the first is self-inflicted. In this category, once a person is confirmed to be HIV-infected, he or she will be left with depression and fear. He or she begins to isolate him or herself from the public, even before any symptoms develop. In this regard, Rowan (2009:76) observes that, at this stage, people may be overwhelmed with the feeling of shame, guilt, anger and anticipatory grief. The second category is the stigma which is family-inflicted (Nyanzi-Wakholi et al., 2009:905). These authors note that once people disclose their status, they are inviting being abandoned by the family. Some families may even feel that caring for the HIV-positive person is a waste of resources, because the death is certain once the person is diagnosed as HIV-positive (Malema, Malaka & Mothiba, 2010:15). The community inflicts the third category by discriminating against individuals who have disclosed their status (Nyanzi-Wakholi et al., 2009:905).

How the stigma works against the self, starts where the person experiencing it perceives herself as being devalued and socially “marked”, and subsequently, tries to escape by taking substances such as marijuana and other drugs, coupled with risky sexual encounters (Clum et al., 2009:1455). This is a serious matter that requires attention. The detrimental effects of HIV-related stigma and discrimination within the family and community on women living with HIV, unsurprisingly is the cause for keeping it a secret, thereby making disclosure to the loved ones a difficult and complex process (Evans & Becker, 2009:124).

As a partial solution to HIV, all those involved in the planning and delivery of services should understand the fact that this disease is, by nature, stigmatising (Anderson & Doyal, 2004:104). This has to be coupled with the on-going assessment and coordination of plans of services in order to provide the on-going support for the persons infected with the virus, together with their families (Links, 2011:221). In fact it is argued that the face of social work as a profession has totally changed with the advent of HIV and AIDS (Links, 2011:225).

Even though the development of HIV and AIDS came as a shock to the practitioners of every profession concerned (Links, 2011:221), social work due to its long-standing service rendering to and in working with the disadvantaged, had to take the lead in

researching about it, organising HIV-related conferences, volunteer services, consulting and education work; providing policy and legislative responses (Links, 2011:221-3). This was based on the fact that social workers have been trained as facilitators, advocates for the disadvantaged, educators and empowering the hopeless and the severely traumatised. Furthermore, this pandemic is still going to stay for a long time after a vaccination and cure have been discovered, it is estimated that this may take another thirty or more years after the breakthrough (Links, 2011:227).

As this study focuses on women, it was anticipated that most of the participants (social workers) would be women. The participants in this study were social workers rendering services to women living with HIV. This anticipation was based on the study by Schenk (2003:2) who found that 92 per cent of social workers were women as social work is predominantly a female profession. In this study the researcher wanted to develop an in-depth understanding of the experiences and challenges of women living with HIV in the Pietermaritzburg region in KwaZulu-Natal from the perspectives of social workers. Therefore, it was required to establish the experiences and challenges of both male and female social workers in this regard.

The study conducted by Schenck (2003) in South Africa provides a clear picture of the experiences and challenges faced by the social workers in the process of rendering their social services in general. In this study (Schenck, 2003:3) the following factors are clearly outlined under the heading 'The working conditions and resources':

- **The availability of cars:** Cars are very crucial in pursuing social work services, particularly in rural areas where most of the people do not have access to social workers, due to the distance travelled as well as the remoteness of the area. In most cases community members are unable to pay the transport fee to travel to the organisation. Sometimes the organisation's cars that might be available are not fit for the gravel roads they have to travel.
- **Subsidised cars:** In cases where social workers are in possession of subsidised cars, they might not be suitable for the roads which demand the use of four wheel drive (4x4) vehicles.

- **Offices of social workers:** The conditions of the social workers' offices were appalling. Park homes were used as offices and the conditions were unfavourable, particularly for clients. In some instances there were no toilets for both the social workers and the clients. The disabled experienced difficulties in some situations where one would have to use stairs to reach the office. Under these conditions, the professionals were unable to show respect for clients especially where there was a lack of confidentiality. This is similarly the case at UMzimkhulu, where the researcher is working. Social workers converge and see clients in a big hall and the principle of confidentiality is breached so that very few clients consult social workers, especially in HIV related cases.
- **Fax machines:** The situation at the UMzimkhulu Service office is no different from the one described in the study. For instance, here social workers use the municipal offices, the garage where their vehicles are serviced, as well as the Department of Justice for receiving official fax messages. This becomes a time consuming exercise.
- **Computers:** Schenk's (2003:3) study showed clearly that it is not easy for the social workers in many areas, particularly those in the rural areas where there is a lack of computers and typing facilities and sometimes electricity, to execute their duties.
- **Telephones:** In some areas telephones are not accessible. This is the same case at UMzimkhulu. It took a hard effort for social workers to acquire telephone facilities. After they had lodged numerous complaints to the authorities, three cellular phones were provided.

These conditions demonstrate the difficulties faced by social workers in the rural areas. The context of this study is also predominantly rural (KwaZulu-Natal Provincial Economic Cluster, 2006:4). In conducting this study, a great deal of commonality became evident between the findings of this research with the findings of Schenk's (2003:9-16) study.

Recognition is given to the tremendous amount of work that has already been done in South Africa in an endeavour to fight the spread of HIV amongst women. For instance,

the Sexual Offences and Related Matters Act (Act No. 32 of 2007) and the Domestic Violence Act (Act No. 116 of 1998) seek to protect young women, in particular, against abuse by their own parents and all related parties that may put them at risk. In the National Strategic Plan, the fight against the abuse of women and children is prioritised through law enforcement, as well as education and awareness (National Strategic plan on HIV, STIs and TB 2012-2016).

The problem statement is a description of the subject matter currently existing, providing the context for the research study and simultaneously generating the questions which the research aims to answer (Bwisa, 2008:1). It is given as one or two sentences in the form of a clear statement giving an idea as to what the researcher intends studying (Porte, 2010:12). In this study therefore, the researcher wants to explore and describe the experiences and challenges of WLWHIV from the perspectives of the social workers rendering services to women living with HIV in the Pietermaritzburg region, KwaZulu-Natal. Thus the problem statement for this particular inquiry was that: There is lack of information on the experiences and challenges of WLHIV from the perspectives of the social workers.

KwaZulu-Natal Province has a high prevalence of HIV and AIDS which is attributed to its geographic location on the trucking routes from the Southern African Development Community (SADC) countries to the major seaport of Durban (Office of the Premier, 2005:2). This province is predominantly rural with high level of poverty which results in more people being dependent on the state (KwaZulu-Natal Provincial Economic Cluster, 2006:4).

Generally, an inquiry is derived from the researcher's world of thinking, and in most cases from the relationship of the researcher with the topic of research that he or she intends studying Fouche' and De Vos (2005:262). The researcher in this study is a social worker as well as an HIV and AIDS coordinator in the Department of Social Development (DSD) in KwaZulu-Natal. His position has naturally afforded him enough opportunity to observe the problem very closely.

Fundamentally, less is known about the involvement of the social workers who render services to women living with HIV in South Africa, in spite of the fact that we have a vast body of knowledge in the form of literature on the subject of HIV and AIDS. In general the following is the rationale for this particular study:

- The burden of women playing a dual purpose of being family caregivers and patients, simultaneously, is a critical challenge in dealing with the question of HIV, but little research has explored this phenomenon so far (Hackl, Somlai, Kelly & Kalichman (1997).
- Very little is known about how women living with HIV are coping with their situations (Perry, Davis-Maye & Onolemhemen, 2007:40).
- More studies have been conducted in America in particular, and very little is known about the lived experiences of African women living with the virus (Perry, Davis-Maye, Onolemhemen & 2007:40).
- Guidelines, policies and procedures aimed at improving the quality of care for all women living with HIV, have to be developed, hence a dire need for further research (Bennett, 2007:5).
- More studies have been done with men than with women about the matter, especially regarding the aspect of anxiety and depression (Catz et al., 2002:54), thereby emphasising the need for more information and hence more research about women's situation regarding the matter.

Furthermore, Schenck (2003) who wrote about social workers' experiences and challenges when providing 'general social work services,' has also not said much about women who are infected with the virus, except to mention the fact that both men and women who are migrant workers serve as the vehicles for carrying the virus from the cities to the rural areas.

## **1.2. THE RESEARCH QUESTION, PRIMARY GOAL AND OBJECTIVES OF THE RESEARCH**

In this section the presentation focuses on the research question, the goal and the objectives of the study.

### **1.2.1 Research question**

Essentially, the research question is what the researcher wants to know (Maree, 2007:1) about the matter concerned. Similarly, Breakwell, Hammond, Fife-Shaw and Smith (2006:27) state that the research question is what the researcher wants to find out about the topic. A research question, as defined by Grove, Burns and Gray (2013:140) is a concise, interrogative statement that is worded in the present tense. It is argued that in every research undertaking, data collected should strive to answer the research question, such that failure to do this, will necessitate a repetition of the inquiry in a different form or other sets of methods would have to be selected (Blessing & Chakrabarti, 2009:123-130; Maree & Van Der Westhuizen, 2009:6). Badenhorst (2007:25) states that research questions are not the questions the researchers use to interview participants when they collect data. According to O'Brien and DeSisto (2013:83) a well formulated research question must be relevant, feasible, focused and ethical, but most importantly, it must be researchable. Hence, the inquiry for this study sought to answer the following research questions from the perspectives of the social workers:

- What are the experiences and challenges of women living with HIV in the Pietermaritzburg region, KwaZulu-Natal Province from the perspectives of the social workers?
- What are the social work services rendered by social workers to WLWHIV in the Pietermaritzburg Region, KwaZulu-Natal?

The research goals and objectives of the research emanating from the research question are discussed below.

### **1.2.2 Research goal**

The concept “goal” within the context of research is “the end toward which effort or ambition is directed” Fouche’ and De Vos (2005:104). Fouche and De Vos (2005:104) further argue that the terms “goal”, “purpose” and “aim” are synonymous and can be used interchangeably. The goal or aim of a research project is the overall driving force

as to why one wants to study a particular phenomenon (Carey, 2009:23). Therefore, a research goal is the “overarching purpose of the research project which set the stage for the objectives of the study” (Thomas & Hodges, 2010:38). Thus, the research goals for this investigation were:

Thus, the goal in this investigation was:

- To develop an in-depth understanding of the experiences and challenges of WLWHIV in the Pietermaritzburg region, KwaZulu-Natal Province from the perspectives of the social workers.
- To develop an understanding of the experiences and challenges of social workers providing social work services to women living with HIV in the Pietermaritzburg Region, KwaZulu-Natal.

### **1.2.3. Research objectives**

Grove, Burns and Gray (2013:266) assert that, based on the open-endedness of qualitative research, the researcher is free not to specify the research objectives in order to avoid prematurely narrowing the topic. However, in this inquiry objectives were specified to provide direction to the study. According to Brink, van der Walt and van Rensburg (2012:85) a research objective is a concrete, measurable end towards which effort and/or ambition is directed. Furthermore, objectives are clear, concise, declarative statements written in the present tense focusing on one or two variables (Brink et al., 2012:85).

The research objectives are also seen as the steps taken to accomplish the goal of the study and state what purpose the collection of data will achieve (Gilbert, 2008:53). In addition, the process followed in respect of achieving the goal can be accomplished by formulating objectives. Objectives are the steps that a researcher has to follow one by one, realistically at grassroots level, within a certain time span (De Vos et al., 2005:104) to achieve the research goal.

It is important, then, to state the research objectives and task objectives distinctively, though the line between the two concepts is very thin (McNabb, 2008:73). McNabb

(2008:73) says that research objectives come as the next step after identifying the research problem. Following this, the research objectives derived from the goal were:

- To explore and describe the experiences and challenges faced by WLHIV Pietermaritzburg region, KwaZulu-Natal Province from the perspectives of the social workers.
- To explore and describe the experiences and challenges of social workers providing social work services to women living with HIV in the Pietermaritzburg region of KwaZulu-Natal.

The following task objectives were set to realise the research objective:

- To obtain a sample of social workers who provide services to WLHIV in the Pietermaritzburg region, KwaZulu-Natal.
- To conduct semi-structured interviews aided by open-ended questions contained in an interview guide, with this sample of social workers in order to explore the experiences and challenges of WLHIV in the Pietermaritzburg region, KwaZulu-Natal from the perspectives of the social workers.
- To transcribe, sift, sort and analyse the data using Tesch's eight steps for qualitative data analysis (as cited by Creswell, 2009:186).
- To describe the experiences and challenges of WLHIV from the perspectives of the social workers.
- To interpret the data and conduct a literature control in order to verify the findings.
- To draw conclusions and make recommendations about the needs, experiences and challenges of social workers who provide social work services to WLWHIV.
- To draw conclusions and make recommendations based on the perceptions of social workers with regard to the experiences and challenges faced by WLWHIV in the Pietermaritzburg Region, KwaZulu-Natal.

## 1.1. RESEARCH APPROACH

The study was qualitative in nature. A detailed explanation on the application of qualitative approach in this study is provided in Chapter Two. Creswell (2003:181) identified the following characteristics of qualitative approach that capture traditional perspectives, the newer advocacy for participants and the self-reflective perspective of a qualitative inquiry:

- Qualitative research takes place in the natural setting. The qualitative researcher often goes to the site (such as the home or office) of the participant to conduct the research. This enables the researcher to develop a level of detail about the individual or place and to be highly involved in actual experiences of the participants;
- Qualitative research uses multiple methods that are interactive and humanistic. The methods of data collection are growing and they increasingly involve active participation by participants and sensitivity to the participants in the study. Qualitative researchers look for involvement of their participants in data collection and seek to build rapport and credibility with the individuals in the study. They do not disturb the site any more than is necessary.
- Qualitative research is emergent rather than tightly prefigured. Several aspects emerge during a qualitative study. The research question may change and be refined as the inquirer learns what to ask and to whom it should be asked.
- Qualitative research is fundamentally interpretive. This means that the researcher makes an interpretation of the data. This includes developing a description of an individual, or setting, analysing data for themes or categories, and finally making an interpretation or drawing conclusions about its meaning personally and theoretically, stating the lessons learned, and offering further questions to be asked.
- The qualitative researcher views social phenomena holistically. This explains why qualitative research studies appear as broad, panoramic views rather than

micro-analyses. The more complex, interactive, and encompassing the narrative, the better the quality study,

- The qualitative researcher systematically reflects on who he or she is in the inquiry and is sensitive to his or her personal biography and how it shapes the study. This introspection and acknowledgement of biases, values, and interests (or reflectivity) typifies qualitative research today.
- The qualitative researcher uses complex reasoning that is multifaceted, iterative, and simultaneous. Although the reasoning is largely inductive, both inductive and deductive processes are at work. The thinking process is also repetitive, cycling back and forth from data collection and analysis to problem reformulation and back. Added to this are the simultaneous activities of collecting, analysing, and writing up data.

#### **1.4. ETHICAL CONSIDERATIONS**

Ethics are the principles which guide the conduct of the social research (Ramcharan & Cutcliffe, 2001:359). Every research project is based on what the German philosopher Emmanuel Kant instilled a long time ago, that human subjects should be treated with respect and dignity in any study pursued, by way of complying with universal moral rules (Carey, 2009:11). Strydom (2011:113) asserts that research should be based on mutual trust between parties involved in the research project. Hence, the researcher was cautious during all the stages of the research project namely; planning, designing, implementing and report writing, to observe the fundamental ethical considerations (Terre Blanche et al., 2006:61) regarding informed consent or voluntary participation; no harm to the participants, anonymity, confidentiality and management of information.

After the research proposal was approved by the Department of Social Work Research and Ethics Committee at Unisa, the researcher wrote a letter to the head of the Regional DSD requesting permission to conduct the study among social workers who provide services to WLWHIV in the Pietermaritzburg Region (See Addendum G). After this permission was granted the researcher proceeded to approach social workers to participate in the project.

On the other hand, Marshall and Rossman (2011:154) highlighted the following ethical considerations that should be borne in mind in dealing with participants:

- The researcher should be careful to disclosing more information than would make the participant uncomfortable.
- The researcher must work in a collaborative manner with the participant so as to avoid any form of ethical mishaps.
- The researcher should at all costs protect the full identity and facts relating to the participant's private life.

In compliance with this scientific obligation, the researcher observed the following ethical considerations or norms in this study: informed consent and voluntary participation; no harm to the participants, anonymity and confidentiality, and lastly the management of the data obtained in the research.

#### **1.4.1. Informed consent and voluntary participation**

Participation in research should at all times be voluntary and no one should be forced to participate in a project (Babbie & Mouton, 2001:521). The researcher may not knowingly give wrong information about research requirements to deceive participants for the sake of securing participation (Strydom, 2011a:116). The participants' ability to consent is defined as "the ability to comprehend information relevant to the decision, consider the choices as they relate to personal values and goals, and communicate with others verbally or nonverbally" (Appelbaum in Waldrop, 2004:242).

The researcher ensured that the participants were not in any way compelled to take part in this study. Once the participants were recruited and showed willingness to participate in the study, the purpose of the study, the benefits of participation and the fact that participation was voluntary and that they may terminate their participation at any stage without fear. It was explained that the consent form that had to be signed by all participants (see Addendum A) serves as evidence that the participants were not coerced to take part in the inquiry. This ethical consideration was critical for the researcher to observe, since the study was conducted among colleagues who may

have thought that they would be penalised by their managers who were supportive of this venture. The participants' ages ranged between 26 and 48 years.

#### **1.4.2. No harm to participants**

The principle of avoidance of harm requires that social research must bring no harm to the people being studied (Babbie & Mouton, 2001:522). Strydom (2005:58) advises that participants should be thoroughly informed of the potential impact of the investigation.

Streubert, Speziale and Carpenter (2007:63) suggest that the inquirer should inform the participants about the purpose of the research, the types of questions that might be asked, how the results will be used, and how the researcher will protect their anonymity. As it were, this was done in this inquiry. The researcher adhered to this requirement as explained under the section on informed consent above.

#### **1.4.3. Anonymity and confidentiality**

Anonymity and confidentiality are different and therefore should not be confused (Babbie, 2004:65). Babbie (2004:65) explains that with anonymity, the researcher himself should not be able to identify a given response from a given participants. Strydom (2011a:119) has added privacy as an integral part of anonymity and confidentiality. According to the author privacy means keeping to oneself that which is normally not intended for others while confidentiality is a continuation of privacy to ensure anonymity of the person (Strydom, 2011:120). To cater for this, Creswell (2009:91) suggests that in qualitative research, the use of aliases and pseudonyms for participants and places is suitable for the protection of identities. The researcher therefore gave the participants pseudonyms on the transcripts to conceal their identity. Even though office names have been used in Chapter Three, the reader will not be able to match the responses with a particular participant. Confidentiality was observed by not sharing information gathered during the interviews with others and all the transcripts were stored in a computer and protected by a password known by the researcher only.

#### 1.4.4 Data management

Researchers spend much of their time collecting data in order to confirm or reject a hypothesis, identify new areas of investigative techniques, and other objectives (Steneck, 2009:89). Therefore, once data have been collected, it should be properly stored and protected from any mishaps of accidental damage, loss or theft. The decision of when and with whom to share the data lies with the researcher, but a warning is signalled that before reaching whoever is involved, the data should have been carefully checked and validated (Steneck, 2009:89).

