

**Foster parents' perspectives on psychosocial support received
while caring for foster care children living with HIV and AIDS**

by

MOKGADI MERRIAM MAKGOPELA

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SUPERVISOR: PROF ML SHIRINDI

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DEDICATION

This dissertation is dedicated to all the foster parents who are raising foster children living with HIV, for their selflessness, courage and resilience in the face of adversity. I also dedicate this study to my daughter, Regoikantse, for her endless understanding when mommy was unavailable and busy with the research study.

DECLARATION

Name: Mokgadi Merriam Makgopela

Student number: 66075807

Degree: Master of Social Work

TITLE: Foster parents' perspectives on psychosocial support received while caring for foster care children living with HIV and AIDS

I declare that the above dissertation is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I further declare that I submitted the dissertation to originality-checking software and that it falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other higher education institution.



SIGNATURE

NAME: Mokgadi Makgopela

DATE

January 2025

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ABSTRACT

Foster care was established as a child protection system in South Africa aimed at, providing vulnerable and orphaned children with alternate placement options to remain with their families. Orphans living with HIV benefit profoundly from these placements since their grandmothers, who are the source of support for many, offer them a chance to experience love, care, and protection. This study aimed at gaining a glimpse of the experiences of foster parents caring for foster care children living with HIV and AIDS. Resilience theory was applied as the foundation of the study. To gather rich data, a qualitative approach was employed underpinned by phenomenological, exploratory, descriptive and contextual research designs. Through this approach, the researcher was able to fully immerse themselves in the participants' world and gain insight into their thoughts, emotions, experiences, and meanings attached to foster caregiving. Foster parents served as a sample for the study and their realities were collected through semi-structured interviews. Five phases as outlined by Yin were utilised for data analysis. The research findings disclosed significant obstacles faced by foster parents, including unstable finances, delinquent behaviour among foster children, and insufficient emotional support from relatives. Despite numerous obstacles foster parents showed tenacity in foster caregiving. Their sources of resilience include spiritual beliefs, and social work and health care support from social workers and health care providers. Given that support and care originate within the family unit, maintaining family preservation is integral to strengthening foster parents' resilience.

Keywords: foster care, foster parents, foster children, HIV, psychosocial support, social work

TABLE OF CONTENTS

DEDICATION	i
DECLARATION.....	ii
ACKNOWLEDGEMENTS	iii
ABSTRACT	iv
LIST OF TABLES	x
FIGURE.....	xi
LIST OF ACRONYMS	xi
CHAPTER ONE	1
GENERAL ORIENTATION TO THE STUDY	1
1.1 INTRODUCTION AND BACKGROUND OF THE STUDY	1
1.1.1 The relevance of psychosocial support	2
1.1.2 The prevalence of HIV and Aids: Modes of transmission	3
1.1.3 Strategies to combat HIV and Aids.....	4
1.1.4 Bio-psycho socio-economic (BPSE) effects of foster caregiving	5
1.1.5 Role reversal and change in family structure	7
1.1.6 South African legislation and its role concerning foster care families	7
1.1.7 The role of social work in the provision of services and support	8
1.2 PROBLEM FORMULATION AND PROBLEM STATEMENT	9
1.3 RATIONALE OF THE STUDY	12
1.4 THEORETICAL FRAMEWORK.....	14
1.5 RESEARCH QUESTIONS, GOALS AND OBJECTIVES OF THE STUDY	15
1.5.1 Research questions.....	15
1.5.2 Goals of the study.....	16
1.5.3 Research objectives	16
1.6 RESEARCH METHODOLOGY	17
1.7 ETHICAL CONSIDERATIONS	17
1.8 CLARIFICATION OF KEY CONCEPTS	17
1.8.1 Psychosocial support	18
1.8.2 Foster care	18
1.8.3 Foster parents	18
1.8.4 Foster care children.....	19
1.8.5 Social work.....	19

1.8.6 Perspective	19
1.8.7 HIV/AIDS	19
1.9 OUTLINE OF CHAPTERS	20
1.10 DISSEMINATION OF RESEARCH RESULTS	21
1.11 CONCLUSION	21
CHAPTER TWO.....	23
LITERATURE REVIEW ON FOSTER PARENTS AND PSYCHOSOCIAL SUPPORT RECEIVED WHILE CARING FOR FOSTER CARE CHILDREN LIVING WITH HIV AND AIDS	23
2.1 INTRODUCTION	23
2.2 STATISTICS ON CHILDREN LIVING WITH HIV	23
2.3 SOCIAL WORK INTERVENTION	26
2.3.1 Resilience theory.....	27
2.3.2 Health belief model.....	28
2.4 SOUTH AFRICAN LEGISLATIONS ON FOSTER PARENTS LIVING WITH FOSTER CHILDREN WITH HIV	31
2.5 EXPERIENCES OF FOSTER PARENTS CARING FOR ILL FOSTER CHILDREN PARENT(S).....	32
2.6 THE ROLE OF SOCIAL WORK IN THE PROVISION OF SERVICES AND SUPPORT	35
2.6.1 Psychosocial support offered by social workers and other social and health care professionals	36
2.6.1.1 Mental health counselling	37
2.6.1.2 Health Education	37
2.6.1.3 Religion, Spiritual and group support	38
2.6.2 Community support for foster parents caring for children living with HIV	39
2.7 CHALLENGES, DEMANDS, FEARS OF RAISING A FOSTER CHILD LIVING WITH HIV AND AIDS	40
2.8 IMPLICATIONS REGARDING DISCLOSURE OF HIV POSITIVE CHILD	40
2.8.1 Reactions after foster parents have learnt about the child's HIV status.....	41
2.9 CONCLUSION.....	42
CHAPTER THREE	43
APPLICATION OF THE RESEARCH METHODOLOGY	43
3.1 INTRODUCTION	43

3.2 RESEARCH METHODOLOGY	43
3.3 RESEARCH PARADIGM	43
3.4 RESEARCH APPROACH.....	47
3.5 RESEARCH DESIGN.....	50
3.5.1 Phenomenological research inquiry	51
3.5.2 Exploratory research design.....	52
3.5.3 Descriptive research design	52
3.5.4 Contextual research design.....	53
3.6 RESEARCH METHODS.....	55
3.6.1 Population, sampling and sampling techniques	55
3.6.1.1 Population	55
3.6.1.2 Sampling	56
3.6.1.3 Sampling techniques	57
3.7 PREPARATION FOR DATA COLLECTION	59
3.7.1 Data collection methods and procedure	61
3.7.2 Method/s of data collection	61
3.7.3 Pilot testing	64
3.8 DATA ANALYSIS METHOD	65
3.9 DATA VERIFICATION.....	67
3.9.1 Credibility	67
3.9.2 Transferability.....	68
3.9.3 Dependability.....	68
3.9.4 Conformability	69
3.9.5 Reflexivity and bracketing.....	69
3.10 ETHICAL CONSIDERATIONS	70
3.10.1 Informed consent.....	71
3.10.2 Voluntary participation	71
3.10.3 No harm to participant	72
3.10.4 Anonymity.....	73
3.10.5 Confidentiality.....	73
3.10.6 Deception	74
3.10.7 Data Management.....	74
3.10.8 Debriefing	75
3.11 CONCLUSION	75

CHAPTER FOUR.....	76
RESEARCH FINDINGS ON THE EXPERIENCES OF FOSTER PARENTS AND PSYCHOSOCIAL SUPPORT RECEIVED WHILE CARING FOR FOSTER CARE CHILDREN WITH HIV AND AIDS	76
4.1 INTRODUCTION	76
4.2 BIOGRAPHICAL PROFILES FOR THE PARTICIPANTS	77
4.2.1 Age of participants.....	81
4.2.2 Marital status of participants.....	82
4.2.3 Participants' highest qualification	82
4.2.4 Race and language	83
4.2.5 Employment status of participants.....	83
4.2.6 Number of grandchildren	84
4.2.7 Participant's number of foster children and their age in years	84
4.2.8 Foster children's years of age	85
4.2.9 Year of care.....	85
4.2.10 Grade which the foster children are in	86
4.2.11 Relationship with foster children	86
4.3 THEMES, SUB-THEMES AND CATEGORIES	87
4.3.1 Theme 1: Circumstances that led to placement of children in foster care	88
4.3.1.1 Sub-theme 1.1: Participants' knowledge of the cause of death of children's mothers	90
4.3.1.2 Sub-theme 1.2: Participants' awareness of the foster children's HIV status .	94
4.3.1.3 Sub-theme 1.3: Participants' confirmation of the children's HIV status.....	96
4.3.2 Theme 2: Children's discovery of their HIV status	99
4.3.2.1 Sub-theme 2.1: Confirmation of children's HIV-positive status by professionals	99
4.3.2.2 Sub-theme 2.2: Disclosure of HIV diagnosis to HIV-infected children	100
4.3.2.3 Sub-theme 2.3: Disclosure of children's HIV status to relatives.....	106
4.3.3 Theme 3: Foster parents for children living with HIV	113
4.3.3.1 Sub-theme 3.1: Maternal grandmothers caring for grandchildren.....	114
4.3.3.2 Sub-theme 3.2: Children cared for by volunteers	115
4.3.4 Theme 4: Participants' experiences in caring for children living with HIV	117
4.3.4.1 Sub-theme 4.1: Participants' knowledge of HIV.....	118

4.3.4.2 Sub-theme 4.2: Information and training received by participants on caring for children living with HIV	121
4.3.4.3 Sub-theme 4.3: Precautionary measures taken by participants	124
4.3.4.4 Sub-theme 4.4: Family support for participants and children.....	127
4.3.5 Theme 5: Challenges facing foster parents caring for children living with HIV	130
4.3.5.1 Sub-theme 5.1: Children’s behavioural, social, financial and health issues	130
4.3.5.2 Sub-theme 5.2: Medical treatment for children living with HIV	138
4.3.5.3 Sub-theme 5.3: Participants’ fearlessness of their responsibilities	142
4.3.5.4 Sub-theme 5.4: Support participants received from individuals and organisations.....	143
4.3.6 Theme 6: Social work services provided to participants and the children	147
4.3.6.1 Sub-theme 6.1: Participants’ satisfaction with social work services.....	148
4.3.6.2 Sub-theme 6.2: Psychosocial support provided by social workers	152
4.3.6.3 Sub-theme 6.3: Required social work services and support.....	154
4.3.6.4 Sub-theme 6.4: Available community resources.....	155
4.5 CONCLUSION.....	162
CHAPTER FIVE	163
Summary OF FINDINGS, CONCLUSION AND RECOMMENDATIONS	163
5.1 INTRODUCTION	163
5.2 SUMMARIES, CONCLUSIONS AND RECOMMENDATIONS OF THE RESEARCH STUDY	163
5.2.1 Summaries of previous chapters	163
5.2.2 Summaries and conclusions based on the research process.....	165
5.3 SUMMARIES AND CONCLUSIONS BASED ON THE RESEARCH FINDINGS OF THE STUDY	166
5.3.1 Theme 1: Circumstances that led to placement of children in foster care	166
5.3.2 Theme 2: Children’s discovery of their HIV status	169
5.3.3 Theme 3: Foster parents for children living with HIV	171
5.3.4 Theme 4: Participants’ experiences in caring for children living with HIV	171
5.3.5 Theme 5: Challenges facing foster parents caring for children living with HIV	173
5.3.6 Theme 6: Social work services provided to participants and children.....	177
5.4 SUGGESTIONS FOR SOCIAL WORK PRACTICE	180

5.4.1 Training of foster parents.....	180
5.4.2 Strengthen food parcel programmes to compliment foster care grant	180
5.4.3 Suitable intervention to motivate families for support	180
5.4.4 Establishment of online/face-to-face support groups.....	181
5.4.5 Collaborative efforts to offer financial skill development.....	181
5.4.6 Mobile services in support of door-to-door home visit approach	181
5.4.7 Enhance family preservation	182
5.5 RECOMMENDATIONS FOR POLICY.....	182
5.6 RECOMMENDATIONS FOR EDUCATION.....	183
5.7 RECOMMENDATIONS FOR FUTURE RESEARCH	183
5.8 LIMITATIONS FOR THE STUDY	183
5.9 CONCLUSION.....	184
REFERENCES.....	185
ADDENDUM A: ETHICS APPROVAL CERTIFICATE	214
ADDENDUM B: LETTER ASKING PERMISSION TO CONDUCT A STUDY AT THE DEPARTMENT OF SOCIAL DEVELOPMENT	216
ADDENDUM C: APPROVAL LETTER TO CONDUCT THE STUDY	218
ADDENDUM D: PARTICIPANT INFORMATION SHEET	219
ADDENDUM E: CONSENT FORM TO PARTICIPATE IN A RESEARCH STUDY	226
ADDENDUM F: RESEARCHER ACKNOWLEDGEMENT	227
ADDENDUM G: CONFIDENTIALITY AGREEMENT WITH RESEARCH THIRD PARTY	228
ADDENDUM H: RISK ASSESSMENT TOOL	229
ADDENDUM I: DATA COLLECTION TOOL	233
ADDENDUM J: LETTER OF EDITOR.....	235

LIST OF TABLES

Table 1.1: Various studies foster care children living with HIV	11
Table 4.1: Biographical profiles/particulars of the participants	778
Table 4.2: Themes, sub-themes and categories	887

FIGURE

Figure 2.1: Children living with HIV (0–14) and children having lost one or both parents due to AIDS (0–17) in the most affected countries in sub-Saharan Africa by number (WHO, 2015)..... 25

LIST OF ACRONYMS

HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
PLWHIV	People living with HIV
SACSSP	South African Council for Social Service Professions
UNICEF	United Nations Children’s Fund
UNISA	University of South Africa
WHO	World Health Organisation
PMTCT	Prevention of Mother to Child Transmission
NASW	National Association of Social Work
UNAIDS	United Nations Programme on HIV/AIDS

CHAPTER ONE

GENERAL ORIENTATION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND OF THE STUDY

Psychosocial support is significant in addressing the psychological and social challenges of foster care parents caring for children living with Human immunodeficiency Virus and Acquired Immunodeficiency Syndrome. Foster parents' psychosocial wellbeing is dependent on the capacity to receive effective and efficient psychosocial support services in response to their everyday challenges. The establishment of psychosocial support has been recognised as having a substantial positive influence on people's health (Department of Health [SA], nd.:03). Psychosocial support comprises rebuilding and strengthening relations which are crucial to human development (Department of Health [SA], nd.:03). A chronic disease such as HIV and AIDS affects all areas of an individual's life such as the physical, psychological, social and spiritual being of a person, hence it is imperative for social workers to recognise the relevance of psychosocial support in the lives of foster parents. HIV and AIDS was discovered in 1981 and due to its progression, the universal health sector regards it as a massive predicament (Decock, Jaffe & Curran, 2012:1205). HIV and AIDS is a pandemic which not only affects individuals but also the families of the infected. HIV and AIDS is still prevalent. For instance, the UNAIDS factsheet (2020:1) indicates that, globally, a sum of 38 million people and 1.8 million children were living with HIV at the end of 2019. Towards the end of 2019, 1.7 million people contracted HIV, whilst 690 000 people passed away due to opportunistic illnesses linked to HIV (UNAIDS, 2020:1). The overall HIV prevalence rate in South Africa is estimated to be approximately 12.7% of the population. The total number of people living with HIV (PLWHIV) is estimated at approximately 8,0 million in 2024. For adults aged 15–49 years, an estimated 16,7% of the population is HIV positive (Stats SA, 2024).

Based on the statistics of people that have passed away and those who have been newly infected with the disease, it can be established that HIV and AIDS has an enormous negative impact on the lives of individuals. Although, there is ample

information regarding HIV and the accessibility of Antiretroviral drugs (ARVs), the number of HIV orphans and vulnerable children is still increasing and people still die from illnesses associated with HIV.

The research study was conducted in Gauteng, Tshwane region. The City of Tshwane is the capital of South Africa and is the largest municipality, as measured by land mass. According to Gross Domestic Product (GDP), Tshwane is the second-biggest metropolitan municipality in Gauteng and one of the six largest in South Africa.

1.1.1 The relevance of psychosocial support

Psychosocial support facilitates resilience within individuals and families. It promotes the restoration of positive mental, physical and social wellbeing (Kohrt & Song, 2018:354). Psychosocial support may comprise psychological health counselling, education, and spiritual and group support as well as many other services (Mhaka-Mutepfa, Cumming & Mpofu, 2014:1023). These services are commonly provided by social and health care professionals, such as psychologists, social workers, counsellors, specialised nurses, clergy, pastoral counsellors, and others. These professionals might also use a referral system to link service users with available resources. A conceptual framework by the Department of Social Development (2011:11) describes the relevance and significance of psychosocial support by emphasizing its impact on the emotional, social, and mental well-being, furthermore its contribution to building resilience, and the pivotal role in fostering positive personal growth.

Grandparents of children living with HIV and AIDS require a range of care and support to safeguard their social, emotional and mental wellbeing. Psychosocial support tackles the constant psychological and social predicaments encountered by an HIV-infected person, their companions, families and caregivers (World Health Organization, 2020:1). Various studies (Masquillier, Wouters, Mortelmans, Van Wyk, Hausler & Van Damme, 2016:2; Adejumo, Malee, Ryscavage, Hunter & Taiwo, 2015:9; Masquillier, 2016:10) articulate that adequate focus must be afforded the psychosocial aspects of chronic ailments and caregiving in order to inform successful guidance and intervention for patients living with chronic diseases. Adejumo, et al. (2015:9) and Masquillier et al., 2016:10) indicate that social support is imperative to help manage a chronic illness and other related psychosocial challenges. Caregivers

contribute positively by reminding individuals infected with HIV and AIDS to take their chronic medication regularly. This confirms that it is crucial to invest in empowering families, friends and acquaintances of children living with HIV. Kohrt and Song (2018:354) are of the view that psychosocial support has a crucial role in shielding the detrimental outcomes that may be brought about by a foster caregiving role. It stimulates the wellbeing of a person. Psychosocial support has an enormous impact on foster parents' hope, social support and coping abilities. The majority of foster parents rely on the emotional and psychosocial support given by their respective designated social workers (Mhaka-Mutepfa, Cumming & Mpofu, 2014:1023).

The South African Children's Act 38 of 2005, section 7 (c) emphasises that when considering the best interests of a child, the capability of the parent or any other caregiver to provide for the needs of the child, including emotional and intellectual needs is of supreme importance. Therefore, taking into consideration the difficulties attached to raising foster care children living with HIV, the capacity of foster parents must be fuelled by the provision of proficient psychosocial support services. Psychosocial support offered by social workers will equip foster parents with emotional stability thus enabling them to cope with every challenge/situation.

1.1.2 The prevalence of HIV and Aids: Modes of transmission

Sub-Saharan Africa has a huge population with a high rate of infections, which accounts for over 25 million of people living with HIV and AIDS (World Health Organization, 2020:1; Kharsany & Karim, 2016:34). South Africa (SA) is known to be the central point of HIV and AIDS given the high rate of HIV diagnoses (Simelela, Pillay & Serenata, 2017:1; Bradshaw, Msemburi, Dorrington, et al., 2016:771; Kharsany & Karim, 2016:35). The overall number of people living with HIV in South Africa has increased from a projected 3.8 million in 2002 to 7.8 million by 2020 (Statistic South Africa, 2020:1). UNICEF (2020:1) estimates that there are 3.7 million children in South Africa who are orphans and almost half of these children's parents died due to AIDS-related illnesses. Most of the affected children reside with guardians who are ill and physically drained. An estimation by UNAIDS (2020:1) and the World Health Organization (2020:1) indicates that in South Africa the number of people living with HIV is 7 700 00. Out of this number, 260 000 are children aged between 0 and 14

years. UNAIDS further indicates that an estimated 240 000 children and adults in SA were newly infected with HIV and AIDS by 2018. The researcher acknowledges that these figures may not be a true reflection given the fact that many people fear disclosure because of the stigma attached to HIV and AIDS. Given the statistics above, it can be concluded that HIV and AIDS has an enormous negative impact on the lives of individuals. Although, there is ample information regarding HIV and the accessibility to ARVs, the number of HIV orphans and vulnerable children is still increasing.

Various sources concurs that HIV's mode of transmission from one person to another includes sexual transmission, utilising the same needle and/ or drug injection, and through mother-to-child transmission (World Health Organization, 2020:1; UNAIDS, 2020:1; National Association of Social Work [NASW], 2020:1; Becerra, Bildstein & Gach, 2016:454). From the abovementioned modes of transmissions, sexual intercourse is the most popular and fuels the spread of HIV in many countries, especially in sub-Saharan Africa (Kharsany & Karim, 2016:35; Becerra, Bildstein & Gach, 2016:35). Another means of transmitting HIV that contributes to its peak is mother-to-child transmissions (Becerra, Bildstein & Gach, 2016:454; Kharsany & Karim, 2016:35; World Health Organization, 2020:1). The researcher's topic investigates foster parents of children who have been infected by the virus through mother-to-child transmission. According to the World Health Organization (2020:1) mother-to-child transmission is when an HIV-positive mother transmits the virus to her baby either when she is pregnant, during labour/delivery or during breastfeeding. The World Health Organization (2020:1) further indicates that the danger of mother-to-child transmission can be diminished if the mother and her child are given ARVs in the early stages of pregnancy and during the course of breastfeeding.

1.1.3 Strategies to combat HIV and Aids

The world at large is experiencing the detrimental effects of HIV, hence strategies have been implemented that are aimed at combating the disease. One of the recent strategies is the '**90 90 90 strategy**'. UNAIDS (2020:1) plans to test 90% of all individuals who do not know their HIV status by 2030 after consent has been granted. By 2030, 90% of the people diagnosed with HIV should be receiving continuous antiretroviral therapy (ART) and lastly, by 2030, the viral load of 90% of people are on

ART will have been suppressed. Should the '90 90 90 strategy' be achieved, Jamieson and Kellerman (2016) mention that there would be a decrease in the HIV epidemic. Furthermore, Jamieson and Kellerman (2016) expressed possible challenges that could be encountered in the implementation of the '90 90 90 strategy'. However, they also noted possible solutions to tackle these challenges. All proposed and implemented strategies may only work when all citizens take it upon themselves to be involved in these strategies by being active, empowering themselves with HIV information and participating in all initiatives aimed at eradicating HIV.

1.1.4 Bio-psycho socio-economic (BPSE) effects of foster caregiving

Given the background above, it is disconcerting to know that 32.7 million people have died due to HIV-related illnesses (UNAIDS, 2020:1). This has resulted in many children being infected with HIV and AIDS (UNICEF, 2020:1). Subsequently, grandparents have to endure the consequences of caring for the affected children. Moreover, at the same time, grandparents have their own health challenges (Mokone, 2004:195; Chazan, 2014:1647). Providing care for children living with HIV and AIDS may have serious bio-psycho, socio-economic and emotional effects, which may subsequently affect the holistic functioning of foster parents. Therefore, foster care parents need psychosocial support to cope with their caregiving role.

Chazan (2014:1641) points out that in sub-Saharan Africa severe financial, physical and psychological difficulties experienced by caregivers raising children at risk, is rooted in the impact of HIV and AIDS. Most of the people providing a caregiver role are older people (Chazan 2014:1641). This point corresponds with the results of the study conducted by Phetlhu and Watson (2014:351), which indicates that grandparents encounter financial problems, hence, they are unable to meet the basic needs of orphans and vulnerable kids, such as clothes and food. The financial means of support for foster care families are largely tied to foster care grants to fulfil such basic needs.

Psychosocial and emotional challenges in the lives of grandparents raising children living with HIV and AIDS were also observed in various studies (Phetlhu & Watson, 2014:52; Mtshali, 2016:375, Lee, Clarkson-Hendrix & Lee, 2016:29) . Lee et al. (2016:29) indicate that foster care families are unlikely to get family support, adequate resources or supportive services, which may likely aggravate stress. In support of Lee

et al. (2016:29), Musil, Warner, Zauszniewski, Wykle and Standing (2009:2) remark that grandmothers caring for grandchildren encounter additional depressive symptoms compared to their counterparts. Moreover, their stress levels may increase, especially, when the child's parent has died, due to the fact that grandparents must simultaneously manage their own grief as well as that of their grandchildren. (Sampson & Hertlein, 2015:77). Furthermore, Mokone (2006:189) adds that fulfilling a caregiving role in old age is a challenge for the aged as they experience physical milestones such as menopause, they are physically weak and have less income as they depend on social grants. In addition, most of the grandparents have chronic illnesses such as hypertension, arthritis and diabetes resulting in them struggling to offer proper care to their grandchildren (Chazan, 2014:1647). A study conducted by Mokone (2004:195) indicates that social problems are part of the predicament experienced by grandparents. In their study, participants mentioned they were unable to attend church and luncheon clubs due to a lack of leisure time as most of their time was devoted to caring for the children concerned. The researcher can confirm that in practice foster parents also note the sacrifice they make to dedicate all their time to foster children. Some of the foster parents even go to the extent of leaving their jobs to focus on the upbringing of these children.

Foster parents contribute greatly towards the educational, emotional, medical and physical developmental needs of their grandchildren. For instance, they ensure the provision of basic necessities such as school uniforms, stationary, food and health care. According to De Jager (2011:73) there are many expectations of foster parents during the parenting process of foster care children. It is anticipated that they create an acceptable grandparent-grandchild relationship and enrich and motivate their personal growth. Moreover, they are expected to shield, comfort, groom and impart values and wisdom to their grandchildren. They further have to wrestle with the behavioural problems as the children grow up. With such expectations, at times, some grandparents are disheartened by the reality of poverty. In a nutshell, foster parents are faced with two predicaments. Firstly, they have to cope with the parental responsibility of raising grandchildren, and secondly, they take a full accountability for a child who has a chronic illness. The researcher envisages that fair and equal courtesy must be given to both the infected and the affected. Subsequently, their social functioning will improve.

1.1.5 Role reversal and change in family structure

Given the rise of orphans and vulnerable children left in the care of families, roles have changed in the family setting. Mtshali (2016:369) elaborates on the rapid change in structure and functions of families in communities due to HIV and AIDS-related deaths. Mtshali (2016:369), Kinyua (2013:1), and Mhaka-Mutepfa, Mpofu and Cumming (2014:258) indicate that the consequences of HIV and AIDS-related deaths contribute to role reversal, whereby grandparents take on the primary role of caregiving. The status of older foster parents has transformed from “retired” to key carers as they turn into full-time carers due to the death of their children (Mhaka-Mutepfa, Mpofu & Cumming, 2014: 476). Mathambo and Gibbs (2008), as quoted by Kinyua (2013:1), mention that the rise of grandparents as prime caregivers for their grandchildren, risks separating the ‘inter-generational bond.’ In numerous disadvantaged societies, grandparents expect to be cared for by their children, however, the recent social relationship is now broken as the middle generation passes away and grandparents are obligated to care for their children (Kinyua, 2013:2). With such inevitable consequences that come with caring for foster care children living with HIV and AIDS, social work intervention, in particular psychosocial support is of paramount importance to the affected and infected families.

1.1.6 South African legislation and its role concerning foster care families

It should be acknowledged that foster parents are also humans who probably were taking care of the deceased parents during the period they were ill. Taking into consideration the physical and mental challenges as a result of HIV and AIDS, it should be acknowledged that foster parents and foster children are not in this dilemma alone. The Constitution of the Republic of South Africa (1996) (Chapter 2 of the Bill of Rights) and the Children’s Act 38 of 2005 protects the rights of both foster parents and foster children. For instance, the Constitution has informed numerous policies and legislations on children and older persons. These legislations were able to address some of the injustices of the past in taking the best interests of children and older persons to heart (Older Persons Act 13 of 2006; Children’s Act 38 of 2005; National Action Plan for Orphans and other Children made Vulnerable by HIV and AIDS, South Africa 2006 – 2008; National Policy Framework for Orphans and other children made

vulnerable by HIV/AIDS [OVC], 2005; National Guidelines for Social Services to Children Infected and Affected by HIV/AIDS, 2002). In addition, the White Paper for Social Welfare (1997), Children's Act 38 of 2005 (as amended), and the Social Assistance Act, 2004 are some of the crucial legislation that are supported by the vision of the Constitution of South Africa (1996). Amongst others, the stated legislation is used to promote advocacy on issues related to children, promote mobilisation of financial and material resources for orphans and child-headed households, and provide social welfare and legal support services. Social work carries out the goals and objectives of the South African Constitution (1996). They serve as catalysts of change as they assume the task of promoting and supporting change in the lives of vulnerable situations. Social work aims at empowering, protecting and ensuring that the basic rights of vulnerable groups are respected. With social workers being change agents their intervention is of value to both the affected and infected by HIV and AIDS.

1.1.7 The role of social work in the provision of services and support

Social workers play a pivotal part in foster care families. HIV and AIDS is a sensitive subject to engage on, however, social workers are guided by ethical values and principles when providing services to families of people living with HIV and AIDS (National Association of Social work [NASW], 2017). Notably, the mandate of social workers is to improve the wellbeing of grandparents caring for children living with HIV and AIDS (National Association of Social work [NASW], 2017:1). Social workers promote care, physical development and safety of foster children. Social workers ensure that the foster care placement order is valid and that the child receives the foster care grant monthly. They liaise with school class teachers to monitor the academic progress of the foster child. Social workers conduct comprehensive assessments that guide effective intervention for foster children and foster parents. HIV and AIDS is a delicate matter, when a foster parent discloses the HIV status of the children they are fostering, social workers ensure they provide the necessary psychosocial support and do not convey a judgmental attitude.

The background of the study underscored the importance of psychosocial support for foster parents who are responsible for foster children diagnosed with HIV. To understand the history, in particular the spread of HIV, detailed information about HIV/AIDS was presented. The impacts of foster caregiving on the bio-psycho, socio-

economic, and emotional levels were further discussed by the researcher. The background described the laws and policies that govern social work. Additionally, the background emphasizes the reversal of roles due to the increase in orphans and vulnerable children left in family care. The significant role social workers play in ensuring the delivery of psychosocial support was essential to the background of the study. The problem statement and formulation are derived from the background context and are covered in more detail below.

1.2 PROBLEM FORMULATION AND PROBLEM STATEMENT

The construction of a research problem is the most important feature as it influences the value and significance of the research study (Kumar, 2014:67). Research problems can stem from an individual observation and experience (Kaniki, 2014:19, Brink, Van der Walt & Van Rensburg, 2018:43). The majority of researchable problems can be recognised by reading and probing historical, theoretical and empirical work that has been formerly issued (Kaniki, 2014:19). Hofstee (2006:85) and Brink et al (2018:43) elaborate that within the topic that the researcher has presented there has to be a problem that the researcher will be exploring. Hofstee (2015:85) further mentions that in this aspect, the researcher may possibly ask the subsequent questions: 'What is precisely the problem?', 'Why is it considered a problem?', 'What aspect does the problem pose?' and 'What attempts had been made to tackle the problem?'

The researcher comprehends that research problems are issues that can be derived from various sources encountered in personal and work experiences. Problems can also be found in other researchers' findings or be read or viewed in the media. The problem statement of the proposed research study was instituted by the predicaments encountered in practice by the foster parents caring for foster care children in respect of the proposed study, limited information is known on the provision of psychosocial support for foster parents who care for children living with HIV and AIDS. This study will help the researcher to know if such care is either infrequently provided, has not been documented or is offered as part of overall care and support of people with HIV/AIDS.

Individuals would think scholars and other relevant stakeholders have mastered the ability to tackle this pandemic, however, there are new infections and deaths related to AIDS as per the data gathered by the United Nations Children's Fund (2020:1). The research problem emanates from numerous findings made by various researchers. For instance, the findings of Phetlhu and Watson's (2014:348-356) study revealed various challenges encountered by grandparents caring for vulnerable children whose parents had died due to HIV and AIDS in the North West Province of South Africa. It was also noted from the findings that the grandparents' grief is frequently not acknowledged and they are not given the necessary support. Gomo, Raniga and Motloun's (2017:197) study reveals that foster parents play a considerable role in enhancing resilience amongst children living with HIV. Mavangira and Raniga, (2015:430) mention that there is a dire need for constant psycho- social support networks for children living with HIV and AIDS. The researchers' observations also noted the fundamental role played by social workers when providing intervention (Mavangira & Raniga, 2015:423), especially to assist grandparents to freely express their challenges in order to cope with the emotional chaos that arises during the caregiving process (Gomo et al., 2017:197). Therefore, it is crucial that the perspectives of foster parents on the psychosocial support and services offered to them by social workers and other social and health care providers, be explored. The intended research will enlighten social workers on how best to offer psychosocial support to both grandparents and children living with HIV and AIDS and it will also inform aspects of social work services that need improvement in order to achieve a sustainable and efficient intervention. With so much literature emphasising that the affected are the cornerstone of support to those who are infected by HIV and AIDS, it is appalling that the enormous amount of research has been conducted only on people who are infected with HIV and AIDS (De Jager, 2011; Tangwe, Khumalo, & Gutura, 2017; Dunga, 2014; Breckenridge, Black-Hughes, Rautenbach & Mckinley, 2019).

It is essential to acknowledge that the infected do not live in isolation; they are immersed in a family system. Having read, amongst others, the mentioned studies in Table 1.1, below, shows that the researcher discovered that little attention has been paid to foster parents caring for children living with HIV and AIDS. The attention is always on the predicament and needs encountered by children living with HIV and AIDS. Therefore, the research study will focus on the psychosocial support offered to

foster parents caring for foster children living with HIV and AIDS in South Africa, Tshwane region in particular.

Table.1.1: Various studies on foster care children living with HIV

Authors' names and year of publication	Title of paper & Country	Type of research
Muchanyerei (2015)	Challenges experienced by social workers in placing children living with HIV in foster care in Johannesburg	Qualitative approach
De Jager (2011)	Foster care of AIDS orphans: Social worker's perspective	Qualitative approach
Gomo, Tanusha Raniga, Motloun (2017)	Resilience amongst children living with HIV: Voice of foster parents residing in Bhambayi, KwaZulu Natal, South Africa	Qualitative approach
Tangwe, Khumalo and Gutura (2017)	Three decades of HIV/AIDS Pandemic: Challenges faced by orphans in Tembisa, South Africa	Qualitative approach
Breckenridge, Black –Hughes, Rautenbach and Mckinley (2019)	HIV/AIDS orphans in South Africa: NGO intervention supporting transitions to alternative care	Qualitative approach
Dunga (2014)	An investigation of the services provided by the Bhambayi drop- in centre in Inanda, Kwa Zulu Natal for orphans and vulnerable children affected by HIV and AIDS	Qualitative approach

Several studies have been conducted on foster children living with HIV. From the literature gathered, majority of the authors conducted their research utilizing qualitative approach. For instance, authors such as Mucheyerei (2015) investigated the challenges experienced by social workers in placing children living with HIV in foster care in Johannesburg. De Jager (2011) Gomo, Tanusha Raniga, Motloun (2017), Tangwe, Khumalo and Gutura (2017), Breckenridge, Black –Hughes, Rautenbach and Mckinley (2019) and Dunga (2014) focused their studies on orphans and vulnerable children. Hence, the latter studies stimulated the researcher's interest on foster

parents of children living with HIV, thus resulting in a lack of literature pertaining to the psychosocial support offered to foster parents.

Based on the aforementioned discussion, the problem statement of this research study is formulated as follows: *“There is a lack of sufficient data on the psychosocial support for foster parents caring for foster care children living with HIV and AIDS.* Insights from this study will be vital for social workers at the forefront, offering direct services to foster parents caring for children living with HIV and AIDS.

1.3 RATIONALE OF THE STUDY

As of June 2021, UNAIDS marked four decades since the first reported cases of AIDS (UNAIDS,2021). HIV remains a highly relevant and widely discussed subject (Tangwe, Khumalo & Gutura, 2017; Piot & Quinn, 2013:2210; Decock, Jaffe & Curran, 2012:120). However, the illness still remains a-hard-hitting topic to address with the foster parents encountered in practice by the researcher. The researcher concord that in practice foster care applications are still received where a child has contracted HIV through mother to child transmission. In practice, the researcher has noticed new infection cases and biological parents passing away due to AIDS-related illnesses. At the researcher’s service point about 5-10 cases of foster care placement a month are registered. Based on data collected from the researcher's service point, an estimated 60 foster children are now living with HIV and AIDS. The number is still increasing thus indicating more new infections. This clearly reveals that even after decades of knowing about this illness, social workers have a big role to play in providing psychosocial support to both infected and affected families.

In practice the researcher has observed some foster parents who feel embarrassed to divulge that their foster children are HIV positive. Being infected with HIV is still stigmatised and it is difficult to imagine how grandparents cope with this predicament. HIV and AIDS is still a sensitive subject, it is not the norm for foster parents to express their feelings about the disease and how they are coping with their caregiving role. The majority of foster parents encountered by the researcher and their colleagues discovered that their foster children had a chronic illness after the death of their biological parents or when the children got sick. Having read various research studies pertaining to people infected and affected by HIV and AIDS it can be concluded that

psychosocial support is of paramount importance for people to function at their optimum level, as stated in the Manual for Action for the Rights of Children (2009:9). This manual further indicates that psychosocial support is of value to sustain a continuum of family and community-centred care and support in the period of and after humanitarian predicaments. It also decreases the duration of mental health illness.

The impact of this study would be acknowledged at various levels. For instance, at an individual level, when foster parents feel supported and equipped - psychologically, socially, and emotionally - they will be armed to create a nurturing environment that promotes both the physical and emotional development of the child in their care. At the family level, the family network will have a decisive influence on the health care provided to children who is infected by HIV and AIDS, particularly for adherence to antiretroviral therapy (ART) (Silva & Tavares 2015:1114). At the community level, offering support within community settings will strengthen community resilience and improve their collective capacity to care for and assist one another – thus acknowledging the spirit of *ubuntu*.

The aforementioned observations unequivocally show how important psychosocial support is in every aspect of life. Psychosocial assistance must be acknowledged as a significant and vital part of care to promote emotional, social, and mental stability, especially for vulnerable groups like children living with HIV and grandparents who are providing care.

Motivated by the findings of various researchers who conducted studies related to the topic of this study (see Table 1.1), this proposed research will establish what psychosocial support is offered by social workers to grandparents caring for children living with HIV and AIDS. Since psychosocial support is not only limited to social work, the study will benefit various social and health care practitioners by enabling them to develop responsive intervention strategies for foster parents caring for children living with HIV. Moreover, findings of the study could assist in identifying any gaps that might be filled when social workers render psychosocial support, which is one of the aims of their services. Furthermore, the findings will assist in improving service delivery and strengthening responsive intervention strategies. The White Paper for Social Welfare (1997:60) indicates that the welfare of the children relies on the ability of families to function efficiently, therefore it is imperative to empower the aptitude of caregivers,

acquaintances and educators to offer daily psychosocial care and support to all children (ARC, 2009:11).

In order to strengthen the capability of caregivers to provide everyday care and support to children, it is evident that the supply of psychosocial support by social workers is crucial, therefore an investigation in relation to that is imperative.

1.4 THEORETICAL FRAMEWORK

According to Grant and Osanloo (2014:12), the value of using a theoretical framework in a study cannot be over-emphasised. The theoretical framework is the groundwork from which all information is formulated for a research study (Grant & Osanloo, 2014:12). A theoretical framework is said to function as the structure and support for the root of the study, which informs the problem statement, purpose, significance and research question (Grant & Osanloo, 2014:12). The researcher understands that a theoretical framework acts as a fundamental foundation of the research. It further guides the direction of the research. Anfara and Mertz (2015:15) define a theoretical framework as any empirical or quasi-empirical theory that can be applied to explain and understand a phenomenon.