Having to make careful plans, is a prerequisite for managing large quantities of data (Grove et al., 2013:531) until analysed. Babbie and Mouton (2001) warn that central to every research should be the concerns with the protection of the participants' interests and well-being by way of protecting their identity. Babbie and Mouton (2001) provided four points for consideration in this regard, namely to:

- safely lock the audio recordings of the interviews away, together with the field notes and transcripts;
- use pseudonyms in order to protect and cover the real identity of the participants; and
- deny the supervisor access to the names of the participants.

In addition, Creswell (2009:91) argues that at some stage, especially after data have been collected and analysed, the records should be discarded so that they cannot end up falling into the 'wrong hands'. In this regard, Creswell (2009:91) suggests that a period of 5-10 years is adequate. The researcher will adhere to this suggestion considering that he intends to publish the findings of this study in an accredited journal and would require the transcripts as reference. The information will be closely guarded as suggested by Fouche and De Vos (2005:63).

The researcher did all the above, thus keeping his promise to the participants. After completion of the research report in a form of a dissertation and the approval thereof by Unisa and the publication of the research findings, the tapes and documents will be stored in a safe place and will be destroyed after five years (Creswell, 2009:91).

## **1.5. CLARIFICATION OF KEY CONCEPTS**

The researcher wishes to explain the key concepts used in this research in this section in terms of their usage and meaning in the context of this research.

### **1.5.1 Counselling**

Counselling is the skilled and principled use of relationship to facilitate self-knowledge, emotional acceptance and growth, and optimal development of personal resources, aiming at an opportunity to work towards living more satisfyingly and resourcefully, respecting the client's values, personal resources and capacity for self-determination, and with persons who are considered to be functioning well and those who are having more serious problems (Gladding, 2004:189).

In this scenario social workers are positioned as professional practitioners who should be rendering social work services to the HIV positive women in order for them to cope with their new status and further lead a positive life despite the traumatic situation of being HIV positive.

### **1.5.2 Experiences**

**Experience** is the accumulated knowledge especially of practical matters (World English Dictionary, 2012). Therefore, experience refers to observing, encountering things in general as they occur in the course of time (Dictionary.com, 2012). In this study, the term refers to that which the social workers (who are rendering services to women infected with HIV) come across and how they handle those situations.

### **1.5.3 Challenges**

A **challenge** refers to something that serves as a call to battle, contest, special effort or a difficulty in a job that is stimulating to one engaged in it (World English Dictionary, 2012). Challenges are difficult situations which are mind challenging and sometimes may make someone to feel like giving up. In this context challenge refers to the experiences that social workers consider difficult to handle for various reasons such as lack of appropriate resources and skills.

#### **1.5.4 HIV**

HIV stands for Human Immune Virus. Lashley and Durham (2009:4) define HIV as a retrovirus belonging to the Lentivirus genus of the Retriviridae family. These authors state that there are two types of HIV, which are commonly known as HIV-1 and HIV-2. However as it is not relevant for this study, there will be no categorisation of this concept in this research report.

HIV means the virus in a human body which can later develop into AIDS where opportunistic infections will develop and if not properly attended will lead to immediate death.

#### **1.5.5 AIDS**

AIDS stands for acquired immune deficiency syndrome. This is a medical issue hence it is defined as such. Watstein and Jovanovic (2003:48) argue that HIV causes AIDS and in fact, is its final stage. HIV weakens the body, to such an extent that it is disempowered to fight normally manageable infections such as cancer and other diseases, as it attacks the white blood cells which are the backbone of the immune system (Watstein & Jovanovic, 2003:48). When one reaches this stage, he or she is said to have AIDS.

#### **1.5.6 Women (within the family structure)**

The term “woman” means any female human being who is capable of delivering a baby and is biologically distinguished with female organs. The structural functionalists describe personality traits of a woman as those which encourage warmth, emotionality, nurturing, and sensitivity, of which these are all qualities appropriate for someone caring for a family and home (Strong, DeVault & Cohen, 2010:40). For the purpose of this research, the concept “woman” refers to an HIV positive woman who has a family.

#### **1.5.7 Social worker**

In terms of the international definition of the concept “social worker”, a social worker is a practitioner responsible for assisting people improve their behaviour or circumstances

so as to be able to once again play a meaningful role in life, promoting a social change, problem solving as well as empowerment and liberation of people so that their wellbeing can be enhanced (The Global Minimum Qualifying Standards Committee, 2012). Munson (2002:327) defines a social worker as a person who is authorized to practice social work which includes amongst other things, rendering social services to individuals, groups and communities. A social worker also is a generalist practitioner who assists clients to attain a higher level of social functioning (Ambrosino, Heffernan & Shuttlesworth, 2007:122). On the basis of the definition given by Nicholas, Rautenbach and Maistry (2010:5) for social work, a social worker is a practitioner who promotes social change, problem solving in human relationships, and the empowerment and liberation of people to enhance well-being utilising human behaviour and social systems and intervening at the points where people interact with their environments guided by the principles of human rights and social justice.

In South African statutory terms, a person only is a social worker if he or she is registered as a social worker under section 17 of the South African Social Services Professions Act (110 of 1978 as amended) (SACSSP, 1999:Sections 1 and 17). To be registered, a social worker is any person holding the prescribed qualifications and satisfying the prescribed conditions, who satisfies the South African Council for Social Service Professions that he or she is a fit and proper person to be allowed to practise the profession of social work (SACSSP, 1999:Section 17).

### **1.5.8 Social work**

The internationally accepted definition of social work reads as follows (International Federation of Social Workers and International Association of Schools of Social Work, 2000):

*The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilizing theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.*

This international definition was adopted for this study.

### **1.5.9 Psychosocial support**

Psychosocial support is a professional service designed to help clients achieve long term self-sufficiency in managing the psychological and social challenges that result from trauma (Thyre-Murray, 2009:350). Through psychosocial support a person's emotional, social, mental and spiritual needs, which are the essential elements of positive human development, are met, based on the fact that this process also includes counselling which is aimed at helping people cope better with situations they are facing (International Federation of Red Cross & Red Crescent Societies, 2010).

Psychosocial support includes encouraging better connections between people and building a better sense of community. It is expressed through caring and respectful relationships, that communicate understanding, tolerance and acceptance (Morgan, nd:10). For instance, when children do not have vital documents such as birth certificates, they are assisted to acquire them from the Department of Home Affairs. Psychosocial support is related to obtaining hopefulness about the future, happiness, enjoyment of life, as well as being as good as other people (Setswe, Davids & The SAHA/SHRC PSS project team, 2009:17).

The National Department and the Provincial DSD in KwaZulu-Natal have clearly described deliverables required in terms of psychosocial support to people infected and affected by HIV and AIDS which are as follows:

- Care and support to families infected and affected by HIV and AIDS.
- Provision of food parcels to the disadvantaged and destitute families.
- Home visits by community home-based caregivers.
- Promotion of income generation projects in the communities.
- Psychosocial support to individuals infected with the virus.

## **1.6 OUTLINE OF THE REPORT**

The research report is divided into four chapters which are as follows:

Chapter 1 covers the introductory orientation focusing on the background, and problem formulation, problem statement, rationale for the research, research questions, goal and objectives, the characteristics of the research approach, ethical considerations, definition and explanation of key concepts the layout of the research report.

Chapter 2 focuses on the research methodology including the application of the qualitative approach, research designs, method of data collection, analysis and data verification.

Chapter 3 presents the findings of the inquiry

Chapter 4 outlines the overall summaries, conclusions and recommendations of this research.

## **CHAPTER TWO**

### **THE APPLICATION OF THE QUALITATIVE RESEARCH PROCESS**

#### **2.1. INTRODUCTION**

Gender inequality is the root cause of the vulnerability of women to HIV (Hale and Vazquez (2011). Hence, the international community instituted the 16 Days of Activism in 1991, with the aim of raising awareness about the gender-based violence which is seen as a critical human rights violation. The main aim for raising such awareness was basically to ensure the protection of women against any form of violence. A great effort has been made in this regard and out of this scourge a number of organisations which claim to be advocating for women have emerged. This also led to the legislation of the Domestic Violence Act (Act No. 116 of 1998). Unfortunately, as far as could be established, minimal effort has been made so far to determine the quality of social work services WLWHIV access and receive. Hence, the researcher's decision to embark on this study and seek a better understanding of this phenomenon.

This chapter focuses on the implementation of the qualitative research approach, the research design, sampling techniques, analysis and verification of data.

In qualitative studies, the reporting of the data is in a literary style enriched with participant commentaries: When reporting the findings, the researcher used the participants' storylines to demonstrate their experiences. The researcher focused on learning what the problem means to the participants (Creswell, 2009:175). In the following sub-section the research approach will be discussed.

#### **2.2 RESEARCH METHODOLOGY**

Research methodology refers to as a set procedures and techniques which a researcher uses in order to create a project's research information or evidence, by looking at the data sources, that is, who or what is going to be the source of data in this inquiry; how this information will be sourced from the potential participants and lastly, how this data or evidence will be processed, analysed or interpreted into the useful

research findings (Thomas & Hodges, 2010). The methodology that guided this inquiry and a comprehensive description on its implementation is presented below.

### **2.2.1 Research approach**

In this study, a qualitative approach was employed. Qualitative research is defined as a broad umbrella term for research methodologies that explore, describe and explain the participants' experiences, behaviours, interactions and social contexts without quantification (Fossey, Harvey, McDermott, & Davidson, 2002:717). Mack et al. (2005:1) define qualitative research as a type of scientific research consisting of an investigation that: seeks to answer a question; systematically uses a predefined set of procedures to answer the question; collects evidence; produces findings that were not determined in advance and produces findings that are applicable beyond the immediate boundaries of the study.

Qualitative research is used when little or nothing is known about a phenomenon. For this reason qualitative research was used in this study, because not much was known about the social work services rendered by social workers in relation to WLWHIV and what they ought to do (Brink et al., 2012:120). Another reason for choosing a qualitative research approach for this study was that this approach has a capacity to describe how people experience phenomena or events and to further check what meaning the particular population being researched attributes to such experiences (Burns and Grove, 2009:45).

Qualitative research explores themes such as attitudes, behaviour and experience of specific social groups, in great detail (Carey, 2009:36). Leedy and Ormrod (2005:94) are of the view that the qualitative approach is used to answer questions about the complex nature of phenomena with the purpose of describing them from the viewpoint of the participants. Hence, it was deemed appropriate to describe the experiences and challenges of WLWHIV in the Pietermaritzburg region of the KwaZulu-Natal Province from the perspectives of the social workers.

From the perspective of Streubert et al. (2007:20-23) qualitative research has six characteristics which are the following:

- Qualitative research focuses on multiple realities i.e. different opinions and different perspectives. For instance, in this study, the participants provided different individual experiences and challenges in relation to the provision of social work services to WLWHIV.
- The qualitative approach is committed to discovery through the use of multiple ways of understanding. In this study, the face-to-face semi-structured interviews enabled the researcher to gather relevant information in order to understand their experiences and challenges when providing social work services to WLWHIV. Qualitative research values the participant's viewpoint. The open-ended questions afforded the participants an opportunity to share their experiences in their own words. Hence, the participants were at liberty to express themselves in their mother tongue either in isiZulu or isiXhosa mixed with English.
- The researcher employing a qualitative approach conducts the inquiry in a way that limits disruption of the natural context of the phenomena of interest. In this study, the participants' elected for the interviews to be conducted at their places of work, so that they did not have to spend time to travel long distances.
- In qualitative research the participation of the researcher in the research process is acknowledged. Researchers serve as key instruments in the collection of data such as examining documents, observing behaviour, and interviewing participants (Creswell, 2009:175).

In addition, Mack, Woodson, MacQueen, Guest and McNamey (2005:1) note the advantages of the qualitative approach over others are that:

- Through probing and the use of open-ended questions, participants have the opportunity to respond in their own words. Open-ended questions, for instance, have the ability to evoke responses that are culturally important to the participants; anticipated by the researcher; and rich and explanatory in nature.
- Open-ended questions allow the researcher the flexibility to probe further with such questions as why or how to obtain more detailed information.

The following advantages of applying the qualitative research approach, pointed out by Johnston and Onwuegbuzie (2004:20) were relevant in this research undertaking:

- Providing a better understanding of a phenomenon, thereby providing a new perspective on it. This inquiry enabled the researcher to gain insight into the experiences and challenges of social workers providing social work services to WLWHIV in the Pietermaritzburg region.
- Enabling the collection and the exploration of data that cannot be conveyed quantitatively. Through the use of the semi-structured interviews with the participants, the researcher was in a position to explore the participants' unique experiences and challenges in providing social work services to WLWHIV in the Pietermaritzburg region.
- The ability to explore sensitive topics. HIV is a sensitive topic as it relates to sexual matters. Many people who are HIV infected are stigmatized and discriminated against due to lack of understanding. To this end, the application of the qualitative approach was appropriate to explore and describe the participants' experiences and challenges when providing social work services to WLWHIV. This is important as the participants had an opportunity to talk on behalf of their clients.

### **2.2.2 The research design**

The research design is a clearly outlined plan of a study indicating how it will be conducted, for instance, how data will be collected and analysed (Langford, 2001:110). Fouche and Delport (2005:132) defines the research design as a plan of how the researcher intends conducting the study. In the same vein, Kumar (2008:13) asserts that the research design has a specific function to accomplish, which is to provide for the collection of relevant evidence with the minimal expenditure of effort, time and money.

A research design is a work plan that the researcher uses with rigour to ensure that the research question is answered as unambiguously as possible (Orme & Shemmings,

2010:82). Bhattacharjee (2012:22) maintains that a research design refers to the practical way in which the study will take place in an attempt to produce data that will satisfactorily answer the research question. The research design of this study was compiled as a directive to structure and conduct the study as set out above.

### **2.2.2.1 Explorative research design**

Yegidis and Weinbach (2002:106) describe exploration as the beginning stage of the process of knowledge building. The explorative design usually examines a subject that is relatively new, thereby trying to gain an initial understanding of the problem area (Krysik & Finn, 2010:58). This research design is mostly used to gain insight into a situation, a phenomenon, a community or individuals (Fouche' & Delport, 2007:106). Babbie (2010:92) says this research design is more relevant and suitable in a subject and interest of study which is relatively new with little or nothing known about it. Indeed, not much was known about social work services provided to WLWHIV prior to this research. Applying an explorative research design enabled the researcher to gain insight into the perspectives of the social workers rendering social work services to WLWHIV and based on the findings, recommendations could be made and presented about the matter in Chapter Four of this research report.

### **2.2.2.2 Descriptive research design**

The descriptive research design provides a detailed description of what was explored and further allows the researcher the opportunity to look with intense accuracy at the phenomenon being studied (Burns & Groves, 2005:44). It further describes situations and events (Babbie, 2010:93) and captures the essence of participants' subjective experiences and ensures that the researcher avoids imposing his theories on them (Harper, 2012:89).

A descriptive research design is a scientific method which involves observing and describing behaviour of the participants without influencing it in any way (Engel & Schutt, 2010:379). In addition, a descriptive design is set to describe the natural phenomena based on the data the researcher has collected about the study at hand (Zainal, 2007:3; Noor, 2008:1603). Applying this research design enabled the

researcher to gather data without influencing the responses of the participants. After the analysis of the data, the description of the experiences and challenges of the social workers in providing social work services to women who are living with HIV in the Pietermaritzburg region are provided in Chapter Three of this research report.

### **2.2.2.3 Contextual research design**

Contextual research designs are aimed at seeking insights of phenomena being researched within the natural environment of the participants to gain a broader understanding of it (Noor, 2008:1603). A contextual research design is the interpretation of the socially constructed nature of reality (Yucesoy, 2006:63).

The participants were interviewed in the Pietermaritzburg region where they are rendering social work services to WLWHIV. The DSD in this region is constituted of three district municipalities, namely, Umgungundlovu, Ugu and Sisonke, newly named, Harry Gwala. This region stretches from Mooi River to Port Shepstone, and is neighbouring Durban. It is predominantly rural, with a large farming area. Vast parts of the area are occupied by Africans. The participants were sourced from all the three districts, though not necessarily equilaterally.

Health facilities are available in the city of Pietermaritzburg. However, these resources are scarce in the neighbouring villages. This is problematic considering the large number of people in need of health care that live in these villages and the fact that KwaZulu-Natal is one of the provinces with a high rate of people infected with HIV and AIDS.

## **2.3 RESEARCH METHOD**

In this section, the focus is on the population at which this research was aimed, the sampling techniques and how they were employed in the study and the method of data collection, analysis and verification including the ethical considerations observed during the research process.

### **2.3.1 Population**

The population is made up of all the potential subjects with all the attributes as required by the researcher, and this is where the sample is drawn from Strydom (2005:192). Thyer (2010:41) has the same perception of the population, arguing that it is a large set of persons about which the researcher wants to learn.

Monette, Sullivan and DeJong (2008:136) define a population as a group of people with a potential to be appropriate for the purpose of the research project by virtue of their characteristics which are relevant to the intended study. Similarly, in order to answer the research questions, a population has to have specific and realistic characteristics that the researcher is interested in studying (Yegidis & Weinbach, 2002:180). Hence, in this study the population consisted of the social workers involved in the provision of social work services to women who are infected with HIV in the Pietermaritzburg Region in KwaZulu-Natal. These social workers were the units of analysis based on the definition by Fouche and De Vos (2005:104).

### **2.3.2 Sampling**

Sampling is the process of selecting particular entities from, for example, a variety of people, objects, text materials, and audio visual and electronic records (Leedy & Ormrod, 2005:144). It is the process of selecting units of observation (Babbie, 2010:204) in research. The basic reason why a sample is used is that in terms of time and money it would not be feasible to conduct research with the entire population. In selecting a sample for this study, the researcher employed the non-probability purposive and snowball sampling techniques in this research.

Purposive sampling technique is sometimes referred to as the typical case sampling in qualitative research, where typical cases are sought and selected for the study (Marlow cited by De Vos et al., 2011:392). Purposive sampling is a grouping of “participants according to preselected criteria relevant to a particular research question” (Mack et al., 2005:6). In applying this technique, participants are selected according to specific criteria for inclusion which in this case entailed that social workers should have had a

minimum experience of one year employment as social workers by the DSD in the Pietermaritzburg region that included rendering social work services to WLWHIV.

Regarding snowball sampling, the researcher requested the first three participants who were recruited because they met the set criteria for inclusion, to identify other potential participants. There were no challenges experienced in the recruitment of the identified potential participants and this supports Offredy and Vickers' (2010:132) view that participants recommended by their colleagues and friends are likely to agree and take part in the research study.

No sample size was set at the outset of the study and the principle of data saturation was applied. In this regard, Fossey et al. (2002:726) state that: "...sampling in qualitative research continues until themes emerging from the research are fully developed, in the sense that diverse instances have been explored, and further sampling is redundant. In other words, patterns are recurring or no new information emerges". Once such a stage is reached, the researcher will realise that a full understanding of the phenomenon under investigation has been reached (Donalek & Soldwisch, 2004:356). Eighteen semi-structured interviews were conducted with thirteen participants (five participants were interviewed twice) before the researcher became convinced that data saturation has been reached when the information shared became repetitive. At this point the data collection process was terminated as in reaching a point of data saturation, the sample consisted of a sufficient number of participants.

Owing to the large nature of the population, it would be somewhat impossible to study the whole community of interest; hence, a sample is selected from the population (Gilbert, 2008:167). Other basic reasons for the use of a sample in research is firstly, to save time and money, and secondly, because a much better response rate occurs in this instance, rather than in the case of the entire population participating (Offredy & Vickers, 2010:131). For this research project to be realised not all social workers rendering services to WLWHIV in the Pietermaritzburg Region could be included in the study and therefore, a sample was procured from the population under study which is 527 (Orme and Shemmings, 2010:118). It should be borne in mind that, the type of

sampling employed is determined by the methodology selected and the topic under investigation (Higginbottom, 2004:12). Since the researcher embarked on a qualitative study, the non-probability purposive and snowball sampling techniques were suitable for the procurement of a sample among the population of social workers who render services to WLWHIV in the Pietermaritzburg Region.

It was not easy for the researcher to find identified potential participants he was referred to. Not all of them could avail themselves for various reasons such as work and family responsibilities. This matter is discussed in more detail in section 2.5.1.

### **2.3.2.1. Purposive sampling**

Purposive sampling involves choosing people or documents from which the researcher can substantially learn about their experiences (Polkinghorne, 2009:140). Although researchers use their own judgement in selecting the sample, the individuals sampled must be able to provide the information about a specific phenomenon such as the provision of social work services to WLWHIV in this case (Holloway & Wheeler, 2002:122). The advantage of applying purposive sampling is that it allows a repetitive process which provides for the capturing of different behaviours, experiences and attitudes of participants in the course of the study (Higginbottom, 2004:13). This flexibility made it possible for the researcher to conduct second semi-structured interviews with the participants whose information from the first interview was deemed inadequate.

The criteria for inclusion in the sample for this study were as follows with the participants having to be social workers -

- working for the D SD in the Pietermaritzburg region rendering social work services to women living with HIV;
- with a minimum of one year of experience in rendering social work services to women living with HIV were included;
- from both urban and rural areas; and
- who were willing to take part in the study.

### **2.3.2.2 Snowball sampling**

This nonprobability sampling technique consists of the researcher being referred to one or more persons with similar characteristics, by participants in the research Schurink, Fouche' and De Vos (2011:393). In this study, a total of eighteen semi-structured interviews were conducted - thirteenth interviews and four additional second interviews with five participants before coming to the conclusion that no new information was coming forth and data saturation was reached.

Sometimes the researcher meets participants whom he or she has known over a long period of time (Offredy & Vickers, 2010:131) who could refer him or her to other possible participants. This was the case in this study. The researcher is employed by the DSD in the Pietermaritzburg region where he identified and recruited three participants who were known to him and met the criteria for inclusion in the sample. Thereafter, the snowball sampling technique was applied by these participants referring him to other potential participants who were rendering social work services to WLWHIV.

No sample size was set at the beginning of this inquiry, but the principle of data saturation was applied. Barroso (in LoBiondo-Wood & Haber, 2009:91) maintains that qualitative research has no set sample size, but data are collected to the point of data saturation, which means the information shared by participants becomes repetitive. Thirteen social workers participated in this study. A total of eighteen semi-structured interviews were conducted - thirteen first interviews and five additional interviews with five participants. The researcher then came to the conclusion that no new information was coming forth and that data saturation was reached. Consequently, no additional participants were interviewed.

The sample size is often determined on the basis of theoretical saturation (Mack et al., 2005:05). Grove, Burns and Gray (2013:268) refer to this as theoretical sufficiency, basing their argument on the fact that one can never completely know all there is to know about a topic. Lincoln and Guba (cited by Merriam, 2009) argue that, at this stage, a broad perspective of the phenomenon is reached.

In this study, after conducting a semi-structured interview, the researcher transcribed the interview and in four instances, the researcher discovered that a substantial part of the relevant information was not obtained in certain instances. Therefore, second interviews were arranged with the participants concerned to gather the relevant data. The process of transcribing the interviews during the data gathering process helped the researcher to determine the areas that had become saturated. However, he continued with three additional interviews to close the minor gaps identified in the data in relation to clarifying what the participants meant by for instance, providing counselling services to WLWHIV. After the researcher had satisfied himself that the interviews were no longer yielding any new information, the data collection process was ended.

## **2.4 METHOD OF DATA COLLECTION**

Data collection is the most critical process in every study. In qualitative research, there are various methods used for data collection. Information may be collected through unstructured and semi-structured interviews, observation, documents, focus groups discussions and visual materials, and establishing the protocol for recording information (Creswell, 2003:185). According to Hennink, Hutter and Bailey (2011:08), observation, focus group discussions and in-depth interviews are most suitable to examine people's experiences in detail from their own perspectives. Data collection is the process of selecting the persons from whom a researcher will gather data (Grove et al., 2013:523). Semi-structured interviews facilitated by open-ended questions contained in an interview guide were used to gather rich information from the participants in this study.

A semi-structured interview is a set of predetermined questions on an interview schedule which guides the interview (Greeff, 2011:352). The advantage of using semi-structured interviews is that they illuminate the participant experiences with the guide of the researcher (DiCicco-Bloom & Crabtree, 2006:315). Nyanjaya and Masango (2012:3) describe an interview as a method of collecting data of greater depth that provides an opportunity to gain insight into how people interpret and order their life worlds. An interview guide contains broad questions which prompt the participants to discuss their experiences in their own words (Haley, 2001:91). Using an interview guide affords the researcher to loosely stick to a recognizable plan with the interview, while allowing

deviation where the interviewee decides that new information is needed (Nicholls, 2009:640). Hence, semi-structured interviews facilitated by open-ended questions included in the interview guide, were used to gather data from the participants.

#### **2.4 1 Preparation for data collection**

After the research proposal was approved by the Department of Social Work Research and Ethics Committee at the University of South Africa (Unisa), the researcher wrote a formal letter dated 25 April 2012 (Addendum F) to the head of the Regional DSD at Kwa-Zulu Natal, requesting permission to conduct the study. The purpose of the study and its significance were explained in the letter. The necessary permission to undertake the study was granted (Addendum G).

There are four points that Harwood and Hutchinson (cited by Grove et al. 2013:507) advise with regard to decision-making, that the researcher should consider to apply, namely the:

- purpose and complexity of the study;
- availability of financial and physical resources;
- characteristics of the participants and how best to gain access to them from the population, and
- skills and preferences as a researcher.

These aspects served as a guide for the researcher when he set out to prepare for the data collection for this research.

Prior to approaching different (DSD) offices in the Pietermaritzburg Region, the researcher adhered to the ethical principles by writing a formal letter dated 25 April 2012 to the head of the Regional DSD in Kwa-Zulu Natal, requesting for permission to conduct the study (Addendum F). The purpose of the study, its significance and benefits for the regional DSD and the researcher, were explained in the letter. In addition, it was mentioned that the research proposal has been approved by the Department of Social Work Research and Ethics Committee at Unisa and the ethics clearance certificate issued by the University was attached as evidence to that effect. The contact details of

the study leader were provided in case clarification was required. Official permission for the study to be undertaken was subsequently granted (Addendum G).

Immediately after receiving the letter of permission, the researcher showed it to a potential participant during the recruitment process. Once the first potential participant had consented to participate in the research, she tasked permission from her Service Office Manager to participate in the research, which was granted. Thereafter, a meeting was held with the participant to explain the purpose of the study, potential benefits, the need for recording the interview and completion of the consent form to illustrate that the participant took part voluntarily. The date and time of the interview were negotiated with the participant and later endorsed by the Office Manager (gatekeeper). This process of recruitment and preparation for data gathering was followed with all the other twelve participants.

Prior to the interviews, the researcher ensured that his digital recording equipment was in good order and started rehearsing how to conduct the semi-structured interview to identify any possible problem and familiarising himself with the interview guide. He wife and colleagues became the participants during rehearsals. This exercise assisted the researcher as he was not anxious during the first interview.

As cautioned by Grove et al. (2013:507), the researcher was time-conscious, even though there were unforeseen circumstances that arose. For instance, when the letter of approval came from the Head of Department, the second potential participant was going on long vacation leave, but fortunately, she managed to recruit two colleagues to take part in the study.

The participants were informed that there may be a need for a second interview, should it transpire during transcription of the interviews that vital information was missing. Clarification was provided that failure to gather such information from the same participants would compromise the quality of the research towards meeting the set goals. All the participants expressed their understanding and willingness to cooperate with the researcher in this regard. Hence it was possible to conduct four additional interviews.

The **biographical questions** used to gather data from the participants were as follows:

- Gender
- Age?
- What are your qualifications?
- Where did you obtain your BSW degree?
- What are you currently studying?
- How do you classify the area you are working in? (urban or rural)
- Are you working in the same area where you live?

The **questions related to the topic** were as follows:

- How long have you been involved in the provision of services<sup>1</sup> to women living with HIV?
- Share with me the type of training you have acquired to prepare you for the provision of services to women living with HIV?
- Tell me about your experiences in providing services to women living with HIV.
- Can you share with me the process that you follow in providing the services to women living with HIV?
- What are the challenges you face in providing services to women living with HIV? (For instance, the support that you receive from your supervisors, material resources such as vehicles for conducting family visits).
- How do you deal with such challenges?
- What type of support would you need to enhance your services to women living with HIV?
- How receptive are your clients towards the support services that you render as a social worker?
- What are the benefits of your services to women living with HIV?

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<sup>1</sup> Use of the term “services” in these questions refers to social work services.

The answers to these questions were subsequently analysed and the findings and recommendations are presented in Chapter Three and Four respectively.

The interviewing techniques discussed below were used to building rapport and establishing a trusting relationship with the participants since the interviews involved personal interaction and necessitated co-operation (Denzin & Lincoln, 2000). According to Howe (2009:159) only once a good rapport has been established with the participants, can the researcher try to explore, reflect, analyse, assess, support, encourage, seek meaning and find solutions to the identified challenges. As a result, to make the participants feel at ease, the researcher heed Howe's (2009:160) notion that "one of the major skills of social work is to recognize and understand what goes on when the researcher and participant meet". Therefore, the researcher demonstrated warmth, friendliness, and listened attentively to the participants. The questions and requests posed to the participants were phrased in such a way that they will elicit the required information. The participants were at liberty to respond in their mother tongue being isiZulu and isiXhosa. In their responses, most of the participants mixed one of these indigenous languages with English. Probing was used to seek clarification from the participants.

Some of the skills used during semi-structured interviews include active listening which the researcher demonstrated by maintaining eye contact and using appropriate gestures such as nodding the head (Hesse-Biber & Leavy, 2011:105). Rephrasing was also used to ascertain that the participant understood the research question in order to elicit responses that meet the research purpose (Glesne, 2011:119). Clarification assisted the researcher to probe for additional information (Nieuwenhuis & Smit, 2012:133). Silences were used though minimally, to afford the participants a chance to think about their responses and to fully answer questions (Hesse-Biber & Leavy, 2011:110). The researcher also utilised silences during the interviews to move at the participants' pace.

## 2.4.2 Pilot testing

A pilot study is an integral part of the research process in the preparation for data collection and provides a means of assessing whether the questions actually illicit the sought data (Burkard, Knox & Hill, 2012:87). A pilot testing is a purposeful exercise conducted by the researcher to test, learn, get acquainted with and improve the research methods, questions and skills (Glesne, 2011:56; Hennink et al., 2011:120). The pilot study is usually done with one or a few individuals who meet the criteria of inclusion in the sample, though the data collected during this period are never going to be included in the main study (Brink et al., 2012:174). Grove et al., 2013:523) state that a pilot study helps the researcher to identify possible problems that may occur during the interviews, it equips the researcher with an opportunity for developing some strategies to counter such challenges.

Pilot testing is done with participants who have similar characteristics as the target population. The researcher should clarify the purpose of the pilot testing to the participants (Glesne, 2011:56). It is a process of assessing the applicability of the questions, concepts, sentences and wording into the context of the participants (Hennink et al., 2011:120). After conducting the pilot testing, the researcher should ask the participants whether the questions were clear, appropriate and whether there are additional questions that can be included in the study (Glesne, 2011:56). From the pilot testing results, the researcher might rephrase the questions or change the order of the question and also determine the length of the interviews (Glesne, 2011:57; Hennink et al., 2011:120). Conducting pilot testing also fulfils a secondary function, as Marshall and Rossman (2010:96) states that this can be useful in understanding oneself as a researcher. This was the case with the researcher when conducting the pilot testing with two of his colleagues. This exercise helped the researcher to improve his interviewing skills and to have confidence when asking questions.

The researcher conducted pilot testing with two participants who met the criteria for inclusion in the sample required for the study. The data collected from the two participants during the pilot study, did not form part of the information gathered for the actual research. Overall, the participants indicated that the questions were well

constructed and clear. After transcribing the interviews, the researcher was also satisfied that the questions yielded relevant information for the study. It should be noted that the data obtained from the two participants in the pilot testing do not form part of the research findings for this inquiry.

## **2.5 METHOD OF DATA ANALYSIS**

Polit and Beck (2006:498) state that data analysis is a systematic organisation and synthesis of data. According to Creswell (2003:133; Botma et al. (2010:221 and Macmillan and Schmacher (2001:462), data analysis in qualitative research is primarily an inductive process of organising data into categories and identifying relationships among the categories. The semi-structured interviews were audio-recorded and transcribed immediately after each interview. The data were later analysed. Three main themes, seven sub-themes and sixteen categories emerged. A detailed description on these findings is presented in Chapter Three of this research report.

The researcher and the independent coder followed the well-known eight steps provided by Tesch (cited by Creswell (2009:186) to analyse the data independently. It should be noted that there is no rigid and definite procedure in this process (Creswell, 2008:251-252), the application of which entailed the following:

- The researcher read through all the transcripts and wrote down ideas in the margin as they came to mind in connection with each topic.
- The researcher read through the transcribed interviews thinking of the underlying meaning rather than the actual substance of the data.
- Similar topics were clustered together into “major topics”, “unique topics” and “leftovers.” In order to ensure that a list of all topics was acquired, the researcher had to repeat this process over and over again.
- Abbreviation of topics was used to be able to see if new categories and codes have emerged. The researcher then proceeded to make abbreviations for each of the topics in the form of codes and wrote them next to the appropriate segments of the text.

- Topics were turned into categories, a process wherein the researcher found the wording that was most descriptive for the topics to be turned into categories. The total list of categories was reduced by means of grouping all those topics that relate to each other.
- The codes were alphabetised after the final decision has been made on the abbreviation for each category.
- The researcher used the cut-and paste method to assemble the data belonging to each theme or category in one place and conducted a preliminary analysis.
- Thereafter, the researcher commenced with reporting on the research findings.

The outcome of the analysis is regarded as credible because when the researcher and the independent coder compared their findings, they realised that they had arrived at the same conclusion regarding the themes, sub-themes and categories that emerged from the analysis. Similarities were observed between the researcher's and the independent coder's findings. The final outcome of the analysis was reached after consultation between the student, the independent coder and the study leader/supervisor.

## **2.6 METHOD OF DATA VERIFICATION**

The data verification process is critical in social research. At this stage the researcher checks the data in terms of accuracy and inconsistencies. Mainly, in the data verification process, reliability, validity and rigour are the elements which determine the trustworthiness of the research findings (Carey, 2009:42-43). Furthermore, if similar results can be obtained after the method applied in the research has been repeated, it means that the findings are reliable.

In terms of validity, the researcher should begin to ask him or herself the question whether the findings are genuine, authentic and sound (Carey, 2009:42-43). A practical way of doing this would be, at a later stage, after the interviews have been conducted, to discuss the findings with the participants. Rigour considers the credibility and authenticity of the findings.

To ensure trustworthiness of the research project, the researcher must respond to the questions that serve as evaluation criteria (De Vos et al., 2005:345). A few examples of these questions are as follows:

- By what criteria can the credibility of the findings of the study be judged?
- Can these findings be transferred and applied to another setting or group of people?
- Can the findings be replicated if the study were conducted with the same participants in the same context?
- Can we be sure that the findings are not the creation of the researcher's biases or prejudice, and are indeed reflective of the participants?

Offredy and Vickers (2010:27) even went so far as to recommend sending transcripts of the interviews to the participants inviting their comments in order to seek their opinions of the analysis and interpretations. Due to time and financial constraints, the researcher, could not meet with the thirteen participants, nor provide them with transcripts to give them an opportunity to verify the data. However, the transcripts were sent to three participants for their perusal and opinion and they were very positive about what was recorded and transcribed. The fact that the researcher was unable to do the same with other participants may be regarded as a shortcoming for this study.

The data verification model addresses four components of trustworthiness that are relevant to qualitative research namely, truth-value (credibility), applicability (transferability), consistency (dependability) and neutrality (confirmability) (Thomas & Magilvy, 2011:152). The four components of trustworthiness are discussed below in relation to their implementation in the study.

### **2.6.1 Credibility of findings**

In meeting credibility, the findings of the study should be compatible with participants' perceptions. This is achieved with prolonged engagement in the field, persistent observation, triangulation of data and negative analysis (Nicholls, 2009:645). According to Nieuwenhuis and Smit (2012:137) the researcher should ensure that the natural

setting does not change as a result of the contact made. Hence, creating a safe and non-threatening environment through establishing an open, trustworthy and relaxed relationship with participants becomes critical in authenticating the findings (Nieuwenhuis & Smit, 2012:137).

In this study, the researcher was able to make the participants feel at ease by establishing rapport with them during the recruitment phase and by applying relevant interviewing skills during semi-structured interviews as outlined under data collection methods.). Various interviewing techniques such as probing, verbal and non-verbal expressions paraphrasing, clarifying were used to enhance the credibility of the study.

Triangulation is used to ensure completeness of findings or to confirm them (Speziale, Streubert and Carpenter, 2010:82). In triangulation the answers and responses of the different people interviewed are compared with each other, put together, and referred to each other in the analysis (Flick, 2009:27). The frequency and distribution across the whole sample is used for analysis (Flick, 2009:27). This is a comparison of multiple perspectives using different methods of data collection (Krefting, 1991:219).

Social workers who are providing social work services to people living with HIV were interviewed and each one provided an independent opinion. Their multiple opinions made the study credible (Krefting, 1991:219). Nykiel (2007:73) perceives triangulation as used above as a way of checking the truth of informants' statements, as well as providing useful insights and even suggesting new lines of inquiry. Therefore, the researcher succeeded in using triangulation of data sources since data were collected from thirteen participants rendering social work services to WLWHIV in the Pietermaritzburg Region.

## **2.6.2 Transferability of findings**

Transferability of findings relates to providing evidence that can be related to other contexts or groups (Nicholls, 2009:645). To ensure that the findings are transferrable,

the researcher should provide evidence of rich thick descriptions on the phenomenon under study (Creswell, 2013:252; Nicholls, 2009:645).

After data collection, the researcher compiles a qualitative report which provides detailed information on the experiences of the participants in such a way that the reader would be convinced that the phenomenon exists (Rubin & Babbie, 2010:89). Studying the report should leave the reader with a sense of having walked in the shoes of the participants, a deeper sense and meaning of the subjective situations and experiences of the participants (Rubin & Babbie, 2010:89).

To meet the transferability of the findings, the researcher utilised the purposive sampling technique to select information rich participants who could provide relevant information on their experiences and challenges of providing services to WLWHIV. The semi-structured interviews conducted with the participants yielded the themes, sub-themes and categories presented in Chapter Three and supported by direct quotations.