For the purpose of this study, the applicable theoretical framework is resilience theory. Support plays a crucial role in resilience (Gillan, 2017:446; Herrman, Stewart, Diaz-Granados, Berger, Jackson & Yuen, 2011:260). Taking into consideration the significance of support for resilience, it is crucial to observe that support may come in different ways and from various sources (Gillan, 2017:446). An individual may receive support from family members, companions, friends and neighbours. The amount of adversity a person encounters can have an impact on the possibility of resilience (Gillan, 2017:446). Grandparents are unique, and therefore may not cope in the same way. The difference in coping with adversity may be due to the type of support they receive as they confront adversity. Resilience theory clearly acknowledges the importance of psychosocial support that has the ability to contribute positively to the resilience of those facing adversity. Social workers cultivate resilience by acknowledging that every case they encounter is unique (Gillan, 2017:449). Thus, resilience is not a trait, since it can be learnt or fostered by outside intervention (Gillan, 2017). In this instance, psychosocial support is relevant to boosting the wellbeing of

foster parents caring for foster care children living with HIV and AIDS. Therefore, resilience theory is applicable as the foundation of the study.

Resilience theory highlights the importance of empowerment and strength-based perspectives to foster positive development in adversity. Nonetheless, its effectiveness is context-dependent and has limitations. Mahdiani and Ungar (2021) caution that resilience can sometimes be misapplied to perpetuate social disparities or defer necessary systemic change, shifting the responsibility of transformation to individuals lacking resources. Thus, while resilience is crucial, it must be applied judiciously and equitably. The authors suggest that there are circumstances where vulnerability is appropriate, arguing that expectations of resilience should be adjusted based on individuals' backgrounds. Consequently, researchers must consider the diverse backgrounds of participants, recognizing that levels of resilience may differ accordingly.

1.5 RESEARCH QUESTIONS, GOALS AND OBJECTIVES OF THE STUDY

The research questions, goals and objectives of the study are discussed in this section

1.5.1 Research questions

Qualitative research questions attempt to describe what the researcher wants to research. Tracy (2013:15) asserts that a unique feature in qualitative research is the design of a research question. Research questions reaffirm the purpose of the research study. Research questions usually begin with “what” or “how” instead of “why” (Creswell & Poth, 2018:245). A research question must be broad in order to describe, examine and clarify the phenomenon being researched (Korstens & Moser, 2017:275). It is understood that a qualitative research question is versatile, hence it permits changes. The research questions for this study are formulated as follows:

- *What views do foster parents caring for foster care children living with HIV and AIDS have with regard to the psychosocial support services rendered to them by social workers in Tshwane region?*

- *From the perspective of foster care parents caring for foster care children, which suggestions could be considered on the improvements of psychosocial support services offered by social workers in Tshwane region?*

1.5.2 Goals of the study

A goal is an anticipated outcome, or future plans an individual or a system visualises and pledges to accomplish in a personal or organisational preferred end point (James, 2013:17). A goal is a precise and measurable accomplishment expected to be achieved within a specific period of time and under specific cost constraints (O'Leary, 2018:86). Makondo (1999:58) is of the view that a goal is an overall long-term statement of what the researcher anticipates to attain. A goal is viewed as an ambition or a purpose. It habitually suggests the broader, more abstract conception of something which the researcher intends to implement or achieve.

The goals of this research study were:

- *To develop an in-depth understanding of foster parents' perspectives on psychosocial support received while caring for foster care children living with HIV and AIDS in Tshwane region.*
- *To proffer suggestions on the improvements of psychosocial support services offered by social workers.*

1.5.3 Research objectives

Objectives give a clear view of what must be implemented in order to successfully accomplish the goal/s that were set. According to Kumar (2019:12) objectives are the goals researchers plan to attain in their study. It informs the reader of what the researcher wants to achieve in the study. Neuman (2014:24) states that an objective entails an entity where efforts are administered. Tracy (2013:98) indicates that objectives serve as a guide to steps that must be implemented in order to achieve the goal. Objectives inform the overall outcome of the goal and procedures that must be utilised to attain the set goal.

To achieve the goals of the study the following objectives were formulated:

- To explore the perspective of foster parents caring for foster care children living with HIV and AIDS on the psychosocial support services offered to them by social workers.
- To describe foster parents' suggestions on the improvement of psychosocial support services offered by social workers.
- To describe the value of psychosocial support intervention in families affected by HIV and AIDS.

1.6 RESEARCH METHODOLOGY

Research methodology refers to “the sum of all the methods and stepwise procedures put in place in a chronological order to be illustrated practically in the research” (Engwa, 2015:32). Creswell (2014:295) concurs with Engwa (2015:32) in that research methods encompass data collection, analysis and interpretation that researchers intend to use for their research studies. The research approach applied in this study was qualitative approach corroborated by phenomenological, exploratory, descriptive and contextual research designs. More details on the applicable methodology are shared in chapter three.

1.7 ETHICAL CONSIDERATIONS

Neuman (2014:157) elaborates that ethics are established by professional societies to inform research practice and draw a line between ethical and unethical conduct. Ethics are morals that must be implemented by the researcher in engagements with the participants. They serve as a conscience that guides the researcher in their involvement with participants during and after the research study has been finalised. Informed consent, voluntary participation, no harm to participants, anonymity and confidentiality are some of the ethical principles adhered to by the research which are discussed in detail in Chapter three.

1.8 CLARIFICATION OF KEY CONCEPTS

Concepts are essential components of theory and are better explained and grasped in the context of a particular theory (Fain, 2017:108). Concepts are words or expressions that assist in classifying, explaining and creating structure and limitations

for terms generated regarding a phenomenon (Johnson & Webber, 2005:357; Sarantakos, 2013:468). This section clarifies the key concepts used in this study.

1.8.1 Psychosocial support

According to the World Health Organization (2020), psychosocial support includes various interventions used to enhance the wellbeing of individuals. Psychosocial support is generally provided by professionals with advanced specialised training. A conceptual framework by the Government's Department of Social Development (2011:11) explains that psychosocial support alludes to a range of care and support that intends to safeguard the social, emotional and mental welfare of a person, their families and society. With regard to the proposed study, psychosocial support means an intervention which targets the holistic wellbeing of foster parents.

1.8.2 Foster care

According to the Children's Act No 38 of 2005 (as amended) foster care means care of a child as described in section 180(1) and includes foster care in a registered cluster foster care scheme. Foster care includes raising or supervision of foster children in an institution, group home or private home, usually arranged through a government or social-service agency that provides remuneration for expenses (Collins dictionary, 2020, sv "Foster care"). In this study foster care includes a legal placement granted by the children's court to a relative or non-relative member caring for children who are diagnosed with HIV and AIDS.

1.8.3 Foster parents

A foster parent is a person who has been appointed to offer foster care to a child by order of the children's court and includes an active member of an organisation operating a cluster foster care scheme who has been assigned responsibility for the foster care child (Children's Act No. 38 of 2005 [as amended]). Foster parents in the context of this study are parents who are conferred parental responsibility by the children's court to be legal parents of foster children living with HIV and AIDS.

1.8.4 Foster care children

A child who is in the care of a guardian as per court order is regarded as a foster child. The placement is done when a child is orphaned, deserted and/or exposed to harm (South African Government, 2020). A foster child is a minor who does not have parental care and protection and is therefore placed in the care of a relative by a social worker or court order. For this study, a foster child is a minor who is in the foster care placement of a foster parent.

1.8.5 Social work

Social work is a practice-based profession that upholds social change and development; it promotes the principles of social justice, and human rights (International Federation of Social Workers, 2014; Department of Social Development 2020). Ronald Malar, and Laavanya (2013:8) elaborate that social work seeks to improve the living standards of individuals, groups and communities. The Department of Social Development (2020) further explains that social work enhances problem solving in people's relationships, thus fostering empowerment. In the framework of this study, social work entails a service of psychosocial support rendered to foster parents who are caring for foster care children living with HIV and AIDS.

1.8.6 Perspective

The term "perspective" can be described in various ways, as it is determined on the circumstance which it is utilised (Hugh, 2005:771). A certain way of reflecting on something, in particular, something that is swayed by one's own ideologies and knowledge is called "perspective" (Collins 2020, sv "perspective"). The Collins' (2020) definition will be adopted for the purpose of this study.

1.8.7 HIV/AIDS

HIV is an abbreviation of Human Immunodeficiency Virus (World Health Organization, 2020:1; United Nations Programme on HIV/AIDS (UNAIDS, 2020; Duffy, 2018:9; Simelela, Pillay & Serenata, 2017:1). The WHO (2020) and Duffy (2018:9) explain that the "Human immunodeficiency virus (HIV) weakens the body's immune system, specifically the white blood cells called CD4 cells". HIV illnesses may lead to the

development of Acquired Immune Deficiency Syndrome (AIDS) (Becerra, Bildstein & Gach, 2016:451; WHO, 2020; Duffy, 2018:9). It is said that the virus is acquired because it is transmitted amongst people by means of body fluid and is therefore, not hereditary (Duffy, 2018:10). WHO (2020) and UNAIDS (2020) define AIDS as the name “originally given to a collection of diseases and malignancies that arise in people who previously had healthy immune systems”.

According to the World Health Organization (2017), “acquired immunodeficiency syndrome (AIDS) is a phrase that applies to the most progressed phases of HIV infection”. It is defined by the occurrence of any of the more than 20 life-threatening cancers or “opportunistic infections”. In addition, UNAIDS (2020) indicate that AIDS is a final stage of HIV where infections and disease overpowers the immune system, furthermore the level of immunodeficiency or the presence of specific infections are used as indicators that HIV infection has advanced to AIDS. In the context of this study, the above definitions are adopted.

1.9 OUTLINE OF CHAPTERS

Chapter one: Introduction and background to the study

This chapter provides an overview of the main research study and how it was conducted. This chapter outlines the main content of the study. It serves as a road map which assists the researcher to know how to go about conducting the research. The chapter entails the introduction, problem formulation, problem statement, motivation for the study, research question, the study’s goals and objectives, research approach and design, ethical aspects, clarification of key concepts, and the content plan of the research report.

Chapter two: Literature review

This chapter unpacks the theoretical perspectives on psychosocial support, foster care parents and children living with HIV and AIDS. This chapter also presents current trends and statistics of HIV and AIDS.

Chapter three: Methodology

This chapter emphasises the applications of the research methodology. The chapter gives an exposition of the findings of the data which were obtained by means of semi-structured interviews.

Chapter four: Data analysis

This chapter consists of information on how the data was gathered and the steps taken to safeguard the true reporting of the data.

Chapter five: Summary, conclusions, and recommendations

This chapter focuses was on the conclusions and recommendations of the study. The chapter identifies possible suggestions and solutions to the problem based on the findings, and summarises the information contained in Chapters one to four. This chapter further confirms if the research question has been answered.

1.10 DISSEMINATION OF RESEARCH RESULTS

The publication of the study findings is the final step of the research process. It includes the distribution of information collected throughout the research process. It is crucial that the researcher gives feedback to the academic community regarding the status of the research study and also informs the concerned parties as well as the government about the findings (Sarantakos, 2013:441). Leavy (2017:45) concurs with Sarantakos (2013), that it is vital that the researcher disseminates the research findings to the participants of the study and also to the academic research community. Edwards (2015:465) further elaborates that researchers are morally obliged to publish their research outcomes. However, the research findings must be compiled in such a way that the findings can be understood by others (Sarantakos, 2013:441). Various methods of disseminating data are available. The researcher can make use of peer review journals, research reports, books and conference presentations (Leavy, 2017:43, Edwards, 2015: 465).

The research outcomes of the study will be disseminated through a research report that will be submitted to Unisa and the Department of Social Development. Findings will also be prepared for submission to a scientific journal for possible publication. The researcher will further inform participants who voluntarily took part in the study about the outcomes of the research.

1.11 CONCLUSION

Chapter one comprises the background and rationale of the study, the problem statement, research question, aims and objectives of the study. A qualitative research

approach was applied and implemented in this study. This chapter further outlines the ethical aspects executed in this study in pursuit of the researcher's obligation to protect participants from all harm throughout the whole research process. Chapter two below provides the theoretical perspectives on foster parents receiving psychosocial support while caring for foster care children living with HIV and AIDS.

CHAPTER TWO

LITERATURE REVIEW ON FOSTER PARENTS AND PSYCHOSOCIAL SUPPORT RECEIVED WHILE CARING FOR FOSTER CARE CHILDREN LIVING WITH HIV AND AIDS

2.1 INTRODUCTION

This chapter discusses the literature associated with the topic of study. This study sought to explore foster parents' perspectives on psychosocial support received while caring for foster care children living with HIV and AIDS. Foster parents' psychosocial wellbeing is dependent on the capacity to receive effective and efficient psychosocial support services in response to their everyday challenges. The provision of psychosocial support has been recognised as having a substantial and positive influence on people's health (Department of Health [SA], nd.:03). Psychosocial support comprises rebuilding and strengthening relations, which are crucial to human development (Department of Health [SA], nd.:03). A chronic disease such as HIV and AIDS disturbs all aspects of a person's life such as the physical, psychological, social and spiritual being of a person, hence it is crucial for social workers to recognise the relevance of psychosocial support in the lives of foster parents.

2.2 STATISTICS ON CHILDREN LIVING WITH HIV

Foster care for children living with HIV presents unique challenges that require empathy, support, and collaborative approaches. Numerous authors have explored the experiences of children with HIV, resulting in a substantial body of research on the topic. For instance, various researchers worldwide, including Essajee and Bains (2023), Davtyan, Kacanek, Lee, Berman, Chadwick, Smith, Salomon, and Frederick (2023), and Ely (2008), have focused on issues such as disclosure and the needs of children living with HIV. In comparison to the international literature, South Africa has prioritized research on children living with HIV. Several scholars have conducted in-depth studies on this population, with significant contributions from researchers like Roberts, Sherr, Haag, Smith, Jochim, Toska, Marlow, and Cluver (2022). Gomo, Raniga, and Motloun (2017) examined resilience among children with HIV through the perspectives of foster parents in Bhambayi, KwaZulu-Natal, South Africa, while Warwick and Langba (2017) addressed the challenges faced in providing foster care

for children living with HIV in South Africa. Dube and Smith (2016) have explored the difficult issue of status disclosure for HIV-positive children in a child and youth care facility located in Johannesburg, South Africa. These studies are relevant in reminding social workers and other stakeholders on the support that should be offered to foster care families. The caregivers of those living with HIV/AIDS have not been given sufficient attention. Grandparents play a critical role as caregivers. Ntuli and Madiba (2019:1) indicate that since the beginning of the HIV and AIDS endemic, limited research has been conducted on the older people' providing HIV-interrelated care to adult children, and as a result, assume the caring role whilst deprived of resources and support. Older people are burdened as they take care of their grownup children who have AIDS-related ailments. Despite a significant rise in the administration of ART in several sub-Saharan African nations, the burden of caregiving remains unchanged. Ultimately, older people take on the crucial responsibility of providing support and care for their adult offspring when they are weakened by AIDS-related diseases (Ntuli & Madiba, 2019:1).

Figure 2.1 below reveals that South Africa experiences the highest number of losses of parents compared to other neighbouring countries. An estimated 19.5% of South African adults aged 15-49 years are reported to be living with HIV/AIDS.

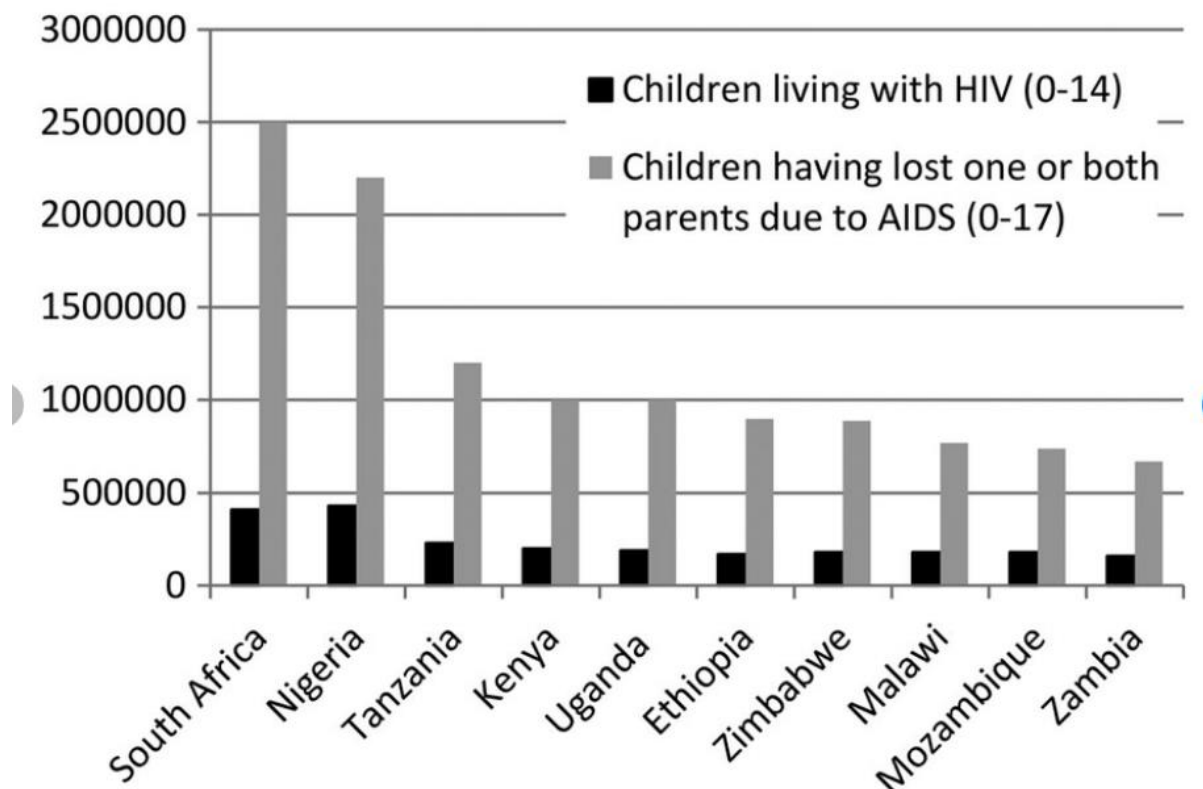


Figure 1: Children living with HIV (0–14) and children having lost one or both parents due to AIDS (0–17) in the most affected countries in sub-Saharan Africa by number (WHO, 2015).

In 2015, the global population of orphaned children was estimated at approximately 140 million, with 52 million residing in Africa (Braitstein, DeLong, Ayuku Braitstein et al., 2021:2). Of this total, 15.1 million children had lost both parents commonly referred to as double orphans. Importantly, 16.6 million children were orphaned consequential to parental deaths related to HIV/AIDS, with the vast majority (approximately 90%) pinpointed in sub-Saharan Africa. Despite the high number, the majority of separated and orphaned children and teenagers are not completely alone; they are frequently cared for and reared by a living parent or by family members in their extended family network.

Family caregiving is primarily informal and unpaid in South Africa HIV's chronicity and the likelihood that it would be passed down through generations make conventional family caring duties more challenging (Maddocks & Chetty, 2020:1-2). In the event of significant parental illness or death, grandparents or extended family members are expected to assume the responsibility of caring for CLHIV, usually with little resource

According to UNICEF and international partners, an orphan is defined as a child under 18 years of age who has experienced the loss of one or both parents to any cause of death. Based on this definition, there were nearly 140 million orphans globally in 2015, including 61 million in Asia, 52 million in Africa, 10 million in Latin America and the Caribbean, and 7.3 million in Eastern Europe and Central Asia. It is important to note that this large figure encompasses not only children who have lost both parents, but also those who have lost a father but have a surviving mother or have lost their mother but have a surviving father.

Of the nearly 140 million children classified as orphans, 15.1 million have lost both parents. Evidence clearly shows that the vast majority of orphans are living with a surviving parent grandparent, or other family member 95 % of all orphans are over the age of five.

Therefore looking at the above statistics, it is evident that the caregiving role will persist in coming years. It is also evident that families take more responsibility for the care of individuals living with HIV.

2.3 SOCIAL WORK INTERVENTION

The core principle of social work is to protect children, and social work intervention is paramount. This research is applicable in the social work profession since HIV/AIDS is not only a health issue but a social issue. Since a social worker is a catalyst for change, their intervention with caregivers raising children living with HIV is important. A service rendered by social workers, which is known as psychosocial support (PSS), contributes significantly to the continuous adherence to and retention in ART for youngsters living with human immunodeficiency (Okonji, Mukumbang, Orth, Vickerman-Delport & Van Wyk, 2022:2).

Subsequently, with the introduction of ART substantial gains have been made in modifying the impact of the HIV/AIDS pandemic. As a result of people living prolonged lives due to the availability of ARVs, they encounter life challenges that need social work intervention. High levels of anxiety, seclusion, depression and suicide ideation have been noted among Young People Living with HIV (YPLWH). Studies suggest psychosocial support for YPLWH in addition to standard ART services to help them to adapt and cope with the chronicity and stigma linked with HIV (Okonji, Mukumbang, Orth, Vickerman-Delport & Van Wyk, 2022:2).

During social work intervention, an integrated approach allows social workers to be versatile in finding solutions and responding to the challenges of foster care caregivers. The incorporation of theories in service delivery helps promote and sustain the resilience of foster care parents based on their relevance to each unique service user's situation. Amongst other theories, the resilience and health belief models are discussed below.

2.3.1 Resilience theory

Resilience is demonstrated by three core characteristics: self-esteem, self-efficacy and the ability to solve problems. Foster children living with HIV encounter the dual difficulties of coping with their HIV status. Thus, foster parents play an important role in increasing resilience amongst children living with HIV (Gomo et al., 2017). To further enhance the resilience of children living with HIV placed in foster care, HIV public awareness campaigns to de-stigmatise HIV through media platforms cannot be underestimated (Mavangira & Raniga, 2015). Resilient people are those who “navigate their way to health-sustaining resources, including prospects to experience feelings of well-being and circumstances of the person's family, community and culture to deliver these health resources in culturally eloquent ways after one's exposure to substantial adversity, whether psychological, environmental or both” (Gomo et al., 2017).

There has been a developing interest from various disciplines pertaining to the study of resilience theory (Van Breda, 2018; Herrman et al., 2011; Gillan 2017). Whilst consulting various literature sources it became evident that the conceptualisation of resilience varies across disciplines, however, there were some commonalities with regard to those different definitions. The researcher opted for a definition that correlates with the social science discipline. Whilst describing what resilience is, it is imperative to be clear if resilience is being regarded as a trait, a procedure or the end result (Southwick et al., 2014:2). In response, Southwick et al. (2014:2) and Gillan (2017:442) assert that resilience cannot be described in respect of the character of a person. However, Herrman et al. (2011: 259) argue that resilience may be associated with the trait of a person. Personal aspects such as honesty, self-efficacy, confidence and having a positive outlook on life contribute to the resilience of a person (Herrman et al., 2011:259). Resilience can be better understood as the ability to successfully surpass obstacles meant to disturb one's equilibrium and recuperate positive mental

health (Masten, 2014:10; Gillan 2014:441, Herrman et al., 2011:259). Bonanno (2014:6) indicates that resilience does not have value as a single word, therefore adversity is a key feature in respect of resilience. This means there must be adversity to qualify resilience, they are both interlinked. With regard to the intended study the adversity that is faced by foster parents is HIV. They have lost their family member due to HIV and now have to take over the duty of raising a child who lives with HIV. Losing their loved ones and having to carry the huge responsibility of looking after a child living with HIV is an adversity where their resilience is challenged.

Gillan (2017:442) implies that adversity can be categorised into two phases. Phase one deals with the unexpected death of a family member or acquaintance, while the second phase considers the chronic situation. The author illustrates that this second phase can entail chronic adversity due to poverty and/ or encountering difficulties for a longer period. Bonanno (2014) shares the same argument as Gillan that resilience can appear in two categories of adversity, which is chronic and acute. When applying the views of Bonanno (2014) and Gillan (2017) pertaining to categories of adversity the researcher is of the view that adversity in the lives of the foster parents occurs in two stages. The first one occurs when they lose a loved one, who was a parent to a foster care child. The second phase, which is chronic, is observed when foster parents are left with the huge responsibility of caring for a child living with HIV. The caregiving role will continue for a long time, at least until the foster child reaches 21 years old.

With different kinds of adversity one can encounter in life, Gillan (2017:448) is of the view that resilience can contribute to the intentions and views that people uphold regarding their ability and situation. However, it should be noted that resilience cannot change those circumstances. Resilience has the power to positively impact the coping ability of an individual or how they identify their circumstance (Gillan, 2014:448). Although, foster parents demonstrate resilience towards their adversity, it does not mean their situation of caring for grandchildren living with HIV may change, however, their resilience will foster their coping abilities and enable them to raise the concerned children.

2.3.2 Health belief model

One of the key popular theoretical frameworks in health behaviour research since the 1950s is the Health Belief Model (HBM), which is used to both explain changes in

health-related behaviours and serve as a framework for intervention (Skinner, Tiro & Champion, 2015:75). Skinner et al. (2015:76) state that the health model encompasses various crucial components that envisage whether and why people will take action to prevent, detect or control illness conditions.

According to Skinner et al. (2015:76), the main idea behind the HBM is that individuals are more likely to adopt a healthy behaviour if they believe that:

- They are susceptible to a condition (at risk for a disease);
- The condition could have potentially serious consequences;
- A course of action (behaviour) available to them could be of benefit in reducing either their susceptibility to, or the severity of the condition;
- There are benefits to taking action; and.
- The perceived barriers (or costs) are outweighed by the benefits and are not strong enough to prevent action.

In order to understand the construct of HBM, Skinner et al. (2015:77) give the following explanation:

Perceived susceptibility is described as a belief regarding the probability of acquiring an illness or condition. HIV is a serious illness that has a detrimental impact should it not be taken care of. HIV and AIDS continue to be a universal public health catastrophe that disproportionately affects women, and as a result, an extensive number of children in turn acquire HIV (Moshoeshoe & Madiba, 2021:1). The foster children are already living with HIV, an illness which they acquired through mother to child transmission. For the foster parents who are caring for the children, it is crucial that that they do not get infected in the midst of raising their foster children living with HIV (Skinner et al 2015:77).

Perceived severity is a belief about the seriousness of acquiring a virus or condition or of not treating it, in conjunction with the physical consequences (death, incapacity, suffering), and social repercussions (retaining relationships with others, experiencing stigmatisation). HIV is a chronic disease that can be controlled by medication (ARVs). It can be deadly if there is no compliance to the medication regimen. The foster parent

in this study was aware of the seriousness of the illness and ensured that they implemented precautionary measures so as not become infected in the course of caring for their foster children living with HIV (Skinner et al 2015:77).

Perceived threat is a hypothesis, created by the combination of vulnerability and severity. Perceived susceptibility ought to be increased by perceived severity to analyse perceived threat thus if either of this component is zero, the perceived threat would be zero. One of the biggest fears is to die from HIV or be infected with it, as HIV is a brutal illness. It is expected that it will be considered a threat to individuals.

Perceived benefits are beliefs about positive features or advantages of a proposed action to reduce a threat. These benefits might decrease the threat of an ailment or its consequences (Skinner et al 2015:77). The study indicates that when foster parents ensure adherence to antiretroviral medications (ARVs) for children, it enhances the quality of life. Educating themselves and the foster child about HIV can reduce stigma and foster psychosocial well-being. Additionally, this perceived benefit may motivate foster parents to maintain consistent caregiving practices, including medication management and regular clinic visits, as they trust that these actions will lead to improved health and emotional welfare for the child.

Personal barriers are outlined as possible barriers to taking action, which can comprise negative outcomes following from an action. These identified obstacles and negative results hinder action or subsequent engagement in the behaviour. Due to the increased access to ART and developments in treatment, the quality of life for various women has progressed, leading to their living healthy lives after the early diagnosis of HIV (Moshoeshoe & Madiba, 2021:2). The perceived benefit of taking HIV medication is that one will live a longer life and be healthy. Concerning HIV, it is evident that the benefits of taking the medication outweigh the disadvantages.

HIV is a health problem. The health belief model is a model that is employed to guide health promotion and disease prevention programmes. The key element of this model is that it predicts individual health-related behaviours (Rural Health Information Hub, 2024:1). The HBM model which intervention can be implemented to tackle the health problem, which in this case is HIV. The HBM model equips researchers with the knowledge for understanding the behaviour, the perspective of individuals pertaining

to the health issue or illness and adherence of regimen. It allows the researcher to formulate interventions aimed at tackling health issues and promoting healthy living.

Although the Health belief model (HBM) was employed in this study, the researcher acknowledges the limitation attached to it. The model has demonstrated to be remarkable in effectively addressing behaviour from disease prevention to treatment adherence as seen in numerous studies (Siddiqui, Ghazal, Bibi, Ahmed and Sajjad, 2016) Joho (2021), Ryan, Brindal, Roberts and Hickson (2024), Appau, Aboagye, Nyahe, Khuzwayo and Tarkang (2024). However, Siddiqui, Ghazal, Bibi, Ahmed and Sajjad (2016:12) highlight that the HBM does not adequately consider environmental and economic factors that may hinder an individual's ability to adopt recommended health behaviors. The model overlooks the emotional aspects of behavior, which are crucial in understanding actions influenced by feelings and psychological states.

2.4 SOUTH AFRICAN LEGISLATIONS ON FOSTER PARENTS LIVING WITH FOSTER CHILDREN WITH HIV

Section 28(1)(b) of the Constitution of South Africa stipulates that the child has the right to family care or to alternative care in the absence of family circumstances. Irrespective of the child's HIV status, the child has a right to shelter, basic care services, social care services and basic nutrition (Gallinetti & Sloth-Nielsen, 2014). Parent care in Section 28(1)(b) also refers to foster care parents in addition to birth parents, adoptive parents and step-parents. In South Africa, orphaned children are ruled by the Children's Act 38 of 2005, this legislation is also applicable to foster parents living with HIV foster children as it takes into consideration the best interests of the child irrespective of the child's HIV status. Foster parents are to provide intellectual, emotional and social development for the children.

Furthermore, the Constitution of the Republic of South Africa (1996) (Chapter 2 of the Bill of Rights) and the Children's Act 38 of 2005 protects the rights of both foster parents and foster children. For instance, the Constitution has informed numerous policies and legislations on children and older persons. South African legislation, such as the Older Persons Act 13 of 2006 and the Children's Act 38 of 2005, has effectively

addressed historical injustices while prioritizing the welfare of children and the elderly. The National Plan of Action for Children (2006-2008) plays a critical role in safeguarding children's rights and monitoring compliance with international standards, including the United Nations Convention on the Rights of the Child. Furthermore, the National Policy Framework for Orphans and Children affected by HIV and AIDS enhances existing guidelines, ensuring comprehensive care and support for vulnerable children. This framework promotes collaborative efforts among government and civil society to foster an environment where these children can thrive and achieve their full potential.

National Guidelines for Social Services to Children Infected and Affected by HIV/AIDS, was issued by South Africa's Department of Social Development in 2002, which provided a framework for organizations and individuals delivering services to children impacted by HIV/AIDS. These guidelines emphasize essential services, including early identification, psychosocial support, and ensuring access to healthcare and education. In addition, the Social Service Profession Act (110 of 1978), the White Paper for Social Welfare (1997), Children's Act 38 of 2005 as (amended), and Social Assistance Act, 2004 are some of the crucial legislations that emanates from the vision of the Constitution of South Africa.

Amongst others, the stated legislation is used to promote advocacy on matters related to children, promote mobilisation of financial and material resources for orphans and child-headed households, and provide social welfare and legal support services. Social workers carry out the goals and objectives of the South African Constitution (1996) and the Children's Act 38 of 2005. They serve as catalysts of change as they assume the task of promoting and supporting change in the lives of those living in vulnerable situations.

2.5 EXPERIENCES OF FOSTER PARENTS CARING FOR ILL FOSTER CHILDREN PARENT(S).

In a world severely affected by HIV, older adults have a critical role in providing long-term personal and health care to their adult HIV-positive offspring and orphaned grandchildren (Nyirenda, Evandrou, Mutevedzi, Hosegood, Falkingham & Newell, 2015:171). A substantial number of adults who die due to AIDS-related illnesses often

reside with their elderly parents during the fatal stage of their sicknesses (Ntuli & Madiba, 2019:1)

Taking care of an ailing adult child may have an effect on the elderly parent's health. Older parents who are also caregivers may experience significant psychological distress when they see their child struggle and die. Thus, providing care requires a considerable amount of time and energy, particularly when AIDS is in its last stages (Tanyi, Pelser & Okeibunor, 2018:08).

The death of an adult child has consequences, when an adult child dies from HIV/AIDS, it can be devastating for the parents, especially if they depend on them financially or had intended to do so. If the deceased adult child provides financial assistance for the parents, current financial wellbeing can be negatively affected (Tanyi, Pelser & Okeibunor, 2018:08).

The role of foster care giving

According to Beck, Rogan, and Hawkins (2024:2), like any other illness, HIV affects individuals regardless of background and frequently has far-reaching consequences for both families and children. Traditionally, in South African family structures, older adults were typically supported and cared for by their children (Beck et al., 2024:6). However, the burden of HIV has disrupted these roles, often reversing caregiving responsibilities within households. Adams and Amod (2025:10) stipulate that the role of foster parents is complex and challenging and usually results in foster parents facing high levels of parental stress and frustration.

Caring for orphans, particularly those living with HIV and AIDS, involves significant commitment, as these children often have complex needs that increase the demands of caregiving. As Akimanimpaye, Bimerew, and Phetlhu (2024:1) note, for grandparents, who frequently assume this role, the responsibilities are intensified by their own age-related challenges. These may include emotional distress, physical health concerns, inadequate nutrition, and severely limited financial resources, all of which place additional strain on their overall well-being (Akimanimpaye et al, 2024:1)

The everyday responsibilities of caring for a child living with HIV can take a heavy toll on grandparents. As they navigate the physical demands of caregiving—often with aching bodies and tired backs they also carry an emotional weight. Many experience

ongoing stress, anxiety, and even depression, all while trying to provide love, stability, and care in the face of limited resources and their own aging bodies (Akimanimpaye et al, 2024:1). In support, Beck et al (2024:8) also highlight that grandparents experience emotional and social distress as grandmothers whose grandchildren are on ART have anxiety because they fear the grandchildren will experience stigmatization for having HIV (Beck et al, 2024:8).

Challenges of foster parents

The challenges faced by older caregivers are often substantial, and without adequate support, these struggles can compromise their ability to provide consistent, high-quality care to children living with HIV. Balancing the demands of caregiving with their own physical limitations and emotional strain can make it challenging to meet the complex needs of these children (Osafo, Knizek, Mugisha & Kinyanda 2015: 2122).

Chronic illness can significantly reduce the capacity of older adults to care for their grandchildren, especially when the children are living with HIV. This reality highlights the crucial role of psychosocial support and accessible resources, which help create the conditions necessary for caregivers to provide stable, nurturing, and effective care (Beck et al., 2024:8).

The social and psychosocial well-being of grandparents is essential in fostering the overall well-being of the children in their care. When caregivers are emotionally supported, socially connected, and psychologically resilient, they are better equipped to provide the consistent love, stability, and attention that children especially those living with HIV, need to thrive. In practice, the majority of caregivers are grandparents; therefore, considering the information provided above, the experience of foster grandmothers underscores the critical need for comprehensive psychosocial support systems.

The research study highlights a notable gap in the literature concerning the experiences of foster parents caring for children with HIV, as most available information primarily focuses on the children themselves and is largely outdated. This scarcity of current data on foster parents' experiences underscores the need for further research in this area. The following studies are noted.

- Mphephu (2023:74) studies expressed hardship and stress in raising teenage foster children. Foster children would back chat, disrespect, demand foster care grant and coming home late at night. The study however does not include foster children living with HIV.

Carers of HIV positive children in South Africa experience numerous challenges in their efforts to provide care for their HIV positive foster children and as a result, have specific support needs. The stress linked to foster care is played out and experienced in the family in which the foster child is placed (Warwick & Langba, 2017:44).

The lack of literature that focus on foster parents caring for foster care children living with HIV, justify the need for this current study.

2.6 THE ROLE OF SOCIAL WORK IN THE PROVISION OF SERVICES AND SUPPORT

Social work is a practice-based occupation that upholds social evolution and development. It promotes the principles of social justice and human rights (International Federation of Social Workers, 2014:1). Ronald et al. (2013:8) add that social work aims to upgrade the living standards of individuals, groups and communities. Social workers who are employed in different health and welfare sectors have pledged to advocate for the constitutional rights of all individuals. Therefore, this puts them in a good position to contribute positively in the worldwide attempt to tackle the HIV and AIDS epidemic (International Federation of Social workers, 2012:1).

An individual living with or impacted by HIV and AIDS's experience is intensified by poverty, homelessness, addictions, unhygienic living conditions, trauma, discrimination and societal indifference (International Federation, 2012:1; Dejman, Ardakani, Malekafzali, Moradi, Gouya, Shushtari, Alinaghi, & Mohraz, 2015:1). The White Paper for Social Welfare (1997:62) indicates that the adversity of managing chronic illnesses can also lead to increased "economic and psychological strain for parents and children". Therefore, an interdisciplinary team of social workers, psychologist, doctors, and educators is directly positioned to provide psychosocial support.

2.6.1 Psychosocial support offered by social workers and other social and health care professionals

Chitiyo et al. (2016) report that there is a continued demand for psychosocial support services in Africa in response to the enormous number of children left orphaned as a result of the HIV/AIDS pandemic. Social workers and health care professionals visit the homes of children infected with HIV, they give food parcels, clothes and school materials to foster parents caring for children living with HIV/AIDS (Zibengwa & Bila, 2021). Health care professionals play a fundamental role in empowering caregivers and those infected with HIV with health information on the availability and administration of appropriate medicines and treatments.

It is imperative that those infected and affected by HIV, receives psychosocial support as it facilitates resilience within individuals and families. It promotes the restoration of positive mental, physical and social wellbeing (Kohrt & Song, 2018:354). Psychosocial support may comprise mental health counselling, education, spiritual and group support as well as many other services (Mhaka-Mutepe, Cumming & Mpofu, 2014:1023). These services are generally provided by social and health care professionals, such as psychologists, social workers, counsellors, specialised nurses, clergy, pastoral counsellors, and others. These experts might also use a referral system to link service users with available resources. A conceptual framework by the Department of Social Development (2011:11) describes the relevance and significance of psychosocial support. Grandparents of children living with HIV and AIDS require a range of care and support to safeguard their social, emotional and mental wellbeing. Psychosocial support tackles the constant psychological and social predicaments encountered by an HIV infected person, their companions, families and caregivers (WHO, 2020:1). Various studies (Masquillier et al 2016:2; Adejumo, et al 2015:9; Masquiler 2016:10) articulate that adequate focus must be afforded the psychosocial aspects of chronic ailments and caregiving in order to inform successful guidance and intervention of patients living with chronic illnesses. Adejumo, et al. (2015:9) and Masquiler (2016:10) indicate that social support is imperative to manage chronic illnesses and other related psychosocial challenges. Caregivers contribute positively by reminding individuals infected with HIV and AIDS to take their chronic medication regularly. This confirms that it is crucial to invest in empowering families, friends, and acquaintances of children living with HIV.

Kohrt and Song (2018:354) are of the view that psychosocial support have a crucial role in shielding the grandparents from the detrimental outcomes that may be brought by a foster caregiving role. It stimulates the wellbeing of a person. Psychosocial support will have an enormous impact on a foster parent's hope, social support and coping abilities. The majority of foster parents rely on the emotional and psychosocial support given by their respective designated social workers (Mhaka-Mutepfa, Cumming & Mpofu, 2014:1023). The Children's Act 38 of 2005, section 7 (c) emphasises that when looking at the best interests of a child, the capacity of the parent or any other caregiver to provide for the needs of the child, including emotional and intellectual needs, is of paramount importance. Therefore, taking into consideration the difficulties attached in to raising foster care children living with HIV, the capacity of foster parents must be fuelled by the provision of proficient psychosocial support services. Psychosocial support offered by social workers will equip foster parents with emotional stability, thus enabling them to cope with every challenge/situation. The psychosocial support is linked to various relevant services that can be provided to foster parents and children, which few are discussed below.