### **2.6.3 Dependability of findings**

The researcher should demonstrate consistency and accuracy in data collection, coding and analysis, by creating an audit trail which would enable another researcher to repeat the process (Thomas & Magilvy, 2011:153; Shenton, 2004:71; Nicholls, 2009:645). This involves providing explicit, detailed and interrelated information about the procedures and the methodology of the study in such a way that the reader is able to have complete information about all aspects of the research study and to follow the procedures (Miles et al., 2014:311-312).

The researcher is required to provide detailed descriptions of the purpose of the study, sampling methods, data collection methods, data analysis, interpretation and presentation of the research findings (Thomas & Magilvy, 2011:153). The detailed descriptions on the findings are presented in Chapters Four and Five of this report.

The dependability of the findings can be improved when the responses are stable to multiple coders of data (Creswell, 2013:253). This was accomplished in this study when the researcher and an independent coder coded the data independently and reached similar conclusions on the findings. Consensus was reached on the themes, sub-themes and categories.

#### **2.6.4 Confirmability of findings**

Confirmability is based on the researcher's reasonable detachment from bias (Miles et al., 2014:311). The research results should be clear evidence of the outcomes of the study not the researcher's selective output (Nicholls, 2009:645). To address bias, the researcher can make use of reflexivity which relates to being thoughtful and sensitive about the possible impact of one's personal views and understanding when interacting with the participants and interpreting their experiences (Doyle, 2013:252-253). Utilising reflexivity enables the researcher to be open to the unexpected, thus maintaining focus on the research purpose (Doyle, 2013:253).

To ensure confirmability of the findings, the researcher utilised reflexivity to guard against interference in the analysis and interpretations of data gathered from the participants. For example, the researcher was perturbed by the general and vague descriptions provided by the participants of the services they render to WLWHIV. Some of them talked about counselling and some could not explain the services they render during counselling. Some prematurely referred WLWHIV to support groups prior to conducting a thorough assessment to determine their needs. The lack of a holistic integrated approach is attributed to the shortage of social workers and the fact that those who are available carry heavy caseloads.

### **2.7 CONCLUSION**

This chapter provided evidence on how qualitative research was successfully implemented as an appropriate research method to facilitated the accomplishment of the research goals which were firstly to explore and describe the experiences and challenges faced by the social workers when rendering social work services to women

living with HIV in the Pietermaritzburg region, KwaZulu-Natal, and second, to explore and describe the social work services rendered by social workers to women living with the virus in the Pietermaritzburg region, KwaZulu-Natal. The findings of the study are presented in the next chapter.

## **CHAPTER THREE**

### **RESEARCH FINDINGS AND LITERATURE CONTROL**

#### **3.1. INTRODUCTION**

A qualitative study was conducted among social workers who render social work services to WLWHIV. The non-probability purposive and snowball sampling techniques were employed to identify and recruit potential participants who met the criteria outlined in the previous chapter (Item 2.3.2.1) Semi-structured interviews were conducted with thirteen participants and second interviews were conducted with five participants to gather additional information at which point the interviewing was concluded since data saturation had been reached. The eight steps of data analysis by Tesch (cited by Creswell, 2009:251-252) were used by the researcher to identify the themes, sub-themes and categories that emerged from the data. In addition, an independent coder also analysed the data and thereafter a discussion with the coder and study supervisor was held during which consensus was reached on the identified themes, sub-themes and categories.

In this chapter, the researcher presents the collected data which were based on the social workers' experiences and challenges facing WLWHIV and their experiences in rendering social work services to WLWHIV in KwaZulu-Natal, Pietermaritzburg Region. The biographical data of the sample and particulars of the geographical area where the study was conducted are presented. This is followed by the presentation of the findings based on the qualitative data obtained, subjected to a literature control to compare and contrast the findings.

#### **3.2. SAMPLING AND GEOGRAPHICAL DISTRIBUTION**

This study was conducted in the Pietermaritzburg Region of KwaZulu-Natal Province. A sample of thirteen participants was drawn from the three main district municipalities, namely uMgungundlovu District Municipality, Sisonke District Municipality (recently renamed the Harry Gwala District Municipality) and the Ugu District Municipality. Six of

the participants were from uMgungundlovu, three were from Ugu DM, and four from Harry Gwala DM, respectively. Where necessary, the researcher conducted some follow-up interviews in order to obtain enriched data. As is usual in qualitative research, the sampling size of this study was not predetermined and the researcher relied on data saturation to conclude the interviews and determine the size of the sample.

### 3.3 BIOGRAPHIC DATA OF THE PARTICIPANTS

The biographic data of participants are presented in Table3.1 and described below.

**Table 3.1: Biographic data of participants**

Participant	Municipality	Years of social work experience	Age of participant	No. of interviews conducted
1.	Harry Gwala	1, 11 months	27	1
2.	Umgungundlovu	4	32	1
3.	Harry Gwala	2	28	2
4.	Harry Gwala	5	26	1
5.	Ugu	3	31	1
6.	Ugu	4	28	1
7.	Ugu	4	35	1
8.	Harry Gwala	3	48	1
9.	Umgungundlovu	9	40	1
10.	Umgungundlovu	3	28	2
11	Umgungundlovu	2	30	2
12	Umgungundlovu	3	32	2
13	Umgungundlovu	5	28	2

Table 3.1 indicates that the research participants were sourced from all three the DMs of the Pietermaritzburg Region of KwaZulu Natal Province. Three participants were based at the Ugu DM, four at the Harry Gwala DM and six at the Umgungundlovu DM. The ages of the research participants ranged from twenty-six to forty-eight with an average age of 32 years. In terms of work experience, the longest serving participant had nine years' social work experience while one had only one year and eleven months' experience of working with WLWHIV. The majority of the participants (ten) are still in young adulthood stage with their ages ranging between late twenties and early thirties. Of the thirteen participants, nine are working in rural areas while four are based in urban

areas. All the research participants were female social workers. This confirms Whalley's (2011) view that social work has been seen, traditionally as a "caring" profession with the majority of social workers being women with a minority of men. With regard to the number of interviews conducted with the participants, one interview was conducted with eight participants while two interviews were conducted with five participants to allow the researcher to gather additional information not covered during the first interviews. In terms of race, Pietermaritzburg is a racially diverse region with most of the social workers belonging to the Indian, coloured and white based mainly in cluster offices, head office and non-governmental organisations (NGOs). This resulted in accessibility of only black female participants who met the inclusion criteria of this study (see paragraphs 1.5.2 and 2.4.2.1).

### 3.4. DISCUSSION OF FINDINGS IN RELATION TO THE LITERATURE

After the data were collected and transcribed, it was analysed and the analysis process resulted in four dominant themes, seven sub-themes and seventeen categories an overview of which is presented in Table 3.2 and discussed in more detail below.

**Table 3.2: Themes, sub-themes and categories from qualitative data**

<b>THEME</b>	<b>SUB-THEME</b>	<b>CATEGORY</b>
<b><i>Theme1:</i></b> Descriptions relating to training received by social workers in offering services to WLWHIV	<i>Sub-theme 1.1</i> Training relating to HIV/AIDS prevention and support	<i>Category 1.1.1:</i> Training for HIV prevention and education <i>Category 1.1.2:</i> Training for support and counselling
	<i>Sub-theme 1.2:</i> <i>Perceptions with regard to the value of training.</i>	<i>Category 1.2.1: Mixed reaction to the value of training</i>
<b><i>Theme 2:</i></b> Descriptions relating to social workers' experiences in working with WLWHIV	<i>Sub-theme 2.1:</i> Perceptions relating to personal relationships of WLWHIV	<i>Category 2.1.1:</i> Domestic violence and relationship breakdown <i>Category 2.1.2:</i> The positive relationship between WLWHIV and their children

		Category 2.1.3 The concerns of WLWHIV about the welfare of their children
	<i>Sub-theme 2.2:</i> Perceptions relating to disclosure by WLWHIV	<i>Category 2.2.1:</i> Disclosure and reaction to disclosure.
	<i>Sub-theme 2.3:</i> Perceptions relating to Fear of WLWHIV	<i>Category 2.3.1:</i> Fear of disclosure <i>Category 2.3.2:</i> Fear of stigma. <i>Category 2.3.3:</i> Fear of death and dying.
	<i>Sub-theme 2.4:</i> Perceptions relating to Self-blame by WLWHIV	<i>Category 2.4.1:</i> WLWHIV blame themselves for their diagnosis.
<i>Theme 3:</i> Descriptions relating to challenges faced by social workers	<i>Sub-theme 3.1:</i> The working conditions and resources.	<i>Category 3.1.1:</i> Lack of office space <i>Category 3.1.2:</i> Inadequate human resources.
<i>Theme 4:</i> Descriptions relating to Social work services for WLWHIV	<i>Sub-theme 4.1:</i> Types of social work services for WLWHIV	<i>Category 4.1.1:</i> Building trust with WLWHIV <i>Category 4.1.2:</i> Coordinated social work services for WLWHIV <i>Category 4.1.3:</i> A holistic approach to social work service delivery <i>Category 4.1.4:</i> Prioritisation of children of WLWHIV in social work service delivery

### **3.4.1 THEME 1: DESCRIPTIONS RELATING TO TRAINING RECEIVED BY SOCIAL WORKERS IN OFFERING SERVICES WLWHIV**

In their article titled, “trainee characteristics and perceptions of HIV/AIDS training quality”, Panther, Huba, Anderson, Driscoll, German, Henderson, Henderson, Lalonde, Uldall and Zalumas (2000:149) state that education and training have played a vital role in keeping health providers up to date on emerging developments and approaches. It is also one of the social worker’s obligations to ensure that they remain up to date regarding the developments of their respective fields of practice. Participants of this study also indicated that they received training on issues related to HIV and AIDS offered by several service providers like the AIDS Foundation of South Africa, Khethimpilo Trust, Michaelmas College and Abafundi College. During the time of this study, two of the participants reported that they did not receive any HIV and AIDS related training from their current employers as they were respectively trained by the previous employer and the university before they could join the current employer.

The specific impressions made by the participants about such training are captured below in terms of sub-themes and categories:

#### **3.4.1.1 Sub-theme 1.1 Training relating to HIV/AIDS prevention and support**

HIV/AIDS prevention and support are the two among four main pillars adopted by the South African government (through the National Strategic Plan on HIV/AIDS) and the international communities to fight the scourge of HIV/AIDS (Adogame, 2007; Department of health, 2011; UNAIDS, 2011). As shown in the following category, it became apparent in this study that prevention and support emerged as the crucial areas wherein participants were equipped through training in order to address the challenges faced by their clients.

- **Category 1.1.1 Training relating to HIV and AIDS prevention and education**

Training of social workers on HIV and AIDS prevention in a form of education was also reported by participants as one of the ways through which social workers can ensure

that people remain empowered with regard to HIV and AIDS related issues. The participants' perceptions with regard to training relating to HIV and AIDS education were reported by one participant who said, *"The training that I received was about the HIV and AIDS management, as well as, HCT, that is HIV Counselling and Testing. Those are the only trainings I underwent. Firstly, the HCT was emphasising the importance of knowing your status and how people living with HIV should be treated, both the clients and colleagues. We were even trained on how to conduct the testing itself."*

As highlighted by the participants above, training appears to be one of the crucial ways through which HIV/AIDS can be prevented and its impacts be mitigated. This is also highlighted by Panther et al., (2000) when they say, "The call for HIV/AIDS education and training for health providers has been well articulated in the past two decades by researchers representing several disciplines." The same sentiment is held by Lalonde, Uldall, Huba, Panther, Zalumas, Wolfe, Rohveder, Colgrove, Henderson, German, Taylor, Anderson, & Melchior (2002:303) who view education and training as paramount to restraining the AIDS pandemic.

The role of a social worker in relation to HIV/AIDS education and training is a crucial one to an extent that they themselves need to remain thoroughly capacitated in order to ensure that their clients are equipped to deal with any challenges that they encounter. As indicated in the following category, this training includes among others training of CCGs and other stakeholders involved in HIV/AIDS prevention on communication skills, counseling and support skills.

- **Category 1.1.2. Training for HIV/AIDS support and counselling**

Support and counseling were some of the areas wherein participants received training. The training was mainly aimed at ensuring that they are equipped with counseling and support skills so that they can ensure that their clients receive the necessary support as they go through various challenges. As indicated by one of the participants in the extracts, training of participants on the issues of HIV/AIDS management was also offered where an emphasis was placed on ensuring administrative support of organisations.

With regard to counselling, one of the participants said that: *“I was trained in HIV and AIDS counselling. I can say the trainings did assist me, but it added value to the counselling skills that I had acquired during the social work training”*. The value of training of HIV and AIDS education and prevention was also highlighted by another participant when she said: *“I can remember, we also had some role plays during the training. What I learnt from the training is that HIV and AIDS counselling is educational. You have to know first how much the client knows about HIV and AIDS, and then you begin to educate him or her of all those things he or she might not be aware of.”*

Although one of the participants did not attend training offered by her current employer, she highlighted how her previous training on HIV and AIDS counselling became relevant to ensure support for WLWHIV by saying: *“I never attended any training ever since I joined the department [2 years], except for the fact that I once was trained on HIV and AIDS counselling before I joined the department. So I am using that particular knowledge.”*

From their knowledge and experience, participants conducted capacity building training aimed at supporting the CCGs as elucidated by one participant who said, *“Concerning women, we have been running support groups, capacitating the community caregivers, in particular as to how they should run the support groups We have further capacitated these CCGs on the income generating projects and soup kitchens for them to be able to assist those women who have already started taking treatment in order for them not to default because of the lack of food.”*. The need to support the CCGs has also been noted by some previous studies which have shown that caregivers often perceive caregiving to PLWAs as a responsibility which often means fulfilling their social and religious responsibilities and giving love and comfort to the patient (Aga, Kylvä & Nikkonen, 2009). This in turn leaves the CCGs in a situation where they are overwhelmed and even prone to burnout. The broader perspective of the support challenges faced by CCGs is highlighted by Oxfam (2004) who report that the emotional and psychological impact of the epidemic on NGO staff members is not being addressed adequately, for various reasons; a lack of financial and skilled human resources; stigma affecting disclosure and identification of HIV/AIDS-related needs;

inadequate understanding of the impact of HIV/AIDS and inadequate knowledge of options currently available for support and of the need for strategic planning for the future. In an attempt to address some of the strategic challenges faced by the CCGs, social workers reported training on the administrative support of funded organisations. This was highlighted by one participant who said, *“Then the HIV/AIDS Management was basically on how to administer the funded organisations.”*

#### **3.4.1.2 Sub-theme: 1.2 Perceptions relating to the value of training**

As opposed to most of the participants who appreciated the value of training, two participants did not see any value of undergoing training which was to them impractical and inappropriate. Their views are presented in the following category:

- **Category 1.2.1 Mixed reaction to the value of training**

One of the participants described her perception of the training by saying *“I have attended a number of these trainings ever since I joined the department in 2007. All trainings are said to be trainings of HIV and AIDS, but when you are there you would find that these trainings are not assisting at all when it comes to the field. All those things that we are told about in the trainings are not practicable and are therefore irrelevant.”* These views confirm among others the views held by Kaboru, Ndubani, Falkenberg, Pharris, Muchimba, Solo, Höjer, Faxelid, and the Bridging Gaps Research Team (2008), who report that several programs have attempted to train traditional health providers to prepare them to deliver HIV/AIDS-related services, including health education, condom distribution, and counseling services. The same view was shared by another participant who indicated that, the training was general and did not help that much because it did not cater for the specific targeted client system which is WLWHIV. She said *“In as much we never were equipped with skills to deal exclusively with women who are living with HIV.”*

Two participants with two and three years' experiences in working with WLWHIV respectively did not receive training on HIV and AIDS offered by their current employers. However, they managed to apply the skills and knowledge from the training

they had received from their previous employers and the university and this seem to have been valuable for them. This was highlighted by one of the participants by saying *“Nothing other than workshops on HIV and AIDS counseling, education, peer group. Where I used to work [NGO] before joining the department I was running a support group for the care givers who were living with HIV. These workshops helped me a great deal.”* Another participant who only received training offered by the university said *“Since started working [3 years] I was never trained in anything related to HIV and AIDS, but I am using the knowledge I acquired from the university. I studied a lot about HIV and AIDS.”*

Overall, the participants’ responses imply that they did not have access to or applied the Social development departmental guidelines on psychosocial support for adults living with HIV and AIDS (2010) provided by the National DSD.

### **3.4.2 THEME 2: DESCRIPTIONS RELATING TO SOCIAL WORKERS’ EXPERIENCES IN WORKING WITH WLWHIV**

As highlighted in Table 3.2, one of the main themes identified were the participants’ experiences in rendering social work services to WLWHIV. Four subthemes and six categories emerged from this theme. Following is a discussion of these themes, subthemes and categories in relation to existing literatures.

#### **3.4.2.1 Sub-theme 2.1: Perceptions relating to personal relationships of WLWHIV**

HIV-diagnosis can bring with it certain changes in a person’s relationships. In this study, the changes manifested in a form of eruption of domestic violence between WLWHIV and their partners and the care and support offered to WLWHIV by their children. These changes are discussed as categories of the subtheme.

- **Category 2.1.1: Domestic violence and relationship breakdown**

From the research data, it emerged that relationships of WLWHIV and their intimate partners were strained as a result of their HIV-positive diagnosis. Violence is described

by Weir, Bard, O'Brien, Casciato and Stark (2008:945) as high in the case of women whose sex risks often occur in situations where women typically experience an imbalance of power with sexual partners. This is particularly true with WLWHIV in the KwaZulu-Natal Province where culturally and economically women are inferior to their male counterparts. It is therefore not amazing to observe some experiences of domestic violence due to this power imbalance as highlighted by Weir et al. (2008:945). Some of the signs of domestic violence were highlighted by one of the participants who stated that, "*It [HIV-positive diagnosis] is not easy sometimes. In some cases partners begin to fight and blame each other.*" Violence is identified by Sakthi (2010:23), as a factor which increases the risk of women's vulnerability to HIV infection.

The presence of HIV in the family often compromises the relationship between a husband and a wife which could therefore make violence to be both the cause and the outcome of HIV-diagnosis. In their study of women infected with HIV, Zierler, Cunningham, Anderson, Shapiro, Nakazono, Morton (in Gielen, Ghandour, Burke, Mahoney, McDonnell & O'campo, 2007:191) found that 20% of their participants reported physical harm, after diagnosis and one half believed it was related to the diagnosis, with 4% of women saying they experienced physical abuse directly attributable to disclosure of their status. Rodrigo and Rajapakse (2010:12) escalate their description of women in developing countries as subjected to violence in various settings ranging from inter partner violence to civil wars and an association of violence with HIV positivity.

The emergence of domestic violence under these circumstances is also acknowledged by Liamputtong (2013:2) who states that because of their HIV-positive status, many women experience violence from their partners or significant others. For instance, in expressing the strained personal relationships of WLWHIV, two of the participants said:

*"Many [WLWHIV] said they had an unbearable hatred towards their partners as they knew that they themselves were faithful to them [their partners]"*.

*"They [WLWHIV] said they would fight with their partners time and again. They [WLWHIV] were so angry with them [their partners]"*.

Blaming games in this situation which often lead to repeated abuse and severe domestic violence or divorce, become common, as none of the two parties wants to take responsibility for bringing the virus in the family. Women are normally the first ones to know their HIV status as they are compelled to undergo some tests during pregnancy. They therefore find themselves being confronted by a double edged sword of gender inequality which is perpetuated by the patriarchal society that tends to blame women for being carriers of the virus and for infecting their husbands although it was not necessarily the case.

This is what two participants had to say regarding their experiences of domestic violence:

*“It is not easy sometimes for the WLWHIV. In some cases partners begin to fight and blame each other.”*

*“Their partners (WLWHIV’s partners) would sometimes shift the blame. It (an HIV-positive diagnosis) was never easy. To some this led to the break of relationships”.*

*“Many of them [WLWHIV] will tell you that once their partners know about this [HIV-positive diagnosis], they immediately shift the blame and say it is them who have brought the virus. The sad part about this [an HIV-positive positive diagnosis] is that, some [WLWHIV] would tell you that they have been so faithful to their partners, but again they are to blame when this [HIV-positive diagnosis] comes up.”*

These and other stories highlighted in this section indicate how intimate relationships of WLWHIV become strained as a result of an HIV-positive diagnosis.

Akeroyd (2008:96) confirms the above excerpts when she states in her writing about the situation of women, that women are not necessarily safer in their homes. This assertion was confirmed by one of the participants by saying, “...*women are more concerned with their partners not willing to use condoms*”. This participant’s experience confirms the findings noted by previous researchers.

It has been noted for instance by Sachdeva and Wanchu, (2006:01) that women are unable to negotiate for the use of a condom for fear of being accused of cheating. The male partners' refusal to use a condom may serve as a sole source of violence against women (Sachdeva & Wanchu, 2006:01). Such practice prevails, despite calls and commitments for gender equality and the cessation of any form of violence against women (UNAIDS; 2013). Furthermore, husbands have beaten and/or abandoned their wives who were thought to be HIV positive, despite the fact that many women contract the virus from their husbands (Rankin et al., 2005:704).

The lack of support for WLWHIV by their partners has also been indicated as a challenge by one of the participants who said:

*“Many of these women’s partners are never ready to go and test, such that mostly, they instead blame these poor women for the disease. I can say then, they [WLWHIV] are not getting any kind of support from their partners.”*

Existing literature on women and HIV and AIDS, reveals that it is not easy to distinguish between violence against women and HIV and AIDS, as both are rooted in gender discrimination, women’s subordination, disregard for human rights and power imbalances between women and men (WHO, 2004:01; United Nations Entity for Gender Equality and Empowerment of Women, 2012:01). In other words, both gender-related violence and HIV and AIDS have a severe negative impact on women and their intimate relationships.

Another aspect which tends to facilitate submissiveness and accelerate the emergence of strained intimate relationships is the economic status of WLWHIV. Given the fact that some of these women find themselves in relationships where they fully depend on their intimate partners who are mostly the sole breadwinners, women find themselves in positions where they are unable to challenge any wrong doing due to fear of losing economic benefits. One participant for instance, stated that:

*“Most of them [WLWHIV] depend on men for survival. Even those that are married most of them are depending on their husbands. They [WLWHIV] are not assertive enough to say what they like and what they do not like about their*

*partners, such that even when they feel unhappy with having unsafe sex, they cannot express themselves with their partners, because of fearing to be dumped”.*

Submissiveness and its impact on relationships are identified by Zulu, Dodoo and Ezeh (2008:171) who demonstrate how women’s vulnerability to HIV infection is aggravated by economic hardships and inequality.

Some of the reasons for these women choosing to stay in the unrewarding relationships are that they are dependent on their partners for survival economically (Bell & Orza, 2006:01). Rankin et al. (2005:704) have also noted that in much of sub-Saharan Africa, women are a subordinate group who are only expected to become pregnant, bear children, and fulfil the sexual desires of their husbands without hesitation.

The husbands’ economic status was also found to be another factor which fast-tracked the strenuous intimate relationships in which WLWHIV found themselves. One participant said: *“Most of them [WLWHIV] are complaining that it is their partners who bring this virus because most of their partners are work in big cities.”*

According to Sakthi (2010), the economic dependence of women on their partners heightens the lower status of women within the family and society where women are made to feel less powerful to control their reproductive health. The feeling of powerlessness both in personal relationship and in the society has resulted in keeping silent in sexual interaction and not changing their traditional role by demanding the use of condoms for safe sex. This situation is articulated in the following statement from one of the participants:

*“There is no stage where a woman in our area is ready to challenge a man. In fact what I learnt from here is that if you do that, you are perceived as rude. So what I can say is that this is part of socialisation. Even mothers tell their daughters that one has to respect a man, no matter what.”*

The above statements reveal how an HIV-positive diagnosis compromises the intimate relationships of WLWHIV and therefore continues to place women in the marginalised

positions where they find themselves having to continue to tolerate abuse, blame, gender violence and inequality perpetuated by their intimate partners.

- **Category 2.1.2: The positive relationship between WLWHIV and their children**

It has been apparent from the findings of this study that modern children seem to have a better knowledge of HIV and AIDS than their predecessors. It was also revealed in this study that after finding out that their mothers are infected with HIV, some of the children provide support as much as they could. This kind of practice is termed by The University of California's National Abandoned Infants Assistance Resource Center (2011) as "parentification". Herington (2009) refers to this as a situation where the child assumes the role of a parent – taking household tasks such as caring for the siblings and giving emotional support to the parent. This was highlighted by one of the participants who said, "*Children are very understanding. They know better about the question of HIV and AIDS such that they give much support to their mothers, like for instance reminding them with taking treatment and other things such as dates for appointments.*" Similar findings were reported by Barnes (2013:117) who found that years after women were told their HIV (-positive) status, the effects of their diagnosis on their mothering practices shaped their relationships with children into their adulthood. In other words, children become closer to their mothers and the positive relationship extended into their children's adulthood.

Another participant confirmed this finding when she said, "*There was one who even narrated her story and said that her eldest son would even hit his father telling him that his actions are the cause for their mother's illness.*" This reveals the children's ability to care and support their HIV-positive mothers which is closely linked to Kalaude's findings (in Feldman, Chitalu, Murdock, Bhat, Gomez-Marin, Mwinga & Baboo, 2008) that many young women do not regard [HIV and] AIDS as a threat to their lives and do not even consider it as a hindrance to sexual relationships. In other words children (especially females) are becoming more aware of HIV and AIDS and tend to understand that it is not their parents' fault and that instead of ridiculing and blaming them they should offer the necessary support. In highlighting the children's support for their HIV-positive

mothers, a participant said, *“Children would also be sympathetic as well, but they would show better understanding of the disease, especially the teenagers.”* Another participant confirmed the children’s support of their mothers who are living with HIV, when she said, *“Children are very understanding. They know better about the question of HIV and AIDS such that they give much support to their mothers, like for instance reminding them with taking treatment and other things such as dates for appointments.”*

Another participant described the support and care offered by children to their infected mothers by saying, *“Some children become so supportive and sympathetic to their mothers. Some even think that their mothers are going to die.”* Another participant described her experiences of children’s involvement in supporting their children when she said, *“It is easier speaking to older children, because they understand. The worrying factor about the younger ones is that they become too sympathetic to their mothers”.*

As much as the support and care which is offered by children to their parents is a positive thing to do and well appreciated, it can also result in negative consequences to the children. The researchers warn against this practice. The University of California’s National Abandoned Infants Assistance Resource Center (2011:03) reports that over the years, there has been much research examining the effects of parentification on children. Early on, it was assumed that parentification would consistently lead to poor outcomes including maladaptive behaviours and difficulties later in life; whilst more recent studies have shown that this isn’t always the case (University of California’s National Abandoned Infants Assistance Resource Center 2011:03)). In other words, it is important for social workers not to blindly appreciate what children of WLWHIV do to support them, but they must also consider the negative implications this might have on the children. Although the findings of this study reveal positive relationship which emerged as children become more supportive to their HIV-infected mothers, the implications of the HIV-positive diagnosis on the children should never be underestimated. In their studies of women who have divulged their HIV-positive statuses to their children, Brackis-Cott, Mellins, Dolezal and Spiegel (2007:67) reveal that mothers who disclosed their HIV-positive status to their children endorsed greater depressive symptomatology than those who did not disclose and children to whom it

had been disclosed to were more likely to score in the clinically depressed range of the Child Depression Inventory than those who did not. In other words, as much as the support offered by these children to their mothers is appreciated, it is also imperative to highlight the damage, such disclosure and subsequent support have on the child.

- **Category 2.1.3: The concerns of WLWHIV about the welfare of their children**

Children are adversely affected by HIV and this causes some stress to their mothers as they often are concerned about their welfare, especially in the event of their death when they would leave them behind. In this study, concern about child welfare by WLWHIV emerged as one of the critical factors. Concerns of WLWHIV about their children's welfare were highlighted by one of the participants when she said, *"Many of them [WLWHIV] showed more concern for their children. They would even say at least if one would die after their children had started working for themselves, then they would accept dying."* Another participant described the welfare concerns of WLWHIV's by saying the following:

*"Some [WLWHIV] were even having fears of leaving their girl children with their partners. Apparently, many women would show distrust of their partners, particularly in terms of sexual abuse to their girl children. What matters worse with many of the WLWHIV is whether their children will be able to continue schooling after their death, and who is actually going to take care of them? Some, whilst they are still alive, cannot provide for their children and that is even why they worry more of the aftermath."*

Concerns raised by WLWHIV regarding the welfare of their children are also documented in existing literature as noted by Ritcher, Manegold and Pather (cited in Deacon & Stephney, 2007:01) who state that the pandemic can adversely affect household stability and sustainability, children's access to healthcare and schooling, state of health and nutrition and increase affected children's vulnerability to infection. For WLWHIV, these experiences are evident in their daily lives and make them feel worried when they see them affecting other children who lost their parents due to HIV and AIDS related conditions. This is explained by one of the participants who reported

that, *“They [WLWHIV] are much worried as to who would look after their children..... whether their children will be able to continue schooling or not... all such worries.”* Another participant had to say that, *“They [WLWHIV] are always thinking of their children as to what they are going to provide to their children on a daily basis.”*

Concerns of the WLWHIV about the welfare of their children are reasonable especially when one considers the challenges faced by children who are left by parents due to HIV and AIDS-related deaths. Another participant said that, *“I think the age of their children makes more concern. These clients become more worried when their children are still very young.”* The above highlighted experiences are clearly documented in existing literature. Deacon and Stephney (2007:01) for example, highlight the plight of children of WLWHIV when they state that the HIV pandemic possess a major threat to the socio-economic and psychological welfare of HIV-affected and infected children. It is therefore not amazing to hear WLWHIV having fears and concerns about the future of their children more than their own HIV-positive conditions.

#### **3.4.2.2 Sub-theme 2.2 Perceptions relating to disclosure by WLWHIV**

- Another subtheme which was identified from the data analysis process was disclosure which as indicated below, manifested itself as disclosure by WLWHIV and reaction to disclosure by their family members.
- **Category 2.2.1 Disclosure and reaction to disclosure**

Women are often regarded as pillars of the families. They are in the forefront of raising their children, providing for their families and most importantly in maintaining support and stability in the family. To their extended families (i.e. their in-laws), women are expected to uphold the highest moral standards and in most cases they are often blamed when their families are not functioning well. When confronted with an HIV-positive diagnosis, WLWHIV find it to be very difficult to disclose their HIV-positive status to their families. This has been confirmed by the Tanzanian study by Mwangi (2012:04) which revealed that many people who are voluntarily tested for HIV do not

disclose their status to their partners and or relatives. However, disclosure tend to result in a sense of relieve to WLWHIV as they tend to feel at ease once they decide to tell friends and families about their HIV-positive statuses. According to Weiner et al (in Murphy, 2008:107), mothers who are living with HIV who have disclosed their HIV-positive status report significantly lower levels of depression than mothers who had not disclosed it. The family also tends to play a significant role in cementing its support base for its female members who are living with HIV. Murphy (2008:107) found in her study that women who discussed their HIV status with their immediate families reported stronger family cohesion than mothers who had not disclosed it.

The challenge of disclosure is also noted by Fiore, Flanigan, Hoogan, Cram, Schuman, Scoenbaum, Solomon and Moore (2001:209) who emphasise that for disclosure to happen one requires a strong social and family support. The disclosure challenge was also noted during this study, as one of the participants said that, *“There were few [WLWHIV] of course, who said they immediately shared this news with their families. Many of them took time before sharing the news with their families.”* Reluctance by WLWHIV when coming to disclosing their HIV positive-status to family members was mainly due to their fear of reaction by such family members. This was highlighted by another participant who said, *“Some would like to disclose with their families and it becomes difficult because they think that they might be rejected by their own families.”* As indicated by the above participants, it is clearly apparent that disclosing one’s HIV-positive status to family members is a difficult process, particularly if anticipated reaction of the recipient is negative (Serovich, Kimberley & Greene, 1998:15). One of the participants highlighted the reaction to disclosure of WLWHIV by family members by saying that, *“There were a few [WLWHIV] who began blaming them (WLWHIV) [for] promiscuity.”* Another participant said that, *“This affected the family relations so badly.”*

The above statements as made by participants regarding WLWHIV’s disclosure corresponds with that of Mwanga (2012:03) who reported that HIV status disclosure by PLWHA has negative consequences including stigmatisation, discrimination, abandonment, rejection, divorce, physical violence, denied socio-economic support and fear of being accused of infidelity.

Young unmarried WLWHIV are particularly vulnerable as they depend upon their parents to whom they are supposed to disclose their status. They would therefore receive support when their parents are in good moods whilst their parents would turn against them when in bad moods. This was highlighted by one participant who said the following:

*“You’ll find that many of these women are very young and they therefore depend on their parents with everything. Parents, most of the time, have an alcoholic problem and this make them to appear sympathetic to their children when they are sober, but when they get drunk they call them names and insult their children on the same disease.”*

In their study titled *“Perceived family member reaction to women’s disclosure of HIV-positive information”*, Serovich, Kimberley and Greene (1998) found that their participants expressed a variety of reactions after disclosing their status to family members. Some of their participants’ family members were eager to gather information about the conditions of their family members who are diagnosed with HIV, some offered advice or instructions, some offered hugs, some started crying, others became violent, some became upset, some took a deep breath (a sign of shock), others offered prayers, some questioned the relationship, others offered help, some blamed them, some supported/comforted them, some began to get afraid of contagion, others shunned/rejected them, some became angry towards them and had some hope for a cure, while some even became embarrassed by them (Serovich et al., 1998:15).

A participant described how one WLWHIV’s relatives became over-protective to her in the following manner: *“You know when your relatives know that you are faced with a life threatening situation, they sympathise with you too much, sometimes talk of your situation frequently and this might not be very pleasant with the person infected with the virus. They even stop one from doing certain chores because they say you are ill, even before you actually get ill. So these women are avoiding such a treatment (by not disclosing)”*.

From some participants' descriptions, WLWHIV received more care and support and this made them to cope positively with their HIV-positive diagnosis. One of the participants described how WLWHIV received support from family members by saying, *"Some showed that they never had any problems after disclosing [to] their families. Instead they got as much support as they needed."* Another participant described as follows how older people offer more support to WLWHIV than younger ones: *"As they would say, more of the elders were too sympathetic and thinking that they would soon die and would even try and give any help even when it is not necessary"*.

As one can see above, disclosure of persons' HIV positive status can result in mixed reactions from their family members. Some would accept and offer some necessary support while others would be shunned at and even blamed for being HIV positive. Contemplation of disclosure might indeed include the possibility of garnering emotional and instrumental support to PLWHIV while at the same time also subjecting them to rejection (Draimin, in Ostrom, Serovich, Lim & Mason, 2006:60).

#### **3.4.2.3 Sub-theme 2.3: Perceptions relating to fear of WLWHIV**

Another sub-theme identified from this process was the way the social workers explained their clients' (WLWHIV) fear of disclosure, fear of death and dying and fear of stigma as presented below.

- **Category 2.3.1: Fear of disclosure**

Being diagnosed as HIV-positive tends to carry with it many challenges, including fear of disclosure of one's HIV-positive status and avoiding being identified and stigmatised and labelled as being HIV-positive. According to Reynolds, Caswell and Shiripinda (2008:23), individuals are often concerned about disclosure: either indirect disclosure, through being seen accessing sexual health clinics, or direct exposure, with the perception being that general practice reception staff may disclose their status to community members. This appears to be common among WLWHIV as described by one of the participants of this study who said, *"What I can say is that people are so secretive about their status. They are ashamed."* Another participant referred to some

WLWHIV's avoidance of support groups which they feel would expose them, as follows: *"If I begin to tell them of support groups and any other source of help, that to them tells they will be known by the community."* The tendency of reluctance to disclosure due to fear, as highlighted above, confirms Daftary, Padayatchi and Padilla's (2007:574) findings where participants in their research (who were patients at a hospital), were less likely to disclose their HIV status or testing history than their TB status.

Being diagnosed with HIV is clearly not an easy experience for WLWHIV. Disclosure becomes even more difficult, especially considering the stigma and discrimination against PLWHIV which has become rife. One of the participants described WLWHIV in this regard, by saying, *"There are so many people living with HIV, but the problem is that people are so scared to disclose their status. So they do not come to us until they become ill and are sent by the clinics for counselling."* The fear of disclosure is also highlighted by a longitudinal study of WLWHIV by Ostrom, Serovich, Lim and Mason (2006) who found that their participants thought that their diagnosis was personal and reported not disclosing because of the disclosing stress. This highlights the fear of disclosure as a mechanism adopted by PLWHIV and therefore results in silence about HIV and AIDS-related issues. Consequently one finds the proliferation of stigma and HIV and AIDS itself which emanates out of this silence and fear.

- **Category 2.3.2: Fear of stigma**

Stigma and discrimination play a very detrimental role in the fight against HIV and AIDS (Ayesha, Kharsany, Karim & Karim, 2010:533). In other words, as people develop fear and silence prevails, knowledge regarding HIV/AIDS preventions, treatment and support also remain suppressed. Stigma is clearly one of the main obstacles in the fight against HIV/AIDS. One of the participants described WLWHIV's fear of stigma by saying, *"You will find some of them disclosing immediately and later denying this and beginning to claim that it is witchcraft which makes them sick."* The fear of stigma is also acknowledged by Ross' (2013:192) findings where she reveals that Thai mothers with HIV infection had fear of stigmatisation and rejection from family and friends and this resulted in their lonely struggle. In other words, her participants' fear compromised their

trust of even family members and friends. Due to the fear of stigma, WLWHIV prefer to be alone rather than get support from their significant others like fellow WLWHIV. One of the participants described the WLWHIV's experiences of stigma as she said, *"These women also struggle with the question of stigma in their families and in their neighbourhoods. If for instance, they are known their status, their children also get stigmatised and are told by their parents not to play with their children."*

Another participant described her experiences of how fear of stigma forces WLWHIV to remain silent when she said, *"What I can say is that people are so secretive about their status. They are ashamed."* Another way through which stigma manifested itself in this study as described by another participant was through WLWHIV's reluctance to access treatment at their nearest treatment centres as they felt it would expose them and make their status known. A participant had the following to say about WLWHIV in this regard: *"A number of people choose to walk long distances and struggle accessing help and resources when assistance is available in their immediate locality. They do not want to be known by the local people."* Another participant said, *"The interesting part is that, they hardly attend in their own localities. They choose to travel or walk long distances."* From the above excerpts one can clearly see that fear of being identified as living with HIV, labelled, marginalised and even attacked forces women to bottle-up and feel their pain in silence. These findings are similar to the ones revealed by Lekganyane (2010) who found that among HIV-positive women in the Chris Hani Baragwanath Hospital, some of the women do leave resources like the ARV clinics from their local areas and travel distances to access the ones in areas where they are not known due to fear of HIV-related stigma in their local areas.