2.6.1.1 Mental health counselling

UNICEF (2018:4) indicates that good mental health is related to mental and psychosocial well-being. Mental health is our emotional, psychological, and social well-being. It involves how we think, feel, and behave in daily life. Mental health influences how we manage stress, interact with others, and make decisions. It plays a vital role throughout all stages of life—from childhood and teenage years to adulthood. The researcher is of the view that mental health counselling is a crucial element of psychosocial support for foster parents who are caring for foster children living with HIV. It enhances the resilience of foster parents as they are empowered to navigate challenges encountered in caring for children living with HIV. To effectively manage the challenges associated with HIV, it requires strong mental health and psychosocial well-being.

2.6.1.2 Health Education

Charles (2023:1) Health education is essential in enhancing the health and wellbeing of individuals, communities, and the broader society. It serves an imperative function in equipping individuals with the knowledge and skills required to make informed health related decisions and to adopt healthy behaviours that can prevent disease

and expand their overall quality of life. Furthermore, Charles (2023:1) elaborates that the fundamental components of health education is health literacy, which refers to an individual's capacity to find, comprehend, and apply health information in making informed decisions about their well-being

Pertaining to the research study, health education assist people in being capacitated with accurate Knowledge about anything related to HIV/AIDS. While dealing with a chronic illness like HIV/AIDS which is attached by misconception, stigma, and fear, it is imperative that those infected and affected be empowered with education. Health education could play a pivotal role in empowering foster parents with knowledge on how to cope with the emotional turmoil associated with caring for a child living with HIV. Additionally, being informed diminishes fear and misinformation, which are commonly the underlying root of stigma and discrimination. Being well informed will have a positive impact on the psychosocial well-being of foster parents.

2.6.1.3 Religion, Spiritual and group support

Knegtering, Bruggeman, and Spoelstra (2024:1) stipulate that there is an increasing emphasis on the significance of spirituality in mental health. Spirituality includes connecting to a more profound sense of purpose, finding meaning in life and transcendence. The National Alliance on Mental Illness (2016:1) states that religion is an organized, community-oriented system of beliefs, while spirituality is more personal and rooted in an individual's own sense of belief and meaning. Both can positively influence mental health, and, in some ways, they offer similar benefits such as enduring stress by fostering a sense of peace, purpose and forgiveness. Spirituality often includes practices that promote both mental and physical well-being, contributing positively to emotional health and psychological resilience.

Spirituality is also linked to group support as it encourages individuals to initiate social connections with other members and can create a sense of belonging to a group. (The National Alliance on mental illness, 2016:1). Since spirituality is linked to mental health, foster parents can utilize spiritual coping strategies to navigate adversity, it contributes positively in the ability of foster parents to cope and be resilient thus enhancing their psychosocial wellbeing. Religion is described as an organized

community-based system of belief, which implies that foster parents can seek psychosocial support from the community of their religion.

2.6.2 Community support for foster parents caring for children living with HIV

The importance of community support is elaborated in a study by Sitienei and Pillay (2019) where a community-based organisation in Kenya offered psychosocial support to orphans and vulnerable children. Community support for foster parents caring for children living with HIV was given through counselling and peer-group support (Sitienei & Pillay, 2019). The community can further support foster parents through community awareness campaigns as there is still a stigma and discrimination against persons affected and infected with HIV/AIDS. This fact is supported by findings from Zibengwa and Bila (2021), where the authors state that children living with HIV often experience stigma and isolation and are ostracised by community members. Churches established within our communities may offer a supportive environment where HIV/AIDS orphans and other vulnerable children can experience acceptance.

Looking at the challenges encountered by social workers, it is unquestionably that social workers may not be capable of providing for the needs of children in foster care. Social workers are overwhelmed with high caseloads and as an outcome they are not able to monitor children in foster care on a regular basis, such as ensuring that they adhere to treatment, receive correct homework support, and receive appropriate education about their illness (Frood & Purssell, 2020). However, community volunteers are offering services to children living with HIV in communities. Community care workers (CCWs) in rural South Africa provide medical, personal, household, educational and social care services to their clients (Moshabela, Sips & Barten, 2015:1). Families and communities are taking on more accountability for offering care as a result of the marked growth in the burden of illnesses in South Africa, which is placing a strain on the health system to meet the country's high demand. As a result, up to 90% of disease treatment may be provided at home, improving the ability to treat patients who are chronically ill (Moshabela, Sips & Barten, 2015:1). Community care professionals support families in providing care. CCWs are becoming more widely recognised as an essential component of the health care industry's human resource pool, especially in environments with limited resources (Moshabela, Sips & Barten, 2015:2).

2.7 CHALLENGES, DEMANDS, FEARS OF RAISING A FOSTER CHILD LIVING WITH HIV AND AIDS

With regard to HIV-positive children in South Africa who are no longer under their parents' care, foster care is now the primary type of care provided. Therefore, it is crucial to recognise the demands and difficulties faced by foster caregivers. Foster care presents a number of difficulties even if it seems like a promising way to care for children who are HIV-positive (Warwick & Langba, 2017:44). Despite the fact that they are often overworked and under-resourced, family caregivers for children living with HIV/AIDS are thought to be the main source of support for these children. Various obstacles that caregivers face impact their children's adherence to ART (Yiryuo, Kpekura, Osman, Kukeba, Mumuni, Mwinbam & Dery, 2024:1)

Although foster parents may encounter challenges, Gomo et al. (2017) argue that foster parents manage to adjust positively and are capable of offering genuine love and care to children who are living with HIV/AIDS. The authors further state that these foster parents can cope with children living with HIV/AIDS with the help of socio-cultural resources and the social support grant. In Zambia, it was found that 56% of orphans are most likely to be separated from their siblings. Northcut and Hailu (2016:25) state, "the psychosocial predicaments that vulnerable children encounter are even less recognised because children are less able to articulate their emotional and psychological difficulties and most adults are unexperienced, culturally or professionally, to detect and empathise with these difficulties". Therefore, the challenges, demands and fears of raising a foster child living with HIV and AIDS are much deeper than we can realise.

2.8 IMPLICATIONS REGARDING DISCLOSURE OF HIV POSITIVE CHILD

The researcher adopted Amankwah-Poku, Klutsey and Asante's (2021:1) definition of disclosure which they utilised for the purpose of their study, it states "Pediatric disclosure in this study signifies a child or an adolescent's knowledge or awareness of his/her HIV status". The World Health Organization endorses full disclosure to children by age 12 years (World Health Organization, 2011). According to the findings of the research study by Gomo et al. (2017), "All the participants in their study were of the opinion that disclosing the diagnosis of HIV to a child placed in foster care is a

controversial and emotionally charged matter”. Disclosure is identified in three main patterns, non-disclosure, partial-disclosure and full-disclosure. In full-disclosure, the primary caregiver has open communication with the child about their potentially life-threatening illness (Mavangira & Raniga, 2015). Partial disclosure entails withholding significant information about their illness for fear of distress to the child, whereas non-disclosure means HIV is not mentioned to the child in the early years. Disclosure of HIV-status to the child can have implications on their social life and wellbeing. Thus, foster parents employ non-disclosure until the child is old enough to understand the HIV diagnosis. Foster parents do this to protect the child as they fear the child would be traumatised by their HIV status (Gomo et al., 2017). Caregivers in Kampala, Uganda have stated that they fear that disclosing the HIV status to the children may damage the relationship they have with the children and that the disclosure may psychologically harm the child (Namukwaya et al., 2017:5). In support of Namukwaya et al. (2017;5) Amankwah-Poku et al. highlight that the some of the implications of disclosure are fear that the diagnosis might not be kept private, fear that the child might disclose their status, fear of being held responsible for the infection, stigma, and the claim that the child is not mature enough to comprehend what the illness means. Caregivers are, therefore challenged with the predicament of whether to disclose or not to disclose the status of their children to them.

Nonetheless, of the implications regarding the disclosure of HIV to an infected child, there are many advantages that outweigh the disadvantages, for example Amankwah-Poku et al. (2021:1-2) report that an increased adherence to ART, better access to support services, open conversations in the family, and enhanced psychological wellness have all been linked to disclosure. A child's status disclosure is essential for effective psychosocial support. It enhances the child's understanding of their health, promotes emotional stability, and facilitates access to supportive relationships and resources, such as counselling and programs that contribute to their psychological and social wellbeing.

2.8.1 Reactions after foster parents have learnt about the child's HIV status

Accepting the child's diagnosis and not knowing what caused the sickness is the first issue most foster parents face. The children's primary caretakers clarified that they

were unaware of the children's HIV-status. In a study conducted by Bejane, Havenga and Aswegen (2013:73) participants indicated that they were at their wits' end with the children's recurrent illnesses and inability to respond to the treatment. Some grandparents experienced the HIV-positive test diagnosis as a shock, not only for their grandchildren, but also because they grasped for the first time that their adult children had died from AIDS (Bejane, Havenga & Aswegen, 2013:73). With HIV being a stigmatised illness, it does not come as a surprise that foster parents are shocked, experience loneliness, anxiety, sadness, anger and pain (Maseko & Madiba, 2020; Moshoeshe & Madiba, 2021) when realising the HIV-status of their children. The shock comes with the reality of the responsibility that lies ahead after the diagnosis.

2.9 CONCLUSION

In this literature review, the impact of HIV and AIDS on vulnerable children was discussed. The findings showed that the diagnosis poses significant risks for grandparents, including increased anxiety, sadness and anger. Studies consistently show that although foster parents encounter challenges, their resilience to manage caring for children who are living with HIV/AIDS is applauded. Chapter 3 discusses the application of the research methodology.

CHAPTER THREE

APPLICATION OF THE RESEARCH METHODOLOGY

3.1 INTRODUCTION

The focus of Chapter three is to present the methodological aspects that were utilised in the study. The chapter's focal point is on the research methodology used in conducting the study as well as the empirical findings collected during the interviews with foster parents raising foster care children living with HIV and AIDS. The chapter outlines the components of the research methodology. The research methodology that was utilised in the research study will be presented comprehensively in this chapter.

3.2 RESEARCH METHODOLOGY

According to Sileyew (2019:1) research methodology can be regarded as a route which the researcher must adhere to in order to accomplish the goals of his/her research study. It indicates the way researchers convey their problem, objectives and disclose their end results acquired during the study. From the definitions above, the researcher understood the concept "research methodology" as a map that introduces various methods to be followed in order to attain the goals and research objectives of the research study. It basically gives a picture of the start and end result of the research and how the research study will unfold.

3.3 RESEARCH PARADIGM

A paradigm is a definition of a researcher's philosophical orientation, perspective, way of thinking, school of thought, or set of shared views that guide the questions to be answered, the methods to be used, and the interpretation to be made of the study's findings (Okesina, 2020:58). Kivunja, and Kuyin (2017:27) further add that a paradigm is a set of theoretical ideas and principles that guide a researcher's perception, interpretation, and behaviour in the world. A paradigm basically serves as a model and guideline about which methodology to use in the research project.

The three pillars of a paradigm are discussed below:

- **Ontology**

Ontology is a philosophical perspective on the nature of reality, existence, and being, as well as the major classifications of entities and their relationships. It describes the researcher's fundamental worldview on the nature of existence and being (Khatri, 2020:1436, Kivunja & Kuyin, 2017:27). The ontology paradigm will be employed. HIV is a global reality. For the participants of this study, HIV was their reality as they had to raise children living with HIV. The researcher aimed to gain a glimpse of the world of foster parents raising foster children living with HIV. The ontology paradigm permits the researcher to consider how foster parents perceive their roles, challenges and the essence of their caregiving experience. As the goals of the study are to grasp the experience of psychosocial support received by foster parent, this paradigm have exposed how they are able to navigate the adversity. Acknowledging the personal narrative and how they see and interpret their reality could have a substantial impact on the psychosocial intervention that would be solely tailored to them.

- **Axiology**

Kivunja, and Kuyin (2017:28) indicate that the ethical concerns that should be taken into account while organising a study proposal are described as axiology. It comprises identifying, assessing, and comprehending concepts of appropriate and inappropriate behaviour with regard to the study. It takes into consideration the values placed on the numerous components of our study, the participants, the data, and the audience to whom we will present the findings. Axiology is another element of a research paradigm focusing on ethical matters that must be taken into consideration during research work (Khatri, 2020:1438). As the study is about getting a glimpse of the perspective of foster parents regarding psychosocial support services rendered to them, the axiology paradigm guides the researcher in grasping and acknowledging the caregiver's values, beliefs, and ethical consideration to ensure that the psychosocial support intervention is aligned with the foster parent's value system. For instance, foster parents may encounter difficulties about disclosure or treatment adherence of the child

due to their belief or cultural system however providing guidance that consider their value systems can assist in navigating these challenges.

- **Epistemology**

Kivunja and Kuyin (2017:27) mention that epistemology concentrates on the essentials of knowledge, including its nature, forms, acquisition, and transferability to other human beings. It centres on the variety of human knowledge and comprehension that the researcher might be able to gain, so as to deepen, expand, and spread understanding within an area of study. As a social worker/researcher whose line of work entails tackling social issues, HIV being one of the biggest predicaments we are faced with. Foster care is one of the imperative alternative forms of care within Social Development. Some of the foster care cases consist of foster parents who are raising children living with HIV. Pertaining to the study, the epistemology paradigm gives the opportunity to investigate the knowledge base of the foster parents and how they interpret and apply it. Comprehension about HIV, psychosocial support, and disclosure are imperative to discern the caregiving role. The epistemology gave permit to the empowerment of foster parents with credible information, thus resulting in achieving support strategies that are effective.

The paradigms linked to qualitative methods are:

- **Constructivism**

Sharma and Bansal (2017:209) indicate that constructivism is essentially a hypothesis about how people learn, established on scientific research and observation. Pooman (2017:183) further elaborates that constructivism is a psychology learning theory that describes how individuals learn and gain knowledge, as such, it directly relates to education. According to the theory, people use their experiences to create meaning and knowledge. This paradigm is embedded in the learning theory that people gain information that influences their experience. Looking at the research study, foster parents are gaining knowledge about HIV through the experience of raising children living with HIV, their learning experience advances their knowledge. Since core

elements of constructivism are knowledge, learning and experience, incorporating these elements concept into psychosocial support can yield effective outcomes.

- **Positivism**

Turin, Raihan and Chowdhury (2024:1) highlight that the paradigm of positivism holds that there is only one objective reality that can be scientifically measured and witnessed. The positivist paradigm believes that reality exists independently of human experience. It is also assumed that knowledge comes from first-hand experiences and observations, which may be accomplished through quantitative methods like hypothesis testing and determining dose-response or cause-and-effect linkages.

Rehman and Alharthi (2016:53) confirm that positivism believes that reality exists apart from people. It is regulated by unchangeable rules and is not mediated by our senses. Unlike interpretivism and constructivism, positivism is more focused on the scientific part that can be utilised to measure the reality of the individual. The positivism paradigm is quantitative in nature, which is less focused on the feelings of an individual. This paradigm is appropriate, taking into consideration that it will highlight the knowledge that foster parents might have regarding HIV, adherence, and the importance of psychosocial support which can have a considerable impact on the health outcome of their foster child and themselves. Furthermore, it will enhance support strategies applicable and assessment of the effectiveness of psychosocial support intervention, if it meets the actual needs of foster parents caring for children living with HIV.

- **Interpretivism**

Pulla and Carter (2018:09) state that interpretivism is a research paradigm that is linked to qualitative research. A social work researcher who adopts an interpretivist perspective is curious about the significance people attach to comprehending other humans and their culture (Pulla & Carter, 2018:10). Developing generalisations or separating and measuring variables objectively are not the main goals of interpretative research. In order to better grasp a person's behaviour, it instead concentrates on developing an empathetic knowledge of their views and the significance they attribute

to daily life (Pulla & Carter, 2018:11). Furthermore, Thanh and Thành (2015:24) assert that by using an interpretative paradigm, researchers can see the world from the participants' perspective and experiences. Using such experiences, the interpretative paradigm researcher builds and interprets their knowledge from the collected data in order to find the answers for their research questions.

Interpretivism acknowledges that each foster parent's journey is unique and shaped by personal, cultural, and social factors therefore a uniform approach or intervention may not be universally applicable therefore interventions must be grounded in the realities of the foster parents. As a researcher in a social work field, working with foster parents raising children living with HIV, perpetuates interest in how the foster parents cope and manoeuvre in their world taking on the enormous responsibility of caring for children living with HIV. One of the qualities of a social worker is being empathetic, therefore it is applicable to attempt to understand the world of the foster parents. Taking into consideration the features of interpretivism, it is appropriate to employ the theory in this study, which will assist in attaining the goals and objectives of the study.

3.4 RESEARCH APPROACH

The research approach is a plan that outlines the research steps to implement methods of data collection, analysis and interpretation (Creswell & Poth, 2023). Three approaches in social research are outlined as quantitative, qualitative and mixed methods approaches. The quantitative approach is the method of employing numerical values derived from observations to explain and describe the phenomena that the observations can reflect on them furthermore numerical data is analyzed using mathematical methods (Taherdoost, 2025:54)

Mixed method approach involves collecting, analyzing and in some way integrating both quantitative and qualitative data in a single project (Leavy 2023:9)

Out of these 3 approaches, a qualitative research approach was employed for the purpose of this study. Qualitative research is a methodology that permits a researcher to analyse people's experiences in detail (Hennink, Hutter & Bailey, 2011:9; Johnson & Christensen, 2014:82). This is possible by using a specific set of research methods such as "in-depth interviews, focus group discussion, observation, content analysis,

visual methods, and life histories or biographies” (Hennink, Hutter & Bailey, 2011:9). This type of approach is utilised when there is no in-depth information on a specific issue or problem and when the researcher wants to gain extensive knowledge regarding the issue (Faulkner & Faulkner, 2019:28; Johnson & Christensen, 2014:82). Creswell (2014:33) further elaborates that a qualitative approach is a method aimed at scrutinising and grasping the level of importance people attach to social or individual issues.

This method assisted the researcher to acquire a broader insight into the psychosocial support available for foster parents caring for children living with HIV. Furthermore, this approach permitted the researcher to become submerged in the world of the participants to gain a glimpse of their thoughts and the meaning attached to the phenomenon. A qualitative approach afforded the researcher the opportunity to gather rich data that explored the overall world of participants. Qualitative data provided the researcher with comprehensive information pertaining to a problem that was being investigated. The approach is versatile as it permits participants to express aspects that the researcher has not thought of, thus creating an opportunity to correct the lack of research findings and add to the knowledge, thereby contributing to the closing of the gaps in research studies. Taking into consideration the above qualitative research explanation, it became evident that qualitative research was of value to the study because it was more focused on the problems encountered worldwide or in practice.

Creswell and Poth (2018:43) indicate that there are several characteristics of a qualitative approach. The features of a qualitative approach are as follows according to Creswell and Poth (2018).

- Qualitative approach is done in a natural setting - researchers using this approach gather data at the grassroots level where participants encounter the issue or problem under investigation. Face-to-face contact is implemented instead of bringing partakers to a lab or posting instruments to participants for completion. The researcher reached out to participants by conducting the research in their natural setting, which was in the comfort of their own homes where they experience the problem or issue under study. Face-to-face interviews were conducted with the participants.
- Researchers are regarded as key instruments in qualitative research - researchers are the ones who gather their data by means of probing documents, observing

behaviour and interviewing participants. The instrument that they utilise is constructed by the researcher using open ended questions. Interaction by means of semi-structured interviews was applied in the study. The researcher had planned to utilise telephonic interviews as another method of collecting data, however only face-to-face interviews were implemented whilst taking precautions in line with Covid 19 regulations. Semi-structured interviews were implemented using open-ended questions to yield the views of foster parents raising foster children living with HIV/AIDS.

- They can implement multiple methods - researchers can collect data from numerous sources such as interviews, observations and documents instead of relying on a single data source. For this research, the researcher made use of interviews and observations to gather data.
- A qualitative approach values participants' multiple perspectives and meanings - with regard to the overall qualitative research procedure, a qualitative researcher's main focus is comprehending the experience of the participants regarding the issue or problem under study rather than the assumptions that the investigator brings to the research study. The researcher was intrigued by the experience of foster parents caring for foster care children living with HIV. Their views mattered and were crucial in assisting with the suggestions or recommendations for improving psychosocial support services implemented by social workers and/ or other social/health professionals.

Although the qualitative approach was best suited for the study, it has its own weaknesses as, according to Mwita (2022:622), in qualitative research, themes are often drawn from the researcher's interpretation of the data. However, this interpretation can differ depending on factors such as an individual's emotional state, cultural background or social context. Because of this, qualitative research is inherently interpretive and subjective. Researchers must make sense of what they see, hear, or experience, but the way one person understands something might differ from how someone else sees it. What one person views as positive, another might see differently. This variation highlights one of the key criticisms of qualitative research, its subjectivity and the challenge of achieving consistent interpretations (Mwita 2022:622). The researcher comprehends that surpassing subjectivity in

qualitative study is imperative in achieving credibility. While empathy is a fundamental skill in social work, the researcher ensured to be self-aware and consciously adopted the role of a researcher rather than that of a social worker. This approach assisted the researcher to refrain from sympathy, bias and preconceived information about the challenges encountered by foster parents in practice. To further minimize subjectivity, an independent coder was engaged to analyze the transcripts, and results were compared to ensure consistency.

Furthermore, another weakness of qualitative study is generalizability, qualitative studies tend to use small sample. The debate on whether the findings of qualitative studies are appropriate for making generalisations has existed for decades. The issue of small sample sizes used in qualitative research has raised some doubts (Mwita 2022:622). One of the reasons for the researcher to employ qualitative research was to grasp experience of foster parents, engage on the emotions and psychological dimension, in order to achieve this the sample was minimized to 16 participants. The researcher also indicated that one of the limitations of the study was that it included 16 participants from the Tshwane region, thus implying that the findings cannot be generalized to all the foster parents raising foster children living with HIV.

HIV and AIDS, as a worldwide social problem, affects everyone, therefore for the purpose of this study, the researcher explored the psychosocial support offered by social workers to foster parents taking care of children living with HIV and AIDS.

HIV and AIDS is a sensitive issue that needs to be grasped by means of observing emotions, non-verbal cues and probing the perspectives of the participants. The application of a qualitative approach had a profound outcome with regard to this research as it produced an extensive understanding of the views of the foster parents regarding the psychosocial service rendered to them.

3.5 RESEARCH DESIGN

Research designs are forms of inquiry in qualitative, quantitative and mixed method approaches (Creswell, 2014:294). Research designs give precise direction for the research process. Saunders, Lewis and Thornhill (2016:163-164) indicate that a

research design is the overall proposal of how the researcher plans to answer the research question. It entails clear objectives resulting from the research question and stipulates the sources from which the researcher anticipates gathering the data. Engwa (2015:48) also indicates that a research design can best be understood as a theoretical structure that originates from the research question. The research design outlines how the investigation will be performed. Based on the above descriptions, the research design served as a map that provides a direction for how the research is going to be conducted and implemented to answer the research question. Research designs that were implemented for the purpose of this study were phenomenology, exploratory, descriptive and contextual.

3.5.1 Phenomenological research inquiry

Rubin and Babbie (2016:304) indicate that qualitative research is linked to the term “phenomenology”. The aim of phenomenological research is to gain insight into the research participants' personal worlds, the meaning of their everyday experience and to comprehend their individualised meanings (Johnson & Christensen, 2014:592, Fain, 2017:193). Johnson and Christensen (2014:592) indicate that the term phenomenology defines how one or more people observe and experience a phenomenon, for instance losing a loved one, seeing oneself as a teacher, really teaching, experiencing being a member of a minority group, or experiencing victory in a soccer match. The researcher understood that phenomenology entails understanding the world of the participant in how they perceive or experience it. This design has empowered the researcher to walk in the shoes of the participants by being empathetic.

Annisa (2024:238) indicate that phenomenology is often criticized for its limitation in generalizing findings because its focus on unique individual experience tends to ignore the social, cultural and historical context that may influence those experience which makes it difficult to generalize phenomenology findings to broader population and limits its relevance in more general theory development.

Biases caused by researchers can influence research, because they are influenced by feelings of empathy so that they become less objective or experience misunderstandings in capturing the meaning conveyed so that in the end they can be trapped in the researcher's own imagination and meaning (Annissa, 2024:241). Given

the participant's experiences, the researcher was occasionally emotional; nevertheless, because she was wearing the hat of a researcher, she refrained from letting her feelings affect her capacity as the researcher.

3.5.2 Exploratory research design

An exploratory research design is relevant whilst the researcher is investigating a unique phenomenon or wants to improve the approaches utilised in a scientific research study (Rubin & Babbie, 2016:60). This design assists researchers to examine a topic that is fairly new or lacks sufficient research. Researchers use exploratory research when the topic is new, and little to nothing is known about it (Kumar, 2011:31; Neuman, 2014:38). Exploratory research yields decisive answers; and addresses the “what” question (Neuman, 2014:38). It also provides an important means to probe open-ended questions and to acquire understanding about the concerned topic (Saunders et al., 2016:174). An exploratory research design is the kind of design which permits the researcher to acquire considerable insight into a phenomenon. In this current study, the researcher employed an exploratory research design since little was known about the psychosocial support offered to foster parents caring for foster care children living with HIV.

Even though exploratory research can lead researchers in right direction, the answer provided by it is usually inconclusive (Swaraj, 2019:669). Many of the times, exploratory research involves a smaller sample size, therefore, the results cannot be accurately interpreted for a generalized population (Swaraj, 2019:669). The data saturation principle served as the researcher's guide for determining the sample size.

3.5.3 Descriptive research design

A descriptive research design refers to a thorough inspection of phenomena and their deeper meanings (Rubin & Babbie, 2016: 61). Kumar (2011:30) confirms that descriptive research aims to systematically describe a situation, problem or phenomenon. The main purpose of descriptive research design is to define what is prevalent with respect to the issue or problem under study. According to Neuman (2014:38), the primary purpose of a descriptive research design is to “paint a picture” using words or numbers and to present a profile or a classification of types, and it

includes answering questions such as “who, when, where, and how” (Neuman, 2014:38; Saunders et al., 2016:175). The researcher’s comprehension of this design is that it tends to be more focused on conveying a sense of what it is like to walk in the shoes of the people being studied, affording rich details about their environments, interactions, meanings and everyday lives. This research design entails conducting an in-depth investigation into the issue being studied. In a descriptive research design, the researcher focuses on getting a better understanding of the perspectives of participants about the phenomenon. Psychosocial support is one of the core functions of social work services, the research study afforded the researcher with the opportunity to gather perspectives of foster parents with regard to psychosocial support services offered to them to manage their caregiving role and responsibilities.

Neuman (2014:38) and Saunders et al (2016:175) indicate that a descriptive research design includes answering questions such as “who, when, where, and how”. The researcher can confirm that indeed these were the type of ‘question words’ that were used to formulate research questions to probe for more information from participants.

Although descriptive design has so many strengths, Manjunatha (2019:866) highlights certain limitations that warrant consideration, one of such limitation is the potential for the “Halo effect”: If the research observer has a potential bias towards the research topic or some respondents in the research, may inadvertently influence observations, thereby compromising the authenticity of the data. Furthermore, elements of confidentiality are a concern as participants aren’t always truthful if questions are too personal or they feel they are being “watched.” Such dynamics can ultimately undermine the validity and reliability of the findings. The researcher ensured that her professional background did not interfere with the integrity or credibility of the interview process and data collection. Moreover, the establishment of a strong rapport with participants, facilitated in part by the empathetic and person-centered nature of the social work profession, created a safe and supportive environment. This, in turn, enabled participants to openly share their experiences on deeply personal and sensitive issues, such as caring for a child living with HIV/AIDS.

3.5.4 Contextual research design

A contextual research design was also employed in this study. Ormston and Ritchie (2014:31) specify that a contextual research design “is concerned with identifying what

exists in the social world and the way it manifests itself". In support of Ormston and Ritchie (2014), Korsjens and Moser (2017:275) explain that contextual research design considers the natural context by which a person or group functions. One of the goals of this design is to deliver detailed knowledge of the actual real-life difficulties of participants. This enables the researcher to discover how the problems are perceived by the people in contact with them (Ormston & Ritchie, 2014:31). The crucial purpose is to probe and accurately record the version of social phenomena as lived and comprehended by the participants (Ormston & Ritchie, 2014:32). With regard to the natural setting emphasised in a contextual design, Creswell and Poth (2018:43) mention that qualitative researchers often gather data in the field at the site where participants experience the issue or problem under study. Thus, the research is done in a natural setting for participants to gather rich and detailed data.

Researchers collect up-close information by directly communicating with participants and observing them behave within their circumstance. A contextual design allows the researcher to gain an understanding of the perspectives of the participants and how they view or experience their world. Thus, the researcher employed the necessary communication skills such as listening, paraphrasing and probing, when interacting with the participants. This allowed the grandparents to express themselves fully and they were comfortable enough to articulate their views. They were in the comfort of their own home, where they encounter their difficulties/challenges or experience the phenomena under study.

Just like any other design, contextual design has its limitations. Duda, Warburton and Black (2020:6) indicate that one of the key challenges lies in the intensive effort required to recruit participants, often necessitating greater incentives to encourage individuals to allow researchers to observe their everyday activities. Additionally, legal and ethical considerations that need to be adhered to may arise. Davis and Beidas (2021:1) further add that conducting contextual research requires significant time and financial investment to carry out effectively. The researcher acknowledges that one of the challenges experienced with this design was its time-consuming nature. Due to constraints during regular working hours, the researcher had to utilize personal vacation leave to conduct interviews. Additionally, financial implications were also encountered, as the researcher needed to travel to various locations to meet participants, which required covering transportation costs out-of-pocket.

The above four research designs aided the researcher in exploring the magnitude of the research problem being studied. These designs allowed the researcher to explore and describe the perspective of foster parents regarding the psychosocial support rendered to them in their context. The research designs that were utilised enabled the researcher to handle the enormous amount of data, and to probe the problems that lacked sufficient research. In this case little was known about the psychosocial support for foster parents caring for foster care children living with HIV and AIDS. An exploratory research design permitted the researcher to elicit more knowledge about the phenomenon under study. Since the researcher sought to gain an in-depth understanding, this was achieved by utilising a contextual design that promoted the natural setting of the participants.

3.6 RESEARCH METHODS

Research methods is a comprehensive term that incorporates diverse methods used in qualitative research. Research methods comprise “the procedures and activities for selecting, collecting, organising and analysing data” (Blaikie, 2010:8). This section presents the research methods that were applied namely, population of the study, sampling and sampling methods, preparation of data collection and methods of data collection, and data analysis and data verification, which involves data processing, data management and quality control.

3.6.1 Population, sampling and sampling techniques

The following are the research techniques employed in this current study. The population of the study, sampling and sampling techniques are explained in detail.

3.6.1.1 Population

A population is a segment or component from which the researcher wants to extract their sample (Babbie, 2014:119; Leavy, 2017:76; Neuman, 2014:247). Babbie (2014:119) elaborates that a population usually refers to participants who will be recruited to partake in the study. In addition, Fain (2017:134) indicates that a population is a detailed group which consists of participants that hold certain

characteristics. A population can be regarded as people the researcher wants to involve in the research study. In the context of this study, the population consisted of foster parents who are caring for children living with HIV and AIDS, serviced by social workers from the Social Welfare Government Department in Gauteng province, Tshwane region. For this study, participants were purposively recruited from a subset of these service points, while others were not included due to non-participation. This approach ensured that recruitment was conducted through established social service structures, while maintaining confidentiality and respecting the privacy of foster families affected by HIV/AIDS.

3.6.1.2 Sampling

A sample is described as the overall number of different cases that the researcher in due course draws and from which information is catalysed (Leavy, 2017:76). Neuman (2014:246) defines a sample as a minor collection of cases a researcher chooses from a bigger group and unifies the population. Johnson and Christensen (2014:345) further elaborate that a sample is a set of components that is extracted from a bigger population in respect of specific guidelines. A sample is understood as taking out a few individuals from a group or population and utilising those individuals for a research study. The study sample comprised 16 foster parents who met the inclusion criteria for the study. Access to potential participants was facilitated through the appropriate structures within the Gauteng Department of Social Development after the necessary permissions had been obtained (Addendum C). Recruitment and participation were guided by approved ethical protocols, including the protection of confidentiality and voluntary participation. Given the sensitive nature of the study topic and the need to protect confidentiality, access to potential participants was facilitated through the appropriate departmental structures. Potential participants were informed about the study and given the opportunity to decide whether they wished to be contacted by the researcher. Participation was entirely voluntary, and some individuals chose not to participate. These decisions were respected, and confidentiality was maintained throughout the recruitment and data collection processes. In total, 18 participants were involved in the study, including those who participated in the pilot phase.

3.6.1.3 Sampling techniques

A qualitative sampling method uses the principle of data saturation to determine how many observations, discussions, focus groups or cases are required to guarantee that the outcome will yield rich information (Korsjens & Moser, 2018:10). Korsjens and Moser (2018:10) explain that a sampling plan outlines a sampling method, size and the process that will be taken to enlist people who will take part in the research. Engwa (2015:63) further explains that “sampling is the procedure of choosing participants for a study from a population in correspondence to its parameters utilising a sample design”. It is the method by which the researcher reduces the total research population for a research study to a restricted sum which is reasonably feasible and theoretically acceptable (Engwa, 2015:63). Similarly, Kumar (2011:177) states that sampling includes the approach of selecting a limited sample from a larger group, referred to as sampling a population.

The type of sampling that was employed for this study was non-probability sampling. The purpose for electing this sampling method was due to the fact that not all foster parents were going to form part of the study, only specific foster parents who had similar characteristics and were voluntarily willing to participate in this study were included. The type of non-probability sampling that was applicable is purposive sampling. According to Babbie (2014:200) purposive sampling is a kind of non-probability sampling where participants are chosen based on the discretion of the researcher. Johnson and Christensen (2014:364) concur with Babbie (2014:200) that when it comes to purposive sampling the researcher stipulates the traits of the people in focus and thereafter traces those people who have those specific features. Neuman (2014:273) further mentions that purposive sampling is when the researcher utilises a comprehensive collection of approaches to trace potential cases of a specific and limited accessible population. It is understood that purposive sampling is a kind of sampling where the researcher identifies prospective participants who have specific similarities and who also contribute significantly to the intended study due to specific traits they possess. Potential participants who met the inclusion criteria of the study were identified through approved departmental processes. Prior to participant recruitment, permission to conduct the study was obtained from the Gauteng Department of Social Development, Tshwane Region, through the relevant research and policy coordination structures. A research proposal was submitted and approved

by the Department. All recruitment procedures complied with approved ethical requirements and safeguarded participant confidentiality. To recruit participants, the following inclusion criteria were applied to identify and select participants that were suitable to participate in the study:

Inclusion criteria

- Foster parents who had at least three years' experience caring for a child/children living with HIV and AIDS. In that three years the foster child would have adapted to the foster care placement and the foster parent would have experienced milestones associated with caring for a foster child living with HIV. Therefore, they can provide the researcher with a vast amount of information during the interview process.
- Grandparents who were officially appointed as foster caregivers, 40 years and above, who provided care to children living with HIV. Grandparents who are 40+ years old are at the peak of their lives and have mastered life's difficulties, as a result they possess adequate experience and wisdom that was of value to the proposed study.
- Foster parents were female participants. The women had different perspectives and experiences, thus resulting in the researcher gathering rich data.
- Participants were clients who are serviced by the Department of Social Development. It was advantageous and convenient for the researcher to access prospective participants from the database of respective service points, as the working relationship already exists between the researcher and social workers from different service points.
- Participants were permanent residents of Tshwane. This was to obtain valid information from representatives of Tshwane region participants. Areas or provinces differ in terms of the quality of services, life conditions and resources, therefore employing those who were permanent residents of Tshwane yielded accurate information.

Exclusion criteria

- Foster parents raising foster children who are not living with HIV.
- Foster parents who are not permanent residents of Tshwane area.
- Foster parents who have less than 3 years of experience caring for children living with HIV.

3.7 PREPARATION FOR DATA COLLECTION

Creswell (2014:132) states that before the researcher conducts the research study they must examine their professional standards. They must also gain informed consent from participants.

The researcher prepared the participants before the process of data collection. The case managers were the ones who introduced the researcher before the implementation of the interviews, this was to ease the participants to know the person who is going to interview them in order to properly welcome the researcher in their respective homes during scheduled individual interview appointment, thus creating a working relationship that was characterised by trust. During the interview the researcher created an atmosphere where participants felt comfortable to convey their viewpoints. The researcher further prepared herself with the continuous reading of literature so that she was well equipped with information on about qualitative scientific research. Participants were given an invitation letter beforehand, which specified the purpose and procedures of the study as well as how their contribution would be significant to the study.

After permission and approval to conduct the study was granted by the University College Research Ethics Committee (CREC) and the Gauteng Department of Social Development, (refer to Addendum A, B and C) access to potential participants was facilitated through the appropriate departmental structures within the study area. Individuals who met the inclusion criteria were approached in accordance with approved recruitment procedures. All recruitment activities were conducted in a manner that protected participants' confidentiality, privacy, and voluntary participation.

The researcher contacted foster parents and explained how their contact details were obtained, however their respective social workers had already informed them and acquired permission to give out their details. Gatekeepers (either occupy an official or unofficial role) are known as 'decision makers' 'who have the authority to grant access to the research site (Tracy, 2013:71, Neuman, 2014:441; King, Horrocks & Brooks, 2019:59). In this instance gatekeepers were social workers of respective cases of foster parents who are raising foster children living HIV/AIDS. Information leaflets providing an overview and rationale of the study were distributed to the participants.

The Protection of Personal Information Act 4 of 2013 (POPIA) was officially published in the South African Government Gazette and signed into law by the President in November 2013. The Act acknowledges that every individual has a constitutional right to privacy, as outlined in Section 14 of the Constitution of the Republic of South Africa (1996). In alignment with international standards, POPIA aims to ensure that personal information shared with public and private institutions is handled with care, respect, and accountability (De Waal, 2022:232).

Recruiting participants who are infected and/or affected by HIV must be handled with delicacy considering the ethical and legal aspect attached to HIV. In adherence to the POPIA ACT- the respective social workers had a prior session with clients (prospective participants) regarding the study of the researcher. At the end of the interviews, the researcher found that the participants had benefited from the process because the majority of them reported that the interview had been therapeutic in some way, giving them a forum to share their experiences. As a result, none of the participants wanted to be debriefed. The respective social workers, before giving out the names of the participants, acquired permission first from their clients. They explained to them how their information will be used with assurance that their anonymity would be respected throughout the research process. By allowing social workers to introduce the research study to their clients, an additional foundation of ethical protection and enhanced trust among the researcher and the participants.

South African Council for Social Service Professions (2012:11) stipulate that researchers and evaluators are obligated to protect the privacy, anonymity, and confidentiality of participants and the data collected from them. Participants must be

informed of any limitations to confidentiality, the strategies in place to safeguard their information, and the timeline for the elimination of records containing research data. The council further emphasizes that social workers have a responsibility to safeguard the privacy of those who participate in their research. This includes leaving out any personal details that could reveal a participant's identity unless the individual has clearly agreed to share that information. This was achieved by applying pseudonym throughout the research study. As indicated, the respective social workers affirmed confidentiality to their clients whilst obtaining their consent to take part in the research study, participants were further reassured by the fact that the researcher is a qualified social worker, bound by professional ethical standards, including confidentiality and non-judgmental practice.

3.7.1 Data collection methods and procedure

Data collection comprises collecting pertinent and sufficient data that will offer answers to the research question(s). Data collection methods comprise the way in which the researcher prepares the qualitative research process in terms of collecting, analysing, interpreting and reporting data (Sutton & Austin, 2015:229). Data collection in this study is defined in terms of the organisation of data collection, the selected methods of data collection, interview guide, as well as pilot testing.