According to Bond (2004:40), stigma can take three forms, namely self-stigma, perceived stigma and enacted stigma, each entailing the following: Self-stigma is manifested in self-blame and self-deprecation. Perceived stigma is manifested in the fears that people have around being stigmatised if they are HIV positive and/or choose to disclose their HIV status with others. Enacted stigma is when people are actually discriminated against because they have, or are thought to have HIV.

All forms of stigma appear to be apparent in the findings of this study. One of the participants described WLWHIV's self-stigmatisation as she said, *"What I can say is that people are so secretive about their status. They are ashamed."* Another participant highlighted self-stigma by saying, *"For instance they [HLWHIV] think it is an embarrassment to be HIV positive. They are scared of disclosing."* The existence of stigma among WLWHIV was also confirmed by Dover (2004:161-162) among the Zambian villagers of Chiawa, where HIV-related stigma in a form of blaming the victim has been proven to be more directed towards women than men. Men were excused from such blames because they were regarded as being unable to control their sexual desires while women were castigated for having non-marital sexual relationships for money or presents (Dover, 2004:162).

- **Category 2.3.3: Fear of death and dying**

HIV and AIDS have been portrayed by society as a "deadly illness" where PLWHIV are often seen as those who would soon die. This led to a tremendous fear among PLWHIV themselves who appear to be concerned about death and dying. It is therefore not surprising to hear what was shared by a number of participants regarding WLWHIV's fear of death and dying. One of the participants shared how WLWHIV try to avoid talking about the reality of death as she said, *"Why would they talk more about life than death. Even when they are in a group situation where PLWHIV should be strengthening each other, sharing ideas and giving comfort to each other, death becomes a taboo. They avoid it at all costs. In support of this category the following quotations from some of the transcribed interviews are provided"*. Another participant described WLWHIV's fear of death as follows: *"The first thing that comes to the mind of the client is that if she is HIV positive, then she definitely is going to die."*

For these WLWHIV as described by these participants, an HIV-positive diagnosis immediately brings with it the thoughts of death which is a difficult moment for them. In their study of HIV-related stigma, Cao et al. (2006:525) revealed similar findings where HIV-related stigma was associated with death. This is mainly due to the manner in which HIV and AIDS received coverage both in the media and in research society

where it is described as a “deadly virus”, “a plague” or even “an incurable disease” which continues to spark rejection and discrimination of PLWHIV due to people’s fear of being contaminated with this “deadly virus”.

In describing how death related topics were avoided as WLWHIV thought it was imminent, another participant said, *“When you ask the group members of death and dying, they are so scared. They even avoid talking about this, in as much they see it as something that might come at any given moment. The problem becomes that their families are not ready, because they have not disclosed with them.”* Similar expressions were made by another participant who said, *“It is not easy talking of death with clients, especially when they are newly diagnosed, because once you talk of death, they might immediately lose hope and can even be reluctant to meet you again. So mainly we are talking about life and living instead of death and dying.”* The descriptions of WLWHIV’s fears by participants corroborates with existing literature. Lekganyane (2010) for example found in his study of HIV positive outpatients from the Chris Hani Baragwanath Hospital that fear of death was also demonstrated among his participants where some would even avoid attending funerals as they felt it makes them think every young person they burry has died of AIDS-related deaths.

Despite the fear of death as highlighted by the above statements made by participants, one participant reported that some use their faith to accept the fact and reality of death and tend to live with it. She described this by saying, *“One other thing is that more of them were so religious and they believed that if they die, that would be God’s will. Not that they wanted to die, but they had accepted that if it comes, then there is nothing they can do about that.”* Faith has proven to be a blanket through which PLWHIV cover themselves to avoid societal denigrations and atrocities. Lekganyane (2010:72) for example also found from his study of HIV-positive female outpatients that some of his participants resort to prayers and church as a way of coping with HIV-diagnosis and its related stigma. The role of faith in minimizing fear of AIDS-related deaths is also highlighted by Ridge, Williams, Anderson and Elford’s (2008) study which revealed that African PLWHIV in the United Kingdom were able to obtain support in places of worship including one-to-one counselling, collective prayer (considered more powerful than

individual prayer), networking with others for emotional and material support, assistance with financial and asylum seeking issues, participation in meaningful and culturally relevant activities, physical contact and a sense of family and place to belong.

#### **3.4.2.4 Sub-theme 2.4: Perceptions relating to self-blame by WLWHIV**

As described by participants of this study, some of the WLWHIV feel that they are somehow responsible for their HIV-positive diagnosis by being ignorant or failing to insist on safer precautions. They then shifted the blame towards themselves and begin to view themselves as careless and therefore deserving to live with a HIV-positive diagnosis. This subtheme of self-blame is discussed further below.

- **Category 2.4.1: WLWHIV blame themselves for their diagnosis**

Self-blame is self-stigmatisation or internal stigma which clearly takes various forms, one of which is to continuously blame oneself for an HIV-positive diagnosis. Various researchers (Bond, 2004; Lekganyane, 2010; USAID, 2006) believe that self-blame emanates from the internalisation of stigmas which PLWHIV receive from people with whom they interact. In her description of self –blame as experienced by WLWHIV, one of the participants highlighted how one of her clients started blaming herself for remaining in a relationship which was clearly not safe for her when she said, *“I could see that she was blaming herself with staying in such a relationship which at the end of the day brought her a killer disease.”* Another participant highlighted the plight of WLWHIV who started pointing fingers towards themselves as they thought they are the ones who have facilitated the process of their own infection when she said, *“Again there are those women who would tell you that they know for the fact that they have been changing partners too often, not because they are promiscuous, but that they cannot get the right person.”* For some WLWHIV, self-blame is the basic reason why they choose to be secretive about their HIV status, particularly to their families as pointed out by a participant who said, *“Well, yes, especially with the fact that they (WLWHIV) perceive themselves as a disgrace to their families, hence choosing to be secretive about their status.”*

Although self-stigmatisation was apparent among the majority of the participants as highlighted above, one participant reported how one of her clients (a WLWHIV) directed her blame to her husband and even blamed him for infecting her with the virus (Bond, Chase & Aggleton, 2002). She described the event by saying, *“I remember when I asked her of how she got to know about her status she just cried and took time before she could speak. I tried to comfort her and eventually she was ready to speak. She told me that she only had one boyfriend in life and the guy would come and go and she would always accept him when he came back. She said she loved this man and she even thought that they would marry one day and now all those dreams had vanished because she was going to die. She started crying again.”* This tends to highlight that not all WLWHIV could blame themselves for their diagnosis.

### **3.4.3 THEME 3: DESCRIPTIONS RELATING TO CHALLENGES FACED BY SOCIAL WORKERS WORKING WITH WLWHIV.**

The second theme identified by the researcher was the participants’ descriptions regarding challenges faced by social workers working with WLWHIV. This theme was further categorised into two subthemes as described below:

#### **3.4.3.1 Sub-theme 3.1: The working conditions and resources.**

The working conditions of social workers working with WLWHIV were highlighted as a sub-theme in a form of lack of office space, inadequate human resources and poor planning by management.

- **Category 3.1.1:Lack of office space**

Lack of office space was reported as one of the challenges encountered by social workers in their rendering of social work services to PLWHIV. Given the nature of their work which requires social workers to always uphold professional ethical principles such as confidentiality, lack of suitable office space becomes a serious threat not only to them as professionals but to the image of the profession itself. The following statements which were made by three participants prove the existence of office space challenges amongst participants:

*“You know, with the support groups that we are running our main challenge is the private space. Sometimes we run them in school classes. You can see that the members feel very uncomfortable, but there is no other way.”*

*“I think our office environment contributes very negatively towards this. For instance, because there is no privacy in our office many people choose to stay with their problems and not consult the offices.”*

*“The main challenge when they reach the office is the question of the lack of confidentiality due to the office space.”*

The above reports made by participants during the interviews concur with existing research findings which reveal that privacy influences job satisfaction and a relation between reduced privacy and low job satisfaction in open workplaces has been detected (Danielsson & Bodin, 2008). Another participant reported the existence of office space challenge when she said, *“In some offices social workers are still sharing space with SASSA (South African Social Security Agency) which also has a huge number of clientele. The community care in some offices also uses the offices which add to the burden...”* Clearly lack of office space makes the social workers to find it very difficult to perform their tasks especially taking into consideration the WLWHIV’ s fears of death, stigma and self-blame highlighted in the previous theme. In other words, lack of office space frustrates not only social workers working with WLWHIV, but also their clients who desperately need privacy and confidentiality.

- **Category 3.1.2: Inadequate human resources**

Inadequate human resources in dealing with the scourge of HIV and AIDS is one of the major challenges encountered by social workers working with WLWHIV. Lack of personnel to assist in rendering services, as well as lack of support from management in the form of supervision, has proven to be the main concern. One of the participants highlighted inadequate human resources by saying, *“The first thing I would like to mention is that we do not have the supervisor in our office, at all.”* Another participant

described inadequate human resources which even hampers her ability to deliver by saying, *“I have a huge case load in foster care. I am also doing the Early Childhood Development Programme. Also there is an additional function now of the Community Care Givers who have been absorbed by the department and I have to monitor their work, give them all the support they need. There is a lot that I am doing, besides HIV and AIDS. I am also the Batho Pele [People first project] coordinator in my office. I have to make it a point that the clients are treated with dignity and respect.”* Social workers who are working with WLWHIV find themselves particularly affected by this, due to their need for specialised service which requires specialised resources to support their client system. The category of inadequate human resources has also been identified by the South African Department of Labour (2008:72) which states that social workers are frustrated with the overwhelming needs of the community in relation to their own relatively low numbers and their limited (or lack of) access to resources, such as adequate supervision, stationery, office space and furniture, information technology, administrative and language support, vehicles and supporting professionals and institutions such as places of safety.

Lack of support and guidance from organisational leadership is also a concern for other researchers. Gormley, McCaffery and Quain (2011:113) for example, found in their study that there is a tendency to assume that once plans have been developed, implementation will occur naturally—which, of course, is not the case. Inclusive stakeholder groups at national level can provide the leadership to implement plans to close the human resources gap. In other words, the people on the ground, the social workers and other professionals and practitioners are in need of more support in order to ensure effective and thorough implementation.

Lack of support and poor support from management were described by one participant who said, *“I think supervisors are doing the best they can, but the situation is beyond their control. For instance, supervisors see the need for more social workers because of the volume of work that we have, but as long as that is not seen by the senior managers, nothing is going to happen.”* In their efforts to address what they term Human Resources for Health (HRH), Gormley, McCaffery and Quain (2011:113)

recommend that human resources management system be strengthened because most of the human resources are fragmented, weak and understaffed – a serious impediment for any sustained change. Gormley et al.'s (2011:113) assertion above corroborates with the experiences of social workers as presented by one participant who said, *“To begin with, I want to state that we only have one supervisor and as I had already indicated, we are twelve social workers. At one stage you need assistance from the supervisor and she is not around, so in such a situation you end up asking for assistance from a colleague who is at the same level as you.”* Inadequate human resources are not only a challenge to social workers. Their clients are also compromised as they might not receive the required adequate attention due to social workers' efforts of spreading their attention to all off their clients.

#### **3.4.4 THEME 4: DESCRIPTIONS RELATING TO SOCIAL WORK SERVICES FOR WLWHIV**

The third theme that was identified during data analysis is about the services offered by social workers working with WLWHIV. This theme is manifested in a form of the descriptions provided by participants regarding the types of services offered by social workers working with WLWHIV to their client system.

##### **3.4.4.1 Sub-theme 4.1: Types of social work services for WLWHIV**

One of the sub-themes of services is the type of social work services provided to WLWHIV. This sub-theme is categorised into four categories which are presented below.

- **Category 4.1.1: Building with WLWHIV**

Given the special nature of challenges experienced by WLWHIV, there is no doubt that they also need to be served by a special calibre of social workers, a calibre that will be very patient to understand their conditions very well and offer appropriate support where necessary. Trust has been emphasised by participants as one of the features that social workers need to possess. As presented below, the need for social workers to ensure that their relationships with WLWHIV are based on trust, was identified by one of the

participants who said, *“For you to be able to talk about death and dying with a client, it is very important that you establish a very good relationship first.”*

Trust is one of the critical components that enable PLWHIV to be open and feel free to express their challenges within a non-threatening context. Chow, Chin and Fong (in Carr, 2001:36) share the same sentiment on the importance of trust when they say that the trusting relationship between provider and patient is a factor in HIV antiviral therapy adherence. A participant shared her opinion on trust as a foundation of relationship between her and her client system when she said, *“You have to establish a rapport and build a good relationship with them, first. They have to gain that trust in you.”*

Similar views are shared by Semmes (in Carr, 2001), who recognises trust as a factor in patient’s acceptance of treatments. In other words patients feel more open to adhere to treatment if they feel free, not judged, not blamed and being assured of care and support by the helpers. Trust is therefore one of the critical components of treatment, care and support in this context and should be ensured in any relationship with the clients. Dealing with a highly stigmatised condition such as HIV requires some extra professional readiness. A person living with HIV needs to feel accepted unconditionally and free to express herself (Sarangi, nd: 01).

- **Category 4.1.2: Coordinated social work services for WLWHIV**

Social workers, particularly those that work with WLWHIV have a special task of working collaboratively with relevant stakeholders for the betterment of the living conditions of these groups. Given the stigma attached to HIV and AIDS, most WLWHIV do not immediately tell social workers what their actual problem is. It therefore requires a special form of patience and empathy from the social workers in order to fully get to the crux of their matters. Most of the time the decision for WLWHIV to come for help is not voluntary one, but due to advice from their significant others. As it stands, some of these women may be referred by community care givers or community based organisations (CBOs) which have played a pivotal role in the fight against HIV and AIDS. This is what is called coordinated service delivery where all stakeholders play a role in helping PLWHIV. One of the participants described coordinated service by

saying, *“Others are referred by neighbours and friends, and sometimes their counsellors.”* Another participant described how community care givers are part of the coordinated service providers when she said, *“You know, we have Community Care Givers that are working in the communities. They then refer these people to the organisation.”* Coordinated service is recognised by Chibamba (2011:226) who asserts that Botswana was seen as the best practice for Africa due to its declaration of HIV and AIDS as a national crisis and thereby inviting all sectors to participate in the fight against it, including the CBOs. One of the participants described how she experienced coordinated service delivery in one of the centres when she says, *“It is a centre which renders HIV and AIDS related services such as doing home visits and providing food parcels. They help us with the HIV and AIDS programs. It is the centres which we fund as the department which reach where we cannot. They utilise our funds in providing the services. We monitor them in utilising the funds of the government.”*

HIV and AIDS is clearly a very broad phenomenon which cannot be fought by a single sector. Involvement of all societal sectors both at the national and the community level is imperative in order to win the battle against this phenomenon. This approach to fight HIV and AIDS corroborates with Vassall, Remme and Watts’ (2012:248) assertion when they state that there is growing evidence that community mobilisation and stigma reduction could be enablers of other core HIV-prevention interventions. Another participant described coordinated service delivery by saying, *“It is paramount that we should work very closely with the Department of Health, the Department of Education, Home Affairs, and Agriculture.”*

One way in which coordinated service delivery is conducted in the Pietermaritzburg Region is through what is called a ‘war room’ where different stakeholders discuss all the social issues of a particular community ward and come up with solutions to address them. One of the participants described her experiences of a war room by saying, *“The war room is a structure where different stakeholders, the government departments in particular, gather together and discuss all issues of that particular ward. The departments get all the information from the community care givers (CGs) as they are*

*directly in the community. The war room has somebody who acts as a leader, someone who convenes the meetings.”*

This kind of practice supports Kitahata, Tegger, Wagner and Holmes’ (2002:956) view when they say that integration and coordination of services are important elements of the WHO (World Health Organisation) chronic disease model that could optimise the use of resources and increase access to HIV care. In her description of coordinated service, one of the participants said, *“Then, this is how they are supposed to do, but unfortunately, they do not attend most of the time. At the moment, nothing happens.”*

Another way through which coordinated service is practiced in the Pietermaritzburg Region is through appointment of social workers who are tasked specifically with coordinating the HIV and AIDS programme throughout the region. One of the participants described her experiences of HIV and AIDS programme coordination by saying, *“As HIV and AIDS coordinator, most of the time I spend with the organisations, monitoring and evaluating them, ensuring that the money which they are funded with, is spent accordingly and in accordance with the Public Finance Management Act (PFMA).”*

The above excerpts confirm the necessity of considering a multi-sectoral approach to address HIV and AIDS and its concomitant factors. In her support for coordinated service, Egero (2004:210) states that for a long time, AIDS was defined as a health issue, to be handled by the health departments and aid agencies and of health ministries in the poor affected countries. Slowly, AIDS has come to be redefined as a development issue, a perspective that has yet to take a roof (Egero, 2004:201). HIV and AIDS is clearly everyone’s responsibility. It clearly requires the involvement of family members, the neighbours, community leaders, care givers, non-governmental organisations, government departments and ordinary men and women.

- **Category 4.1.3: Holistic approach to social work service delivery**

A number of participants stated that when having a session with the WLWHIV, they do not only concentrate on HIV and AIDS, but they also look broadly at all other needs as prescribed by the social work profession. Social work, as described by Nakazibwe

(2008) is concerned with people and their total life worlds; it cannot extricate itself from the impact of HIV and AIDS. It is therefore important for social workers to listen with the inner ear in order to get a holistic understanding of their clients' stories. In some instances the clients appear not to know exactly what kind of assistance they are actually looking for and it is only through listening deeply that social workers come to understand their needs. One of the participants described how she became aware of her client's problem by listening deeply and adopting a holistic approach when she says, *"Let me make an example of one lady who came to our office and said she needs some help, but did not know exactly what kind of help she needed. When I assessed her, I found that her main problem was with disclosing her status. As a result, out of this case we ended up having a support group, because the same woman was telling me that there are two other ladies who have the same problem, but who were reluctant to come and visit the office."*

Support groups seems to be one of the ways through which a holistic approach can be practised as WLWHIV can come together and share their experiences and therefore enable the social workers to develop a broader understanding by linking their stories.

It is however very unfortunate that very few social workers are involved in conducting support groups for WLWHIV. Those that are not involved cited time constraints as a factor for their inability to do so. This limit their opportunity to adopt a holistic approach in serving WLWHIV as emphasised by Hunt, Jaques, Niles and Wierdzalis (2003:58) who state that counsellors must take a comprehensive and holistic approach when providing services to clients with HIV/AIDS.

One other critical factor was that WLWHIV have no influence as to who should look after their children when they have passed away, as well as, how their assets should actually be administered for the benefit of their children. Only one social worker said she was facilitating that in her support group. She said that, she learnt that at a non-governmental organisation that she worked for before she joined the DSD. She described her experience by saying, *"I asked how many of them have a will. There was no one. Then I asked who of them has got a plan for his or her children as to who is going to look after his or her property and children in the event of death. Again people*

*were saying they do not have the proper plans, but they trust their relatives would take care. There was one who said she is not in good terms with anyone at home and what she thinks is that social workers would have to take care of her children in the event of her death.”*

This means that when providing services to WLWHIV, social workers need to take into consideration the future of the women’s children. They should be broad minded when thinking about the future and prepare their clients psychologically and socially for the wellbeing of their children. Hunt et al. (2003:58) also call for social workers to be broadminded when they say, “Therefore a broad range of skills and understanding is required for helping professionals who work with HIV-positive clients.”

With regards to the one-on-one sessions, almost all the participants demonstrated holistic views as they displayed some high standards of counselling skills which involves educating their clients on how to live positively with the virus. Most of them also extended their services to these clients’ homes where they ensure that someone knows about their status in order to provide the necessary support. They would also motivate those on treatment to adhere to it, while also going as far as to visit the families to provide family therapy.

In terms of practical assistance, social workers would facilitate the initiation of projects such as vegetable gardens at clients’ homes in order for them to get fresh vegetables and keep healthy. They also provide food parcels to their clients as a form of social relief for those who are in very desperate living conditions. Some of those who are eligible for social grants are referred to SASSA to apply for social grants.

The importance of holistic perceptiveness in dealing with issues of WLWHIV supports Carter, Bourgeois, Brien, Abelsohn, Tharao, Greene, Margolese, Kaida, Sanchez, Palmer, Cescon, de Pokomandy, Loutfy and CHIWOS research team ‘s (2013) assertion that managing the illness of women, requires a rigorous adherence to combination of drug therapies and coordination of multiple specialists which may include primary care providers, psychiatrists, HIV specialists, hepatitis C specialists, social workers, outreach workers, pharmacists, ophthalmologists, gynaecologists,

fertility specialists, paediatricians and many others. The implication of this need requires social workers to see beyond what the clients tell them so that they can pick up any relevant issues which might necessitate other professionals' intervention and therefore ensure that referrals are made where necessary.

- **Category 4.1.4: Prioritization of children of WLWHIV in social work service delivery**

Children are not immune to the impact caused by HIV and AIDS. Like women, they are the hardest hit population groups as far as this is concerned. According to UNICEF (2006:2), children are affected by HIV/AIDS either directly or indirectly. Indirectly the children are affected when their communities and the services offered by their communities are strained by the consequences of the epidemic. Nurses and doctors may suffer the disease threatening health care and the health care system they work within may be overwhelmed with new patients, teachers may become ill, disrupting education. This might result in a poor quality of health and education for the community and children become the hardest hit population groups as they fully depend on parents and guardians who may also be ill and could not have access to quality health care. Directly, children are affected when they find themselves in a situation where they live with a chronically ill parent or adult and where they are prone to infection (UNICEF, 2006:2). The plight of children have been described by one of the participants when she says, *“Many of such cases are reported by community caregivers. Even in situations where the mother is incapacitated to take care of her children because of progressed illness, children get placed, temporarily and the same procedure is followed. Soup kitchens where there are CBOs are also of good use in these situations.”*

This practice is in line with the 2001 Social Development's Integrated Plan for Children and Youth Affected by HIV and AIDS (Hickey, Ndlovu & Guthrie, 2004:106), which aims to transform care of children infected and affected by HIV and AIDS, and to identify and build up the strength of families and communities to enhance their effectiveness as caregivers. In terms of this plan, children should be in the forefront to benefit from any efforts aimed at addressing HIV and AIDS and its related factors. One of the participants reported her experiences of putting “children first” when she says,

*“Sometimes we place children with relatives and friends to care of them when their mothers have no capacity to do that.”* In another description of how children are prioritised, another participant said, *“If there is nobody, then one looks at all other alternatives such as children’s homes.”*

The importance of prioritising children confirms Amason (in Deacon & Stephney, 2007:1)’s assertion when he says “the massive impact of the HIV and AIDS pandemic on children and their support systems in families and communities has prompted fears that millions of children will not receive proper care and assistance for their development.” Involvement of communities and extended families in child care during the HIV and AIDS era is imperative as highlighted in the above statements made by the participants. Community centres such as drop-in centres and places of care also play a pivotal role by ensuring that vulnerable children receive necessary care and support. This was highlighted by one of the participants who said, *“Children that are vulnerable, when coming back from school go to the soup kitchen and they get food there.”* This and many other efforts of ensuring care and support to children aim to put children first in their service delivery effort.

The following were seen as the major findings in this study, and they will be expatiated upon in the next chapter, which will also encompass the recommendations based on the findings, broadly.

### **3.5. CONCLUSION**

In this chapter the researcher presented the research findings obtained during the research, comprising of the presentation of the bibliographic particulars of the participants and a discussion of the results of the processing of the data obtained as themes which were compared and contrasted relation to existing literature by means of a literature control. The three dominant themes which were further divided into six subthemes and fourteen categories were identified and discussed in line with existing literature. In the next chapter, the researcher presents the summary, conclusions and recommendations based on the research process, the findings and social work practice.

## **CHAPTER FOUR**

### **SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

#### **4.1. INTRODUCTION**

The main purpose of this study was to obtain a better understanding of the experiences and the challenges of WLWHIV from the perspective of social workers; the conditions under which they render services to WLWHIV; how they manage to render assistance to their clients with challenges confronting them; the support systems that are available to them; and how all these circumstances could be improved.

This chapter concludes the research and consists of a summary of the research report, a presentation of what prompted the researcher to undertake this study; the conclusions and findings that were made during the research; the main findings and the recommendations following the research.

#### **4.2 SUMMARY OF THE RESEARCH REPORT**

The first chapter has orientated the reader to the general introduction and the nature of the study itself. In particular, this chapter presented the reader with a background of the challenges and experiences of WLHIV from the perspective of social workers who provide social work services to WLWHIV. The reader was also inducted to the conducted research process through the presentation of the research question, the research goal, the research objectives and task objectives, the characteristics of the qualitative approach and the manner in which the ethical principles were observed.

Chapter Two, provided a presentation of the actual research process adopted in order to describe the execution and application of the research objectives to achieve the research goal and to obtain answers to the posed research questions. This was done through the detailed presentation of the research approach, the research design, data collection method, data analysis and verification.

In Chapter Three the outcome of the challenging task of analyzing qualitative data is described in terms of the emerged themes, sub-themes and categories which, based on and supported by quotations are subjected to a literature control.

In the current chapter, an emphasis is placed on the summary, conclusions and recommendations of the research. The chapter provides a summary of all the chapters based on the research process and the research findings (that are also presented in this chapter) and highlights the themes and sub-themes that emanated from data analysis and their implications, as a conclusion. Finally, this chapter provides recommendations based on social work practice, policy and programme design and development, the research process, , as well as recommendations for further research.

#### **4.3 SUMMARY AND CONCLUSION OF THE RESEARCH PROCESS**

As indicated in Chapters One and Two, a qualitative research approach was adopted in order to explore and subsequently, describe the experiences and challenges faced by WLWHIV in the Pietermaritzburg Region, KwaZulu-Natal Province from the perspectives of the social workers. There were mainly, two research questions that this study attempted to answer which were the following:

- *What are the experiences and challenges of WLWHIV in the Pietermaritzburg Region, KwaZulu-Natal Province from the perspectives of the social workers?*
- *What are the social work services rendered by social workers to WLWHIV in the Pietermaritzburg region?*

Semi-structured interviews facilitated by open-ended questions contained in an interview guide, were conducted with participants in order to obtain all the required information directly from the participants. The overall goal of this study was:

- *To develop an in-depth understanding of the experiences and challenges of WLWHIV in the Pietermaritzburg region, KwaZulu-Natal Province from the perspectives of the social workers.*

- *To develop an understanding of the experiences and challenges of social workers providing social work services to women living with HIV in the Pietermaritzburg Region, KwaZulu-Natal.*

The goal of this study was accomplished, as the participants contributed by having fully expressed themselves in terms of the experiences and challenges they are faced with when rendering social work services to WLWHIV.

In order to accomplish the afore-mentioned goal, the researcher employed the set research objectives:

- exploring and describing the experiences and challenges of WLWHIV in the Pietermaritzburg region, KwaZulu-Natal from the perspectives of the social workers ; and
- exploring and describing the social work services rendered by social workers to WLWHIV in the Pietermaritzburg Region, KwaZulu-Natal.

The research objectives were attained by means of employing the following task objectives:

- A sample of social workers who provide social work services to WLWHIV in the Pietermaritzburg Region, KwaZulu-Natal was obtained.
- Semi-structured interviews were conducted with this sample of social workers in exploring their perceptions of the experiences and challenges faced by WLWHIV in the Pietermaritzburg region, KwaZulu-Natal.
- The data obtained were sifted, sorted and analysed by using Tesch's eight steps for qualitative data analysis (as cited by Creswell, 2009:186).
- The experiences and challenges of social workers who provide services to WLWHIV were described.
- The data obtained were analysed and interpreted and a literature control was conducted in order to verify the findings.

- Conclusions were drawn and recommendations were made about the needs of social workers who provide social work services to WLWHIV.
- Conclusions were drawn and recommendations were made about the social work services rendered by social workers to WLWHIV in the Pietermaritzburg Region, KwaZulu-Natal.

These objectives are further presented in Themes 1, 2, 3 and 4 below where they are specifically related to the findings of this study and the conclusions drawn from the analysed data.

With regard to the first objective, the required number of participants could not be predetermined in this inquiry by virtue of the fact that in qualitative research only once a data saturation point is reached, a sufficient number of participants have been interviewed. This takes place where the researcher perceives data acquired from participants as having become repetitive. Then the data collection stops, unless further probing is required to enrich the qualitatively generated information. This point was reached after conducting interviews with thirteen social workers meeting the requirements of inclusion, recruited from the Pietermaritzburg Region of the KwaZulu-Natal Province. The participants were interviewed about their experiences and challenges in their provision of social work services to WLWHIV.

The data were analysed through the eight qualitative data analysis steps as provided by Tesch (in Creswell 2009:186) as presented in Chapter Two. The researcher, the promoter/supervisor, together with the independent coder then discussed the outcomes of the analysis. Out of this process of analysis, there emerged themes, sub-themes and categories which were supported accordingly by quotations of what the participants said, which were true reflection of the engagements between the researcher and the participants. Appropriate literature was then used to confirm and or contrast the themes, sub-themes and categories comprising the research findings, by means of a literature control. A detailed description of the data analysis was covered in Chapter Three.

Conclusions were drawn concerning the needs of the social workers working with WLWHIV as well as the social work services rendered by those social workers to

WLWHIV. The conclusions and recommendations are provided in the current chapter, with the recommendations regarding the adopted research process preceding the recommendations based on the practice issues such as, policy issues; issues regarding social work practice; education and training for social workers rendering services to WLWHIV.

The researcher applied a qualitative research approach with an explorative, descriptive and contextual research design, for this study. Semi-structured, in-depth interviews facilitated by open-ended questions contained in an interview guide, were used to get all the information directly from the participants. The rationale for the study demanded some clear-cut objectives in order to have a systematic manner of answering the research questions. All the interviewed social workers were able to give their independent perspectives in relation to experiences and challenges that they encounter in the process of assisting the WLWHIV. The commonalities with how participants perceive their working conditions, as well as the adverse conditions faced by their clients, have made it easy to discern the themes, sub-themes and categories which have enabled the researcher to draw the necessary conclusions which gave rise to the recommendations, which are the end product of every study. The recommendations included policy issues; issues regarding social work practice; education and training for social workers rendering services to WLWHIV; as well as, the proposals for further and/or future research. Should the recommendations and the challenges they constitute, be unattended to, chances are strong that WLWHIV will in some instances continue to receive services that are inconsiderate of their needs.

#### **4.4 SUMMARY AND CONCLUSION OF THE RESEARCH FINDINGS**

As revealed in this chapter, the main findings of the study were found to be related to the specific conditions experienced by the WLWHIV that the social workers participating in this research render social work services to, namely their fear about matters such as their death, domestic violence and their consistent worries relating to their own diagnosis as well as the wellbeing of their own children.

Occupational challenges like inadequate and generalised training offered to social workers as well as a high volume of work also emerged as some of the threats to the social workers' efforts to ensure effective and efficient social work services to WLWHIV. However, against the aforementioned odds, social workers seem to be proactive by implementing various strategies like collaborating with other organisations that could make their work more efficient. Some corporate related issues such as the need for more human resources in the form of a dedicated team of social workers, which would ensure proper planning and support the implementation of coordinated efforts of social work practice, were highlighted as imperative

The summary and conclusion of the research findings are presented in terms of training received by social workers; the social workers' experience in working with WLWHIV; the challenges faced by social workers in this regard and the social work services rendered to WLWHIV.

#### **4.4.1 Theme 1: Descriptions relating to training received by social workers in offering services to WLWHIV**

HIV/AIDS-related training was found to be the primary training received by the social Workers working with WLWHIV. It emerged during the interviews that training that was offered to social workers was categorized according to the intervention priorities of both the provincial and the national government where specific emphasise was placed on training with regard to HIV/AIDS prevention and training with regard to HIV/AIDS support. In addition to the value of training, it also emerged during the study that participants have mixed opinions with regard to the value of training where some found training to be very helpful for them while some expressed their dissatisfaction with regard to the practicality and the appropriateness of training.

#### **4.4.2 Theme 2: Descriptions relating to social workers' experiences in working with WLWHIV**

The findings of this study reveal that social workers working with WLWHIV deal with various issues faced by WLWHIV. Their clients' HIV-positive diagnosis was found to be affecting their relationships in different ways where exposure to domestic violence and

relationship breakdown was evident on the one hand, while positive relationship in a form of support and love was revealed from their children on the other hand.

The social workers' experiences in terms of the relationship with WLWHIV, was also found to be influenced by WLWHIV's concerns about the welfare of their children should they die, as well as the disclosure of their situation, where it remained apparent that their families reacted differently to their disclosure. In this regard one of the participants reported that, "*some showed that they never had any problems after disclosing to their families*" another one said, "*This affected the family relations so badly*". Instead they got as much support as they needed". It is fair to conclude that to some disclosure resulted in support and care while to others, it resulted with negative reactions from significant others and ultimately threatened their relationships. This is also confirmed by existing literature where Serovich et al. (1998) and Ostrom et al. (2006) reveal that disclosure can result in both support and care on the one hand and rejection on the other hand.

Among the social workers' experiences with their clients, it was noted that fear was also common among WLWHIV where their clients (WLWHIV) displayed fear of disclosure, fear of stigma and fear of death and dying. Given these experiences and as proven by existing literature (Daftary et al, 2007; Ostrom et al, 2006; Ayesha et al., 2010; Ross, 2013; Bond, 2004; Dover, 2004; Lekganyane, 2010), it is fair to conclude that HIV/AIDS is a fearful disease. As highlighted in Chapter Three, it can also be concluded that it is clear from the social workers' experiences that WLWHIV often blame themselves for their HIV-positive state. They see themselves as having some form of responsibility for being HIV-positive and feel that they somehow deserve to suffer. This is in line with the findings of Bond (2004), Lekganyane (2010) and the USAID (2006) who all confirm the existence of self-stigmatisation among PLWHIV. Given the above theme as emanated from data analysis, the researcher feels that he has successfully addressed the research goal as he has developed an in-depth understanding of the experiences of social workers rendering services to WLWHIV in the Pietermaritzburg Region of the KwaZulu Natal Province. The researcher has also answered all the research questions. In addition, the researcher can also conclude that through this theme, he has successfully addressed the two research objectives which were *to explore the*

*experiences and challenges faced by social workers rendering social work social work services to women living with HIV in the Pietermaritzburg Region, KwaZulu-Natal and to describe the experiences and challenges faced by the social workers rendering social work services to women living with HIV in the Pietermaritzburg Region, KwaZulu-Natal.*

#### **4.4.3 Theme 3: Descriptions relating to challenges faced by social workers**

It has been apparent from the findings as provided in the previous chapter that social workers are confronted with various challenges in executing their daily duties of providing services to WLWHIV. The need to consistently be informed with regard to recent development for any professional in his or her field of practice is very crucial. This is also the case with social workers who are working with WLWHIV. They need to be trained consistently so that they can be able to understand the current dynamics underlying the disease as well as the experiences of people whom they serve (Wolf & Mitchell, 2002; McPherson-Baker, Jones, Durán, Klimas & Schneiderman, 2005). Training should therefore aim to enable social workers to effectively and efficiently address the challenges faced by WLWHV. Therefore, needs based continuous, relevant and specialised education for social workers is required to help them in addressing the clients' challenges.

Given the sensitivity nature of HIV and AIDS which requires a very private space where victims can develop a sense of trust to the social workers and be open to express themselves, it appears to be very discouraging for social workers to work in conditions where they do not have private space wherein they can talk privately to their clients (Routledge, 2007:1045). An inadequate number of social workers combined with a large volume of work was also found to be a threat to effective delivery of services to WLWHIV. This could not only frustrate the social workers, but would increase the spread of HIV considering the culture of silence and fear among women instilled through domestic violence (Allen, 2006; Long, 2009).

Again looking at this theme, the researcher remains confident that he has managed to address and execute the research objectives and also obtained answers for the posed research questions. This theme is in line with the first task objective namely, *to obtain a*

*sample of social workers who provide social work services to WLWHIV in the Pietermaritzburg Region of KwaZulu-Natal. It was through identifying and recruiting the participants from Pietermaritzburg's three DMs through applying purposive and snowball sampling techniques that the researcher could ultimately conduct the interviews with participants. It was equally the semi-structured interviews guided by the interview guide that enabled the researcher to conduct a tour into the participants' service rendering worlds in order to identify their challenges in their daily operations. This activity was in line with task objective two, namely, to conduct semi-structured interviews with the sampled social workers in order to explore the experiences and challenges of social workers who provide social work services to WLWHIV in the Pietermaritzburg Region of KwaZulu-Natal."*

The researcher has also through this theme, executed the third task objective which was, *to sift, sort and analyse the data using Tesch's eight steps for qualitative data analysis as cited in Creswell (2009:186)*. This was through transcribing and reading through all of the audio taped interviews, to formulate some topics and abbreviate each topic out of the typed interviews and categories in order to make a final decision on the abbreviation of each category. Preliminary analysis was then conducted and where necessary, the data were recoded. From this process, the researcher could identify clear themes, sub-themes and categories which enabled him to provide a clear interpretation of and description of challenges encountered by the participants, through a literature control, comparing and contrasting the story lines presented by the participants' against existing literature. This was completed in order to execute both the fourth and the fifth task objectives which were, *to describe the experiences and challenges of social workers who provide social work services to WLWHIV and to analyse and interpret the data obtained and conduct literature control in order to verify the findings*.

It can also be concluded that executing the sixth task objective, which was, *to draw conclusions and make recommendations about the needs of social workers who provide social work services to WLWHIV*, has also been only partly addressed by this theme.

#### **4.4.4. Theme 4: Descriptions relating to social work services for WLWHIV**

As presented in Chapter Three, unlike rendering services to WLWHIV using general strategies, social workers have specific strategies which they implement to provide services to this group of clients. The importance of maintaining a trustworthy relationship where WLWHIV feel accepted and not judged was highly emphasised. This is found to be in line with existing literature where researchers like Chow et al (2001:36) speculate that the trusting relationship between provider and patient is a factor in HIV antiretroviral therapy adherence. Another point is highlighted by Sarangi (nd) who stated that a person living with HIV needs to feel accepted unconditionally and free to express herself.