3.7.2 Method/s of data collection

Data collection seeks to address the research question and is significantly important for the success of the study (Breckenridge et al., 2018:133). Maree (2016:133) further explains that data gathering defines the route which the researcher uses to answer the research question. Data collection entails methods of attaining data from participants that will be utilised in the research (Faulkner & Faulkner, 2019:59; Johnson & Christensen, 2013:313). The researcher utilised an interview method to collect data. Johnson and Christensen (2013:317) indicate that an interview is a data collection method in which an interviewer asks interviewee open-ended questions. The type of interview that was implemented was a semi-structured interview.

Saunders et al. (2016:391) indicate that a semi-structured interview is when the researcher includes a number of crucial questions in the interview guide. However, the use of those questions may differ from one interview to another. This implies that an interviewer could overlook certain questions in specific interviews taking into consideration the circumstances they face pertaining to the research topic. The directions of questions that will be asked might be diverse as per the sequence of the discussion. Patten and Newhart (2018:161) mention that a semi-structured interview is the most well-known type of interview utilised in qualitative research. When it comes to a semi-structured method an interview guide is prepared in advance, however, the interview may be in accordance with the direction of the discussion per participants' interview. The researcher does not necessarily have to follow the interview guide word for word (Patten & Newhart, 2018:161). With regard to the use of the interview guide, Roller and Lavrakas (2015:53) share the same explanation as Patten and Newhart (2018:161), in that the semi-structured interview is predominantly informal in appeal. During interviews with the participants, the researcher referred to her list of questions in order to ensure that crucial issues were addressed whilst adapting the questions per interview based on the response and circumstance of the participants that were interviewed.

The researcher is of the view that, a semi-structured interview is the kind of interview which allows the researcher the opportunity to probe or go deeper with information provided by participants. This type of interview requires a researcher who is creative, probing, attentive and able to paraphrase during the data collection. The researcher is also of the view that a semi-structured interview has substantial value because it permits the researcher to gather extensive data. The flexibility of this method enabled the researcher to gain in-depth information regarding the psychosocial support services offered to foster parents caring for children living with HIV and AIDS. Taking into consideration that people are unique and express different opinions and feelings, utilising semi-structured interviews provided the opportunity to grasp aspects or themes that the researcher had not thought of.

On 23 March 2020 the president of South Africa announced that the whole country would be on lockdown from 27 March 2020 due to the outbreak of the Covid-19 pandemic. The lockdown was a measure to decrease the spread of the virus. Covid-19 had a negative impact on field research due to the fact that it limited human

interaction. The researcher conducted all 16 interviews in the midst of level 4 and 5 lockdown. Initially, the researcher intended to make use of three different techniques to collect data which were face-to-face interviews, emails and telephonic interviews, however only face-to-face interviews were used. The semi-structured interview was conducted whilst complying with the social distancing rule. The use of hand-sanitizer was employed and a screening form was completed by participants and the researcher. When using face-to-face interviews for data collection, recordings took place following the permission that was obtained from the participants. The following University of South Africa (UNISA) Covid-19 protocols relating to conducting fieldwork/research during the Covid-19 pandemic were adhered to.

Subsequent, precautionary methods were observed during the interviews:

- The table and chairs were disinfected with an alcohol-based sanitiser.
- Hand sanitiser was provided and utilised to decontaminate the participants and researcher's hands frequently throughout the data collection process.
- Face masks were provided and worn by both the participants and the researcher throughout the data collection process.
- Physical distancing of at least one meter was maintained during the process of data collection.
- Sterile wipes were used to sanitise the equipment, such as the digital recorder and pens.

The interview schedule included the following guiding questions to gather biographical information:

- How old are you?
- What is your marital status?
- How many grandchildren do you have? (Number: Girls (...) Boys (...))
- Who are you currently residing with besides your grandchildren?
- What is your highest education level?
- Are you employed? If yes, what kind of employment?
- What is your home language?

Based on the research topic, the following open-ended questions were asked to gather in-depth information:

- Please tell me, in detail, the events that led you to foster the child you are currently fostering (Who chose you to take the responsibility, was it the mother's wish that you care for the child or a family decision?)
- Please share with me your experiences of raising a foster child living with HIV and AIDS (Prompts: challenges, demands, fears).
- Please share with me who explained the health status of your foster child to you.
- What was your foster child's reaction when they learnt about their HIV status? (Prompts: participant's and other family member's reaction)
- Who else in the family was told about the child's status and what was their reaction? (Prompt: Was permission granted by the foster child to disclose their status to family members, social workers and significant others).
- Have you or the child experienced any discrimination regarding the child's status from the community or other family members?
- What support and training have you received to raise a foster child living with HIV?
- What kind of psychosocial support did you receive from social workers? (Prompts: other social and health care professionals)
- What kind of support would you recommend/suggest that you should receive from social workers?
- What type of support exists in your community for foster parents caring for grandchildren living with HIV?
- What other support systems do you have?

3.7.3 Pilot testing

A pilot study is a relatively small version of the proposed study where the researcher utilises a small number of participants who have the same characteristics as the participants (Doody & Doody, 2015:1074; Lancaster, 2015:2). Pilot testing is done in order to give the researcher an opportunity to rehearse and evaluate how efficient their overall proposed research method and questions are (Doody & Doody, 2015:1074). Leavy (2017:116) indicates that a pilot test is a "complete run through of the

researcher's study". In this study, the researcher interviewed two foster parents who met the inclusion criteria of the study. The researcher requested permission to record the pilot-test interview(s) using a digital recorder. The two participants were asked to provide trustworthy feedback pertaining to the interview guide. The researcher informed the participants that the researcher was pre-testing the research questions and that the information provided would not be used in the main study. The researcher tested her interviewing skills and whether the questions in the interview guide were sufficient to yield rich data. The pilot testing was of value because the researcher was able to add two questions on the interview guide, which she had initially not thought of but was prompted to do so from the pilot testing.

3.8 DATA ANALYSIS METHOD

Data analysis extracts the connotations behind the data collected. Babbie (2014:403) states that "qualitative analysis is the non-numerical examination and interpretation of observation for the purpose of discovering underlying meanings and patterns of relationship". According to Creswell and Poth (2018:183) "data analysis in qualitative research comprises of preparing and organising the data for analysis, then lowering the data into themes through a process of coding and condensing the codes. Lastly it, demonstrates the data in figures, tables or discussion". For the purpose of this study, data analysis was conducted using five phases as outlined by Yin (2016:186):

- **Compiling**

The first stage of data analysis is to properly organise the notes gathered from the field. Creswell (2014:247) shares the same view as Yin (2016:186) in that the first stage of data analysis includes the organisation and preparation of data. At this stage, the researcher must write down their field notes of what transpired during the interviews with individual participants in their different settings. Thereafter, the data must be sifted, sorted and arranged into different themes and categories. Other researchers prefer to audiotape their interviews, then write down information gathered from the audiotapes (Faulkner & Faulkner, 2019:43). This first step allowed the researcher to become absorbed in the data obtained from the interviews. The researcher requested participants' consent to use a tape recorder. She then

transcribed the information gathered from the interview word-word. The researcher experienced transcribing as a tiresome and time-consuming process; however it assisted in determining the themes.

- **Disassembling**

Disassembling is the second stage, which entails classifying information that has been amassed according to smaller segments. This phase includes utilising applicable themes that emanate from the compiled information. Thereafter, data is rearranged into various groupings and orders which is found in the initial notes (Yin, 2016:186). Creswell (2014:247) explains that this phase entails using the coding procedure to create a picture of the environment or individuals. It also includes groupings or themes for analysis. Having achieved the coding and memoing, the researcher can start pursuing patterns in their data (Rubin & Babbie, 2016:366). The researcher utilised coding to generate themes or categories for the study.

- **Reassembling**

This stage entails illustrating information gathered in a graphical manner. The researcher can also arrange data in a list or even cylindrical shape. It should be noted that in this phase there could be a repetition of reassembling and disassembling data in a sporadic method (Yin, 2016:187). Creswell (2014:248) reports that themes and sub-themes based on various views of participants will be outlined. During this stage the researcher will also display commonalities of themes and may utilise visuals, figures and tables to illustrate the data. In this current study, the researcher utilised tables to depict information such as the biographical information of participants. Storylines were applied to support the themes and sub-themes that emerged.

- **Interpreting**

This phase includes utilising information that was reassembled to formulate a unique transcription (Yin, 2016:188). This is where the empirical findings of the study are illustrated. During this stage the researcher will also display commonalities of themes and may utilise visuals, figures and tables to illustrate (Yin, 2016:188). For the benefit of this study, the researcher used tables to depict information such as the biographical information of participants. Storylines were used to support the themes and sub-themes that emerged.

- **Concluding**

Yin (2016:187) states that the last phase of data analysis includes establishing the conclusion of the study. Yin (2016:187) stipulates that the conclusion that is formulated should correlate with all phases in the cycle specifically the fourth stage. According to Creswell (2014:250), in the final stage the researcher is expected to interpret qualitative research findings or results. This phase confirms if the goals and objectives of the study were accomplished. The final step enabled the researcher to analyse the information gathered from the literature to determine if it complements data gathered from participants. Recommendations, findings and conclusions form part of this step. The researcher narrated the empirical findings of the study after the process of data collection was completed. It shows information, proceedings, methods, research designs, conclusions and recommendations of the results.

3.9 DATA VERIFICATION

Qualitative research must ensure “trustworthiness” (Korsjens & Moser, 2017:121; Liz & Zayas, 2010:191; Yin, 2016:86). A qualitative study should ensure trustworthiness which signifies approximately similar views of the individuals taking part in the study (Guba & Lincoln as cited by Lietz & Zayas, 2010:191). For the purpose of this study, data verification was implemented following Guba and Lincoln’s model (in Lietz & Zayas, 2010:191).

3.9.1 Credibility

Credibility implies the extent to which the appropriate connotation of the participants complements the findings of the research study. This aspect emphasises the responsibility of the researcher to report data collected from interviews in a correct manner that elicits a true reflection of the sentiments expressed by participants. This needs a researcher to be an attentive listener with the ability to probe and paraphrase views given by participants. Korsjens and Moser (2017:121) indicate that credibility entails the assurance that can be applied in the congruency of the outcomes of the

research. Shenton (2004:64) illustrates that to achieve credibility the researcher must use reputable research questions and methods. To accomplish credibility, the researcher shared information contained in the transcripts that were transcribed from word-for-word with the participants, to establish whether the emerging interpretations and conclusions were true and genuine representations of participant's experiences (Shenton, 2004:66). The interview questions were translated into Setswana, which was the preferred and common language of the participants. Furthermore, to enhance the credibility of the study, the researcher utilized the service of an independent coder.

3.9.2 Transferability

Lincoln and Guba (cited by Lietz & Zayas, 2010:191), define transferability as the extent to which the outcomes of qualitative research are valid and valuable to theory and practice. Transferability necessitates the ability of the qualitative research result to be conveyed to different circumstances of other participants (Korsjens & Moser 2017:121). Shenton (2004: 70) indicated that it is imperative that ample depiction of an aspect being researched be conveyed to participants to permit readers to fully understand the phenomenon. This will enable participants to gain an understanding of the phenomena. Transferability implies that data obtained from a specific population should at least resonate with the experience or views of those in similar conditions but in different contexts. Regarding the current study, the researcher safeguarded that the results of the study were understood within the context of participants. The researcher interviewed participants experiencing similar predicaments, however they reside in different areas of Tshwane. They expressed similar challenges and experiences although they live in different settings.

3.9.3 Dependability

Shenton (2004:71) states that dependability means that should the research study be conducted again in a similar environment whilst utilising the exact research methods on the same participants, the findings must yield similar outcomes. This is where credibility of the study prevails; if the researcher reports data as per the perspective of the participants, their research study can be regarded as trustworthy. The researcher

accomplished dependability of the research study by employing the service of an independent coder who identified themes, sub-themes and categories yielded from the data collected by the researcher.

3.9.4 Conformability

Conformability is the ability of others to confirm or corroborate the findings (Guba & Lincoln). Korsjens and Moser (2017:121) emphasise that conformability illustrates that information, and the analysis of the research findings are not fabricated by the researcher but a true reflection of the gathered data. This addresses the issue of bias. The researcher comprehended the ideas of participants and reported these views as they were, because the views of participants must be reported and not those of the researcher, taking into account the dependability and transferability of the research study.

3.9.5 Reflexivity and bracketing

A crucial approach that is utilised to comprehend a researcher's prejudice is termed reflexivity (Cypress, 2017:259). Reflexivity is the ability of the researcher to carefully examine, through self-awareness, their potential ability to be biased in a qualitative study (Lietz & Zayas, 2010:198; Johnson & Christensen, 2014:411). It recognises that qualitative researchers are a part of the social world that they examine and that they are prone to be influenced by their values, presumptions, prior experiences and expertise (Maritz & Jooste, 2011:973). In the process of reflexivity, researchers learn more about themselves, check their biases, and make an effort to manage it (Cypress, 2017:259).

It is understood by the researcher that reflexivity includes the ability of the researcher to self-introspect aspects that could possibly have a detrimental outcome or tamper with the results of the research study. The researcher concurs with the above authors regarding reflexivity. The researcher on a personal and work level has experienced the predicament faced by those infected and affected by HIV, hence it was crucial to acknowledge such feelings/experience prior to and during the interviews so that those feelings and/or experiences did not cloud her judgement thus affecting the

interpretation of the whole study. The researcher ensured that her pre-conceived thoughts/ideas did not play a role in the interpretation and analysis of data. To achieve this, the researcher noted her thoughts, experiences, feelings and expectations which could have an effect on the results of the research.

When researching topics that have delicacy such as the perspective of foster parents caring for foster children living with HIV, reflexivity becomes essential in ensuring that the data collected and verified are a true reflection of the participants' realities. Ultimately, reflexivity in data verification safeguards that findings are not only trustworthy but also conscientious, respectful of participant's voice, and meaningful for policy and practice. In the case of foster parents of children living with HIV, this approach enhances the relevance of psychosocial support interventions by grounding them in real-life experiences, needs, and strengths of the foster parents. The foster parents are the ones who have experiential knowledge pertaining to the psychosocial challenges they encounter, and therefore, capturing their true realities will enable them to develop appropriate psychosocial programs and theoretical models that recognize the challenges, emotions, perspectives, and trauma of foster parents caring for foster care children living with HIV.

According to Cypress (2017:259), bracketing is another approach that can be used to regulate one's bias. Some researchers make use of the technique of bracketing to decrease the possibly harmful impacts of unconscious biases related to research and to improve the project's integrity (Tufford & Newman, 2010:81). In addition, Peters and Halcomb (2015:16) define bracketing as a deliberate use of a researcher's background as a research instrument. The researcher grasps bracketing as an alternative method that is similar to reflexivity that a researcher can employ in order to control one's prejudice so as to achieve trustworthy outcomes in the research study. In this regard it is crucial that the research bracket their own preconceived ideas and professional intake pertaining to psychosocial support and HIV as this will permit the voices of foster parents to emerge without being subjected to any influence.

3.10 ETHICAL CONSIDERATIONS

Johnson and Christensen (2014:194) confirm that research ethics are values that are formulated to give light and support to researchers to conduct studies in an ethical manner. In addition, Neuman (2014:157) and Johnson and Christensen (2014:192)

are of the same view that ethics are principles that protect participants from any harm. The researcher was not only guided by research ethical considerations but also social work values and principles. The different ethical behaviour aspects that are crucial and were implemented during and after the research study are presented below.

3.10.1 Informed consent

Informed consent is a standard in which participants base their voluntary participation in research projects with full knowledge of the potential risks involved (Barbie, 2017:65). According to Johnson and Christensen (2014: 202) informed consent entails participants “consenting to partake in a study after being equipped with information of its purpose, procedures, risk, benefits, alternative procedures and limits of confidentiality”. Tracy (2013:10) concurs with Johnson and Christensen that informed consent is the procedure whereby the researcher enlightens the prospective participants about risk, benefits, and other things involved in agreeing to take part in a study.

Notably, Fain (2017:38) indicates that the vital aspects of informed consent are (1) to provide potential participants with sufficient information about the purpose of a study, and (2) assure participants that participation is voluntary and can be withdrawn at any time without being discriminated against. Voluntary participants were encouraged to sign an informed consent. Informed consent means potential participants give permission to form part of the study. The researcher was transparent with regard to the nature of the study. This assisted participants to make an informed decision about taking part or not. The contents pertaining to the purpose of the study contained in the Participant Information Sheet (Addendum D) were shared with participants who took part in the study, whose age maturity was appropriate, and who were rightfully competent to give written consent (Addendum E).

3.10.2 Voluntary participation

All participants were informed that participating in the study was voluntary. Saunders et al. (2016:244) are of the opinion that the decision not to take part in a research study must be respected. Participants have the right to decide how they will take part in the

data collection procedure, the right not to reply to any questions; or to withdraw from participation and information they have given to the researcher. Rubin and Babbie (2016:82) indicate that a 'major tenet' of research ethics is that participation must be voluntary. The researcher understood that voluntary participation meant that prospective participants must, out of their own free will, agree to take part in the research study. They must not be forced or manipulated to engage in the study. The researcher, through the permission of the DSD research and policy coordination office, liaised with social workers to identify foster parents who are caring for foster children living with HIV/AIDS from their case databases. Although foster parents were encouraged to participate, it was strongly emphasised that they were not obliged to take part in the research and that it was within their right to decline to participate.

3.10.3 No harm to participant

Although potential participants agree to participate voluntarily, it does not mean they must be subjected to any kind of harm. Fain (2017:35) emphasises that prospective participants have a reasonable expectation that the study will be free from risk of injury or harm. The researcher must estimate the risks and benefits involved. Participants must be informed of any potential mental or physical risk as well as personal benefit, including procedures or activities that may pose any risks. Babbie (2017:63) is in support of Fain (2017:35), in that participants must not only be unharmed physically but also psychologically; hence the researcher has to take precautions to prevent any harm. HIV and AIDS can have a detrimental effect on the emotional and psychological state of those infected and affected. This ethic corresponds with voluntary participation; therefore the researcher informed the participants in advance that there might be possible harm during or after the research and they would be referred to a debriefer for professional help and support if needed. None of the participants requested to be referred for any psychological intervention, instead they mentioned that it was therapeutic for them to talk about their challenges of raising their foster children living with HIV with the researcher.

3.10.4 Anonymity

Implies that the researcher will not gather any deceptive data pertaining to the participant in the research study (Faulkner & Faulkner, 2019:15). Fain (2017:37) indicates that anonymity refers to ensuring that the reader cannot identify participants and that there is restrictive access to information that is collected pertaining to the participants. Fain (2017:37) advises that we can enhance anonymity by utilising code numbers for participants' information to avert others from connecting reported information to them. In addition, Rubin and Babbie (2016:85) indicate that a participant may be considered anonymous when the researcher cannot recognise a given response linked to a participant. The researcher understands that anonymity is connected with secrecy and no identity will be attached to a given response. Research participants were assured that whatever was discussed during the research process will be kept anonymous and information shared will not be linked to them by their social workers or anyone involved in the research process.

3.10.5 Confidentiality

Confidentiality is when the researcher guarantees participants that all information gathered for the purpose of this study, will only be known by the researcher, her supervisor and the independent coder (Johnson & Christensen, 2014:212; Faulkner & Faulkner, 2019:15). Participants were assured that no external person would have access to the information. Fain (2017:37) defines confidentiality as the researcher's duty to protect participants' data by not divulging information that is gathered without their permission to do so. This right is extremely important in a case where the information may promote stigma. Confidentiality means that whatever information that the participants revealed during interviews would not be repeated outside among colleagues but rather would only be used for the purpose of the research study. Confidentiality is the cornerstone of social work's ethics, therefore, the researcher knew the paramount importance of implementing this ethical aspect. HIV is still a shameful topic to talk about. Not every person is comfortable with other people knowing that they are caring for a HIV-positive family member, therefore participants were assured of confidentiality, and that no one would know about the health status of their grandchildren. The researcher ensured confidentiality by not mentioning the

names of the participants in the research report. The findings of the research were handled in a professional and confidential manner and were not utilised for any reason other than for the purposes of the research.

3.10.6 Deception

Deception is deceiving or censoring information from the person who is taking part in the research study (Johnson & Christensen, 2014:208). Rubin and Babbie (2016:86) argue that “misleading people is unethical and within social research, deception needs to be justified by convincing scientific or administrative concerns, even then, justification will be arguable.” Deception takes place when a participant is intentionally given fabricated information regarding the research, which comprises false responses, and utilisation of joint or false information about the process to be followed (Frey, 2018:2). In contrast, Rubin and Babbie (2016:86) disregard using deception, and Johnson and Christensen (2014) justify that there are instances where providing detailed information and purpose about the study will weaken the outcome and invalidate the study. In such instances, it is crucial to use deception on research subjects. Based on the explanation from these various authors, the researcher grasped deception as not being truthful, misinterpreting information to the people who volunteered and gave informed consent to be part of the study. The researcher agrees with Rubin and Babbie (2016) that using deception is wrong. Therefore, deception was not used in this study. Participants who were part of the study were provided with detailed information about the intended study.

3.10.7 Data Management

Data management includes various practical issues which have ethical repercussions (Flick, 2018:442). According to Creswell (2014), the management of data includes the gathering and administration of information from one or additional sources as well as the dissemination of that information to various audiences. It is crucial for the researcher to comply with the ethical principle of confidentiality by ensuring that transcripts, audio tapes and other data collected from the study are kept safe. The researcher ensured that data was locked in her cupboard, and that no one had access

to the data expect the researcher. The researcher must also be devoted to report all research outcomes in an authentic manner (Leedy & Ormrod, 2013:108). The researcher acknowledged and appreciated the participants who made a considerable contribution to the study.

3.10.8 Debriefing

Another crucial ethical aspect is debriefing. According to Faulkner and Faulkner (2019:22) debriefing entails the procedure of giving participants detailed information regarding the nature of the research. In relation to Faulkner and Faulkner's explanation about what debriefing is Johnson and Christensen (2014:209) who suggest that debriefing entails a "post study interview in which all parts of the research are indicated, any reasons for dishonesty are clarified, and any questions the participants have regarding the study are answered". Babbie (2014:71) further indicates that participants are interviewed to learn about their experiences of participation and to inform them of any unrevealed purpose. The researcher understands debriefing as an interview conducted after the research proceedings to assist with any negative emotions or thoughts encountered by the participants. Given the topic of the study, the researcher anticipated debriefing sessions with the participants after the study had been completed, as the study might arouse some disturbing emotions from participants, however the participants indicated that they did not need any debriefing.

3.11 CONCLUSION

The chapter's focal point was the research methodology used in conducting the study as well as the empirical findings collected during the interviews with foster parents raising foster children living with HIV/AIDS. This chapter gave an exposition of the processes used to collect data by means of semi-structured interviews. The next chapter's focal point is on the findings and recommendation of the study.

CHAPTER FOUR

RESEARCH FINDINGS ON THE EXPERIENCES OF FOSTER PARENTS AND PSYCHOSOCIAL SUPPORT RECEIVED WHILE CARING FOR FOSTER CARE CHILDREN WITH HIV AND AIDS

4.1 INTRODUCTION

This chapter details the findings based on the experiences of foster parents' on psychosocial support received while caring for foster care children living with HIV and AIDS. A phenomenological enquiry supported by descriptive, exploratory, and contextual research designs was utilised for the purpose of this study. A purposive sampling method was used to recruit suitable participants.

Data was collected through face-to-face semi-structured interviews. Even though the participants came from diverse language backgrounds, the interviews were conducted in Setswana, a comfortable and familiar language for all. The researcher translated the Setswana transcripts into English, a crucial step given her first-hand experience of what transpired during the data collection process.

To achieve credibility of this study, the researcher made use of an independent coder service. Both the researcher and the independent coder¹ independently identified the primary themes to give credence and trustworthiness to the study. A discussion with the researcher and the supervisor was undertaken to reach a consensus on themes, sub-themes and categories. The themes and demographic characteristics are discussed in a tabular format in Table 4.2.

¹ In this study, an independent coder is an external researcher (qualified) who applies a range of viewpoints to the data to identify themes without analysing or interpreting the data (O'Connor & Joffe, 2023; Keene, 2023). The researcher of this study developed her own themes independently without being influenced by the independent coder's identified themes. The themes identified were then compared with those of the independent coder. The supervisor and researcher came to an agreement on the final themes.

4.2 BIOGRAPHICAL PROFILES FOR THE PARTICIPANTS

This section presents the biographical profiles of participants who met the inclusion criteria for the study. A total of 16 participants voluntarily participated in this study. The biographical data in Table 4.1 provides information on each participant who was assigned a numerical number to ensure anonymity.

Table 4.1: Biographical profiles/particulars of the participants

Participant	Age in years	Marital status	Highest education level	Home language Instead of ethnicity	Employment	Number of family members staying/ living together	Number of grandchildren	Number of foster children and their ages in years/ Relationship	Age when data was gathered	Relationship	Year of care/ care-giving role	Foster care placement	Grade
1 Maternal cousin	45	S	Grade 2	Sepedi	Office block cleaner	3 grandsons niece, 3 maternal cousins (1 girl and 2 boys)	3 grandchildren (boys)	3 (1 has HIV)	17- has the illness) 13 20	Female cousin Male cousin Male cousin	2010	26/12/2013 26/12/2013 26/12/2013	Grade 10 Special school Grade 12
2 Maternal aunt	49	S	Grade 10	isiNdebele	Hospice health care worker	Participant's mother, uncle, niece	4 boys 2 girls	1 has HIV	17	Niece	2017	21/12/2010	Grade 5
3 Maternal grandmother	55	D	Grade 11	Setswana & Sepedi	Office administrator	4 Grandchildren	4 (2 boys & 2 girls)	2 (both have HIV)	16 12	Grandson Granddaughter	2011	16/01/2012 16/01/2012	Grade 11 Grade 6
4 Maternal aunt	56	M	Grade 7	Xitsonga isiSwati	Unemployed	Husband, son, grandchild, stepson & niece	2 (boy & girl)	1 has HIV	17	Niece	2007	06/10/2009	Grade 10
5 Maternal grandmother	58	M	Never attended school	isiZulu	Unemployed	Husband & son, 2 grandchildren	2 (boy, & girl)	1 has HIV	17	Granddaughter	2011	24/10/2013	Grade 11
6 Sister of maternal grandmother	59	S	Grade 9	isiNdebele	Self employed	Daughter, niece & 2 grandchildren	2 (boy & girl)	1 has HIV	13	Grandson	2012	01/07/2019	Grade 7

7 Maternal aunt	62	W	Grade 8	Setswana	Pensioner	Brother, 2 children (Girl & Boy) 4 grandchildren, nephew	4 (boys)	1 has HIV	16	Nephew	2008	09/05/2014	Grade 9
8 Maternal grandmother	64	Separated from traditional marriage	Grade 7	Setswana	Pensioner	2 daughters 12 grandchildren	6 boys & 6 girls	1 has HIV	17	Granddaughter	2009	23/06/2010	Grade 11
9 Maternal grandmother	65	M	Grade 4	Sepedi	Retired	Husband & 2 grandchildren	2 (boy & girl)	1 has HIV	18	Grandson	2008	16/03/2009	Grade 11
10 Maternal grandmother	66(a)	Separated from traditional marriage	Grade 5	XiTsonga	Retired	2 grandchildren 3 great grandchildren	2 grandchildren (girls) 3 great- grandchildren (a boy & 2 girls)	1 has HIV	18	Granddaughter	2009	22/12/2014	Grade 10
11 Paternal aunt	66(b)	M	Never attended school	Sepedi	Casual work – doing laundry for someone	2 grandchildren (Boy and Girl), 4 children (3 boys & girl), 2 niece, daughter in law	9 grandchildren (5 girls & 4 boys)	2 (only 1 has HIV)	15 13	Niece (has the illness) Niece	2013 2013	06/11/2013 06/11/2013	Grade 9 Grade 7
12 Maternal grandmother	67	S	Grade 7	isiNdebele	Retired	1 Daughter, 1 son & 4 grandchildren (2 boys & 2 girls)	20 grandchildren (11 boys & 9 girls)	2 (only 1 has HIV)	16 13(has the illness)	Grandson Grandson	2011 2011	2012/02/27 2012/02/27	Grade 10 Grade 7

13 Maternal grandmother	69	M	Grade 7	Setswana	Unemployed	Husband, daughter & 3 grandchildren	5 grandchildren	2 foster children (only 1 has HIV)	17	Granddaughter	2008	03/04/2010	Grade 12
									14 (has the illness)	Granddaughter	2008	03/04/2010	Grade 09
14 Maternal grandmother	70	W (polygamous marriage - 2 wives)	Never attended school	XiTsonga	Pensioner	Son, 2 grandchildren & a great grandchild	2 grandchildren (Boy & a girl) & a great grandchild (boy)	1 has HIV	17	Grandson	2010	19/01/2015	Grade 9
15 Not related	76	W	Grade 7	Setswana	Managing a home for older persons from 2007	1 grandson, 3 foster children (boys)	1 grandson	3 foster children (boys) (2 have HIV)	17(has illness)	Unrelated	2004	28/06/2010	Grade 10
									15 (has illness)	Unrelated	2006	14/09/2007	Grade 08
									15	Unrelated	2006	17/08/2006	Grade 08
16 Maternal grandmother	79	M	Never attended school	Tsonga	Unemployed	3 - grandchildren	12 (4 girls & 8 boys)	3 foster children (2 have HIV)	21(has the illness)	Grandson	2011	30/12/2019	College
									18 (has the illness: recently passed on 20 May 2022)	Grandson		30/12/2019	Grade 12
									14	Grandson		30/12/2019	Grade 7

D = divorced, M = married, S = single, W = widowed.

4.2.1 Age of participants

The number of participants was sixteen in total. The youngest participant was 45 years while the oldest was 79 years. Their mean age was 63 years. Nine participants were divided into five age groups: two were 45–49, four were 55–59, seven were 62–69, and three were 70–79. To comprehend the participants' life stages, Erikson's psychological development theory will be applied. According to Mcleod (2014:1), Erikson's theory of psychological development maintains that personality evolves through eight distinct stages of psychosocial development, which occur in a predetermined order from childhood to adulthood. Since the study participants' ages ranged from 45 to 79, only two stages of Erikson's psychosocial development will be covered. Six individuals were classified as adults (ages 45-64), and ten were classified as elderly people (ages 65–79).

Participants falling between the ages of 45-64, correspond to Erikson's 7th stage of Generativity vs. Stagnation - which occurs during middle adulthood. Generativity involves creating lasting impact through mentoring or beneficial changes, and the key characteristics of generativity involve being content with positively impacting others' lives. Contributing to society through raising children, working hard, and participating in events produces a sense of purpose, while failure leads to stagnation. Erikson's 8th stage, Integrity vs. Despair, begins around the age of 65 and ends at death – six participants fell into this stage. It involves reflecting on achievements, cultivating integrity, and embracing death without fear. Successful individuals can cultivate wisdom, leading to a sense of fulfilment and closure.

Chronic illnesses, such as hypertension, diabetes, and heart disease, are a significant health burden for old age people in South Africa, with the proportion of seniors with chronic illnesses increasing rapidly (Gumede, Meyer-Weitz, Edwards & Seelay, 2022:2). The elderly often suffering from illnesses, are actively involved in their grandchildren's upbringing and provide care to foster children. This selflessness reflects the 7th and 8th stages of Erikson, which fosters a sense of generativity, fulfilment and selflessness.

4.2.2 Marital status of participants

Regarding marital status, six participants were married whilst three were widows. Two of the participants have separated from their partners whereas only one was divorced. Only four participants were single. For the ten years between 2011 and 2020, the number of registered weddings has consistently decreased, according to Statistics South Africa (2020:2). In this study, the majority of participants were married. Although the number of divorces among black African couples was higher in 2020 than in any other community, according to Statistic South Africa (2020:2), the divorce rate was low in the current study, with only one (1) participant out of 16 being divorced.

Of the 16 participants there were 10 grandmother-led families. This is in line with scholars (Chavda & Nisarga, 2023) who suggest that, of all single parents worldwide, mothers make up the vast majority (84.3%), suggesting that women are primarily responsible for raising children and ensuring the financial stability of their families.

4.2.3 Participants' highest qualification

The participants' levels of schooling differed greatly. The highest educational level attained by the participants was Grade 11, with only one individual achieving this level. This was followed by one participant achieving Grade 10. Out of all the participants, five completed Grades 2–9. Five of the 16 participants achieved a Grade 7 level, whereas four of the individuals said they had never gone to school.

South Africa has a high level of illiteracy (Kuluvhe, 2022:2). In this study at least 12 out of 16 participants have an educational level. Despite 26 years of democracy, 3.7 million adults remain illiterate (Kuluvhe, 2022:2). The illiteracy rate is primarily female (10.7), limiting women's opportunities in society and the labour force. The traditional family structure may contribute to this issue (Kuluvhe, 2022:2). Traditional family is one that comprise of a husband, wife and children, furthermore it is a family often reflect patriarchal norms where a woman is expected to be submissive to the husband, is expected to manage the household and independently care for children (Garcia 2023:55).

4.2.4 Race and language

The black African population is in the majority (49,07 million) and constitutes approximately 81% of the total South African population (StatsSA, 2021). This justifies why all of the 16 participants' were black, however, they spoke different languages. Five participants were Setswana speaking, three spoke Sepedi and four spoke siTsonga. The other four spoke Nguni language, three spoke siNdebele and one spoke siZulu.

South Africa is a multicultural society with a rich linguistic diversity, with 61.2% of whites speaking Afrikaans and 36.3% speaking English. Black Africans, however, speak a larger variety of languages, including isiZulu, isiXhosa, Sepedi, Setswana, and Sesotho (Government Communication and Information System, 2018/19:3). Anderson and Linares (2012:3) emphasise the importance of culturally sensitive placements for children, highlighting the need for compatibility between biological and foster families. Cultural differences can hinder cooperative parenting practices and increase child conduct issues, especially in spoken language. One participant is responsible for the care of three foster children who are not related to her; however, they share the same language and race.

4.2.5 Employment status of participants

Of all the 16 participants, four participants are working, two are self-employed and three are pensioners. Of the 16 participants, four are unemployed and three are retired.

Grandparents take on obligations related to raising their grandchildren, including providing them with a place to live, food, and clothing. To help underprivileged families, the South African government offers social security benefits to eligible grandparents, including old-age pensions, child support grants, and foster child grants, which they can apply for, both for themselves and their grandchildren (Gumede et al., 2022:2).

These benefits are significant sources of income, particularly for grandmothers in South Africa who are raising grandchildren (Gumede et al., 2022:2). The participants also

benefitted from foster care grants, in terms of Section 7 (a) (i) (ii) and (c) of the Social Assistance Act No 13 of 2004.

4.2.6 Number of grandchildren

All the 16 participants had grandchildren. One of the participants had the highest number of grandchildren (20). Of the participants, 11 out of 16 had 1-5 grandchildren, two had 6-10 grandchildren, and three had 11-20 grandchildren. Historically, grandparents have frequently provided care for their grandchildren because they have been seen as an important family support system in ensuring a vital safety net for children (Gumede et al., 2022:2).

Due to the increased parental sickness and mortality brought on by the HIV epidemic, grandparents' obligations to their grandchildren have been made even more difficult as they become an increasingly crucial source of childcare (Gumede et al., 2022:22). Mawusi (2013:69) affirms that in traditional African communities, the duty of raising a child does not solely fall on the biological parents it is, however a shared responsibility by all in the extended family.

4.2.7 Participant's number of foster children and their age in years

Two participants cared for three foster children, two of whom were living with HIV. Three participants cared for two foster children each while only one foster child out of every two was sick. There was only one participant who had two foster children who are both infected by the disease. One participant also had three foster children of which one foster child had the illness. The rest of the participants (nine) were fostering only one foster child infected by the disease.

The loss of young parents who leave behind young children under the age of eighteen who depend on others for care and assistance, is one of the tragic effects of the HIV pandemic (Akimanimpaye, Bimerew & Phetlhu, 2024:1). According to Mtshali (2016:371), HIV/AIDS is overturning the structure of families by putting more responsibility and weight

on the shoulders of its members, especially grandmothers. The number of children in foster care with the participants does not shock the researcher as the SASSA fact sheet (2023) in the year 2023 states that about 35 804 children were in foster care.

4.2.8 Foster children's years of age

The age distribution of the foster children varied, with the oldest being 21 years and the youngest being 12 years of age. Ten children were between the ages of 17-18 years, and two children were (16 years. Three children were between the ages of 12-13 years, two children belonged to the age group 14-15 years, and the last one was 21 years. A generation of vulnerable children, including orphans, may have resulted from AIDS and child-headed homes as a result of the national ART program's delayed implementation, which started in 2004.

While deliberating on the age of the foster children, the majority of them (10) were born between 2003-2004, when, according to Burton et al (2015:5), the roll out of Prevention of Mother to Child Transmission of Communicable Infection (PMTCT) started to be implemented, meaning they did not benefit from the PMTCT initiative.

4.2.9 Year of care

As per the inclusion requirement of the research study, all the participants had at least 3 years of experience caring for the foster children. The participants took responsibility for caring for the foster children immediately after the death of their parents. The earliest year of care is 2004 whereas the latest year is 2017. From 2004-2010, 10 children were already in the care of someone else other than their parents. The first participant to be granted foster care placement was in the year 2006 and the last year was 2015. Between 2006-2010 seven foster children of the participants were legally placed in foster care while 12 foster children were legally placed in foster care between 2012-2019.

Since South Africa adopted the African Charter on the Rights and Welfare of the Child (ACRWC) in 2000, there have been notable modifications to the country's legislative

framework, which generally protects children and their rights. Foster care is listed as an alternative placement option that a children's court may order under Chapter 12 of the Children's Act (No. 38 of 2005) (Parliament of the Republic of South Africa. 2019:4)

4.2.10 Grade which the foster children are in

The highest grade that a foster child was enrolled for was 1st year in college whereas the lowest grade was Grade 5. Two foster children were in Grades 5-6, three children were in Grades 6-7, five children were in Grades 8-9, seven children were in Grades 10-11, one child was in Grade 12 and the last one was in college.

Section 29(1) of the Constitution of South Africa contains the right to a basic education and the right to a further education, the foster children benefited from this right. Although foster children benefit from free education, in comparison to their peers, foster children have different educational outcomes. For example, school attendance, special education needs, and high school graduation rates have shown to be worse for youth in foster care. Foster adolescents have a lower likelihood of finishing high school and enrolling in and graduating from college (Moyer & Goldberg, 2019:3; McGuire, Gabrielli, Hambrick, Abel, Guler, & Jackson, 2021:1). Fortunately, for the foster children of this study, the majority of them were progressing well.

4.2.11 Relationship with foster children

According to the Children's Act, Act 38 of 2005 a children's court may place a child in foster care (a) with a person who is not a family member of the child (non-kinship); (b) with a family member who is not the parent or guardian of the child; or (c) in a registered cluster foster care scheme. Therefore, not all the 16 participants were biologically related to the foster children, for instance, only one participant is fostering three children who are not biologically related to the foster parent, while 15 participants are biologically related to the foster children.

Foster children require adult care, supervision and attention among other things which can be attained in a family environment. Other ways to accomplish a family environment is through foster care where a child who is deemed to need care and protection can be placed with a family permanently or temporary or until they are able to care for themselves.