Again looking at the findings of this study, it can be concluded that social workers adopt certain strategies in their rendering of social work services to WLWHIV. In the researcher's experience, social workers tend to believe that WLWHIV are vulnerable and they therefore need specialised strategies that will support them. The establishment of a trustworthy relationship, collaborating with other professionals and organisations in service provision and prioritising children in everything that they do, were found to be the main strategies implemented by social workers to address the challenges encountered by WLWHIV while on the other hand ensuring that they feel warm and unconditionally accepted.

Another point worth to be noted is that services rendered to WLWHIV are coordinated holistically with an emphasis being placed on their children. In other words, social workers collaborate with relevant stakeholders while adopting a holistic understanding of their clients in their service provision to this group where more attention is placed on their children. As confirmed by Chibamba (2011:226) who noted the practice of coordinated and collaborative services to PLWHIV in Botswana, the fight against HIV and AIDS cannot be won by one sector of society. In light of this finding and the existing literature (Chibamba, 2011; Chow et al, 2001; Deacon & Stephney, 2007; Hickey et al., 2004; Sarangi, nd; unicef, 2006; Vassall et al., 2012; Kitahata et al., 2002; Egero, 2004; Nakazibwe, 2008; Jaques et al., 2003) it can be concluded that not all types of services can be rendered to WLWHIV, but specialised services based on elements of trust,

coordinated efforts and a holistic approach with an emphasis placed on children of WLWHIV need to be considered.

Clearly, for the researcher to be able to develop the above presented themes, he had to conduct some semi-structured interviews with a sample of social workers who provide social work services to WLWHIV in the Pietermaritzburg Region of KwaZulu-Natal, therefore addressing the research task objectives of *to obtain a sample of social workers who provide services to WLWHIV in the Pietermaritzburg Region of KwaZulu-Natal and to conduct semi-structured interviews with this sample of social workers in order to explore the experiences and challenges of social workers who provide social work services to women living with HIV in the Pietermaritzburg Region, KwaZulu-Natal and to explore and describe the social work services rendered by social workers to women living with the virus in the Pietermaritzburg region, KwaZulu-Natal.*

He has also sifted, sorted and analysed the data in line with Tesch's eight steps (in Creswell, 2009:186) of data analysis and therefore executed the task objectives of *To sift, sort and analyse the data using Tesch's eight steps for qualitative data analysis* as cited in Creswell (2009:186). This therefore enabled him to identify some patterns which eventually led to the development of themes, sub-themes and categories which were ways of making sense of data through data analysis and interpretation. As indicated in Chapter Three, data were eventually compared and contrasted with existing literature through literature control in order to verify the findings. This enabled the researcher to execute the task objective *to analyse and interpret the data and conduct a literature control in order to verify the findings.* Finally taking into consideration the recommendations presented in the next section, the researcher can confidently conclude that he has successfully addressed the research questions and the research goal, by means of successfully executing and achieving the research objectives and the task objectives.

## **4.5 RECOMMENDATIONS**

Given the above conclusions on the research process and the research findings, the recommendations are made for social work practice, policy and further research required relating to the rendering of social work services to women living with HIV.

### **4.5.1 Recommendations for social work practice**

The following recommendations are made for social work practice:

- It is imperative for social workers to be mindful of the impact of HIV-positive diagnosis on the relationships and families of WLWHIV and to implement appropriate intervention measures as required. In particular, social workers should be thoroughly trained to assess and address dysfunctional families of WLWHIV as a result of their HIV-positive diagnosis. They must be offered a continuous specialised training geared to address the problems faced by WLWHIV and their loved ones and to ensure that they remain supported.
- The revelation of HIV and AIDS as a fearful disease is a critical issue in this study. This often tends to drive the epidemic underground and therefore interfere with treatment, prevention care and support for this group of clients. The fear associated with HIV and AIDS must be uprooted if the fight against HIV and AIDS is to be won. It is therefore crucial for social workers to unveil the fear surrounding this disease and encourage openness and disclosure. Some educational programmes and open talks need to be rolled out through the province in order to remove the fear which surrounds this disease.
- It is an issue of concern to realise that WLWHIV are consistently worried about their HIV-positive status as well as the wellbeing of their own children. It is therefore imperative for a specialised team of social workers to be constituted to be dedicated to the wellbeing of these population groups through provision of psycho-social and counselling sessions consistently. The social workers should

collaborate with families to ensure that WLWHIV receive spiritual support from ministers of religion.

- As highlighted in Chapter Three and in the conclusion, it is also imperative to strengthen existing strategies (such as the networks and therapeutic programmes which will build trust) employed by social workers in ensuring that WLWHIV receive appropriate quality services.

#### **4.5.2 Recommendations for policy and programme design and development**

Some of the findings of this study were non-operational and therefore had a lot to do with policy and programme issues. The researcher would therefore like to make the following recommendations for policy and programme designing and development to address HIV and AIDS related issues:

- Existing policies and programmes which address HIV and AIDS domestic violence, child care and family preservation services need to be thoroughly operationalized and supported through deployment of a pool of social workers into various DMs. It is therefore imperative for human resources (social workers who are specially trained to carry out the implementation of this programme and policies) to be recruited to provide services that will address the conditions faced by WLWHIV.
- A dedicated team of social workers who will ensure adequate planning, monitoring and evaluation as well as implementation of the policy and programme is also a crucial issue to be looked at by the DSD.
- Adequate infrastructure in the form of office space is required to address the challenge of lack of infrastructure required for social workers to provide services to WLWHIV in private and uphold the principle of confidentiality.

### **4.5.3 Recommendations for the research process**

Qualitative research has proven to be an appropriate approach to create a conducive context in which participants could openly express their views and experiences and challenges. Further research on this subject should be conducted, approached from a qualitative research method to provide a broad scope of the social workers' experiences, challenges and suggestions on how to overcome such challenges.

### **4.5.4 Recommendations for the research findings**

As indicated in the previous sections of this report, the findings of this study highlighted the training offered to social workers, the social workers' experiences in their work with WLWHIV and the services offered by social workers to WLWHIV. It is therefore on the basis of these findings that the researcher makes the following recommendations:

- Training of social workers working with WLWHIV should be on a continuous basis. In other words, it is imperative to ensure that social workers working with WLWHIV receive training continuously in order to ensure that they remain updated and capacitated to deal with any challenges which are encountered by their clients. This should include gearing training of social workers working with WLWHIV in line with all pillars of challenges posed by the epidemic (i.e. prevention, treatment, care and support). This type of training should also be incorporated into the CPD (Continuous Professional Development) system as developed by the SACSSP (South African Council for Social Services Professions) in order to cater for this specific group of social workers.
- Given the social workers' exposure to the challenges faced by WLWHIV, it is imperative to ensure that social workers form part of the decision making with regard to the development and implementation of services offered to WLWHIV. These services should include among others the family preservation services which will specifically address the relationship breakdown, domestic violence fears and concerns faced by WLWHIV as well as the confidence enhancing services like individual counselling for WLWHIV.

#### **4.5.5 Recommendations for further research**

This research was confined to the Pietermaritzburg Region and its three DMs in the KwaZulu-Natal Province. It is recommended that another qualitative inquiry be conducted in a broader spectrum of the whole province. These studies could be followed up with a comprehensive quantitative study. This proposal is based on the fact that the findings made by the qualitative research could be applicable beyond the immediate boundary of the study.

Another proposed area of study in the context of this research, is that of social workers being suitable to work with WLWHIV. As revealed by this study, it appears that not any social worker should be allocated to work with WLWHIV. A question which remains unanswered relates to the criteria that should be used to determine the appropriateness or suitability of a social worker to work with WLWHIV. It is recommended that this matter be researched with a view to its application in practice.

#### **4.6 CHAPTER SUMMARY**

This chapter marks the end of the research report. It provided a summary based on the three previous chapters and also demonstrated how the goals of the study were met. In addition, key findings which emanated from the data were highlighted under the three themes followed by realistic recommendations.

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## LIST OF ADDENDA

### ADDENDUM A



#### INFORMATION AND INFORMED CONSENT DOCUMENT

Dear \_\_\_\_\_

I, Sipiwo Zandisile Tayo, the undersigned, am working for the Department of Social Development at Umzimkhulu Service Office, and I am furthering my studies, thereby doing a Master's degree in social work. As an academic requirement therefore I have to undertake a research project, and the following is the research title:

THE EXPERIENCES AND CHALLENGES OF SOCIAL WORKERS RENDERING SERVICES TO WOMEN LIVING WITH HIV IN THE PIETERMARITZBURG REGION, KWAZULU-NATAL PROVINCE.

This study, for its success, requires some individuals with first-hand experience of this topic and I have seen you as one of those. I will provide you with all the necessary information for you to take a voluntary decision to participate in this inquiry. I will further explain to you fully what the aim of the study is, the risks and benefits involved, with absolutely no hidden agenda.

The driving force behind this study is developing an in-depth understanding of the experiences of the social workers when providing services to women living with HIV. Some of the concerns to be addressed here are: 1) what are the challenges faced by social workers providing services to women living with HIV on a daily basis and their needs? How do they cope with these challenges? What can these social workers then suggest as a way improving this practice?

With the maximum of a two-hour conversation with you I think I will be able to get the information I need for this study. I wish to re-assure you that all we will be talking about will be strictly treated as confidential. As audio tapes will be used for the purpose of recording the interviews, permission will be sought from you, and you are being assured again of their safety as all the apparatus will be safely locked in the premises of the researcher.

You are re-assured of confidentiality in every respect with the information gathered as audio tapes and transcripts will all be destroyed upon completion of this study. Identifying information will be disguised and codes will thus be used to ensure anonymity.

I wish to state, however, that as I am a student, there are a few individuals, that is, my supervisor and the independent coder who will also examine the information collected. The said individuals will also be strictly involved for academic reasons only and they will also be made to sign an undertaking that they will treat the information shared by you in a confidential manner.

Based again on the principle of voluntarism, you will be free to withdraw from the study or terminate your participation at any stage of the inquiry. You will be free to withdraw and discontinue participation without any penalty being incurred. Your rights will be protected at all times and signing the consent form has no binding effect.

You will be referred for counselling or debriefing services should the information shared leave you emotionally upset and perturbed.

You are free at all times to ask questions concerning the study. Should you have any questions or concerns about the study, you may contact these numbers: Sipiwo Zandisile Tayo, the researcher at 083 244 2613 or Prof. Makofane at 012 429 6884 - my research advisor/supervisor.

Please note that this study has to be approved by the Research and Ethics Committee in the Department of Social Work at UNISA. Without the approval of this committee, the study cannot be conducted. Should you have any questions and queries not sufficiently addressed by me as the researcher, you can always contact the Chairperson of the Research and Ethics Committee of the Department of Social Work at UNISA. His contact numbers are as follows: Prof. A.H. (Nicky) Alpaslan, telephone number: 012 429 6739, or email [alpasah@UNISA.ac.za](mailto:alpasah@UNISA.ac.za).

If after you have consulted the researcher and the Research and Ethics Committee in the Department of Social Work at UNISA, and their answers have not satisfied you, you might direct your question/concerns/queries to the Chairperson, Human Ethics Committee, College of Human Science, P.O. Box 392, UNISA, 0003.

Based upon all the information provided to you above, and being aware of your rights you are asked to give your written consent should you want to participate in this research study by signing and dating the information and consent form provided herewith and initialling each section to indicate that you understand and agree to the conditions.

Thank you for your participation.

Kind regards

---

Sipiwo Zandisile Tayo

Researcher

Contact details: 083 244 2613 (E-mail) [siphiwow@webmail.co.za](mailto:siphiwow@webmail.co.za)

**ADDENDUM B**

**RESEARCH TITLE: THE EXPERIENCES OF AND CHALLENGES OF SOCIAL WORKERS RENDERING SERVICES TO WOMEN LIVING WITH HIV IN THE PIETERMARITZBURG REGION, KWAZULU-NATAL PROVINCE**

PRINCIPAL INVESTIGATOR: Sipiwo Zandisile Tayo

ADDRESS: P.O. Box 254, Umzimkhulu, 3297

Contact Cellular phone number: 083 244 2613

DECLARATION BY THE PARTICIPANT	Initial
<p>I, THE UNDERSIGNED _____, ID No.: _____ the _____ participant</p> <p>_____(address)</p> <p>A. HEREBY CONFIRM AS FOLLOWS:</p> <p>1. I was invited to participate in the above research project which is being undertaken by Sipiwo Zandisile Tayo of the Department of Social Development at the Umzimkhulu Service Office.</p>	

<p>2. The following aspects have been explained to me.</p> <p>2.1. Aim: The researcher is studying :</p> <p>The aim is: developing an in-depth understanding of the experiences of social workers providing social work services to women living with HIV.</p> <p>The information will be used to influence the decisions made in terms of the training needs of the social workers and in strategizing as to how to actually improve the services rendered by social workers to women living with HIV.</p> <p>2.2. I understand the following:</p> <ul style="list-style-type: none"> <li>• The goal of the study, the need for the study and the benefits it will have for the participants and any other stakeholders (i.e. the researcher, the profession).</li> <li>• Why I, in particular, was chosen and that my participation is completely voluntary.</li> <li>• That I will be asked for a face-to-face interview not exceeding two hours.</li> <li>• How the information shared by me will be recorded (i.e. on paper and audiotape).</li> <li>• How these data will be made public (i.e. it will be made known in a research paper and might be used in subsequent scholarly presentations, printed publications and/or further research).</li> <li>• My rights as participant are namely: <ul style="list-style-type: none"> <li>• That I may terminate or withdraw from the study at any point.</li> <li>• That I may ask for clarification or more information throughout the study.</li> <li>• That I may contact the appropriate administrative body if I have any questions about the conduct of the researcher (fieldworker) or the study's procedures.</li> </ul> </li> </ul>	
<p>2.3. Risks:</p> <p>No foreseeable risks.</p>	Initial
<p>2.4. Possible benefits: As a result of my participation in this study</p>	

I, _____ the participant will have an opportunity to contribute to the decision making of the Department of Social Development in KwaZulu-Natal in terms of the improvement of the services rendered by social workers in providing social work services to women living with HIV.	
2.5. Confidentiality: My identity will not be revealed in any discussion, description or scientific publications by the investigators.	Initial
2.6. Access to findings: Any new information/benefit that develops during the course of the study will be shared with me.	Initial
2.7. Voluntary participation/refusal/discontinuation: My participation is voluntary. My decision whether or not to participate will in no way affect me now or in future.	Initial
3. The information above was explained to me, the participant by the researcher, Sipiwo Zandisile Tayo in English and IsiZulu/Xhosa and I am in command of these languages. I was given an opportunity to ask questions and all these questions were answered satisfactorily.	Initial
4. No pressure was exerted on me to consent to participate and I understand that I may withdraw at any stage from the study without ant penalty.	Initial
5. Participation in this study will not result in any additional cost to me.	Initial
B. I HEREBY CONSENT VOLUNTARILY TO PARTICIPATE IN THE ABOVE PROJECT.  Signed at _____ on _____ 20____  _____  Signature of participant	Signature of witness

## ADDENDUM C

<b>CONSENT FORM REQUESTING TO PUBLISH VERBATIM TRANSCRIPTS OF AUDIOTAPE</b>	
As part of this project, I have made a photographic, audio and /or video recording of you. I would like you to indicate (with ticks in the appropriate blocks next to each statement below) what uses of these records you are willing to consent to. This is completely up to you. I will use the records only in ways that you agree to. In any of these records names will not be identified.	Place a tick [ ✓ ] next to the use of the record you consent to
1. The records can be studied by the research team and photographs/quotations from the transcripts made of the recordings can be used in the research report.	
2. The records (i.e. photographs/quotations from the transcripts made of the recordings) can be used for scientific publications and/or meetings.	
3. The written transcripts and/or records can be used by other researchers.	
4. The records (i.e. photographs/quotations from the transcripts made of the recordings) can be shown /used in public presentations to non-scientific groups	
5. The records can be used on television or radio.	
_____	_____
Signature of participant	Date

## ADDENDUM D

IMPORTANT MESSAGE TO PARTICIPANT	
<p>Dear participant</p> <p>Thank you for your participation in this study. Should at any time during the study.</p> <ul style="list-style-type: none"><li>• An emergency arise as a result of the research, or</li><li>• You require any further information with regard to the study, or</li><li>• Anything occur,</li></ul> <p>Please directly call me, Sipiwo Zandisile Tayo (the researcher) at 083 244 2613 or e-mail at <a href="mailto:siphiwow@webmail.co.za">siphiwow@webmail.co.za</a></p>	

## ADDENDUM E

<p>STATEMENT BY INVESTIGATOR</p> <p>I, Sipiwo Zandisile Tayo, declare that:</p> <p>I have explained the information given in this document to _____(name of the participant.</p> <ul style="list-style-type: none"><li>• He /she was encouraged and given ample time to ask me any questions.</li><li>• This conversation was conducted in English and isiZulu/Xhosa and no translator was used.</li></ul> <p>Signed at _____ on _____ 20__</p> <p>(place) (date)</p> <p>_____ _____ Signature of investigator</p> <p>Signature of witness</p>	

## ADDENDUM F

P.O. Box 254

Umzimkhulu

3297

25 April 2012

THE GENERAL MANAGER

Department of Social Development

Pietermaritzburg Cluster

PIETERMARITZBURG

3200

Dear Ms. Khanyile

### **REQUEST FOR AN AUTHORIZATION TO CONDUCT A RESEARCH STUDY IN YOUR INSTITUTION**

I have registered with UNISA in an endeavour to further my studies in social work. It has thus, come as a university requirement for me to conduct a social research study and have subsequently, chosen to work with social workers under your jurisdiction as my potential participants.

For your convenience, I think it would be of paramount importance to state the title of the research study as is: **The experiences and challenges of social workers in rendering services to women living with HIV in the Pietermaritzburg region, KwaZulu-Natal Province.**

This letter is therefore serving as a request to pursue this academic task.

Thanking you in anticipation for cooperation. For any other information you can contact me at this number: **083 244 2613.**

**Yours sincerely**

**S.Z. Tayo**

## ADDENDUM G

### AUTHORISATION LETTER FROM THE HEAD OF THE DEPARTMENT



**social development**  
Department:  
Social Development  
PROVINCE OF KWAZULU-NATAL

---

FAX	: (033) 395 9682	Pietermaritzburg Cluster
Telephone/ Ucingo /Telefoon	: (033) 395 9636	158 Langalibalele, Private Bag X1724
Enquiries / Imibuzo / Navrae	: Mr PC Madonsela	<b>Pietermaritzburg</b>
E-mail	: phumlani.madonsela@kznsocdev.gov.za	3200

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05 September 2012

Mr NM Njomi  
Private Bag X9004  
UMZIMKHULU  
3297

Dear Mr NM Njomi

**REQUEST TO CONDUCT A RESEARCH STUDY IN PIETERMARITZBURG CLUSTER:  
YOURSELF**

1. The above subject matter bears reference.
2. Kindly be advised that the Head of Department has granted the authority for Mr SZ Tayo to conduct a research study within Department as part of his academic obligations for the Master's Degree in Social Work.
3. Kindly note that there will be no financial implications to the Department since this exercise is out of employee's own expense.
4. Your co-operation will be highly appreciated.

*MS Ng Khanyile* 05/09/2012  
MS NG KHANYILE  
GENERAL MANAGER  
PIETERMARITZBURG CLUSTER