4.3 THEMES, SUB-THEMES AND CATEGORIES

The research findings of the study are discussed in this section, along with themes, sub-themes, and categories. The transcribed interviews were verified to ensure consistency. Verbatim quotations were supported and compared with the literature. Table 4.2 below displays the themes, subthemes and categories yielded from the findings of this study

Table 4.2: Themes, sub-themes and categories

Themes	Sub-themes	Categories
1: Circumstances that led to placement of children in foster care	1.1: Participants' knowledge of the cause of death of children's mothers 1.2: Participants' awareness of the foster children's HIV status 1.3: Participants' confirmation of the children's HIV status	1.1.1: Deceased mothers did not disclose their HIV status to significant others 1.2.1: Participants were unaware of the children's HIV status 1.3.1: Participants' reaction to the children's HIV status
2: Children's discovery of their HIV status	2.1: Confirmation of children's HIV positive status by professionals 2.2: Disclosure of HIV diagnosis to HIV-infected children 2.3: Disclosure of children's HIV status to relatives	2.2.1: Children's reaction after discovering that they were HIV positive 2.3.1: Relatives' reaction to information about children's HIV status
3: Foster parents for children living with HIV	3.1: Maternal grandmothers caring for grandchildren 3.2: Children cared for by volunteers	

4: Participants' experiences in caring for children living with HIV	4.1: Participants' knowledge of HIV 4.2: Information and training received by participants on caring for children living with HIV 4.3: Precautionary measures taken by participants 4.4: Family support for participants and children	4.3.1: Precautionary measures shared with children
5: Challenges facing foster parents caring for children living with HIV	5.1: Children's behavioural, social, financial and health issues 5.2: Medical treatment for foster children living with HIV 5.3: Participants' fearlessness of their responsibilities 5.4: Support received by participants from individuals and organisations	5.1.1: Children's disrespectful attitude 5.1.2: Children's irregular school attendance 5.1.3: Children keep bad company 5.1.4: Interference by neighbours 5.2.1: Children's compliance and non-compliance with medication prescription 5.4.1: No discrimination against children and families 5.4.2: Level of discrimination against children
6: Social work services provided to participants and children	6.1: Participants' satisfaction with social work services 6.2: Psychosocial support provided by social workers 6.3: Required social work services and support 6.4: Available community resources	6.1.1: Training offered by social workers 6.2.1: Limited knowledge about social work services 6.4.1: Participants' limited knowledge about available community resources

4.3.1 Theme 1: Circumstances that led to placement of children in foster care

The HIV/ AIDS plague has resulted in millions of children in South Africa being orphaned. As a result of the high number of orphans, grandparents are increasingly taking on the role as the primary caretaker for orphaned children and adolescents, especially in sub-Saharan Africa (Karimli, Ssewamala, Leyla Ismayilova, 2013:3). In many African communities, the immediate family are expected to take care of an orphan, with the major burden falling to the grandparents (Phetlhu & Watson, 2014:348).

The primary reason why children in South Africa are placed in foster care is the death of a parent due to AIDS (Carter & Van Breda, 2016:208). In this study, participants have expressed different views on the circumstances that led to placement of the children in foster care:

It is a difficult question but to be honest, it wasn't anyone's choice, it was by God's design. No one chose me and I'd say God knows everything because their mother was my only daughter and she was infected with the HIV virus at that time she was very secretive about it and she has never told me. She has never told me as her mother that she is sick. (P3, 55 years)

I made the decision on my own seeing the child was orphaned and the child was without a caregiver. – my mother was an elder and seeing that amongst my family, no one had the heart to adopt the child so I asked permission from my mother as the elder and she agreed. Then we went and did all the legal paperwork to show that I take full custody of the child. This was to ensure that in the future I will still have evidence that I took this child legally. I took him when he was 2 years old at the time and today he is 16 years old and in high school. (P7, 62 years)

For me to end up caring for the child, the mother was my 3rd daughter. She was not married hence I was staying with her, here at home. She ended up leaving me with her child, and I decided to take care of the child. (P8, 64 years)

Today they are all grown up. I've been keeping things together, taking care of them, living and growing together with my husband. (P9, 65 years)

The issue of grandparents caring for their orphaned grandchildren is not something new. South African studies resonate with the excerpts where participants indicated that from a cultural perspective, older women are expected to take on the responsibility of raising their grandchildren after an adult die of HIV/AIDS (Mtshali, 2016:371; Akimanimpaye, Bimerew & Petlhu, 2024). Some biological mothers of children living with HIV/AIDS

appointed guardians before passing, while others did not, leaving their siblings and mothers to care for the foster children.

4.3.1.1 Sub-theme 1.1: Participants' knowledge of the cause of death of children's mothers

HIV/AIDS is a pandemic that has imposed so much misery and suffering on people. After getting a positive HIV diagnosis, one of the critical decisions to make as an infected person is to be able to tell someone close to you about your status. In the study, some of the deceased mothers were open to their family about their HIV-status therefore disclosure was done. Disclosure entails the readiness of People Living with HIV/AIDS (PLWHA) to disclose their HIV status to another person (Adeoye-Agboola, Evans, Hewson & Pappas, 2016:14).

Taking into consideration some of the benefits of concealing one's status, some of the deceased mothers disclosed their status to one of their family members. In this case the family member was the participants of this study who are grandmothers, aunts and sisters to the deceased's children.

When the mother tested positive, I was the one taking care of her because I was in a similar situation at the time, living with HIV. After her death, I was crying while at work. (P1, 45 years)

She told me, she told us herself ... My sister has always been positive (living with HIV) and smoking, and she also did not have time for treatment. The child was ill until her mother (my sister) died of meningitis and at the time, they were both staying with our mother. (P2, 49 years)

Similarly, in the study conducted by Baso (2012:41) mothers and sisters were the second most desired audience for HIV-status disclosure information. As confidantes, mothers and sisters were typically favoured. This could be due to their kindness, understanding, and ability to keep a secret (Baso, 2012:41). Although disclosure of HIV sero-status is encouraged in the management of the HIV and AIDS epidemic (Kyaddondo, Wanyenze,

Kinsman, & Hardon, 2013:37), it remains a challenge especially among family members because disclosing one's HIV seropositive status is a complicated matter and a "double-edged sword" that could have either a positive or negative result, or both (Adeoye-Agboola et al., 2016:14).

Pertaining to the research study, some of the deceased's mothers concealed their HIV status from their mothers and sisters, there was, however one participant who was informed about her child's status by the health care professional. This was appalling because the HIV status of a patient is confidential, according to Health Professions Council of South Africa (HPCSA) (2016:3).

The following are the quoted words of participants:

They told me in secret that the mother of this child has HIV. It started showing as TB. They checked her at the hospital and gave her TB medication. After some time, whilst she was pregnant with her child who is also infected, they told her to tell the truth that she is pregnant and has HIV. She also hid the information from me. She never wanted to tell me. (P12, 67 years)

She was very sick, she was on and off – we didn't know what was going on, until we found out she's HIV positive. We then started treatment. But it was that time when HIV was too strong, so she died. And for her to die, she passed in a strange way... She had a stroke and went to the hospital and never came back ... that is where she left us. (P16, 79 years)

Similarly, a study conducted by Ullah (2011:100) showed findings that suggest that a substantial number of health care professionals (80%) disclosed confidential information to other people without a patient's consent. The duty of 'professional secrecy' fosters openness and trust between patients and health care professionals, as patients are assured that their personal information will remain confidential, unless they consent to its disclosure during the intervention process.

One of the ways of not accepting the HIV status is to think it is a 'calling'. Ondwela, Mothiba, Mangi and Ter Goon (2019:316) stipulate that when culture and traditional beliefs reject the existence and management of HIV and AIDS, persons on ART find it difficult to adhere to their medication regimen. Participants believed that the cause of death of their biological children was HIV/AIDS, however, one participant believed that her daughter had a traditional calling and not HIV.

We knew through my late sister-in-law [that they were both living with HIV]. My brother was in denial. He once called and said I must leave my job to come take care of his wife. I said I can't do that and he should take her to the clinic. He then told me that she's not sick but, has a calling and I said he should take her to traditional healers for her initiation. I later asked him about his plan. He brought her to me ... I stayed with her and took her to church for cleansing so she was initiated in an apostle manner since I couldn't afford traditional healers. (P11, 66b years)

The participant's experience is consistent with the findings of a South African study where some traditional healers are of the view that HIV does not exist, rather people either have an ancestral calling or are bewitched (Ndou-Mammbona, 2022).

The findings are also in agreement with the conclusions of Ondwela et al. (2019) study where the participants believed that HIV is caused by witchcraft, therefore, they preferred to visit Traditional Health Professions for protection against witchcraft. The dominance of cultural beliefs contributes to the denial of accepting the health condition.

(a) Category 1.1.1: Deceased mothers did not disclose their HIV status to significant others

The late former-president Nelson Mandela once said, "Many people suffering from AIDS are not killed by the disease itself but are killed by the stigma surrounding everybody who has HIV and AIDS."

To safeguard themselves and their children from social rejection, many mothers used secrecy as a coping method. However, there were detrimental implications to their

seclusion, as it denied them access to social support networks that could have reduced some of the severe sentiments associated with being an HIV-positive mother.

The child's mother (participant's sister) knew all along but she hid the information from us and because her mother was enjoying good health despite not taking treatment, it was difficult to be sure exactly what's going on with the child. Their mother only became ill after conceiving her second child. (P1, 45 years)

... their mother was my only daughter and she was infected with HIV at that time she was very secretive about it and she has never told me. She has never told me as her mother that she is sick. I got a call from my aunt while at work saying she got home and my daughter was not okay. At that time her child was about two months old, the last one. I don't know if she fell ill before or after having children. I think she got ill long before she conceived but I don't know how many years she was sick. ... I am just assuming because it is only two of the four children who are infected. (P3, 55 years)

I am just assuming that she kept the rape incident a secret, after she fell pregnant with this child. She never got the necessary treatment for the child because she hid the information until she gave birth to this child with HIV. (P7, 62 years)

I was heartbroken and I thought my sister sinned by not telling us that she had HIV. Hence, I felt like she did not protect her child by taking medication. I even thought that perhaps she wanted to die together with her child. (P4, 56 years)

Being secretive about one's HIV status has been discussed in many studies (Moshoeshoe & Madiba, 2021; Adeniyi et al., 2021; Madiba & Mokgatle, 2023). The findings of a South African study reveal that mothers purposely concealed their children's HIV diagnosis in order to shield them from the societal implications of an HIV-positive status (Moshoeshoe & Madiba, 2021:8). It can be argued that the deceased mothers did not disclose their HIV status to their families, due to fear of stigmatisation. This also goes

back to the issue of acceptance of a HIV diagnosis by the deceased mothers, if one has not accepted their HIV status it would be difficult for them to confide in their families about an illness.

4.3.1.2 Sub-theme 1.2: Participants' awareness of the foster children's HIV status

Most caregivers of HIV-positive children make a choice to test the child for HIV when the child start to present symptoms of the illness (Lorenz, Grant, Muyindike, Maling, Card, Henry & Nazarali, 2016:22). The participants were unaware of the HIV status of the children they were fostering. They became aware about the foster children's HIV status as they were displaying HIV symptoms.

*I could see for myself that she is positive because she wasn't okay from birth – she had the HIV through birth and the mother was also not ok. She became ill when she got to adolescent stage (at 13 years of age) and it started with her ears being painful. We took her to the clinic when she started coughing and they gave her TB medication, we only found when the cough persisted because her mother was very secretive about her status. We were only told about **** status when she tested for TB. (P1, 45 years)*

I saw her myself when she didn't stop having diarrhoea and I took her to the clinic and they did tests. (P11, 66 years)

Similar to the study conducted by Peltzera (2013:97), some of the symptoms of HIV that alerted caregivers were diarrhoea, TB, headaches, weight loss, and cough, rash and nausea. HIV symptoms are the single most important indicators for patients and practitioners, as they prompt patients to seek medical attention (Peltzera, 2013:97). The current study is also consistent with the study done by Madiba and Mokgatle (2017:178) where it was indicated that children were chronically ill from recurrent infections when caregivers sought HIV testing. The children being sick seemed to be a blessing in disguise, and the doctors were able to detect the virus before it suppressed their immune system. The foster parents and other family members would have been exposed to the virus and not take precautionary measures.

Some of the participants did not rely on the symptoms of the foster children, but rather were informed about the HIV status of the foster children by their deceased mother whilst they were alive. The deceased mothers told participants about their children's condition.

Their mother told me. She was the one taking them to clinic when they were sick. She wasn't working but had casual jobs. So, she told me herself, she left them knowing their status. (P16, 79 years)

When she was pregnant, she transmitted the disease to the child. I am not sure if he was five or six years when his mother passed on. When the mother was alive the child never got sick... I took him to the clinic and he couldn't walk. When I got to the clinic, I explained to the nurses that this child's mother passed on due to a certain illness. I don't know if the child was born with the illness or not. The doctor examined him and took his blood. The blood results showed he has the disease. He started taking treatment, even now he takes his pills. (P14, 70 years)

It was his mother who told us herself that the youngest child was sick. They took the child for testing and the results came back HIV positive ... She (mother of the child) was still alive when we found out. (P6, 59 years)

Similar to a study conducted by Dlamini and Matlakala (2020:3), their participants expressed that they had disclosed the health status of the child. Not every mother is secretive about their children's and their own HIV status. The biological mothers of the foster children in this study had the courage to disclose their status.

(b) Category 1.2.1: Participants were unaware of their children's HIV status

The ongoing denial and secrecy around HIV infection impedes the needed openness for disclosure due to fear of stigmatisation and discrimination (Mandalazi, Bandawe & Umar, 2014:103). HIV and AIDS-related stigma adds another layer to the disease's burden, demanding that a person deal with the conflict between the disease's secrecy and the openness that is vital to afford and obtain care and social support.

In this current study, the majority of the deceased mothers did not reveal their own HIV status from their parents (participants in this study). It does not come as a shock that they also did not reveal that their children were also infected through mother to child transmission to their families. The participants sought assistance from hospitals, not knowing what could be wrong with their foster children.

His mother passed away when he was still young, he was just two years old. He only started to get sick when he was four years old. It was very hard at the beginning. When the child started getting sick, I was the one running around with him, not even knowing what was wrong with the child. I even went to the Hospital, and no one told me what was wrong. (P9, 65 years)

His mother got very ill. I went to so many doctors with him (grandchild) but no one would explain to me what was happening to him. And I only found out the truth at the end. All I could think of was that his mother was killed by the very same disease. The mother of these children was only 37 years old when she passed away. (P9, 65 years)

The reason why the deceased mother did not make the participants aware of the foster children's status was explored in a study conducted in rural Uganda. The study found that many parents choose to conceal the diagnosis of their children. This decision is made to protect the children from the pressures of society and to preserve them from the emotional ordeal of being aware they are suffering from a life-threatening illness (Lorenz et al., 2016). It seems that the biological mother of the foster children hid the information about their children's status to encourage resilience. HIV is an illness that is attached to stigma, it does not come as a surprise that mothers would want to protect their children from the malice of some families, and society's response to HIV-positive people.

4.3.1.3 Sub-theme 1.3: Participants' confirmation of the children's HIV status

From the current study, it is evident that some participants were prompted by their foster child's symptoms to find an underlying cause. Although, HIV-related stigma has been seen as a hindrance for caregivers, a decision to test their foster children (Madiba &

Mokgatle, 2017:175) is the only way to confirm their HIV-status (Kulzer, Penner, Marima, Oyaro, Oyanga, Shade, Blat, Nyabiage, Mwachari, Muttai, Bukusi & Cohen, 2012:3). The Children's Act 38 of 2005 section 130 indicates that children may only be tested for HIV if it is in their best interests. The participants discovered confirmation that children were living with HIV from the doctor who conducted the HIV tests on the children.

It was the doctor who did his tests. He is the one that told me about his status. The day I took him to the hospital, he called me and sat me down. He said mama; you must be strong hearted and care for this child. This child has HIV, and he got it from his mother. He was born with it. (P9, 65 years)

After receiving medication for TB for a year, the child was not well. The clinic gave her grandmother a referral to the hospital where they (participant and child's aunt) learnt that she was HIV positive. We found out at the hospital. We did not know. A doctor told us. (P8, 64 years)

They didn't take long because the hospital was not full, they examined her and told us she was HIV positive ... She is a child and does not know anything and her mother died with a secret and left me with problems. (P8, 64 years)

After the funeral, I took the child to come and stay with me. The child's behaviour at school started to change and I did not know anything. I was called at school and I went there. I sat down with his class teacher and she was open with me, she advised that we visit the clinic after I explained how the mother passed on ... I then took the child to the clinic and they assessed him then they referred me to the Hospital. They tested him. It was then that we discovered that the child is HIV positive. (P7, 62 years)

Findings of the current study are similar to those of rural Uganda where despite efforts to promote HIV testing as part of routine medical care, the vast majority of HIV tests discussed in the interviews were motivated by active symptoms—either in a child, parent, sibling, spouse, or the individual themselves (Lorenz et al., 2016:19). HIV tests were done due to the symptoms the foster children displayed. The doctors are the ones who

conducted the tests at the clinic or hospital. Hence, the HIV status of each foster child was confirmed.

(c) Category 1.3.1: Participants' reaction to the children's HIV status

Family members experience feelings and worries comparable to those of PLWHA, including fear, anger, embarrassment, grief, uncertainty about the illness process, and disease. Stigma frequently leads to social isolation and loneliness, not only for the PLWHA, but also for the carers in the household (Iwelunmor, Airhihenbuwa, Okoror, Brown & Belue, 2012:2).

For the participants of the study, it was a predicament to agree to find out the HIV status of the foster child. Furthermore, after discovering that their grandchildren were HIV-positive, three participants expressed how heartbroken they were.

And even with the kids, it took me a while to accept, adjust, and swallow it and to tell some of the families that I'm living with a child who has a certain condition. I felt like where would I start? What do I say? What if they ask me questions that I lived with the mother of the children knowing her condition whilst they could've helped. (P3, 55 years)

My heart was broken and I couldn't accept it. (P10, 66a years)

I was heartbroken, no amount of pain could ever compare to that. I asked God if this was a punishment for me or her mother because the Bible says I will punish the children for their parents' sins. I wondered what wrong have I done in this world that this innocent child is being punished for. (P8, 64 years)

Yhooo! I cried hysterically, I was heartbroken. I didn't know, but I am grateful for the assistance that they gave me ... (P13, 69 years)

These emotional responses from the participants are similar to those of a study conducted in rural South Africa where participants expressed that after knowing the child's HIV status their initial reactions were anxiety, fear, disbelief, surprise, worry and denial (Kimani-Murage, Manderson, Norris & Kahn, 2010:266). The news left the participants devastated, especially because the children are innocent and did not deserve to be infected. As a result, some considered it to be a punishment from God.

4.3.2 Theme 2: Children's discovery of their HIV status

Participants have expressed different views on the children's discovery of their HIV status since most became ill after the death of their mothers. Selection of age-appropriate information to be shared with children may pose a challenge to foster parents especially grandmothers. Out of all the participants, 14 were able to inform the children of their HIV-status while two participants allowed the health care providers to intervene.

4.3.2.1 Sub-theme 2.1: Confirmation of children's HIV-positive status by professionals

The HIV status of the foster children had to be confirmed through testing. As part of the research study, the biological mother of the foster children passed away from HIV, so it was important to test the foster children for HIV. The legal foster parents gave consent for the HIV testing of the foster children. Health care providers administered the test, revealing that the foster children were HIV positive.

It was a sister at the... clinic. She is the one who conducted a test when I told her how my daughter passed on. When she came back, she confirmed that indeed it is HIV. ...it has been quite a while since he has been taking treatment. As he has grown up now, he goes by himself to fetch medication. He no longer receives his medication at the clinic. He gets his treatment at ... what do they call it? (P14, 70 years)

The youngest child was sick and the helper called me and informed me. I asked her to take her to the doctor, she was then referred to the clinic where she was referred ... hospital and they took tests, that's when we found out she was HIV positive and she got it from her mother. I also took her sister for a test/check-up and it was found that she was also infected. (P3, 55 years)

Similar to the conclusions of research study in Swaziland, participants indicated that their foster care children who were found to be HIV-positive were initially very sick, necessitating a great deal of attention, putting a heavy burden on the elderly carers and disrupting their normal lives (Makadzange & Dolamo, 2011:61). Finding out about the child's health status in a cross-sectional design study revealed that the majority of the caregivers were informed of their children's HIV status at an early age as a result of recurrent illness and frequent hospital stays (Amankwah-Poku et al., 2021). Caregivers searched for answers pertaining to the persistent health problems and ultimately they discovered that the children were HIV-positive.

4.3.2.2 Sub-theme 2.2: Disclosure of HIV diagnosis to HIV-infected children

Caregivers usually encounter uncertainty when it comes to disclosing an HIV-positive status to their children, due to fears of negative consequences such as psychological problems, inability to understand and deal with the diagnosis, stigma, and also unintentional disclosure to others (Elizabeth Glaser Paediatric AIDS Foundation, 2018:7, Amankwah-Poku et al., 2021:2). The participants revealed that they had indeed disclosed to the foster children that they were HIV-positive.

It was me and my brother's child because they're also like that (have HIV illness), she said you and me my cousin's child, are going to take our pills forever like your grandmother, you see she takes her medication for high blood and ulcer – it's all the same. (P10, 66a years)

I explained everything to him. ...I refused and chose to tell him myself when he is comfortable at home rather than him hearing it from someone else. I also explained that there is no shame in living with the disease and that he is not the only one nor is he the first or the last person to live with it. He then answered, saying he takes his treatment with his schoolmates, so he has accepted and is not ashamed that he has the disease and that next time he would go to the clinic himself. (P7, 62 years)

When I explained it to her, she was very calm and understanding and even asked if the medication given to her will help or not and I told her it will assist her. (P2, 49 years)

Yes. We told the child that she did not get the HIV through sexual intercourse and that there is nothing bad that she did. We told her that she got the HIV whilst in her mother's womb. (P5, 58 years)

For the current study, some participants took it upon themselves to disclose the HIV status to their foster child. In contrast a study conducted in Central Region of Ghana where the majority of the participants (n = 16, 66.7%) were able to disclose with the support of their health care providers with only a third (n = 8, 33.3%) being able to do so by themselves (Hayfron-Benjamin, Obiri-Yeboah, Ayisi-Addo, Siakwa & Mupepi, 2018:5). For a study conducted by Amankwah-Poku et al. (2021:5) disclosure was mostly related to medical adherence and the psychological wellbeing of the children. It seems disclosure is a difficult process, hence some parents were able to disclose with the assistance of a health professional. For some, disclosure occurred to encourage adherence.

The participant below mentioned that she waited for the child to mature before disclosing, the delay was to prevent the child from disclosing to people she is not supposed to disclose to.

...Because I waited for her to grow up first, I was afraid if I told her at a young age she will tell her friends "my aunt says I have AIDS" because she is a child and does not know what AIDS is and those that know what it

means would discriminate against her and not want to play with her. So, when the others were not here, and I called her to my room and locked the door. I explained that the pills she's been asking if she's going to take them forever are for [HIV], because she grew up thinking they're for her allergies (P11, 66 years)

The decision to reveal an HIV diagnosis to a child or adolescent is influenced by various factors. Age and developmental maturity are the primary considerations in determining whether a child or adolescent will be informed; typically, the older the child, the greater the likelihood of them being aware of their status (World Health Organization, 2011; Murnane, Sigamoney, Pinillos, et al., 2017).

After picking up the medication one day, a participant heard the child expressing dissatisfaction to their grandmother about having to take medication consistently. This led the participant to believe it was necessary to explain. Likewise, the grandmother disclosed the HIV status of the two younger grandchildren to them and their two older siblings. The infected child inquired about the reason for taking medication, which in turn led to the disclosure.

During the week I sat down with him and told him he's going to start fetching the medication himself – he already knows where to go and I told him when they ask him what kind of medication is he taking, he must say they are for HIV and he said “NO” – you want me to have HIV? I won't say that!” and I said to him everyone he sees at wellness clinic, young and old, are there to collect HIV medication so HIV doesn't kill, So, I told him yes, you have the illness. You got it from your mother – his story is heart-breaking so I couldn't tell him he was born without it because he would be angry at his mother so I just told him he was born with it, it got transmitted through his mother during birth. (P6, 59 years)

...so I sat down with all four of them. ...so I told them I want to explain something to them, I had discovered that your mother had HIV, and when you were born you contracted the disease, ...they said we have the disease

*that means we will die, and I said no, it wasn't easy explaining this to them. More especially because **** is now 12 years old. Last year she started being uncomfortable, asking questions like why is she taking the medication and where is her dad?... (P3, 55 years)*

When questions are asked, responses should be given. A study in Central Region of Ghana indicates that 70.9% of the participants were required to disclose as their children were curious about their regular clinic visits and everyday prescription regimens (Hayfron-Benjamin et al., 2018:5). Similarly, in a South African Study, the majority of caregivers disclosed an HIV-positive status because children were constantly asking about the length and reasons for consuming medications (Mafune, Lebesse & Nemathaga, 2017:5). It is clear that the inquisitiveness of the foster children led to the disclosure of their status, it makes the researcher wonder if they had not questioned their foster parents, would they have known the truth about their health status.

Not all the participants were confident disclosing to the foster children themselves. Two participants requested the assistance of the health care worker. The World Health Organization (2011:103) clarifies that adults always find it difficult with the questions of whether, when, and how to tell children that they have HIV, hence some caregivers prefer to be assisted by health care providers such as a doctor, nurse and/or social worker.

The day we went to take her medication, I then asked the nurses to explain further on what I've already told her. They spoke with her alone, that was then she cried – when I explained it myself, she didn't cry but now the nurses were explaining in further details...(P11, 66 years)

When I took the child to wellness, I saw how she started wanting to read her medical file. I [then] requested the nurse to explain to her. The nurse told me, "Granny I will not explain to you, there is a social worker who will assist you to tackle this problem. I took her to the social worker there. Then the social worker sat me down and told me "Granny, can you please bring along the other siblings who do not have the illness. So that they can sit down with me." She sat down with them and had a talk with them so that

they know, and she was thankful that the elder sister came, as she will be able to assist the child in my absence. (P13, 69 years)

Given that caregivers may lack the skills for disclosing (Madiba & Mokgatle, 2017:177), which is consistent with the findings, a study in West Bengal, India found that participants thought that it was suitable for professionals to disclose the diagnosis to the children. However, the study conducted in the central region of Ghana recorded the highest non-disclosure to children about their HIV status, the highest being 76,7 % of children who were not told about their status by their caregivers (Hayfron-Benjamin et al., 2018:7). Participants of this study did not focus on the complexity of disclosing but rather on the benefits the foster children will get in knowing their HIV-status.

(a) Category 2.2.1: Children's reaction after discovering that they were HIV positive

According to Elizabeth Glaser Paediatric AIDS Foundation (2018:16), children are concerned about what will happen to them during the course of their disease. Children living with HIV/AIDS are susceptible and it is crucial to note the psychosocial needs that come with the HIV status requiring social worker's attention as most children are contending with feelings of fear, anxiety and fatigue (Fabianova, 2011:178).

The research findings confirm that anger, fear and anxiety are some of the expected emotional reactions affecting individuals living with HIV after learning about their diagnosis.

It was not nice. The children were crying. It was not pleasant at all. (P3, 55 years)

He got sick few days after the mother passed on. At night he started complaining that his ears and teeth are painful. He would cry and not sleep. (P14, 70 years)

But as we continued staying with her she became angry again and started threatening to commit suicide and when I reprimand her she would threaten

to kill herself. ...The social worker wrote everything down and further advised that we consult the psychologist ... (P2, 49 years)

Denial is described as a “delusional refusal to accept an unpleasant or threatening truth” (Sykes & Nichols, 2015:138). Some of the foster children did not believe or accept that they were HIV positive. The children refused to associate the illness with themselves.

She did not accept the illness. She said she is not sick, but I could see that she is getting depressed. So, I sat with her down and told her not to worry as everybody gets infected with HIV. I said to her “this thing does not start with you, all of us we are sick. There are children whom I know who are sick and they stay in our street”. I told her that there are children who are infected with HIV and they stay with their grandmothers. (P5, 58 years)

Hei! (sigh) she did not accept ... She does not believe, even now she still does not believe, she says “I don’t have it, I don’t have HIV”. Even now she does not accept. But at school she does hear information pertaining to HIV, but at the hospital when they explained to her and her sister, I found that she did not believe. So, the social worker explained to her that when we mention HIV, it does not mean that the illness is glued to her, HIV is in in her blood. She will not see it. That is how she explained to her. (P13, 69 years)

For now, she is still young, she will not believe because she is still healthy, she will never believe. (P13, 69 years)

The findings concur with a South African study where participants’ most common defence in the face of an HIV-positive test was denial (Mashele, 2012:49). HIV has a stigma attached to it, therefore it does not come as a shock that people diagnosed with the illness refuse to be identified with it.

Not all the foster children were in denial about their HIV-status, some children accepted their HIV status and noted that some of their classmates were also taking ARVs. It became easier for them knowing that they were not the only ones taking medication.

I see she has made peace with it because she even told me that some pupils at her school also take the pills, she thought that she was the only one, she has already seen five of them. She saw one of the learner's container for tablets and saw that it was the same one she has. She said "aunty I have accepted". (P11, 66 years)

She accepted, just the other day she was telling me she has accepted, the day you came, on Thursday, she came back late because the school had called nurses to check all the children, but she said she did not go because she already knows her status and she has accepted it. (P10, 66a years)

He never gave me problems. He just took the news in his stride. (P7, 62 years)

When he started to grow up, I sat down with him and explained to him and he accepted. He said to me "Mama"... and I said "yes?" and he asked if he had the virus and I said Yes. And he said "Okay Mama, I am not the only one". (P9, 65 years)

He was not weary. He just continued playing. Currently, I told him not to tell people outside because they will insult him, like they did at school, that he has HIV. He took this issue lightly, thinking it is something you can casually talk about, I told him, "this thing is an illness my child, you must take care of yourself". (P12, 67 years)

4.3.2.3 Sub-theme 2.3: Disclosure of children's HIV status to relatives

In the case of disclosure of a child's HIV status, the person disclosing must have adequate maturity to comprehend the benefits, dangers and social implications of disclosing a child's HIV status (Grant et al., 2012:25). Almost all the participants indicated that they had disclosed the HIV status of the foster children to their extended families. The terms

"extended family" include relatives who are blood related such as grandparents, fathers, mothers, children, and parents' relatives, all of whom share food, housing, and resources from a communal pool (Ringson & Chereni, 2020:101). In the context of this study, relatives include aunts, uncles, grandmothers and siblings of the foster children. When one family member has the HIV illness, all the family members are affected.

The participants in this study confided in their family regarding the status of the foster children. The participants indicated that some foster children were able to share their status with a brother or uncle or sister. Based on the foster parents, some children felt that their mothers could have done right by informing relevant people about their HIV status.

It is his uncle and brother. He has an older brother but he does not have the illness. He has his own family. It is only the two of them. He talks freely with them. He would say "what his mother did was wrong, she knew she was pregnant with me and had this disease but she gave birth to me. "I even grew up without her taking me to the clinic or explaining to my grandmother to take me to the clinic, for her to explain to the nurses that she was pregnant whilst she had this disease". But it does not matter anymore as long as my grandmother is taking care of me, that is what the child said.
(P14, 70 years)

He sat down with her and spoke to her about it. (P9, 65 years)

According to the participants, the siblings and some family members were suspicious that the foster child might be ill, however, were reluctant to inform the participant. Their suspicions were confirmed.

*I sat both my children down and told them that ****. is infected with HIV, therefore we will continue staying with him in our home. We have to be supportive and compassionate about the whole thing and that we have to work together, when I'm not feeling well enough to take him to the clinic, we*

have to assist each other, and someone else must accompany him for a check-up. (P7, 62 years)

My sister's child and my child were scared to tell me, that they were aware of the possibility that the child could be HIV whilst I did not notice anything. The child had diarrhoea. They say they were afraid to inform me. (P7, 62 years)

My sister knows. It was just the cousin and they didn't really say much. It is my stepmother's family, my stepsisters. (P10, 66a years)

It has been indicated that some of the participants shared information with relatives without the knowledge and permission/consent from the children. As Grant et al. (2012:23) has stipulated, the person disclosing the status of the child must understand the benefits and dangers attached to disclosure. It seems the participants understood the consequences of disclosure, and fortunately for most of them, they received considerable support from their families and not rejection.

In this house it's only me – but my sisters know too, they knew before their mother died because sometimes when she's not well they would come and check up on her so she told them herself. They weren't okay with it but now it's better because it's a part of our lives, back then when someone had the virus we would just wonder where God will place them on earth. It was very difficult. (P16, 79 years)

We did not ask her first. I told her grandfather and uncle so that all of us at home may know and nobody will tell another person about this. It was the child who was going around telling people (friends and boyfriend) about her illness. They blamed her for telling people out there about her life. She said she will never do that again. (P5, 58 years)

It's all the aunts from both paternal sides. Permission was not sought from the child because she was still young. (P8, 64 years)

The child did not give consent because he was too young. It was the aunties and his grandmothers, and their kids, so basically the family. (P6, 59 years)

Everyone in the family knows, I did mention it to them, my husband knows, her elder sister knows, her uncle also knows. I am an expressive person. (P13, 69 years)

The child's aunt and uncle who smokes nyaope knows. (P12, 67 years)

A participant shared information with the child's uncle and aunts without permission because she was still young.

Before I could tell my husband, I sat down with the child and told her that I needed to tell my husband as we will be staying in his house. I told her that my husband needed to know that we needed to give her good treatment due to the sickness. She said that it is fine but she was worried that my husband could tell people. I assured her that my husband would not tell anyone. (P4, 56 years)

Pretty much everyone at home knows. (P1, 45 years)

So far, it's only my two male children. I only told my sons because they were assisting me to take care of her from an early age. They regard her like their sister and are constantly worried about her and her wellbeing. (P2, 49 years)

The participants informed other family members regarding the HIV status of the child. Similar to the South African study conducted in another province, with regards to disclosure of the child's HIV diagnosis to other people, almost all the caregivers reported that other members of their family knew about the child's HIV diagnosis (Madiba, 2012). Those who knew were the grandparents of the child, siblings of the parents or caregivers and other extended family members like aunts and uncles (Madiba, 2012:218).

Foster children and participants also shared information with professionals such as social workers and educators.

The child was the one who communicated directly with them because they would take her somewhere, she wouldn't discuss what they discussed with her. (P8, 64 years)

***** agreed that I reveal her status to the social worker, she did not have a problem. (P2, 49 years)*

*I did not get permission from the child to tell the social worker. The reason I told the social worker is that I experienced some struggles, where ****used to get her treatment was far as she was using transport and some days, I would not have money to give her for transport. Sometimes we use taxis both of us, I accompany her to the clinic because she is still young. (P4, 56 years)*

I think it was last year or 2021, it was the three of us (social worker, participant and the child) at her offices. When I told her about the child's status, she told me she would send you, to a lady she knows who deals with children like these.

I had to tell one of the children's (granted grandmother permission) teacher because she participates in sports at school and other activities so it was going to be hard to hide something like this from a person working so closely with her, so I had to make time and go tell her the information that she knows the condition of the child in case there is an accident so that in the future she wouldn't say I was selfish for withholding important information. (P3, 55 years)

Participants saw the importance of informing the teacher and a social worker about the child's status. Unlike in one South African study, none of the teachers were told of the children's health status, even though school connectedness is seen to be essential for

Children Living with HIV (CLWH) in South Africa (Atanuriba, Apiribu, Mensah, Dzomeku, Afaya, Gazari, Kuunibe & Amooba, 2021:8).

(a) Category 2.3.1: Relatives' reaction to information on children's HIV status

Family members experience a range of emotional reactions upon learning about a child's HIV status, such as fear, anger, shame, and sadness (Lwelunmor, Airhihenbuwa, Okoror, Brown & Belue, 2012). Despite this roller-coaster of emotions, disclosure of HIV status can lead to increased social and emotional support for individuals living with HIV and AIDS. It is assumed that most relatives had information regarding the cause of death of the foster children's mothers hence, they were understanding when they received the news.

They were both very understanding after a while – the youngest one asked how sure were we that those results are legitimate. I assured him that it's true and he asked if it's necessary for her to take the treatment and what's the worst that could happen if she doesn't. I assured him further and he understood. (P2, 49 years)

Everyone was understanding and there were no negative talks or concerns of any 'kind'. (P7, 62 years)

Aaah! they did not have a problem. They saw other people surviving as they took pills. They were disappointed that their sister had this illness when these pills were available, she would still be alive. (P14, 70 years)

The HIV infection of the child was understood by some family members, but others reacted poorly and were emotionally hurt by the news. Despite this, the family members were actively helping and supporting the child with everything related to their illness. The following story lines shows the emotional reaction to the news:

They were hurt by the news, especially because the child was born without it, but they ended up accepting it. (P6, 59 years)

They were hurt and that is why they are assisting me. They tell him the time because he does not have a watch. The doctor told us to buy him a watch, but it is futile. Even if we buy him a watch sometimes, we still need to remind him that it is time to take his pills. He will not check that he must take his pills. Hence, I say sometimes he takes his pills late. But now I made sure that they set reminders on their phones, it must notify him and they must tell him that it is time to take his pills., Initially, I was the only one who used to remind him, currently I am ensuring that he learns because he is growing up. (P12, 67 years)

I could see that my boy is heartbroken when he looks at the HIV positive child. At times, he would volunteer to take the child to crèche while I am around because he felt sorry for the child. Even I felt sorry for her. My son asked me if the child will grow up, I told him that she will as long as I go fetch her treatment at the clinic. My son took time to accept her illness. (P4, 56 years)

*I'd say they were okay with it because they were aware of how ****'s mother was living. (P1, 45 years)*

*It was her aunt who took her to the hospital and she was never okay, she was very hurt, she's the one who found the mother's results when she died and now, she's overprotective of the child. Even when we tell her **** did something – she would say “No, we must let this child be” and I tell her she is being easy on her. The aunt would say “we are with our kids and she doesn't have her mother, let's not treat her bad because she might be rebellious. (P8, 64 years)*

They were hurt because she was young. I explained that she got it whilst in her mother's womb. And that was the time when her mother wasn't taking medication. They are adults and they sometimes read about it from pamphlets we get at the clinic so they know. (P11, 66 years)

The current study shows that some family members are resilient whereas others find it difficult to accept having a family member who has HIV illness. The critical point about the situation, is that, it is how the family navigate the adversity by providing enormous support to the participants about anything concerning the child. The foster children are aided in carrying out their daily life tasks by these individuals. Additionally, they have become involved in the journey and make sure that the foster children do not experience the absence of their mothers.

It is clear that the majority of the participants have considerable support from their family members after disclosure, similar to a study in Ghana, which revealed that good family support is a key factor in creating a positive experience (Afful, Benjamin, Asiedua, Donyeh & Abraham, 2019:7). In addition to the financial support received, siblings and other family members care for the affected children in their absence as well as assisting in performing activities of daily life such as bathing, grooming, and feeding. This support lightens the caregiver's burden (Afful et al., 2019:7).

4.3.3 Theme 3: Foster parents for children living with HIV

Among the various factors that lead South African children to be placed in foster care, is the loss of parents as a result of HIV and AIDS (Carter & Van Breda, 2016:208). Research has shown that some children are not raised by their birth parents due to a variety of factors, such as neglect, abuse, and HIV/AIDS (Tladi & Setlalentoa, 2020:15045). Currently in South Africa foster care is a popular alternative placement and child protection system that is utilised to allow vulnerable children to receive care, safety, and support (Emovon, Gutura & Ntombela, 2019:12; Tladi & Setlalentoa, 2020:15045).

Regarding the care of HIV-infected children, some participants were assigned by the mothers of the foster children before their death, while others, grandmothers and aunts, felt obligated to care for the children. There were only three foster children who were in the care of a volunteer. The research participants legalised care through a foster placement ordered by the district court, making them legally "foster parents" of the foster children.

4.3.3.1 Sub-theme 3.1: Maternal grandmothers caring for grandchildren

Within a lot of African communities, the responsibility for caring for an orphan rest with the closest relatives, with the result that underprivileged grandparents bear the heaviest burden without being financially, physically or emotionally prepared (Phetlhu & Watson, 2014:348).

The role of grandmothers has changed in Africa, and they are viewed as the newest mothers whilst their roles are understood to be changing (Mtshali, 2016:77). Indeed, the grandmothers in this study had to fill the motherly void left by the biological mothers. They felt obliged to take care of their grandchildren following their daughters' passing. One of the maternal grandmothers indicated that it was God's plan for her to care for her grandchildren.

I volunteered because my daughter's children are my children, no one asked me – I just told myself that I will take care of the children as if they were my own, my younger sister asked for them when they were still babies seeing that she doesn't have any children of her own, but I told her they would still remain under my care and if God calls my name, they would be her children. (P10, 66a years)

... I am the one who took the responsibility of caring for them because they are my daughter's children. When their mother passed on, she was residing with me. She was not married, so when she passed on these children were left behind and there is no one else. I am their grandmother. I have to be their mother. I am the one who takes care of them. I am the one who chose myself to offer care to these children. (P13, 69 years)

I struggled with them, and they eventually grew up. Because I kept asking myself that if I don't take care of them then who will because their mother is late and she was my only child, with no siblings ... So, it was my responsibility to take care of these children. Today they are all grown up. I've been keeping things together, taking care of them, living and growing together with my husband. (P9, 65 years)

... it wasn't anyone's choice it was by God's plan. No one chose me and I'd say God knows everything because their mother was my only daughter, and she was infected with the HIV Virus at that time she was very secretive about it and she never told me as her mother that she is sick. (P3, 55 years)

Of the 16 participants, eight were maternal grandmothers. Thus, it is evident that grandparents are an important source of care for children and adolescents. The findings are supported by the study in Uganda where more than 41% of children and adolescents in their study reported living with their grandparents, mostly grandmothers (Karimli et al., 2013:8). Numerous South African studies (Mtshali, 2016:77; Tanga, Khumalo & Gutura, 2017) reveal that grandmothers are indeed taking on the responsibility to care for vulnerable children. This indicates that grandmothers play a crucial role in giving foster children a chance to experience motherhood or motherly love since they are orphaned.

4.3.3.2 Sub-theme 3.2: Children cared for by volunteers

Due to the depletion of the capacity of extended families to adequately care for the children of deceased or incapacitated relatives, many children must be placed outside of the kinship care networks (Carter & Van Breda, 2016:210; Pretorius & Ross, 2014:470). However, where and with whom children are placed is of supreme importance (Font, 2014:2074).

Kinship care is perceived as an ideal alternative to non-relative foster care hence priority is given to family placement over non-family members or cluster foster care (Böning & Ferreira, 2013:520/ 21; Font, 2014:2075). Kinship foster care has long been used among African families. It is usually more advantageous than non-related care because it is easier for a child to adjust to family members whom he or she knows, although, caregivers require time to forge an attachment bond (Font, 2014:2076, Pretorius & Ross 2014:470, Böning & Ferreira, 2013:520/ 21)

It can be understood that when foster parents start fostering foster children at an early age, this gives them an opportunity to form a cohesive bond and for foster children to adjust easier in that kind of placement.

One participant volunteered to foster children they are not related to.

I don't know their mothers as they have passed on. That is the reason they were brought to me. I made the decision myself because I love kids. It was my choice to care for these children. No one came to me and ask to take care of these kids. I met a lady from the Place of Safety, we had a chat and she told to me to report at their offices to register as a foster parent". (P15, 76 years)

Another participant provided a background of how she met the children.

I met a white lady carrying one of them on her breast and pushing the other two in a pram. She was on the other side whilst I was on the other side too. I became worried about her, when I saw how she was holding the baby, I thought there's something wrong with her breasts. When I was busy complaining, the queue controller told me to stand behind the lady that was carrying a child and that was when I asked if there's anything wrong with breasts and she said no, these babies are kangaroos. She then took out the baby to show me, the other two were in a pram. When I look at the kids, it just confirmed how I love children (P15, 76 years)

I went to their centre called Place of Safety. When I got there, we sat down and talked, I wanted to know how they started the place. She gave me a form and told me to fill it in with all the information required, including the type of children I would like to take care of. But like I said, I already had love for orphans and sick children because I want to share my love with them. Indeed, that is what happened, I filled the forms, they then told me they would come to my house after three weeks to asses it. And because God

will bless you if you are doing something that you love – when they came to my house for an assessment, they had two kids. I then asked if that's the right way to do an assessment and they explained that having read my file, they saw me fit to stay with the two babies. They left me with those two kids and I signed all the necessary documents, then they went back. I lived with the kids, they were infants, in fact newborn. (P15, 76 years)

This current study confirms that related foster care is also the most preferred placement as stipulated by scholars (Font, 2014:75, Böning & Ferreira, 2013:520/ 21; Pretorius & Ross, 2014:470) since out of the 16 participants, there was only one volunteer who was fostering three foster children, two of which were living with HIV.

Similar findings were reported in a South African study where family placements dominated the case loads of social workers, with formal foster care by non-family members at 23.55% and family placements/kinship care at 76.5% (Böning & Ferreira, 2013:526). The study suggested that non-relative placements can be ideal for orphan children when the volunteer has a natural love and passion to care for them. In a study conducted by Emovon, Gutura and Ntombela (2019:22), it was found that volunteers caring for non-relative foster children are motivated by their love for children and a desire to make a difference in their lives. This suggests that love and passion for children are crucial qualities for volunteers. Mutual acceptance is crucial for voluntary foster parents, when they start taking care of foster children at birth or before the age of one, it becomes easier to form attachments and bonds.

4.3.4 Theme 4: Participants' experiences in caring for children living with HIV

Experiences of caregivers of PLWH have been recognised to be tiresome (Atanuriba et al., 2021:2; Phetlhu & Watson, 2014:1). However, several studies have documented negative experiences, which imply that parenting a child with HIV/AIDS is linked to numerous undesirable experiences and as a result positive experiences receive little attention (Phetlhu & Watson, 2014:1; Afful et al., 2019:2; Atanuriba et al., 2021:1). Some

caregivers have expressed feelings of completeness and satisfaction while carrying out their responsibilities as family carers. Moreover, they believe that they have performed admirably in their assigned role of caring for PLWH.

The discussion above highlights that caregiving is far from a simple task; it comes with its own set of challenges and meaningful milestones along the way.

It seems that caregiving can offer both positive and negative outcomes. Pertaining to this study, participants have had their fair share of positive and negative experiences in caring for children living with HIV.

4.3.4.1 Sub-theme 4.1: Participants' knowledge of HIV

According to Abdi, Ereg, Ali and Ranhlenbeck (2013:246), knowledge is an important feature in HIV-infection prevention. Thus, knowledge is a powerful weapon to reduce and control HIV stigma (Rahman, 2014:443). The participants are mostly from semi-rural areas where they had ample knowledge regarding HIV.

I understand it's a disease that can be passed on, when you have HIV and AIDS, you must take care of yourself, like when you're injured, the person attending you must take care of themselves, make sure they don't have any open wounds/cuts so your blood doesn't mix, if your blood mixes, it might affect you even if you are negative and as they grow older and become sexually active, we must teach them to protect themselves so they don't infect other kids because it is transmitted when you do not protect, that is what I understand and they must eat healthy too, even if we can't afford that many fruits but they must eat them and vegetables so that their bodies are strong. (P6, 59 years) Those who teach us are the ones at the clinic (Health professions). When they explain in details about HIV, at is when I learn. It also depends on how you conduct yourself in your home. (P13, 69 years)

What I understand is that it's just like any other disease, that when you got your diagnosis on time, if you eat right, take your pills on time, live according to instruction, it is possible to live longer than expected. I don't see it as a

threat if you take the treatment on time and regularly. It is just a normal sickness like cancers and other sicknesses as long as you are on treatment.
(P3, 55 years)

It was learnt that among the participants, two were living with HIV. Their knowledge about HIV seemed to have made their caregiving journey seamless

At the hospital I was also told about how one could get the virus from open wounds and sharing cups. That's how I learnt about HIV, and that's how I was also able to advise the children on which precautions to take, I didn't hide my status from them and instead I use it as an example for them and at the rate they're stressing me out, I've started fainting and the clinic can't detect the disease because it cause by them stressing me out with arguing about the basic house chores like the dishes, cleaning the and doing laundry. (P1, 45 years)

Eish! I don't know how to explain it because a lot of time they (nurses) explain to us at the clinic and wellness, regarding this illness and how it is transmitted. That's where we understood that this illness, is an illness that is in the blood. They also informed us of how you carry yourself when you have the illness. (P13, 69 years)

The participants' views support the findings of a South African study, which showed a remarkably high level of HIV and AIDS knowledge amongst caregivers of HIV positive children in Pretoria (Ofunne, 2014). It is argued that the level of HIV and AIDS awareness varies by geographic area, gender, age, residence, and wealth position (Owusu, 2015:64). One participant, who was a non-relative foster parent, received all the necessary information regarding the foster children's HIV status from staff at the place of safety. She was also fortunate to partake in various courses regarding HIV offered by the place of safety.

At the place of safety, before they gave me the child, the time I went to fill the forms, I went inside K's office, she sat with me, she was looking at my

application form, like you are looking at your document. She said “I see you mentioned this and that” and I explained ...I don’t have a problem with the children’s illness, even if it is “this kind of illness” I do not mind. (P15, 76 years)

The findings of this study raise a concern that other participants had no knowledge of HIV. Out of the 16 participants, only three indicated that they do not have knowledge about the illness, they could not articulate anything related to HIV.

There is nothing that I understand. My child got very sick. I even encountered stress not understanding what is happening whilst she was sick. I did not even attend her burial because I was not ok. I did not go to the cemetery. I was stressed and didn’t understand what was happening. After a long period, that is when I accepted that my child has passed on’. (P14, 70 years)

I don’t understand what it is exactly, it’s not something you can pick up from the floor, like a child with flu. you just see them with flu, what I’m satisfied with is being able to attend to them when they are not well. So until now, God has given them to me, not know what tomorrow has in store but we are living a bit better. (P16, 79 years)

If I said I knew the answer to that question, I would be lying. (P12, 67 years)

Age and limited education are identified as contributing factors to the level of knowledge regarding HIV and awareness (Owusu, 2015:64). The three participants are in their old age, hence they have insufficient knowledge pertaining to HIV. It is also noteworthy that two of the participants never attended school whereas participant 16 only attended until standard 6. Although the mentioned participants had access to information, they were unable to comprehend due to illiteracy. This is not a surprise since scholars (Rahman, Khan, Mondal, Alam, Ahmed & Islam, 2014:442) have found that illiterate participants have a minimum level of knowledge (48.00%), whereas primary, secondary and higher educated participants have shown 59.00%, 61.00% and 63.00% knowledge respectively.

The level of education plays a role in the comprehension of the HIV disease. It is alarming that the three participants have no knowledge yet have a gigantic responsibility of caring for the foster child living with HIV. Positively, the findings of this current study show that thirteen participants had knowledge about HIV. Similarly, a study among villagers of Comilla district, Bangladesh, revealed that participants' knowledge level about HIV/AIDS was 92%.

4.3.4.2 Sub-theme 4.2: Information and training received by participants on caring for children living with HIV

The family is the core function in the life of a child living with HIV. Achema and Ncama (2016:257) state that the family plays an imperative role in the treatment and care of the sick child. Of the utmost importance is that family members work together to improve this care. It is, therefore, critical that family members comprehend the child's illness. Therefore, even after hospitalisation, the family becomes a significant part of the health role players, which affords opportunities for educating the whole family on HIV and AIDS matters, such as treatment options and supportive care.

Four of the participants were equipped with training or information regarding HIV, and were informed by nurses at the hospital. It is evident from the study that health care workers played a pivotal role in training the participants informally with ample knowledge about HIV. However, some of the participants took the liberty of increasing their knowledge about HIV by means of watching TV, listening to the radio, and reading pamphlets related to HIV.

I was told by the nurses. The time that the child started treatment, they gave me hand gloves, when I bath him when he goes to school, I must wear hand gloves. They only told me to take care of him, that I must bath him and give him his medication on time. They said they don't want him to deviate from the time they gave him that he must take the medication'. (P14, 70 years)

He (grandson) had already contracted the illness. They also told me to use Dettol soap when bathing him. We must not change the soap. Even now I buy him the Dettol soap. (P12, 67 years)

Oh yes, they (nurses) have explained, they told me about how to treat the child so that he doesn't feel discriminated or left out. They spoke about how to treat him with love and care. They (nurses) said, if possible, he must be given special treatment so that he feels at home. They (nurses) also spoke about their pills, they said we must make sure they take their medication well, because some (foster parent/guardian) would tell them to take their pills and if you don't supervise them, they don't take them. You must make sure that they take their pills so that they can be fine. (P6, 59 years)

When they (nurses) explained to us at first, they told us when the child is bleeding, we must not touch the blood with our bare hands, we must use hand gloves. (P13, 69 years)

There was one participant who had an advantage since she works at hospice, therefore she was trained in how to care for an HIV infected patient. The following are her words:

*The only training, I had was at hospice, my workplace. I take care of HIV and cancer Patients on a daily basis and I treat all of them equally. Hence it wasn't a problem for me to raise **** without discriminating against her or any of my patients at work. (P2, 49 years)*

The 11 participants who had not received training, applied their intuition in caring for a child living with HIV, caring came naturally as they raised the foster children like any other child. The experience of seeing others living with HIV sheds light for the other participants in caring for a child living with HIV. The following storylines illustrate the views of the participants:

I just raised them, I never went to school or training on how to take care of HIV Positive orphans. I volunteered to take care and raise them, even take

care of their medication. I just make sure they eat, drink, go to school and church'. (P11, 66 years)

It [caring] just came naturally, the only person who assisted was the social worker who alerted me of her mood swings and that I should remain calm at all times, that's as good as it gets. (P10, 66a years)

I have never received any counselling or training; it was just my intuition that guided me on how to raise her the way I did. I have never received counselling, the nurses have never visited me, it was just my instincts that made me raise her the way I have been doing. (P8, 64 years)

It just came naturally as we're living, sometimes, like us having this talk now, I get advice, but I just took them as normal children whom when sick I take to the clinic. When we went for counselling after finding out their status, I asked them [a counsellor] "so what do we do now, where to from here and when the kids are sick, do we bring them here?" and what satisfied me mostly was that they said I can take them anywhere, either to the doctor or to the clinic. (P16, 79 years)

I didn't get any training. I had to learn by myself. I saw how others living with this virus lived their lives and how it (HIV) affected them. And I followed suit. (P9, 65 years)

I have not received any training from anyone. I just told myself that I will gladly raise the child, the same way I was able to take him to the hospital myself and I will raise him through prayers. (P7, 62 years)

I never received any training, I read books sometimes and listen to the radio. And my part-time job also contributes because I work part-time in theatre, but that was before Covid – it's an entertainment industry and I was introduced to it by a friend when I had stress and depression, so I volunteered just to see what they are doing because they have live shows on stage like Generation but it is live. Most of the time they bring HIV Positive children and orphans, sometimes I would sit down with those

teachers and ask them how they dealt with this and that and sometimes they have guidebooks and I read the booklets. Even at work, when we were office based, during AIDS day, they use to light candles, and let people share their stories, whoever has HIV, so I learnt from there so most of the time I motivate myself because I wanted to build a better future for these kids. (P3, 55 years)

Raising a child has its challenges. However, more challenges are encountered whilst raising a child with a chronic illness. It is imperative that caregivers caring for children living with HIV, be well equipped to care for the concerned children to the best of their knowledge and capability using approved HIV health guidelines. To show the importance of training pertaining to HIV, in Warwick's (2013:70) study, participants expressed that they would have felt better equipped to care for their foster children if there had been some sort of training course or material offered to them for effective caregiving.

In a process to stop the overwhelming effects of the HIV and AIDS pandemic in Ghana, the government, private sector, community-based and non-governmental organisations continue to implement a number of educational and promotional programmes to educate the general public about the causes, consequences and prevention of the HIV pandemic (Owusu, 2015:64). Just like Ghana, South Africa is also prompt in educating the masses about HIV/AIDS. The South Africa government (2022:1), in partnership with non-governmental and non-profit organisations offers relevant programmes to promote numerous HIV and AIDS prevention measures, such as antiretroviral treatment, medical male circumcision, prevention of mother-to child transmission, and HIV and AIDS counselling and testing campaigns, amongst others.

4.3.4.3 Sub-theme 4.3: Precautionary measures taken by participants

Raising a child with HIV is not an easy task and requires one to be equipped with the necessary knowledge on how best to care for a child living with HIV. Since some of the

caregivers did not have any knowledge about HIV, it is a concern about which precautionary measure they are implementing when caring for the child living with HIV.

It was exciting to learn that most participants are aware and practice safety measures whilst caring for the foster children.

... when they were young, I would wear hand gloves to be protected so as not to be infected. They said sometimes if they have sores, you must not directly touch the sores, you have to wear hand gloves then cleanse their sores. So, with me the foster children I am fostering, never had such sores, they are healthy children. One got extremely ill, however it was due to any children's illness, he ended up at hospital. He is healed now. During his discharge, he had recovered. There was only few areas on his body that needed to be cleanse. They did not give me problems. (P15, 76 years)

What they told us at the clinic is we must never bath them with our bare hands because her blood can penetrate you, you will get infected. (P12, 67 years)

I've stayed with them for long now and when they have a wound, I am the one who cleanse the wound but I always make sure I am safe by wearing gloves because it something that they say exist although I have never seen anyone contract it from touching the blood. It is like Covid, we've never seen it but we are told it's there. (P3, 55 years)

I know it's nothing to be ashamed of, it's something anyone can get and accidents happen – sometimes a child falls of a tree and hurts themselves and you rush to assist the child, dressing the wounds and everything without wearing gloves or any protection then you contract the disease through open wounds you weren't aware of at the time. So, I go for regular testing at the clinic, they would test me then tell me I do not have the disease. I am not ashamed to test, even when those who test us, they tend to think you will not receive the news well should you test positive. They even take me through counselling and ask me what I would do if my results came back

positive and I always tell them I will take treatment without shame. (P7, 62 years)

Participants ensured that safety precautions were taken to avoid the danger of being exposed to HIV. Their views are supported by a study where caregivers knew that they were not allowed to touch the blood with their bare hands in an incident where a child had injuries or cuts (Bejane, 2012:70). The participants in this study complied with the universal precautions of HIV by knowing the importance of not touching the blood of their HIV-positive foster children. To implement precautions, one has to have knowledge or an understanding about HIV.

(a) Category 4.3.1: Precautionary measures shared with children

It is essential for precautionary measures regarding HIV transmission to be shared with children. When foster children are not equipped by their foster parents about HIV, it can be assumed that they will get information about this illness at school. Since charity begins at home, basic rules should be taught to children by caregivers with the aim to prevent its spread. In this study, participants taught their foster children to be cautious.

*I sat them down and explained the situation and how we should help each other avoid contracting the virus through sharing of toiletry and others, and even assisted in reminding her to take her treatment at times. I told them when they have misplaced their toothbrush, they must not use ****'s toothbrush, because they know her status, should they utilise it they will have the same status as hers, so that's how I inform them. I also told her not to use other people's face cloth and also not purposefully infect them because she has the illness and she indicated that she will never do that. One time she was on her periods and the younger sibling borrowed underwear from her and I told her not to wear ****'s underwear, because she has HIV and if you wear her underwear, you will contract her disease. (P1, 45 years)*

Fortunately, I was lucky that when she went to school, the school would teach them about it. When she was bleeding, she would tell me “Granny don’t touch my blood, at school they taught us not to touch other people’s blood” even with me when I bleed, she would not touch my blood, she would tell me that no, granny that is your blood, I will not touch it, at school they taught us not to touch other people’s blood. That is where I saw that this child is maturing, I did not have a problem. (P13, 69 years)

In Ghana, sexual and reproductive health education, including HIV and AIDS issues, is part of the national curriculum (Owusu, 2015:64). The goal is to provide students with factual information on HIV transmission, impacts, prevention strategies, and the development of a positive attitude.

South Africa is also active in implementing intervention programmes at schools. For example, they implemented a peer education HIV prevention programme in selected high schools. A peer education programme is a health and behaviour change communication intervention used to reach 'hard-to-reach' groups (Mason-Jones, Fisher & Mathews, 2010:563). The goal of such approaches in the school setting is to help young people develop the knowledge, attitudes and skills required for positive behaviour change,

4.3.4.4 Sub-theme 4.4: Family support for participants and children

Although a resilient family is crucial for support for people living with HIV, the family structure may assist in offering the necessary love and care to children who are living with HIV (Achema & Ncama, 2016:261). However, it should be noted that HIV-related isolation and withdrawal, combined with the stigma and other associated factors, can have an impact on the supportive care provided to the children, especially when families and other people connected with the child may not want to be linked with the HIV condition.

In this study, family members contribute to the upbringing of foster children, by offering material and emotional support to the foster parents.

So far, it's my family and the child's, whom I also raised and now is employed at the bank. He is also the one whom I draw strength from. Whenever the child needs anything that I cannot afford, I request his brother to buy that item for him. For instance, when he lost his calculator at school, I the brother to buy it as it is expensive. His brother always provides without hesitation. He would also come here and sit his younger brother down and reprimand him to take care of his belongings. I just let him to live his life, whenever we need him, he is forever there for us. (P7, 62 years)

He then said he will help me, even when I don't have transport fare to the clinic, he will help me so that I will be able to take the child to the clinic'. (P4. 56 years)

My brothers and sister and my husbands' brothers. They are the ones who give us support. (P9, 65 years)

A study using focus group discussions on resilience amongst children living with HIV in Bhambay revealed that foster parents pointed out that extended family, NGOs and other faith-based organisations played a crucial role in providing material assistance and psychosocial support to children (Gomo & Raniga 2017:195).

Family support was also observed in a study conducted by Phetlhu and Watson (2014:353), where their participants pointed out that they received support from their relatives in the form of food, clothes and money, this enabled them to navigate the challenges they encountered. Family support is imperative to improve the psychological resilience and coping strategies of families (Cheraghian, Moradian, & Nouri, 2023).

Some participants did not have the privilege of receiving support from their families, which is worrying given the difficulties they face, particularly older individuals who are primarily taking care of teenagers living with HIV.

I am a single parent. I don't have any one to support me, my relatives don't even care about anything related to me. I don't care and I am struggling, and they don't care about me, actually they don't love me'. (P12, 67 years)

... the children have many aunts and uncles but none of them ever check up on them, not even during school holidays, none even thinks about at least buying the orphaned children Christmas clothes - my neighbours are poor and most of the time, I'm the one helping them. Ever since my partner died, I haven't had anyone else helping. I've been taking care of my 11 children'. (P1, 45 years)

Oh forget about it with regard to families, forget about family. You would rather be assisted by a stranger. Family is nonsense, they want you to struggle, they will undermine you, even when you die they will undermine you, family is not good. I don't know about your family, they don't wish you good things. (P12, 67 years)

Family support was found to be lacking in this study, with only three (3) out of the 16 participants reporting receiving support from extended family members. Similarly, in a South African study, most caregivers experienced a lack of financial, emotional, or physical support from family members (Hlabiyago & Ogunbanjo, 2009:510). Caregivers were hesitant to ask for help due to a desire not to trouble others and feeling ashamed about being dependent. This contrasts with another study where seven out of 15 participants indicated receiving both material and non-material support from their family, including assistance with daily activities and care for affected children in their absence (Afful et al., 2019:4).

Based on this current study's findings, it can be understood that extended families play a mediocre role in providing any kind of support to the participants and the foster children, some even go to the extent of derailing the foster child from their HIV regimen. It is alarming that with all the challenges that come with raising the foster children living with HIV, the majority of participants are not fortunate to have relatives who offer them support.

4.3.5 Theme 5: Challenges facing foster parents caring for children living with HIV

The challenges facing foster carers of HIV-positive children are extensive and can be overwhelming at times (Warwick & Langba, 2017:46). A challenge is a situation, activity or issue that is challenging, different, or complex and that has the potential for putting resources to the test before being perceived as or changed into an opportunity (Horikoshi, 2023:03). The challenges encompass the difficulties that foster parents encounters whilst caring for foster children living with HIV. Despite the strains, uncertainties, and financial struggles caregivers face, it is important to recognise the resilience and strength required for this role.

4.3.5.1 Sub-theme 5.1: Children's behavioural, social, financial and health issues

Numerous children's lives have been spared due to the expansion of PMTCT availability. Nevertheless, despite these improvements, children living with HIV run the danger of not reaching their full developmental potential (Sher, Hensels, Tomlinson, Skeen, & Macedo, 2018:1).

Delays in neurodevelopment and cognition have been linked to HIV (Mwaba, Ngoma, Kusanthan & Menon, 2015:4; Kumar & Kumaravel, 2019: 2156). Children with HIV infection have been found to have behavioural and communication issues (Mwaba et al., 2015:4). Participants' observations on the health of the child are shared.

I see that he is 12 years but his brain due to this illness, is slow. It took him some time, even to be able to speak, it was as if he is not mentally well. It is now that his brain starts working. I also see that even at school he is doing much better. He even speaks English, he surprised me by speaking English with his principal. Even now, you can see his report, it is impressive. (P12, 67 years)

They conducted a scan assessment on her (February 2021). What they said to us was that her brain isn't growing to its full capacity. She's now 17 years old with a brain of a four-year-old. And a lot of things made sense from there

*... So, they said her brain grows slowly, not in accordance with her age.
(P2, 49 years)*

Studies (Mwaba et al., 2015:4; Kumar & Kumaravel, 2019: 2156) show that HIV affects the Central Nervous System (CNS) after becoming infected. For instance, the characteristics of HIV-infected children include reduced intelligence, intellectual disability, specific learning disabilities, visuospatial deficits, psychomotor deficits, and attention deficits (Mwaba et al., 2015:4). In a study conducted by Sherr et al (2019:9) similar findings were reported, where children with HIV were more likely to struggle on a cognitive test and had worse academic accomplishments. It seems that HIV comes with various challenges, one being cognitive milestones. This challenge was also experienced by some foster children as stated above by the participants.

a) Category 5.1.1: Child's mental health issues.

HIV is believed to be one of the leading causes of the increase in mental disorders (Lyambai & Mwape, 2018:98). The likelihood of developing central nervous system (CNS) and mental illness problems is higher in children and teenagers living with HIV. This is due to the impact of HIV infection on the brain. Psychosocial stressors related to living with HIV also prompt mental illness (Nassen, Donald, Walker, Paruk, Vujovic, Duncan, Laughton & Moos, 2014:81)

In addition, research studies (Roux, Bungane & Strydom, 2016:44; Kumar & Kumaravel, 2019: 2160) indicate that children living with HIV and AIDS face serious psychological challenges such as low self-esteem, anxiety, and violent and depressive behaviour. Internalising problems can result in suicide and this will have serious negative impacts to AIDS initiatives programmes (Kumar & Kumaravel 2019:2160). One of the participants also encountered challenges pertaining to the mental functionality of the foster child.

She said even if I hid anything that she can use to commit suicide, one day she would pour hot water on herself and die. It started breaking my heart and what tore me further apart is that she would say I'd be arrested if she ever committed suicide. I then took the matter to the social worker ... and

asked to make a formal report so that should she succeed, I won't be blamed. ...We consulted the psychologist, and she was transferred to a psychiatric hospital ward where she is still receiving treatment. (P2, 49 years)

The most noteworthy conclusion of a study by Horton, McIntos, Ostinelli, Harriss, and Fazel (2025:20) is that it shows that children with HIV have high levels of psychological impairment. These children have a greater prevalence of mental health issues, including psychosis, which is more common than the population average, and psychiatric disorder in kids (55% in one research). Depression, anxiety, suicidality, self-harm, ADHD, oppositional defiant disorder, and conduct disorder are among the disorders that have been reported. Pertaining to the current study, mental health problems were relatively low. However, it is worrisome how the foster child in this study exposed herself to circumstances that could harm her. On top of her illness (HIV) the child is also receiving psychiatric medication. She had a dual diagnosis and had to adhere to medication, it is saddening that the foster child has had a lot to deal with medically.

The foster children were inquisitive, they did not accept taking medication on a regular basis without getting a proper understanding of reasons for consuming medication, they, therefore, requested answers from their foster parents.

She asked "so I will be taking the medication until when?". I responded "for the rest of your life". So, just like me, I am also taking the HIV medication. I have been under the treatment for too long, but they told me I don't have HIV. My husband is HIV positive. (P5, 58 years)

But when she was 10 years old, she asked me why she was taking medication. I told her I don't know the reason. When I fetched her medication from the clinic, I told the nurses that the child is starting to give me problems as she wants to know why she is taking medication. The child observed that there is no one in the house who is taking medication but for her at 7pm every day, I give her medication. (P4, 56 years)

Similarly, in a study conducted in Soweto, South Africa on *experiences of South African caregivers disclosing to their children living with HIV*, children wanted explanations of why they were taking their medication (Joyce, Ramsammy, Galvin, Leshabane, Liberty, Otwombe, Buckley, Milovanovic & Violari, 2022:9). The study further revealed that children who were unaware of their HIV status were more likely to inquire about their medication. Similarly, in this study, the children's curiosity about their treatment stemmed from a lack of information about their illness. This highlights the importance of providing children with appropriate knowledge about their medical condition.

With regards to the financial predicaments, the grandmothers of this current study are the breadwinners, depending on pension grants to meet the needs of the foster children. The current economy of South Africa is dire due to the after effects of Covid-19. Hence, it is not surprising that the majority of grandmothers are not able to fulfil all the basic needs of foster children. Consequently, it becomes even harder if they need to buy special food recommended for people living with HIV. Although the foster care grant is meant to provide for the basic requirements of the foster children, it is unfortunate that it is not enough to do so.

So far, it's only food, sometimes we don't have enough money to buy this and that but I collect bottles for recycling and I use the money to buy necessities. (P10, 66 years)

I endured all the tough times because she's my daughter's child and I can't give her to anyone. I must just take care of her, it was tough, at times she would be sick at night and sometimes I would pat her just to see if she's still alive and at the time she was not receiving a grant and I did not know what was going on and I had to ensure that she gets food. (P8, 64 years)

The findings from the current study resonate with the conclusions of a South African study conducted in Limpopo where they explored the challenges faced by caregivers of children on ART (Mafune, Lebesse & Nemathaga, 2017:3). Similarly, a study in Johannesburg also

discovered challenges experienced by social workers in placing children living with HIV in foster care (Muchanyerei, 2015:56). The studies demonstrated the financial challenges faced by participants, stemming from transport costs for follow-up visits and insufficient funds for food, particularly nutritious options, as well as clothing and pocket money for school lunches (Mafune, Lebesse & Nemathaga, 2017:3; Muchanyerei, 2015:56).

Furthermore, other scholars also concur with the findings of the study in that, even when the majority of the participants were receiving foster care grants, it was not enough to pay for all the costs of parenting an HIV positive child (Warwick & Langba, 2017:47). Similarly, foster carers expressed real worry about their struggles to give their foster children the nutritious meals needed, especially given their circumstances.

(b) Category 5.1.2: Children's disrespectful attitude

Challenging behaviours are common in children and adolescents (Schwartz, Waddell, Barican, Andres & Gray-Grant, 2016:3), with some experiencing more serious behavioural problems that can affect their success at home, school, and in the community (Schwartz et al., 2016:3). Additionally, children and adolescents with HIV have a high frequency of problematic or disruptive behaviours. These behaviours include conduct problems, impulsivity, hyperactivity resembling ADHD, violence, and rebelliousness (Nassen et al, 2014:90). The participants of this study also experience delinquency from their foster children.

She would also curse me out in the streets. She only cursed me once when I reprimanded her and told me that I gave birth when I was 17 years. I must be happy that she does not have a child, so I must not try to control her life. I told her social worker about the incident and they spoke to her about it, he told her not to disrespect me, but she never replied to him, you will just hear her hurling insults in the streets'. (P1, 45 years)

She sometimes shouts at me and one time she uttered the words "you are not my mother" and I told her "I am your mother. You don't have any other mother except me!". She was angry that I went shopping with her sister because I felt she was a bit slow and timid, she is good and energetic when coming to other things, not this, so had I gone with her she would've slowed

me down in a way. I took her sister and she couldn't tell me upright what she was angry about but after a few days she told me and I said I will go with her, even yesterday I went with her, me and her are close and we share everything, I even involve her in my plans'. (P10, 66a years)

She is disrespectful. When I spoke to her, she used to raise her voice at me and leave the yard. I told her that I will beat her until she becomes right if she behaves this way. I told her that no child will disrespect me. (5, 58 years)

She travels too much; the last time she came to me she was smoking cigarettes and when I asked her about it, she was very cheeky and told to me basically mind my own business. It really broke my heart because I started worrying that she might fall victim to other dangerous drugs. (P2, 49 years)

The prevalence of behavioural problems in this study is relatively low compared to a cross sectional study which found that behavioural disorders in children with HIV, were found in 72 (69.3%) of the 104 children that made up the research group (Kumar & Kumaravel, 2019:2159). Other studies also reported behavioural problems as a huge challenge encountered by participants (Xaba, 2021; Pillaya, Tomitab & Paruka, 2021:6). It has been reported that there is a high rate of emotional and behavioural problems and teenagers also tend to be more of a challenge for grandparents than younger children since they are more likely to be experimenting and imitating unacceptable behaviour.

(c) Category 5.1.3: Children's irregular school attendance

Foster children often experience high academic failure rates due to missed schooling, special education needs, and stressful life experiences, despite the significant role of education in their lives (Morton, 2016:4). Therefore, they have a lower likelihood of finishing high school and enrolling in and graduating from college (Moyer & Goldberg, 2019:3). The foster children of this study also experienced challenges with foster children skipping or dropping out of school, thus affects their academic performance.

*Yes – she goes 1 day a week and miss the other days, it was difficult for the teachers to notice her absence, especially those who weren't teaching her class and it was difficult for them to talk to her because she would just keep quiet when probed with questions about her absence. Sometimes she would get on the school bus but I'd still get a call from the school asking about her whereabouts and I told them I was of the impression that **** comes to school with a bus and they indicated that she does not come to school. (P1, 45 years)*

*To be honest, with regard to the social workers when *** started being depressed, it started when she came back from school. She dropped out from school since last year in February, 2020. She cried saying other kids laugh at her and call her illiterate and her class teacher would tell her she's going to take her back to grade R because she couldn't read. This broke her heart, that's where she started to be depressed. (P2, 49 years)*

The findings of a South African study revealed that several caregivers blamed children's low academic performance on absenteeism because they believed that children miss school when they go for check-ups, become sick, or are occasionally confined to the hospital (Mafune, Lebesse & Nemathaga, 2017:7). In this study, it was found that one foster child skipped school for delinquent reasons unrelated to illness, while another dropped out due to a learning disability. These findings align with another South African study that reported similar problems such as slow learning, negative peer reactions, and difficulty focusing (Hecker, 2016:45). Limited support for families with children facing academic challenges hinders their ability to invest in education.

(d) Category 5.1.4: Children keep bad company

Peer groups have a significant impact on teenagers' socialisation and personality development. Adolescents are inclined towards seeking unique, complex and extreme experiences, often engaging in risky behaviours like substance use and dangerous sexual

conduct to fit in with their peers (Siraj, Najam & Ghazal, 2021:1-2). The adage "bad association spoils useful habits" is a common reality in the lives of some foster children.

*Until she started befriending that lady's daughter. They started visiting ****'s sister. She ended up being uncontrollable as she no longer wanted to come back home. (P1, 45 years)*

The people she hangs out with, even the one who told her to claim that I abuse her was pregnant, she quit school and gave birth. I asked what a pregnant student could possibly be telling her, what kind of things does she discuss with her? (P11, 66 years).

The participants of another South African study in another province also encountered similar challenges where the study findings reveal that caregivers face challenges in managing adolescent children's uncontrolled behaviour, including neglect, substance abuse, and disrespectful behaviour (Lesetja, 2020:109). Similar delinquency by foster children was reported in the Western Cape (South Africa) where grandparents caring for AIDS orphans also face frustration and hopelessness in enforcing discipline, especially with alcohol and drug issues (Akimanimpaye, Bimerew & Petlhu, 2024:5).

The study found that foster children tend to hang out with friends who have a negative influence on them. This behaviour may be driven by a desire to fit in or conform to social standards set by their peers, as suggested by Siraj et al. (2021).

(e) Category 5.1.5: Interference by neighbours

Families do not exist in isolation; they are interlinked in a community. The African idiom, "it takes a village to raise a child" means that many people are needed to raise children in a secure, safe environment where they can develop and flourish as well as achieve their goals and aspirations. Not all the responsibility for parenting should fall on parents, therefore support from the community, be it neighbours or relatives, may contribute positively to parenting (Mikucka & Rizzi, 2016:944; Reupert, Straussner, Weimand &

Maybery, 2022:2). The community should make a positive contribution, however in this study interference by neighbours was malicious.

You find that she doesn't clean at our home or do the dishes, instead does so at the neighbour's house – I went there and asked why she's doing that and if she's done the same at her home, her friend would tell her to go to the social workers and tell them I have a drinking problem and that I abuse her. I'd tell her that I'm just asking if she's done that at her home, what does she mean I'm abusing her friend but she would insist she must have me arrested. (P11, 66 years)

The same predicament of interference by other people was encountered in a South African study where it was reported that friends, extended family, and community members negatively influenced children's behaviour, making it challenging for foster parents to parent them (Lesetja, 2020:121). The reality of raising a child with the help of the community/neighbours does not always have a positive outcome as some neighbours perpetuate negative behaviour, leading children who have lost parents to HIV/AIDS into delinquency.

4.3.5.2 Sub-theme 5.2: Medical treatment for children living with HIV

Many children who were severely ill have the chance to enjoy longer, better lives as a result of the development of anti-retroviral medications (Warwick & Langba, 2017:43). Effective ART with exceptional adherence leads to viral suppression, immune system reconstruction, and reduced mortality. This indicates that adherence plays a critical role in the relationship between ART and viro-logic suppression (Kim, Mazenga, Yu, Ahmed, Paul, Kazembe & Abrams, 2017:1).

The majority of foster children understood the importance of adhering to their medication. The participants played a pivotal role in their journey by offering support and encouragement to adhere to the medication regimen.

(a) Category 5.2.1: Children's compliance and non-adherence to medication

Maintaining viral suppression and preventing morbidity and death in HIV-infected individuals depends on adherence to ART (Vreeman, Brittany, McCoy, & Lee, 2017:103). Adherence describes a procedure in which a suitable course of therapy is chosen following a thorough conversation with the patient. Children were compliant with their medication

I was the one taking her to the clinic for her treatment, when it's her day to go to the clinic I would take a day off from work to accompany her until my employers started complaining about my off days. Then we found out that our neighbour was taking the same treatment because we met at wellness clinic, I then asked her to accompany the child and I pay her. Unfortunately, she stopped going with her because at wellness they would ask who is seriously sick and who just needs treatment? My grandchild would say she is not sick but changed her story when she's alone with nurses. That's when we decided she would go there herself because she was 15 years at the time. I told her she will fetch her treatment on her own because the lady I requested to accompany her says she is not truthful when she gets to the clinic'. (P1, 45 years)

Currently, they go alone to the hospital, I no longer go with them to the hospital, I only go to the hospital when they call me. They go together ... They know their appointment dates. Their clinic cards inform them of their next appointment at the hospital. Because the clinic is closer to their school, when they are from school, they just go to the clinic. But now they have closed the clinic but they gave them their medication that would last for 3 months. (P1, 45 years)

Participants understand the fundamentals of taking medication at a specific set time. Pertaining to the adherence to treatment, the foster children were compliant.

They both take their pills, they even show each other, they would say “look I am taking my pills” and that’s what the nanny taught them, that they must not take their tablet on their own, because she does not trust them nor does she trust herself. Therefore, they must depend on each other, when they take pills, they must show her and when she is not there, they must show each other in order to make sure that each takes their medication on time because that is their source of life’. (P3, 55years)

Every day at 7pm she takes her medication. They no longer give those tablets where a person had to take them in the morning, midday and night. She takes one tablet at night only’. (P4, 56 years)

She is now used to taking the medication and she goes to the clinic all by herself. When she comes back from the clinic, she shows me the medication and she tell me her return date. Every day at 7pm she takes her medication. They no longer give those tablets where a person has to take them in the morning, midday and night. She takes one tablet at night only. (P5, 56 years)

And when they get home, I’d just monitor them and make sure they’ve taken their medication. He takes them at 8 pm after he has finished eating. Even if he goes out to play with other kids, when he sees it’s about eight o’clock in the evening, he comes back home. He is thinking of his pills that he must take them on time. (P16, 79 years)

The majority of foster children adhered to their medication regimens through the support offered by their foster parents. This contradicts with a study by Muchanyerei (2016:64) where children would default on their medication due to foster parents forgetting to administer their medication. This was also the case in a study on the ‘*Challenges faced by caregivers of children on antiretroviral therapy at Mutale Municipality selected health care facilities*, where it was reported that due to children arriving home late, medicine dosages, particularly the evening dose, was no longer taken into account (Mafune, Lebesse & Nemathaga, 2017:4). Caregivers expressed dissatisfaction with the lack of

guidance from health professionals on administering treatment due to their busy schedules. Despite this, the participants were committed to ensuring that the children consistently took their medication, highlighting the crucial role of foster parents in promoting medication adherence among foster children.

Poor compliance or non-adherence can result in a viral rebound, disease progression, and medication resistance, which can affect a patient's clinical results and raise the possibility of HIV transmission to uninfected individuals (Kim, Mazenga, Yu, Ahmed, Paul, Kazembe & Abrams, 2017:1). Although foster parents were committed to ensuring that their foster children adhered to their medication, for some foster parent their efforts and commitment were in vain as their foster children were not complying with their regimens. The following storylines shows the adherence challenges.

*The one who is giving me a problem is the eldest, sometimes he takes his medication, some days he does not take his pills. But I am impressed with xxx clinic. The sister who has their file calls them when their appointment date is close by. They take their blood. Do you understand what I am saying, they take blood test that gives results. He is 17 years, sometimes he would not take his pills on a regular basis. Perhaps he was lazy to take his pills, because when you remind him, he would say I am taking them. He knows that he must take his pill at a specific time. He is currently taking it at night. And ****. takes them in the morning and evening before he goes to sleep. He takes his pill, but I am only sure when he took them in my presence in my bedroom. (P15, 76 years)*

Yes, when she was staying here, she was taking her treatment – but sometimes we would find her pills under the bed when we cleaned. she would fetch the treatment but throw some of her pills under the bed, then I asked her why is she collecting her treatment whilst she does not take her medication. and one day she got very ill when her skin cracked up and she started bleeding – this was cause by some of the germs that arise with aids, the nurses couldn't stitch her until the swelling stopped. She was 14 years old at that time. She also has a scar, one would think it is an operation scar,

it was caused by her swelling. But as soon as she went back on track with her medication, her body recovered and the swelling stopped. So, this is the problem I encounter in this house. (P1, 45 years)

Another thing that bothers me is that when I'm not around she doesn't take her treatment. That bothers me a lot. From the hospital prescription she has pills that she should take at night and in the morning, she doesn't take any of them when I'm not around. She also does not take any of the pills she was prescribed including her ARVs. When I'm around I force her to take her medication after she finishes eating. The nurses did and I also explained because I'm also HIV Positive. I showed her my pills and sometimes I would ask her to fetch them for me hoping she would also take hers. (P2, 49 years)

Research studies (Gomo et al., 2017; Mafune, Lebesse & Nemathaga, 2017) suggest that disclosure of HIV-status encourages treatment adherence, however, the current study found that some foster children do not comply with their regimens despite being aware of their status. The findings are supported by Gomo et al.'s (2017) study where it was reported that disclosure had a positive effect on treatment adherence, psychological wellbeing, and resilience in children managing HIV, while Mafune, Lebesse and Nemathaga (2017) found that caregivers lacked clear instructions on administering ARV medication, leading to non-adherence among children. Factors such as coming home late, low literacy, and old age also contributed to the lack of understanding in medication administration (Mafune, Lebesse & Nemathaga, 2017).

4.3.5.3 Sub-theme 5.3: Participants' fearlessness of their responsibilities

There are several methods for measuring fearlessness which can apply to both traits and circumstances (Van Til, Miller, Carter & Lynam, 2024:549). Based on the explanation, it seems fearlessness stems from the character of a person and the situations they encounter. This concluded that fearlessness equates to resilience. In the context of this

study, fearlessness refers to the bravery of the foster parents in caring for children living with HIV.

When I took care of her. I had no fears because I was also in a similar situation' [living with HIV]. (P1, 45 years)

I don't have any because they are my responsibility since their mother left them. The burden is mine. (P16, 79 years)

I had no fears, I had given all hope to God, God knows all, he created us, and he is life, so I had no fears because I was walking by faith. I prayed that God would walk with this child and me through this journey. (P8, 64 years)

Participants approached the caregiving journey without any fears, since they demonstrated confidence and resilience. In contrast, other studies have pointed out that their participants encountered “fear” amid taking responsibility for the children living with HIV. For example, a study in Uganda revealed caregivers experience fear, which stems from the worry of losing their (foster) children to death as a result of acquired high viral load (Nasuuna, Kigozi, Muwanguzi, Babirye, Kiwala, Muganzi, Sewankambo & Nakanjako, 2019:03). Religion significantly influences foster parents' fearlessness, as they rely on their faith in God. This belief encourages fearlessness and trust in God, enabling caregivers to have the courage to take on the responsibility of raising children living with HIV (Moshoeshe & Madiba, 2021:7).

4.3.5.4 Sub-theme 5.4: Support participants received from individuals and organisations

Social support plays a crucial role in improving quality of life. Social support refers to support systems in which a person receives emotional, physical, financial, social and cognitive support from their surroundings (Kumcagiz & Sahin, 2017:2; Al-Mutawtah, Campbell, Kubis & Erjavec, 2023:2). The foster parents received ample support from various entities in their life. They indicated that they received support from colleagues, friends, church assistance and health professionals.

The only additional support I receive is from work – everyone I work with is very empathetic and supportive. Sometimes when I tell them I'm travelling back home, when I come back to work one of the sisters would instruct that I don't over-work myself because I had visited home and she knows I am already exhausted. My colleagues are very supportive. (P2, 49 years)

*I had a lady friend [passed away] who was also taking care of her grandchild whose mother passed on due to this illness. Her child passed on at the time my child **** passed on ... We used to go to the NGO together. Unfortunately, she passed on. (P14, 70 years)*

He got sick, I then asked money from my pastor at church, they gave me money on Sunday, because he also fainted at church and they saw him, that is when they gave me money. I went to the hospital, they put him on oxygen thereafter gave him Panado then he recuperated. They gave me his tablets and the Panado. He used the medication and eventually got well. (P12, 67 years)

At the hospital and those people who work with kids, social workers who gives children clothes and those who are at the hospital, they gave them bathing soap and dawn and they also said they will cook food for them and we must bring the kids to come and eat there. (P12, 67 years)

I gave the nurses my cell numbers. They would call me whenever she missed an appointment and when I got home and asked why didn't you go get/collect her treatment when I gave her money for transport and she would lie and say she went. One the nurses even threatened to have me arrested for not allowing the child to fetch her treatment, but at that time she was old enough to go there on her own and/or decide if she wants to take the treatment or not. (P1, 45 years)

An interesting finding of this study was that participants received ample support from other people other than their immediate families. Similar to a study conducted in Ghana,

participants' immediate family support ranged from little to nothing at all, instead the participants relied on religious support to cope with challenges (Atanuriba, Apiribu, Laari, Bonsu, Dzomeku, Afaya, Salifu & Amooba, 2023:7). Religion significantly impacts foster parents' resilience, as evidenced in a South African study where participants reported prayer and church attendance as positively impacting coping with challenges (Nkosi, 2020).

The participants of this current study were fortunate to receive support from health professionals. The findings resonate with a South African study where participants indicated that the health care providers offered the support they needed most, predominantly at the time of the initial positive diagnosis (Moshoeshe & Madiba, 2021). In contrast, in Kenya a study found that participants did not experience any clinic-related support (Wolf, Halpern-Felsher, Bukusi, Agot, Cohen & Auerswald, 2014:8). Research studies (Chang, Yang, & Hsieh, 2023; Li, Luo, Mu, et al., 2021) have found that a good support network builds and reinforces resilience. Support from trusted family and friends makes stressful situations manageable.

(a) Category 5.4.1: No discrimination against children and families

The act of treating children living with HIV differently than those without it results from a lack of understanding of the disease. It appears that fourteen participants did not experience discrimination towards their foster children because people were not aware of their HIV-status.

No, we have never had any problems like that. There is no discrimination in my family and my husband's family also has no discrimination. Yes, they all know. It is impossible for them to discriminate. Even during Christmas time, they come and take him. (P9, 65 years)

*No, we have never had any problems like that. Since she has been sick there has never been talks within the family about ****'s status. We have never encountered that. (P8, 64 years)*

I have not encountered that. I have not experience that. However, I do not know. I have never experienced discrimination. We are just fine with no hustles. I don't know. She [the child] has never told me anything about being discriminated. (P13, 69 years)

Not even, they accepted her and they love her, even the neighbours don't know the child status. (P10, 66a years)

A study conducted in China had similar results with regard to minimum discrimination by family members (Xu, Ming, Zhang, Wang, Jing & Cheng, 2017:5). The findings show that 94.5 % of the participants did not experience discrimination by their family, instead, they received social support (Xu et al., 2017:5).

(b) Category 5.4.2: Level of discrimination against children

HIV-related stigma and prejudice still puts people at risk for infection and keeps millions of people from using services for testing, prevention and treatment (Terefe & Jembere, 2024:02).

Unfortunately for two participants, their foster children experienced unfair treatment at the hands of the maternal aunt and an incident of discrimination that took place at the crèche.

*I experienced discrimination from my family. They don't know my HIV status because I know the kind of people in my family. [participant is living with HIV] but with ****, I told them that she is HIV positive. When we visited my eldest sister, she puts a plate, cup and spoon aside for **** ... this pains me. One day I took a phone and told my sister that what she is doing is wrong as she made **** feel like she is not a human being but an animal because her utensil is put aside from ours. I told her that ****'s sickness would not be transferred to her through such things. Then she said I misunderstood her, that was not her motive, I told her that her actions speak otherwise. I even told her that if I told her that I have HIV, her as my sister would not accept me but discriminate against me. **** ended up no longer*

*wanting to visit her. But the other family members do not have a problem with ****, like my sister in-law. When she comes to visit, she would request **** to make her tea, or to prepare her food. It is only my elder sister who is out of line. (P4, 56 years)*

*The only incident was when we were staying in *** and she got extremely ill with TB at crèche, that was the only time she was sort of discriminated against. They said they don't want her because she will infect the other kids. At the time she had TB, she was very malnourished and her head was very big. They took her in for three days and they complained and said she will infect other kids. At that time, she had diarrhoea, so at the crèche they told me I should find someone because other parents are not happy when they see **** like that. (P2, 49 years)*

As part of a larger qualitative study of people living with HIV in Yogyakarta and Belu, Indonesia the findings were similar to the experiences in this study (Fauk, Hawke, Mwanri & Ward, 2021:5). The participants reported having experienced the same HIV stigma and discrimination within families by their parents, siblings and in-laws at a certain point in time following the HIV diagnosis (Fauk, Ward, Hawke & Mwanri, 2021:5). Separation of personal belongings such as clothes and eating utensils from those of other family members is still a concern.

4.3.6 Theme 6: Social work services provided to participants and the children

Social welfare intervention for children and families covers comprehensive services such as prevention and early intervention services, assessments, statutory intervention, protection, counselling, care, rehabilitation, therapeutic services, family reunification, and aftercare services. These services are intended to maximise and enhance the wellbeing of specific children and families (Department of Social Development, 2012:22).

4.3.6.1 Sub-theme 6.1: Participants' satisfaction with social work services

The majority of the target populations on the continuum of social service delivery are people with disabilities, individuals affected by HIV and AIDS, and people with other special needs (Engelbrecht & Strydom, 2013:233). It is understood that social work services are tailored for people from a disadvantaged group who are facing social problems they cannot resolve on their own. Participants indicated that the services received were of a statutory nature, and are legally empowered or sanctioned by the Children's Act 38 of 2005. Fourteen participants were satisfied with the social work intervention received.

A social worker came and told me she took over from the other social worker, she made an effort to finish the process (application for foster care grant) and the fund were released. That's why I say she is pillar of strength to me and the children. She told me that I must not resign from work, the foster care grant will at least augment other needs. She is really a helper and I don't think I would be here without her, sometimes I used to cry, ask many questions and she would encourage me to stay strong for the children as they will need me in the future because if I give up who is going to take care of my grandchildren. (P3, 55 years)

When they start reaching puberty, they are kids. When they start showing interest in boys, so that's not what I want. The younger one start roaming around as they are kids, when I see them continuing, I asked the social worker for assistance. She would tell me that we still have a lot of work to do with regards to the girl child, so she would tell them that they must go to school, learn and stop being playful. They must exclude themselves from friends and their friends should be books. When I reprimand them, they are my grandchildren, they don't listen to me because I am their granny, but when I take them to the social worker, they listen well. Maybe they are taking it for granted that they know me but when I take them to their social worker they become well behave. (P13, 69 years)

We then experienced poverty in the house as I was no longer working and there was no one working in the house. I went to the Catholics (offer food parcels and clothes to the poor), I told them I am looking after three of my sister's children and I am not working hence I am looking for help. The social worker said they will come and visit my home. Indeed, they came and assessed our living conditions, they found that we had nothing to eat. Worse, the other child is taking medication on an empty stomach. The social workers said they will help arrange so that I can receive food parcels. I do have a temporary job and go there twice a week. With the money I am getting, I am able to buy toiletries with it. (P4, 56 years)

Social workers have really assisted me. They helped me register for a grant. (P8, 64 years)

The positive social work intervention received by participants, resonates with the positive experience encountered by participants of the study by Warwick (2013: 81). Similarly, in another study, participants mentioned that they received support from the social system like families as well as social workers, who assisted with foster grant applications (Khaba, 2017:60). It is evident that social workers play an integral part in the lives of foster parents. For this current study, the majority of foster parents spoke highly of the efficient service they received from social workers.

Although a high number of participants in this current study appreciated the service they received, not all participants were satisfied as they experienced unfulfilled requests of social work assistance. The participants were hurt that they could not benefit from food parcels like their counterparts.

With money and applying for grants. Sometimes when they [social worker] were distributing food parcels, we would ask for them but never got them. I'm not sure if they were social workers going around handing them out but I once went to the clinic and found a social worker who told me because I'm receiving grants, I can't also get a food parcel, so I just left it there. (P16, 79 years)

What I wanted to ask, last time is that since they were registering people for food parcels. They said they will not be able to register her as she gets social grants and her grandfather also gets social grants for orphans. But why do other people get these food parcels while they also get social grants? Even that grandmother gets food parcels, she registered at an NGO (P5, 58 years)

Related complaints were reported on a systematic review of foster parents' psychological adjustment and parenting style where numerous foster parents had expressed a range of unmet needs and a lack of satisfaction with child welfare agencies. These complaints included not being assisted with requests, failing to receive the proper emotional and financial support and training, as well as failing to be adequately involved in case planning and management (Mancinelli, Dell'Arciprete & Salcuni, 2021:1). A study in South Africa revealed that most foster parents feel that their relationships with social workers are mainly focused on the foster children and lack personal attention (Ntshongwana & Tanga, 2018:18). Participants further noted that social workers seldom inquire about their own challenges in dealing with the foster children's difficult behaviour, thus prioritising the wellbeing of the foster children over that of the foster parents (Ntshongwana & Tanga, 2018:18). It seems that social workers cannot please every client they serve and some will never be satisfied.

(a) Category 6.1.1: Training offered by social workers

Training is essential to modify attitude, knowledge, skills or behaviour through learning experiences to achieve effective performance in an activity or range of activities (Milhem, Abushamsieh, Nieves & Aróstegui, 2014:13). Social workers equip and capacitate foster parents to fully function in their foster parent role.

Yes, they know [that the participant is not their biological grandmother]. When we went for training [Offered by adoption social worker], they told us that when they are 12 years, we have to sit them down and tell them everything so that they don't hear the information from strangers as they will be angry at me. Indeed, all the foster children when they reached 12 years,

*I sat them down. I also told **** that he is not at fault for having HIV, he got it from his parents. I even told **** that he is not at fault, he got this illness from his parents, they must not blame themselves, look at them now, they all grown up (P14, 70 years)*

Yes, they said to us that when the time comes for them to start dating, they should be careful. For instance, if he dates a girl and he does not tell the girl that he has this illness, and they have sexual intercourse, and the girl contract the disease, she can get him arrested and he can go to prison. Before he sleeps with his girlfriend he must sit the girlfriend down, and that's what I told them. When they have at least a year together with a girlfriend, they must explain their illness to their girlfriend. They must both have an agreement with each other, that they will use a condom or not but they must never be intimate without telling their girlfriend, they must agree knowing their condition (P15, 76 years)

The importance of empowering foster parents was acknowledged in a study conducted by Jimenez and Lee (2019:30) on social workers' perception of the needs and services for foster children with special needs. The conclusion of the study indicated that for caregivers to be able to respond in an emergency scenario they must be alert and aware about the child's medical status. Similarly, a South African study acknowledges that foster parents need ongoing support throughout the foster care placement (Ntshongwana & Tanga, 2018:19). Taking into consideration the implications of HIV, it is indeed crucial for foster parents to be capacitated with knowledge regarding the disease so that they can also equip the foster children with information regarding the illness. Training fosters empowerment and strengthens resilience (Kunzler, Helmreich, König, Chmitorz, Wessa, Binder & Lieb, 2020).

4.3.6.2 Sub-theme 6.2: Psychosocial support provided by social workers

Emotional support was noted to be crucial amongst other support given to foster parents by social workers. It was noted that the availability and consistency of social workers, especially in times of crisis, is valued. Frequent home visits and telephone contact to assess if all members of the foster care families are coping well with the placement is essential (Brown et al, 2014:5).

Currently comprehensive programmes for children impacted by HIV often include psychosocial support. Participants shared positive responses about receiving psychosocial support.

I have received quiet a considerable amount of support, the process went well, I even went to court in relation to these children (application for foster care). I went to court with three of them. Their brother is still enrolled at school and is currently working. He was supposed to finish school... They have stopped due to COVID. (P12, 67 years)

Ijooh! I have received significant support from all the social workers I was allocated. Those I have encountered have been very kind to me; they are loving and talk to people with respect. She [social worker] offers me counselling. Whenever I encounter troubles, I confide in her. She would sit me down and show me reasons and how to tackle my problems. Then I would be better. (P13, 69 years)

This child's sister, the one who has this illness ... passed on within the same month with her mother (my daughter). The sister passed on due to migraine. Their passing was a week apart, hence I was stressed and did not know how to approach the situation. It was the social workers and my family members (I only have sisters) who encouraged me not to be weary and to take care of my grandchildren as one day they will take care of me. (P14, 70 years)

The social workers came here and offered me support. They told me that I am not the only person who is responsible for raising the foster child and

that they will also help me raise her. They said I must come to them should I need anything, and they will see to it how they can help me. They said the child is no longer mine alone, but theirs, too. (P4, 56 years)

Similarly, a research study revealed that foster parents need psychosocial support due to stress brought on by worries about their physical condition and their inability to adequately care for their dependents (Rutakumwa, Zalwango, Richards & Seeley, 2015:2132). As much as there is an emphasis on how crucial it is for foster parents to receive psychosocial support, not all grandparents reach out for psychosocial support. For example in a research study on the psychological outcomes and support to grandparents whose grandchildren suffer from a severe physical illness, it was noted that although grandparents experienced a wide range of conflicting emotions and needed support, they rarely or never sought out professional psychological assistance due to a lack of services or resources at their disposal (Priboi, Gantner, Holmer, Silva, Tinner, Roser & Michel, 2022:9).

(b) Category 6.2.1: Limited knowledge about social work services

Every member of society has hopes to lead a balanced life that is safe and reasonably fair, thus services provided by social workers are crucial to accomplish that goal. Social work is an organised profession that uses a variety of professional approaches. Giving a helping hand to a person, a group, or a community to improve and enable them to support themselves is part of the social work service. A social worker can offer psychological counselling, advice and support in the form of empowering the client (Dhavaleshwar, 2016:61). Although participants are aware of social work offices, they seemed to have limited knowledge of the types of services they might benefit from.

I have not received any counselling, the only one I received was when she was telling me about her moods, and where we used to stay, they used to

take them for 'play days' so they sort of forget for a while. They even called us as the parents to come and see our children sing. (P10, 66a years)

Aah! I don't know anything they can or are allowed to do ... they no longer come here regularly. They were disappointed that this child had dropped out of school. So now I am only relying on social workers based at the NGO? They offer me support. Even now, when I was accompanying my daughter-in-law, I came across an NGO social worker. She mentioned that these days I look better, I have lost weight because of my broken heart. They serve everyone with an orphaned child and also conduct home visits. (P14, 70 years)

This was not the case in a study conducted by Sesane and Geyer (2015:8) as the participants had ample knowledge of social work support. Foster parents must be knowledgeable about the services rendered by social workers. Apprehension of social work service will increase awareness of the availability, scope and purpose of social work thus enabling individuals and communities to seek help when needed.

4.3.6.3 Sub-theme 6.3: Required social work services and support

Social workers focus on helping individuals to meet their needs (National Association of Social work [NASW], 2017). It can be understood that the majority of the needs of the participants are of material value, mostly emphasising the need for food. With the challenges encountered whilst raising a child living with HIV, it would be expected that they would need psychosocial support. However, looking at the Maslow hierarchy of needs, the first prominent need is a physiological need.

I need assistance with the youngest sibling regarding her SASSA application. (P1, 4)

I want them to visit me regularly, because when they visit me, they put me at ease. (P14, 70 years)

*The support that I will appreciate from social workers is, as she will be turning 18 – she's going to stop receiving her grants but if she is in school, she might get them, right? So, I ask that the way they continue assisting me because even though the money was little, I could use it to buy food, clothes, for her schooling and to assist when it's her day at the hospital. I would appreciate if they checked up on her every now and then to see if she is still well behaved or if I am treating her right. They have grown up now, they must come and check if **** is still disciplined, if she still continuing with her school. (P8, 64 years)*

Sometimes we are stranded for food, but I look for on-sale items and buy those, I have to pay societies and the social grant isn't enough. Yes – even the stove, we wanted to buy one with an oven so she can bake muffins, cookies and banana bread and sell for profit. (P10, 66a years)

I would appreciate if they included us in the register for food parcel. Because other social workers include their clients in the food parcel registration, so I therefore request our social workers to consider us. (P7, 59 years)

A study conducted by Phetlhu and Watson (2014:354), also showed the need for assistance with the supply of food. Participants who were not beneficiaries of the pension grant and who were not working, yearned to be assisted with groceries whilst waiting for the grant as their children sometimes went to school hungry (Phetlhu & Watson, 2014:354). Physiological needs are the basic needs for sustaining human life (Trivedi & Mehta, 2019:3). These needs include food, shelter, clothing, rest, air, water, sleep and sexual satisfaction. These basic human needs (also called biological needs) lie at the lowest level in the hierarchy of needs as they have priority over all other needs.

4.3.6.4 Sub-theme 6.4: Available community resources

Community resources include places, objects and people that attempt to advance the wellbeing of the community members (Kapur, 2023:1). Social workers help communities

function effectively by conducting needs analyses and making referrals to resources in the community (Sesane & Geyer, 2017:8). Some participants benefited from community resources in their area.

They are from the government, and they assist orphans with food and clothes, when she had a school trip they would see to it that she has everything she needs. (P10, 66a years)

*There is a building nearby called ****. They give food parcel to orphans. So, because this child no longer goes to school they no longer give him food as they only give food to those who attend school. (P14, 70 years)*

*It seems like a centre for orphans. The centre was inviting people at ****, there is a church there. I heard from the grandmother I was telling you about who is living with orphans ... that there is a sister from the clinic there. Apparently, this centre helps people who have mischievous children who doesn't take medication in a proper manner. When I went there, I spoke to the sister about the child as she knows the child. The centre would help the child with school work, but I think this child only went thrice. (P5, 58 years).*

In a study on family adjustment and support interventions in foster care families, the majority of participants acknowledged feelings of comfort and support from the community and neighbours (Nkosi, 2020:105). Church based organisations offer valuable resources and support. For instance, in a study conducted by Bejane (2012:75) the participants found relief at church. Although the participants received support from family members, they regained their strength from religious beliefs. They believe it is God's will, who provides the courage to carry on. Attending church to interact with other members of the congregation is a valuable source of support for foster parents raising children living with HIV. The family resilience is strongly influenced by faith and spirituality, which bolsters the family's ability to cope with challenges (Prasetyo, Faridi, Masruroh, Melizza & Mutmainnah, 2023:3).

(a) Category 6.4.1: Participants' limited knowledge about available community resources

Knowledge is derived from information, but it is more meaningful than information (Mohajan, 2016:2). Some of the participants lacked information about the resources in their community that could be beneficial to them.

We haven't received any support from the community, we only get it from the social workers. There are no such clubs. (P8, 64 years)

In the community I have not seen anything ... (P12, 67 years)

I have not heard them telling us about such [existence of programmes for grandmothers caring for orphans with HIV]. We just go there [older person's club] and exercise then come back. (P13, 69 years)

No – there isn't. They don't even care if a grandmother is playing both roles in the household, raising orphans. I get paid mid-month and the community doesn't see I'm suffering, these kids go to school and they need lunch boxes and school supplies but no one seems to care enough to lend a hand. (P11, 66 years)

A research study shows that many families live in marginalised areas of their communities (Reupert et al., 2022:3). Some households might not be "hard to reach," but rather unable to obtain programmes because of transport or time issues. Developing resilience is complex, which involves a combination of inner strengths and outer resources (Steiner, Blakeney, Baden et al., 2023). Some people might not know about services that could help them, thus they may require social workers to act as their conduits to other services.

4.4 DISCUSSION OF FINDINGS

Theme 1 discusses the circumstance that led to placement of children in foster care) From the perspective of Resilience Theory on this particular theme, the caregivers' response can manifest adaptive capacity in the face of trauma and loss. The foster parents did not simply react to the situation, they actively restructured their lives to protect

and support their foster children, demonstrating resilience. Their competence to provide care despite grief, limited resources, and the emotional toll of HIV-related bereavement supports the theory's emphasis on positive adjustment under stress. Despite being unprepared and uninformed about foster children's illness, the foster parents demonstrated remarkable resilience. They responded to the diagnosis positively by accepting the long-term responsibilities associated with raising a child living with HIV, this is the essence of Resilience Theory.

In relation to the Health Belief Model, participants' knowledge of the biological parents' HIV status also played a significant role. Some caregivers reported that the children's mothers had disclosed their HIV-positive status before passing. This kind of open communication could influence the foster parents' **perceived susceptibility** and **perceived severity** regarding HIV/AIDS. Understanding the cause of death may have motivated caregivers to be more cautious about the foster children's health and this will encourage them to engage in preventive behaviors, and seek healthcare and social services and this will be motivated by perceived benefits of early intervention and the fear to avoid further loss of the loved ones. For foster parents who were never told about the child status, it could be the result of perceived barriers which include fear of being stigmatized or discriminated against.

These theoretical frameworks assist in comprehending why foster parents assumed responsibility for the children, but also how they navigated the emotional and practical challenges involved. Resilience Theory highlights the internal and external strengths they drew upon, while the Health Belief Model provides insight into how knowledge and beliefs shaped their health-related decisions and caregiving role.

Children's discovery of their HIV status is presented as theme 2. The confirmation of the children's HIV status was a critical moment for the participants in this study. While caregivers began to suspect illness due to recurring symptoms, it was only through formal test conducted by health professionals that the children's HIV status was confirmed. This confirms that visible symptoms alone cannot reliably indicate HIV, and that accurate diagnosis necessitates the involvement of trained healthcare providers.

In the lense of the Health Belief Model, this highlights how course of action such as repeated illness or concern from teachers impelled the foster parents to seek medical support. The encouragement of educators, who noticed the children's persistent ill health, also played a vital role in pushing foster parents to engage with healthcare services. The foster parents' ability to cope with the emotional impact of the diagnosis, and to take on the new demands of caregiving for HIV-positive foster children, demonstrates the core of Resilience Theory. Despite the unexpected challenges, caregivers adapted, learned, and remained committed to foster children's wellbeing.

Furthermore, this theme also reinforces the value of multidisciplinary collaboration. Social workers, Teachers and healthcare providers, and social workers each contributed profoundly by mutually forming a support system for both the foster parent and children thus enhancing their psychosocial wellbeing.

Theme 3 outlines foster parents for children living with HIV. HIV continues to be a significant contributing factor in the placement of children into foster care, often following the death of one or both biological parents due to AIDS-related illnesses (Carter & Van Breda, 2016:208). In this study, participants assumed caregiving responsibilities through legally recognized foster placements, formalized by district court orders. As a result, they became the children's official foster parents—though for many, their caregiving role emerged long before any legal process was initiated.

Pertaining to this theme, the Resilience Theory prevails. The participants demonstrated an ability to cope under profound emotional and socioeconomic stress, transforming grief into active caregiving despite their own physical and emotional vulnerabilities.

From the perspective of the Health Belief Model, their perceived responsibility for the children's welfare and their perceived severity of their grandchildren being placed in alternative care or being abandoned contributed to their decisions to take immediate

action. Additionally, their belief in the benefits of familial care strengthened their commitment, even when resources were limited.

This theme highlights the importance of recognizing and supporting grandmothers and by providing psychosocial support. They show resilience however that resilience must be nurtured and reinforced by multi-disciplinary team.

Participants experience in caring for children living with HIV is presented on theme 4. The majority of participants demonstrated a commendable level of knowledge about HIV. Their understanding included the modes of transmission, the importance of avoiding contact with infected blood, and preventive education for the children as they grow older. Participants expressed the need to prepare their foster children to protect themselves and others in future relationships, which shows a proactive, responsible approach to sexual health education.

Importantly, foster parents did not view HIV as a death sentence but rather as a chronic condition that could be effectively managed through medication, proper nutrition, and regular monitoring. This acceptance is in line with Resilience Theory, their perception of HIV from something frightening and stigmatized to regard it as something manageable demonstrates emotional resilience. Furthermore, this also resonates with the Health Belief Model, particularly the element of perceived severity and perceived benefits. While the participants acknowledged HIV as a serious condition, they believed in the benefits of treatment and care, which contributed to their positive attitudes toward caring for a child who has HIV.

Theme 5 discusses the challenges facing foster parents caring for children living with HIV. The journey of caring for children living with HIV, as revealed through the voices of foster parents in this study, has its hardships. While they stepped into their roles with love and a sense of duty, many also found themselves navigating challenges. These challenges were compounded by the realities of fostering their grandchildren.

In the context of this study, foster parents showed remarkable resilience by continuing to care for foster children living with HIV despite emotional burdens, financial constraints, health concerns, behavioral problems and social stigma. stimulating environments that promote psychosocial support, and empowerment is essential in strengthening the resilience of foster parents.

In view of the Health belief Model, pertaining to the condition could be serious' this was evident in the foster parent' concern over neurodevelopmental delays and immune complications of the foster child. Also the benefit to taking action was manifested in foster parents encouraging adherence and attending medical appointments.

Resilience Theory and the Health Belief Model offer valuable frameworks for understanding the psychological and behavioural settings of foster parents therefore effective interventions must be emotionally supportive and knowledge based.

Theme 6 highlights social work services provided to participants and children. Theme 6 captures the role and impact of social work services on both the foster parents and the children living with HIV. From a resilience lens, social workers are not only service providers—they ensure that they safeguard both foster caregivers and children from any kind of potential threat, harm . Resilience Theory highlights that resilience is not a fixed trait, but a learned skill that is shaped by relationships that foster support. In the context of this study, the participants perceived social workers as their pillar of strength as they provided them with food parcels, grants and psychosocial support that enhanced their ability to cope with stresses attached to their caregiving role. The intervention of social workers is aligned with some of the HBM construct. For example, the perceived benefit of training foster parents about HIV, raising teenagers will positively impact the psychosocial wellbeing of both the foster parent and child.

In conclusion, the principles of both Resilience Theory in encouraging strength in adversity and the Health belief model that shapes beliefs of foster parent, empower positive health behaviours and outcomes.

4.5 CONCLUSION

This chapter presented the findings of this study. The biographical profile of the study's participants was outlined in a table format. This was followed by a discussion of the six themes that emerged, namely, the circumstance that led to the placement of the children in foster care, the children's discovery of their HIV status, foster parents for children living with HIV, participants' experiences of caring for children living with HIV, the challenges facing foster parents caring for children living with HIV, and the social work services provided to participants and children. Sub-themes and categories that emerged from the storylines were also discussed. The findings of this study reveal that foster parents encounter challenges in the midst of raising foster children. Some of the prominent challenges were that of financial difficulties, lack of emotional support from immediate families, challenges with foster children's medication intake, and foster children's disrespect. Irrespective of the milestones they encountered, they showed resilience. Social workers, nurses, religion organisations and acquaintances played a vital role in providing support in all aspects.

Conclusions based on the previously provided and discussed findings will be made in the upcoming chapter. It will also provide suggestions for foster care-related practices and policies. Summaries of the findings, conclusions and recommendations of the research study will be outlined in the next chapter.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

This study sought to gain an in-depth understanding of the perspectives of foster parents caring for foster care children who are living with HIV and AIDS, on the psychosocial support services rendered by social workers. This study was of a qualitative nature and semi-structured interviews were used to collect data from 16 foster parents. Five phases, as outlined by Yin (2016:186), were utilised for data analysis. Conclusions and recommendations on the research process and findings of the study are presented below.

5.2 SUMMARIES, CONCLUSIONS AND RECOMMENDATIONS OF THE RESEARCH STUDY

Summaries of the qualitative research process, the major findings, the conclusions reached, as well as recommendations for practice, policy, education, and future research are presented in this section.

5.2.1 Summaries of previous chapters

A brief overview of previous chapters are discussed below.

Chapter one: Introduction and background to the study

The first chapter outlined an overview of the main research study. It served as a road map that assisted the researcher to navigate the primary research question of the study. The first chapter presented the introduction, problem formulation, problem statement, motivation for the study, research question, the study's goals and objectives, clarification of key concepts, and the content plan of the research report.

Chapter two: Literature review

This chapter unpacked the literature review and theoretical perspectives of psychosocial support, foster care parents and children living with HIV and AIDS. Current trends and statistics of HIV and AIDS were outlined. The chapter also indicated the relevance of the study in social work. Support systems for foster parents were also discussed in this chapter.

Chapter three: Methodology

This chapter focused on the applications of the research methodology. To grasp the perspectives of foster parents, a qualitative research method was applied in this study. The research design, population, data analysis method, pilot testing, and data verification formed part of the discussion in Chapter three.

Chapter four: Findings of the study

Chapter four covered the outcomes of the study that emerged from the research process. Storylines of 16 participants were utilised to compile the findings of the study. The qualitative data was analysed by the researcher. Six themes, 20 sub-themes and 16 categories emerged from the storylines. Verbatim citations from the transcripts were utilised to present the findings of the study.

Chapter five: Summary, conclusions, and recommendations

This chapter focuses on the conclusions and recommendations of the study. The chapter gives possible suggestions and solutions to the problem based on the findings. This chapter summarises the information contained in Chapters one to four.

5.2.2 Summaries and conclusions based on the research process

The goals of the research study were achieved by utilising a qualitative research approach. Exploratory, descriptive and contextual research and phenomenology designs were employed in this study to gain insight into the experiences of foster parents raising children living with HIV and AIDS. The goals of the research study were:

- *To develop an in-depth understanding of foster parents' perspectives on psychosocial support received while caring for foster care children living with HIV and AIDS.*
- *To proffer suggestions on the improvements of psychosocial support services offered by social workers.*

During the semi-structured interviews, the researcher referred to her list of questions in order to ensure that crucial issues were addressed whilst adapting the questions based on the responses and circumstances of the participant being interviewed. An interview guide was utilised to yield information from participants. The type of non-probability sampling that was utilised was purposive sampling. For the purpose of the study, data verification was implemented following Guba and Lincoln's model (in Lietz & Zayas, 2010:191). To adhere to the ethical standards of research, the researcher implemented ethical standards such as informed consent, confidentiality, voluntary participation, anonymity, data management and debriefing.

To achieve the goals of the study the following objectives were formulated:

- To explore the perspective of foster parents caring for foster care children living with HIV and AIDS on the psychosocial support services offered to them by social workers. This objective was achieved through the exploration of psychosocial support services rendered by social workers was shared by participants. The majority of participants spoke highly of their respective social workers, indicating that they received considerable support. Participants felt at ease to tackle the adversity they encountered due to the support they received. Social workers served as their pillar of strength. Foster parents who are caring for children with HIV make extensive use of psychosocial support services.

- To describe foster parents' suggestions for the improvement of psychosocial support services offered by social workers. The objective was achieved since the findings showed that foster parents needed after-care services, equal distribution of food parcels, and frequent home visits as part of their social work requirements. These are some of the most significant services that social workers must improve.
- To describe the value of psychosocial support intervention in families affected by HIV and AIDS. This objective was accomplished since the findings confirmed the support received by participants from individuals and organisation. According to the participants, their friends, co-workers, church, and the medical community all provided them with support. These resources were essential in providing foster parents with a safe refuge and motivating them to persevere. Participants' psychosocial assistance lessens the challenges they are experiencing due to the impact of HIV .

5.3 SUMMARIES AND CONCLUSIONS BASED ON THE RESEARCH FINDINGS OF THE STUDY

This section covers a summary of the six themes, 20 sub-themes and 16 categories that emerged from the qualitative data analysis.

5.3.1 Theme 1: Circumstances that led to placement of children in foster care

The findings of this study showed that the children were placed in foster care as result of their biological parents dying from HIV. The participants indicated that the death of the biological parents led them to voluntarily take responsibility for caring for their grandchildren, nieces and nephews. This theme corroborated the norm that women usually presume the parenting role when biological parents pass away. The participants of this study confirmed that they decided to care for the children as there was no one else who was fit to care for them.

- ***Participants' knowledge of the cause of death of children's mothers***

Some participants indicated that biological mothers disclosed their HIV-status, therefore, they had knowledge of the cause of death of the biological parents. This shows that there are still people who are comfortable disclosing their status.

- ***Deceased mothers did not disclose their HIV status to significant others***

Although disclosure of HIV is encouraged in all social, health and public platforms, not everyone feels comfortable being open about their HIV status.

For this study, the participants were left in the dark regarding the HIV status of the foster children and that of the biological mothers. The participants expressed that the biological mothers were very secretive.

Based on the information that mothers concealed the HIV status of their children to protect them, it does not come as a surprise that the biological mothers hid their status information. It seems that they feared being rejected by their families.

- ***Participants' awareness of the children's HIV status***

Some participants were not aware of their foster children's status until the HIV symptoms observed in the children alerted them to a possible health problem. The family only knew about the status when they tested the children. TB was the first symptom of HIV observed in some foster children.

It can be concluded that symptoms of HIV alerted some foster parents about the status of the children.

- ***Participants were unaware of the children's HIV status***

Fear of stigmatisation and discrimination results in many people living with HIV not disclosing their status (Mandalazi et al., 2014:103). Ongoing denial and secrecy around HIV infection impedes the needed openness for disclosure. When asked if they had knowledge of the children's HIV status, the majority of the participants declared that the deceased mothers had not revealed their own HIV status, therefore it did not come as a shock that they also did not reveal to their families that their children were infected through mother to child transmission.

The foster parents were left with a child who later got sick. It is disheartening because the foster parents cared for, and nursed children with an illness they were not aware of and in the process they could have been infected too as they did not know they needed to take precautions.

It can be concluded that the deceased biological parents were also afraid of stigma, and their children being subjected to discrimination, hence they were not comfortable enough to divulge their HIV-status to their family. A family is supposed to be a safety net for its members, however the findings of this study showed that some families are not a safe haven, thus for some deceased mothers, they died with their secret.

- ***Participants' discovery of the children's HIV status***

It was the symptoms of HIV that led the foster parents to seek medication attention. When asked how they discovered the HIV diagnosis of the foster children, the foster parents all specified that the doctor had conducted an HIV test. It can be prominently seen from the storylines of the participants that the doctors and nurses played a pivotal role as they gave hope and empowered the foster parents after they were informed about the children's diagnosis.

Health professions play a critical role as they are the first people to diagnose and see the emotional reaction displayed by those infected and affected, therefore they need to ensure that patients and their families receive sufficient support and knowledge to tackle the challenges they might encounter after the diagnosis.

- ***Participants' reaction to the children's HIV status***

The positive HIV-status of a person does not only affect the infected person but the family as a whole. The whole family is affected with the medical, emotional, social and economic effects of HIV. It was clear that for most of the participants it was challenging to accept the HIV diagnosis of their grandchildren, thus, most reflected feelings of despair. A participant narrated the thought that it was a punishment from God since he punishes children for their parent's mistakes.

This concluded that the emotional turmoil experienced by those who are infected is also experienced by those who are affected, therefore it is crucial that a family serves as a pillar and strong support system for its members.

5.3.2 Theme 2: Children's discovery of their HIV status

One of the most painful things for a person is discovering a positive HIV-status. Out of the 16 participants, 14 foster children were informed about their HIV status by their foster parents whereas two discovered their status from health professionals.

From the study it is clear that the biological parents did not inform their children about their HIV, thus resulting in the foster parents taking the responsibility of disclosing the HIV-status to the foster children.

- ***Confirmation of children's HIV positive status by professionals***

One cannot rely on HIV symptoms to confirm one's positive status. In this study, participants had to be assisted by health professionals in order to confirm the children's HIV-status. An HIV test was conducted and confirmed the -tatus. From the findings of this study, it is apparent that the majority of the foster children were sickly being tested for HIV. Doctors and nurses were the ones who conducted the HIV tests. Educators also played a vital role as they encouraged the foster parents to seek medical attention seeing that the child was not well.

This clearly shows/confirms that health professionals, social services and educators need to work as a multidisciplinary team to tackle this virus. They both can have a positive influence in encouraging people to test, to be alert to the HIV symptoms and offer support.

- ***Disclosure of HIV diagnosis to HIV-infected children***

The findings show that the foster parents took the responsibility of disclosing the HIV diagnosis to the HIV-infected foster children. One participant asked a family member who is also HIV-positive to disclose to the foster child This can be understood as showing

support and putting the foster child at ease that someone familiar/related to them also has the disease. The researcher is of the opinion that the intention could be to foster resilience in the foster child, if they see they are not the only ones who have the virus then the burden of knowing could be easier.

- ***Children's reaction after discovering that they were HIV positive***

Finding out that one has a chronic illness can be devastating, for the chronic illness to be HIV which has a lot of stigma attached to it, could lead to additional emotional turmoil. After discovering their HIV status, the children were deeply affected and some of them cried after learning about their status. Some of them were in denial when they were told about their HIV-status. One participant indicated that the reason the child did not believe they had the virus was because they were healthy. In contrast, the foster parents discovered their HIV status due to the child being sickly/not healthy, however because the child believed they were not sickly then according to them they did not have the virus.

- ***Disclosure of children's HIV status to relatives***

With the stigma attached to HIV, it must be difficult to be vulnerable and disclose your HIV status. For the majority of the children in the study, they partook in the decision to disclose their HIV status to their relatives. For one participant, the family member had suspicions that the child could be HIV-positive due to his symptoms but they were afraid to alert the foster parent. It is widely known that the HIV status of a person is a confidential matter, but some of the foster parents disclosed the HIV status of the children without seeking permission from their infected foster children.

- ***Relatives' reaction to information about children's HIV status***

Fear, anger, shame, sadness and uncertainty about the illness process and disease are some of the emotional reactions experienced by relatives upon finding out about the children's status. The participants of this study received considerable support from their families. The relatives were also affected emotionally and psychologically by the news of

the children having HIV, hence they showed empathy to the participants and the infected children. What was prominent in the storylines was that the relatives were deeply hurt due to the fact that the children are young, yet they are living with this disease.

5.3.3 Theme 3: Foster parents for children living with HIV

HIV is a contributing factor for children to be placed in foster as a consequence of the loss of their parents due to of HIV (Carter & Van Breda, 2016:208). The research participants legalised care through a foster placement ordered by the district court, making them legally "foster parents" of the foster children.

- ***Maternal grandmothers caring for grandchildren***

The responsibility of raising orphans lies with the family, more especially the grandmothers. For the participants of this study, the majority were grandmothers who took responsibility for caring for their grandchildren. Since the foster children were their grandchildren, they automatically thought the responsibility fell onto them, they felt obligated.

- ***Children cared for by volunteers***

Out of the 16 participants, there was only one volunteer. This shows that not a lot of people are willing to take on responsibility of raising orphans, especially if not related to them. The volunteer had a passion for kids and doing good in the community, hence it was easier for her to take such huge responsibility.

5.3.4 Theme 4: Participants' experiences in caring for children living with HIV

The experiences of carers are frequently overlooked, while all interventions are aimed at people living with HIV (Atanuriba et al, 2021:1). It has been argued that negative the experience of raising a child living with HIV is highly recorded/researched whilst little

attention is given to the positive experiences encountered by others who are raising children living with HIV.

- ***Participants' knowledge of HIV***

It is crucial that one is empowered with knowledge. The majority of the participants had ample knowledge about HIV. The participants understood that HIV is a disease that can be transmitted. They highlighted that they know they must not touch their HIV-positive children's blood. The participants also noted the importance of encouraging their children to use protection when they get older so that they do not infect other children they are dating. The participants do not see the illness as a threat but rather an illness that can be monitored and controlled by eating healthy food and taking medication. It is quite clear that the participants have accepted the HIV-status of the children as when they talk about HIV they are knowledgeable and do not speak ill or feel threatened by the illness.

- ***Information and training received by participants on caring for children living with HIV***

The family plays a pivotal role in the lives of children living with HIV, therefore they state that it is crucial that they be capacitated with information and training to properly offer care to children living with HIV.

Not all participants of this study were equipped with the necessary skills and information about providing care for children living with HIV, nonetheless the participants took the burden in their stride and provided care to the foster children to the best of their knowledge. What needs to be highlighted/ acknowledged is that those who received training were capacitated by nurses and doctors. Those who never received training, equipped themselves through social media (TV, radio, HIV pamphlets). The participants were given information to use hand gloves and ensure that the children take their medication on time. What was imperative was that participants were encouraged not to stigmatise the children.

- ***Precautionary measures taken by participants***

While caring for a child living with HIV precaution measures should always be in place. To practice precautionary measures, it is imperative to have knowledge about the transmission of the disease, medication intake and other relevant universal precautions. The majority of the participants had knowledge that when the child has sores they must not touch the sores and blood with their bare hands but utilise gloves. The participants also extended their knowledge of precautionary measure to their family members, for example one indicated that she taught other children in the household and the foster child not to exchange their toothbrush or underwear.

- ***Family support for participants and children***

Family support is imperative to cope with HIV. Few participants received considerable support from the immediate family whilst the majority were not so fortunate to receive any support from their family.

A minor number of participants in this study received family support whilst a larger number of participants were not fortunate to receive support. For those who received support from family members, help came from the siblings of the foster children, the participant's children. They also did not give support to the foster children or foster parents are on their own. With all the challenges encountered when raising a child living with HIV, it is disheartening that foster parents do not have family members they can rely on.

5.3.5 Theme 5: Challenges facing foster parents caring for children living with HIV

During the foster care placement the foster parents encountered challenges in the midst of raising children living with HIV. The foster parents of this study experienced various challenges.

- ***Children's behavioural, social, financial and health issues***

Children living with delays in neurodevelopment and cognition have been linked to HIV (Mwaba et al., 2015:4; Kumar & Kumaravel, 2019: 2156). For one participant, their child had development delays, they even thought he was mentally ill. For one participant, they went to the extent of doing a scan assessment, which revealed that the child's brain was not developing properly. With regard to health issues, children were inquisitive regarding the medication they were taking and could not understand the reason for their daily intake of medication.

Furthermore, from the social domain, financial constraint was one of the negative experience encountered by most foster parents hence it was suggested that foster parents receive adequate support with regard to tailored grants and food parcels. The majority of the foster parents depend on social grants to meet the basic needs of the children. The grant is mostly utilised for transportation to the clinic/hospital to take medication and the special diet food they must buy for the infected children. The findings corroborate with other studies such as one conducted by Afful, Hayfron-Benjamin, Asiedua, Donyeh, Abraham (2019:7) who investigate the experience of *"Caring for Children Living with HIV/AIDS: Family Caregivers Experiences at the Princess Marie Louise Hospital, Ghana"*, where they noted that financial challenges impeded on the care process resulting in inadequate resource for meeting essential need such as nutritious food, treatment and transportation to health care facilities.

Children's disrespectful attitude

The study also found that foster children displayed delinquent behaviour. Some of the foster children did not respect their foster parents, they would curse them and went to the extent of telling them they are not their mothers, yet these foster parents fill the void and responsibilities left by their biological parents. To rectify the disrespectful attitude, one parent threatened to beat up the foster child, and this could get the foster parent in trouble as beating a child is considered child abuse.

Children's irregular school attendance

The foster children of this study were said to not attend school on a regular basis. For one participant, their child would take a school bus under the pretence of going to school, and then the school teacher would call to enquire about her absenteeism. It was

dehumanising for another foster child who dropped out of school, as teachers and learners mocked her for having learning difficulties.

Children keep bad company

Individuals with the same character and interest tend to form close association. Foster children of this study kept bad company who had a negative influence on them. What was evident from the study is that the foster parents blamed the friends for their children's demeanour. This could lead to foster children not taking responsibility for their actions/behaviour if someone else is being blamed for it.

Interference by neighbours

Families do not exist in isolation, they are interlinked in a community. In the current study, the neighbours did not contribute positively to the upbringing of the foster children. Instead of building the children, they projected bad behaviour onto them. For one participant their neighbour influenced their foster child to cry abuse as she was expected to do house chores at home, however, the foster child would do the neighbour's house chores and not regard it as abuse.

• *Medical treatment for foster children living with HIV*

ARVs have given the foster children a prolonged life. The majority of foster children understood the importance of adhering to their medication. The participants played a pivotal role in the journey by offering support and encouragement to adhere to the medication.

Children's compliance and non-compliance with medication prescription

Compliance with ARV medication is fundamental for prolonging the life of children living with HIV. For the study, the foster children were compliant with the medication. The compliance was mostly fostered by the foster parents who played a role in encouraging and reminding the children to take the medication.

Not every foster parents was fortunate that their foster children took the ARV medication regularly. A minority of foster children were reluctant to take medication. Foster parents would be under the impression that the foster children are taking their medication, and to their dismay, they would discover medication under the bed. It was disheartening because all the children in the study knew about their HIV illness, however, some did not want to take their medication on a regular basis, and they had to be forced.

In conclusion, it is evident that foster parents are key in ensuring adherence. It is integral that children receive support from their foster parents for them to comply.

- ***Participants' fearlessness of their responsibilities***

The participants in this study were courageous in taking on the huge responsibility of caring for children living with HIV. They showed fearlessness amid raising foster children living with HIV. For some participants, their faith in God played a pivotal role in enhancing their resilience.

- ***Support received by participants from individuals and organisations***

The participants received considerable support from their colleagues, friends and church organisations. Some of the participants' immediate families did not serve as a safety net for them. It is disheartening that family systems are deteriorating, and a family member's safe haven is with friends and religious organisations. They say charity begins at home, however the participants of this study did not experience this. One of the suggestions of this study is to strengthen family preservation as majority of participants lacked support from their immediate family, this is in contrast with the findings of the study conducted by Afful et al (2019:7) as most of their participants highlighted the beneficial impact of having a strong family support that is a key aspect in their positive social experience.

No discrimination against children and families

The majority of the foster children of the participants were fortunate not to encounter any discrimination. However, it should be noted that one of the reasons most of the foster children had not experienced any discrimination is that their statuses were not disclosed to neighbours, community members or other family members.

Level of discrimination against children

For two out of the 16 participants experienced discrimination. One encountered discrimination at the hand of their maternal aunt, a person who should be shielding her from the cruelty of a society towards people living with HIV. For one participant, their foster child was discriminated against at crèche. Parents and the crèche teachers feared that she would infect other children.

5.3.6 Theme 6: Social work services provided to participants and children

For the participants of the current study, the services they received were statutory in nature. Statutory services in relation to the Children's 'Act 38 of 2008 are services legally empowered or sanctioned by the Act (Department of Social Development, 2012:19). The foster children of this study were placed in foster care by means of a court order.

- ***Participants' satisfaction with social work services***

The majority of participants spoke positively of their social worker. They regarded them as their pillar of strength. The emotional rollercoaster of raising an orphan, especially one who is living with HIV, has its own challenges, however the challenges were tackled through the psychosocial support given by social workers to the foster parents. Not only do social workers provide psychosocial support, they also equip the foster children with life skills when they start to derail. It was also indicated that the social workers encouraged foster children to excel academically. Most participants indicated that prior to receiving the foster care grant, they were unable to make ends meet. Social workers also assisted foster parents with food parcels. The participants also indicated that social workers

equipped them with knowledge about the HIV virus and how they must properly care for the foster children living with HIV.

- ***Training offered by social workers***

The participants of the study indicated that they had received training from social workers. One participant who was fostering unrelated children received training from a social worker about informing the foster children about their status and assuring them it was not their fault that they had contracted HIV. The training also encouraged foster parents to be open with their foster children about sexuality and educate them before they start dating. Capacitating young children about their HIV status, acceptance of the virus, and how to live a healthy life will have a positive impact at a later stage. This will also promote taking responsibility or informing their partners about their status and also encourages healthy living.

- ***Psychosocial support provided by social workers***

The findings of this study are consistent with other empirical studies. It confirms the predicaments encountered by foster parents and importance of psychosocial support towards foster parents. On the Empirical evidence, a study conducted by Gomo, Raniga and Motlounq on the 'Resilience amongst children living with HIV: voices of foster parents residing in Bhambayi, Kwazulu-Natal, South Africa (2017:197) confirms gaps in ongoing psycho-social and support networks required by foster parents caring for children living with HIV. Participants in this study confirmed that they had received considerable support from their social workers. They highlighted that social workers are empathetic, caring and respectful towards them. The participants attest that when they encounter challenges, they confide in their social worker who provides psychosocial support. They further confirm that in times of troubles, social workers offer bereavement counselling to surpass the emotional turmoil of losing a family member in a short period of time.

Social workers utilise a holistic approach, which involves examining all the social factors of a person's life. They do not only give support for anything related to the foster children. One participant had lost her daughter and her grandchild and the social worker gave her

emotional support. Social workers also assure the foster parent that they are not alone in the journey of raising their grandchildren, they also contribute to the upbringing of the foster children.

- ***Limited knowledge about social work services***

Included in the mandate of a social worker is offering a helping hand to a person, group, or community to improve their social functioning. A social worker can offer psychological counselling, advice and support in a form of empowering the client (Dhavaleshwar, 2016:61).

The findings of this study revealed that foster parents are not knowledgeable about the scope of work of social workers. Some participants showed limited knowledge about social work services. Due to insufficient information about services offered to foster parents and children, some participants find some comfort to social workers who are stationed at a nearby NGO.

- ***Required social work services and support***

Participants have expressed a need for varied services from a social worker. For instance, they needed assistance with social grant applications, regular home visits, equal distribution of food parcels, and after care services. They want social workers to check in occasionally on the progress of the foster child, even when they are adults and are no longer benefiting as beneficiaries of foster care.

- ***Available community resources***

Participants were fortunate to have benefited from resources in the community. Food and clothes were distributed by Community Based Organisations within their communities. Churches were used as centres to assist parents who had delinquent children and those who did not want to take their chronic medication. Local health professionals could refer children to the centres for intervention.

- ***Participants' limited knowledge about available community resources***

Not all the participants were knowledgeable about the available resources in their community. The participants indicated that they only sought support from their respective social workers. The community does not provide them with any support. The participants also expressed that the community did not have any programmes tailored for them and they are on their own as grandparents raising children living with HIV.

5.4 SUGGESTIONS FOR SOCIAL WORK PRACTICE

The following suggestions are derived from participants. They indicate who should do what and when.

5.4.1 Training of foster parents

Based on the research findings, social workers should conduct follow up sessions on a monthly basis to capacitate foster parents with knowledge about the scope of work of a social worker in order for them to capitalise on all the social work services that are available to enable them to fully function and tackle social life problems. Training on capacity building pertaining to the latest HIV care practice, psychosocial support and how to parent a teenager.

5.4.2 Strengthen food parcel programmes to compliment foster care grant

Social workers should request that the Department of Social Development strengthen the available programmes on social relief during their annual special meetings, motivating for a special food parcel programme for foster parents raising children living with HIV, since the foster care grant is not sufficient to buy the special food recommended for people living with HIV.

5.4.3 Suitable intervention to motivate families for support

The majority of foster parents indicated that they lack support from their families. Through assessment on a quarterly basis social workers could establish an appropriate intervention to motivate family member's involvement to minimise feelings of overwhelm

and which will provide relief in knowing others are part of the experience. Family involvement can be achieved by monthly awareness, and or family day celebrations.

5.4.4 Establishment of online/face-to-face support groups

Social workers can render monthly support groups for foster parents raising children with HIV. By considering either face-to-face or different online meeting platforms such as Zoom, Google Meet, Microsoft Teams or WhatsApp video conferencing, social workers can establish support groups for foster care parents to share their caregiving experiences and, in the process, learn different coping mechanisms from one another. With the challenges they encounter the support group will have a positive impact on their emotional and psychological functioning, knowing that they are not alone in this predicament. It will also empower them with knowledge on how to properly care for and cope with the challenges that come with raising children living with HIV.

5.4.5 Collaborative efforts to offer financial skill development

Skills development to boost financial support should be a priority. Social workers could liaise with the Department of Agriculture to offer lessons on establishing a vegetable garden skill, which will in turn serve as the start of a small business to earn an income that will supplement their basic needs. Provision of seeds and equipment will be beneficial to the foster parents. The meetings can be held monthly at the service centres taking precautions not to disrupt the daily services. Earlier morning times could be considered prior service start times.

5.4.6 Mobile services in support of door-to-door home visit approach

Based on the research findings, there is a growing need for home visits and after care. Foster parents yearn for social workers to check on them, even when the child is out of the foster care system. Monthly supervision post-foster care placement is recommended.

5.4.7 Enhance family preservation

Encourage family preservation by doing family day events annually where the public will be reminded about the value of family. The Social Development (2021:iv) define family preservation as services to families that aims in enhancing family resilience to strengthen families, so as to keep families together if feasible and desirable. Furthermore, family preservation services entail social workers implementing preventative and therapeutic support through family welfare organizations. The aim is to keep families together and prevent the need to remove children by helping families improve their coping abilities, strengthen their relationships, and access both formal and informal support systems (Strydom, 2012:435). Priority is crucial in encouraging/promoting family preservation as majority of participants indicated that they drew strength from social workers and nurses and received less compassion and support from their families.

5.5 RECOMMENDATIONS FOR POLICY

- In terms of policy implementation, the foster care grant is not sufficient to sustain a household, specifically the special basic needs of a child living with HIV. It is therefore crucial for policymakers to consider a tailored grant for children living with HIV. With the expense that comes with raising a child living with HIV.
- Based on the findings, there are limited community resources, such as NGOs which cater for or offer support programmes to grandparents raising children living with HIV. The Department of Social Development should invest in organisations that foster social support, particularly for those raising children living with HIV.
- Raising a child living with a chronic illness needs one to be fully equipped with knowledge; therefore, targeted Training and education for foster parents is imperative. Department of Social Development should invest in programmes aimed at empowering foster parents with knowledge and skills to adequately offer care to the foster children.

- The Department of Social Development is applauded for its effective Monitoring and Evaluation mechanisms. These mechanisms should continue to strengthen foster care and family programs by collecting data to facilitate the identification of challenges, improve accountability, and support evidence-based research.

5.6 RECOMMENDATIONS FOR EDUCATION

- HIV is an illness that needs to be addressed by a multi-disciplinary team. Workshops and seminars could be utilized as a platform by social work academics to support practice social workers in improving the psychosocial support rendered to guardians raising children living with HIV.
- The findings of this study indicate that foster children are struggling academically. School social workers may request the Department of Education on the possibility of implementing early intervention services so that children living with HIV can be assessed early to appropriately refer them to special schools that can cater to their needs.

5.7 RECOMMENDATIONS FOR FUTURE RESEARCH

- A family was not a source of support for most of the participants. It is recommended that a qualitative study be conducted to examine factors contributing to the lack of support from foster parents' immediate families.
- A quantitative study on the effects of HIV on the cognitive level of children living with HIV. This will help educators and guardians understand children's milestones.
- The research was implemented in Gauteng, the Tshwane region. It would be ideal for similar research to be conducted in other locations or provinces.

5.8 LIMITATIONS FOR THE STUDY

The present study represented a restricted sample of 16 foster parents caring for foster children living with HIV/AIDS. The participants all lived within the Gauteng, Tshwane jurisdiction. Therefore, the findings cannot be generalised, even though the present study provided a glimpse into the dire need for psychosocial support for foster parents caring for foster children living with HIV/AIDS.

5.9 CONCLUSION

This chapter presents an outline of the qualitative research methodology and summaries of the research report chapters. In view of the research findings presented, this chapter concludes the research process. The researcher summarised the themes that emerged from the findings of this research. Six themes, 20 sub-themes and 16 categories were outlined. Furthermore, proposals for social work practice, legislation, education, and future research were discussed.

The foster parents expressed their views regarding the psychosocial support received, and the challenges they encountered whilst raising foster children living with HIV. They further indicated their expectations pertaining to social work services. It is further concluded that social workers and health care professionals play a more central role in the lives of the participants than their immediate family members.

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ADDENDA

ADDENDUM A: ETHICS APPROVAL CERTIFICATE



COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

14 December 2020

Dear Makgopela M.M

NHREC Registration # :
Rec-240816-052
CREC Reference # :
2020-CHS -66075807

Decision:
Ethics Approval from 14 December
2020 to 31 November 2023

Researcher(s): Makgopela M.M

(66075807@mylife.unisa.ac.za)

Supervisor: Prof ML Shirindi

(shiriml@mrc.ac.za)

Title: *Psycho-social support for foster parents caring for foster care children living with HIV and AIDS: Foster Parents Perspective.*

Degree Purpose: MSW

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for three years.

The *low risk application* was reviewed by College of Human Sciences Research Ethics Committee, on 14 December 2020 in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the



University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.

5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
7. No fieldwork activities may continue after the expiry date (31 November 2023). Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

The reference number 2020-CHS-66075807 should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.

Yours sincerely,

Signature :



Dr. K.J. Malesa
CHS Ethics Chairperson
Email: maleski@unisa.ac.za
Tel: (012) 429 4780

Signature : PP



Prof K. Masemola
Executive Dean : CHS
E-mail: masemk@unisa.ac.za
Tel: (012) 429 2298



University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

ADDENDUM B: LETTER ASKING PERMISSION TO CONDUCT A STUDY AT THE DEPARTMENT OF SOCIAL DEVELOPMENT

The Manager

Regional Office

Department of Social Development

Pretoria

My name is Mokgadi Merriam Makgopela and I am currently registered for a Master of Social Work degree at the University of South Africa, student number 66075807. As part of my studies, I am required to conduct research and write a research report. In that regard, I am humbly requesting to conduct a study targeting foster parents caring for foster care children living with HIV and AIDS. I am also requesting permission to access the database of foster parents. I will carefully respect and comply with the guidelines as stipulated in the Protection of Personal Information Act 4 of 2013. The research title is:

THE PSYCHOSOCIAL SUPPORT FOR FOSTER PARENTS CARING FOR FOSTER CARE CHILDREN LIVING WITH HIV AND AIDS: FOSTER PARENT PERSPECTIVE.

The research study will be qualitative in nature and will employ the use of interviews as a data collection method.

The research goals are:

- To develop an in-depth understanding of the perspectives expressed by foster parents caring for foster care children living with HIV and AIDS on the psychosocial support services rendered by social workers.
- To proffer suggestions on the improvements of psychosocial support services offered by social workers.

The research study will only be conducted following the approval of the UNISA College Research and Ethics Committee (CREC). I would appreciate it if you could accept my request in a formal letter confirming that I have been granted permission to recruit foster parents caring for foster care children living with HIV and AIDS in your organisation. If

you have any further questions, please contact me on cell: 081 027 4837 or e-mail:
66075807@mylife.unisa.ac.za

Your assistance will be greatly appreciated.

Kind regards

A handwritten signature in black ink, appearing to read 'Mokgadi Makgopela', written in a cursive style.

Mokgadi Makgopela

ADDENDUM C: APPROVAL LETTER TO CONDUCT THE STUDY



GAUTENG PROVINCE

Enquiries: Dr. Sello Mokoena
Tel: 082 331 0786
File no.: 02/03/21

Dear M Makgopela

RE: APPLICATION TO CONDUCT RESEARCH IN THE GAUTENG DEPARTMENT OF SOCIAL DEVELOPMENT

Thank you for your application to conduct research within the Gauteng Department of Social Development.

Your application to conduct research on **"Psycho-social support for foster parents caring for foster care children living with HIV and AIDS: Foster Parents Perspective"** [University of South Africa] has been considered and approved for support by the Department as it was found to be beneficial to the Department's vision and mission. The approval is subject to the Department's terms and conditions as stated on the GDSD application form.

You have permission to interview officials and beneficiaries within facilities regulated by the department, conduct observations and access relevant documents where necessary.

May I take this opportunity to wish you well on the journey you are about to embark on.

We look forward to a value adding research and a fruitful co-operation.

With thanks

Dr. Sello Mokoena
Director: Research and Policy Coordination
Date: 04/3/2021

ADDENDUM D: PARTICIPANT INFORMATION SHEET

Ethics clearance reference number:

Research permission reference number:

Date:

Title: **Psychosocial support for foster parents caring for foster care children living with HIV and AIDS: Foster Parents Perspective**

Dear Prospective Participant

My name is Mokgadi Merriam Makgopela and I am doing research under the supervision and guidance of Prof. ML Shirindi, towards a MA (Social Work) at the University of South Africa. We are inviting you to participate in a study entitled: Psychosocial support for foster parents caring for foster care children living with HIV and AIDS: Foster Parents Perspective

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to gain an in-depth understanding of the psychosocial support for foster parents caring for foster care children living with HIV and AIDS from the perspective of the foster parents.

Insights from this study will be valuable to generic social workers who play a vital role in offering services in the foster care field.

WHY AM I BEING INVITED TO PARTICIPATE?

The participants for the study will be foster parents in the Tshwane region. Foster parents caring for children living with HIV will be chosen in accordance with the goals of the study, which is to gain an in-depth understanding of the psychosocial support for foster parents caring for foster care children living with HIV and AIDS.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

As a participant, you will be part of the study which will be conducted by the researcher. I hereby request your participation in the study. For you to make a decision whether to participate in this research project or not, I am going to give you information that will give you an overview of the study (the aims of the study and why there is a need for this particular study). Furthermore, you will be informed about what your involvement in this study will entail (i.e. what you will be asked/or what you will be requested to do during the study, the risk and benefits involved by participating in this research project, and your rights as a participant in this study). The biographical details and questions to be asked are as follows:

The following biographical information will be gathered:

- How old are you?
- What is your marital status?
- How many grandchildren do you have? (Number: Girls (...) Boys (...))
- Who are you currently residing with besides your grandchildren?
- What is your highest education level?
- Are you employed? If yes, what kind of employment?
- What is your home language?

Based on the research topic, the following open-ended questions were asked to gather in-depth information:

- Please tell me, in detail, the events that led you to foster the child you are currently fostering (Who chose you to take the responsibility, was it the mother's wish that you care for the child or a family decision?)
- Please share with me your experiences of raising a foster child living with HIV and AIDS (Prompts: challenges, demands, fears).
- Please share with me who explained the health status of your foster child to you.
- What was your foster child's reaction when they learnt about their HIV status? (Prompts: participant's and other family member's reaction)
- Who else in the family was told about the child's status and what was their reaction? (Prompt: Was permission granted by the foster child to disclose their status to family members, social workers and significant others).
- Have you or the child experienced any discrimination regarding the child's status from the community or other family members?
- What support and training have you received to raise a foster child living with HIV?
- What kind of psychosocial support did you receive from social workers? (Prompts: other social and health care professionals)
- What kind of support would you recommend/suggest that you should receive from social workers?
- What type of support exists in your community for foster parents caring for grandchildren living with HIV?
- What other support systems do you have?

The study involves a digital recorder and permission to use digital recorder will be obtained from the participant at the beginning of each interview session. Each session will take approximately 90 minutes.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

In this study, participation will be voluntary and the participant who has a potential to form part of the research study will be assumed to be competent to make an informed decision whether to participate or not. Participants will not be compensated in any form. As a researcher, I will provide full information about the study, which will help you to decide whether you want to participate in the study or not. However, it will not be possible for you to withdraw from the study once data is collected since the researcher shall have guaranteed anonymity and codes will have been used to protect your identity.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

Insights from this study will be valuable to generic social workers who play a vital role in rendering direct services in the foster care placement field.

ARE THERE ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

For this study, the protection of individuals will be taken into account, and any possibilities of harm will be guarded against. The researcher will solicit the services of a person who does debriefing, should it become necessary for you to receive such debriefing.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

Confidentiality will be assured as follows:

All information will be stored in a safe place to prevent the risk of inadvertently disclosing participants' identities. Information will be accessible to the research team, namely the researcher, supervisor, co-supervisor, and independent coder. The password, which the researcher will assign to the data, will also be kept confidential.

Moreover, the researcher will ensure that participants' information is not released to anyone without their permission. All information that will be linked to participants will be removed and the participants' real names will not be used.

Identifying details of the participants will be removed once the researcher has established the coding of each participant. All data, in whatever form, will be destroyed five years after analysis has been completed.

Confidentiality agreements will be submitted to the Research Ethics Review Committee for consideration.

Your anonymous data may be used for other purposes, such as a research report, journal articles and/or conference proceedings. Dissemination of the research results will occur after submission of a research report to the university in the form of a dissertation, for examination purposes. Thereafter a report on the results of the research will be made available to people who assisted in the research as well as the organisations that played a part in identifying participants and the collection of data. An article will also be prepared and submitted for publication in a professional journal.

A consent form requesting permission to publish your information will be included in the package of data collection. The researcher, in ensuring confidentiality, will make sure that the tape-recorded interviews are kept safe in a locked cupboard and inform participants that the research supervisor will be the only person allowed to access such information and that the interview guides, together with the device containing the recorded information will be kept for a period of five years.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

Hard copies of your answers will be stored by the researcher for a minimum period of five years in a locked cupboard/filing cabinet at home for future research or academic purposes. Electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. Information will be destroyed five years after data analysis, e.g. hard copies will be shredded and/or electronic copies will be permanently deleted from the hard drive of the computer using a relevant software programme.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

There will be no reimbursement or incentives for participants.

HAS THE STUDY RECEIVED ETHICS APPROVAL?

This study has received written approval from the Research Ethics Review Committee of the Department of Social Work, Unisa. A copy of the approval letter can be obtained from the researcher should the need arise.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you would like to be informed of the final research findings, please contact Mokgadi Merriam Makgopela on 0810274837 or at the email address: mokgadimakgopela@ymail.com

Should you have concerns about the way in which the research has been conducted, you may contact Prof. ML Shirindi on departmental landline 012 429 6060. Should you require any further information or want to contact the researcher about any aspect of this study contact the Chairperson of the Scientific Research Committee of the Department of Social work at Unisa, Dr Mathebane. The chairperson can be contacted on this landline number: 012 429 6744. Should you feel that the information provided by the above research team is not sufficient enough to give consent to the study, you may direct your queries to the Social Work Department Research Coordinator, Prof. AH Alpaslan at Alpasah@unisa.ac.za.

Should you agree to participate in this research study upon reading and understanding the contents provided, you are requested to give your written consent by signing and dating the information and consent form attached and initialling each section to show that you understand and agree to the conditions.

Thank you for taking time to read this information sheet and for participating in this study.

A handwritten signature in black ink, appearing to read 'Mokgadi Makgopela', written in a cursive style.

Signature:

Name: Mokgadi Makgopela

ADDENDUM E: CONSENT FORM TO PARTICIPATE IN A RESEARCH STUDY

I, _____ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the interview(s) using a digital recorder.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname..... (please print)

Participant Signature.....Date.....

Researcher's Name & Surname..... (please print)

Researcher's signature.....Date.....

ADDENDUM F: RESEARCHER ACKNOWLEDGEMENT

Research title: Psychosocial support for foster parents caring for foster care children living with HIV and AIDS: Foster Parents Perspective

Researcher: Mokgadi Merriam Makgopela

Student number: 66075807

I, Mokgadi Merriam Makgopela, ID number: 9001241112084, hereby in my personal capacity as a researcher, acknowledge that I am aware of and familiar with the stipulations and contents of the

- Unisa Research Policy
- Unisa Ethics Policy
- Unisa IP Policy

and that I shall conform to and abide by these policy requirements

Signature:

A handwritten signature in black ink, appearing to read 'MM Makgopela', written over a faint, illegible printed name.

ADDENDUM G: CONFIDENTIALITY AGREEMENT WITH RESEARCH THIRD PARTY

Hereby, I [name], ID number, in my personal capacity as(a statistician/ transcriber/ external coder etc), collaborating with (Name of researcher) under the supervision of (Name of Supervisor) on a research titled (research title), acknowledge that I am aware of and familiar with the stipulations and contents of the conditions of ethical clearance specific to this study. I shall conform to and abide by these conditions. Furthermore, I am aware of the sensitivity of the information collected and the need for strict controls to ensure confidentiality obligations associated with the study.

I agree to the privacy and confidentiality of the information that I am granted access to in my duties as a (statistician/ research assistant/ translator etc- write what is appropriate to your study). I will not disclose nor sell the information that I have been granted permission to gain access to in good faith, to anyone.

I also confirm that I have been briefed by the research team on the protocols and expectations of my behaviour and involvement in the research as a (write the role of the third party- ie statistician, external coder/ research assistant) as appropriate to your study.

SIGNED: _____

Date: _____

ADDENDUM H: RISK ASSESSMENT TOOL

RISK ASSESSMENT

RESEARCH ETHICS - RISK ASSESSMENT TOOL			
1	Does your research include the direct involvement of any of the following groups of participants? <i>(refer to section 4 in the SOP)</i>	YES	NO
<i>Place an 'x' in the tick box [if yes, provide details in the space allocated for comments]</i>			
a)	Children or young people under the age of 18		X
b)	Persons living with disabilities (physical, mental, and/or sensory)		X
c)	Persons that might find it difficult to make independent and informed decisions for socio, economic, cultural, political, and/or medical reasons		X
d)	Communities that might be considered vulnerable, thus finding it difficult to make independent and informed decisions for socio, economic, cultural, political, and/or medical reasons		X
e)	UNISA employees, student, or alumni. The researcher will apply for permission at the UNISA Research Permission Subcommittee (RPCS) in section 3.1 of the application form to involve any of these participant groups in the proposed research.		X
f)	Persons whose native language differs from the language used for the research.		X
g)	There is likelihood that person or definable group will be identified during the research process and likely to be of concern.		X
h)	Other. Please describe.		X
Comments: The study will be focusing on			

2	Does your research involve any of the following types of activity that could potentially place the participants at risk of harm?	YES	NO
<i>Place an 'x' in the tick box [if yes, provide details in the space allocated for comments]</i>			
a) Collection, use or disclosure of information WITHOUT the consent/assent of the individual or institution that is in possession of the required information, i.e. will be conducted without the knowledge of the participants (with the exception of aggregated data or data from official databases in the public domain)			X
b) Collection, use or disclosure of personal, identifiable information directly from participants with consent			X
c) Personal, identifiable information to be collected about individuals from available records (e.g. employee records, student records, medical records, etc) and/or archives			X
d) Participants being exposed to questions which may be experienced as stressful or upsetting, or to procedures which may have unpleasant or harmful side effects			X
e) Participants being required to commit an act which might diminish self-respect or cause them to experience shame, embarrassment, or regret			X
f) Any form of deception of participants, concealment, or covert observation			X
g) Examination potentially sensitive or contentious issues that could cause harm to the participants			X
h) Research which may be prejudicial to participants			X
i) Research which may intrude on the rights of third parties or people not directly involved			X
j) Audio-visual recordings of participants which may be of a sensitive or compromising nature (with or without consent)			X

k) Disclosure of the findings of the research could place participants at risk of criminal or civil liability or be damaging to their financial standing, employability, professional or personal relationships		X
l) Any form of physically invasive diagnostic, therapeutic or medical procedure such as blood collection, an exercise regime, body measurements or physical examination		X
m)*Psychological inventories / scales / tests		X
m) Other. Please describe		X
Comments: The research topic is considered to be a low risk.		

**Please add details on copyright issues related to standardized psychometric tests and registration at the HPSCA of test administrator if test administration is in South Africa or of an equivalent board if administration is non-South African.*

3	Does your research involve any activity that could potentially place the researcher(s) at risk of harm?	YES	NO
<i>Place an 'x' in the tick box [if yes, provide details in the space allocated for comments]</i>			
a)	Participants will be offered inducements or incentives to encourage their involvement in the research.		X
b)	Participations will incur financial obligations as a result of their participation in the research in the research.		X
c)	The researcher(s) anticipate financial gains from involvement in the research (i.e. contract research.		X
d)	Any other potential conflict of interests, real or perceived, that could be seen as compromising the researcher(s) professional judgement in carrying out or reporting on the research		X
e)	Research will make use of Unisa laboratories.		X

f) Research will be funded by Unisa or by an external funding body that could compromise the integrity of the research project.		X
Comments:		

4	Guided by the information above, classify your research project based on the anticipated degree of risk. <i>[The researcher completes this section. The ERC critically evaluates this benefit-risk analysis to protect participants and other entities.]</i> <i>Place an 'x' in the tick box</i>						
Category 1 Negligible		Category 2 Low risk		Category 3 Medium risk	X	Category 4 High risk	
(a) Briefly justify your choice/classification The potential risks will be mitigated through observing all the ethical considerations outlined above. Participants affected will be referred for a debriefing session.							
(b) In medium and high-risk research, indicate the potential benefits of the study for the research participants and/or other entities.							
(c) In medium and high-risk research, indicate how the potential risks of harm will be mitigated by explaining the steps that will be taken (e.g. referral for counselling, debriefing, etc.).							

ADDENDUM I: DATA COLLECTION TOOL

The following biographical information will be gathered:

- How old are you?
- What is your marital status?
- How many grandchildren do you have? (Number: Girls (...) Boys (...))
- Who are you currently residing with besides your grandchildren?
- What is your highest education level?
- Are you employed? If yes, what kind of employment?
- What is your home language?

Based on the research topic, the following open-ended questions were asked to gather in-depth information:

- Please tell me, in detail, the events that led you to foster the child you are currently fostering (Who chose you to take the responsibility, was it the mother's wish that you care for the child or a family decision?)
- Please share with me your experiences of raising a foster child living with HIV and AIDS (Prompts: challenges, demands, fears).
- Please share with me who explained the health status of your foster child to you.
- What was your foster child's reaction when they learnt about their HIV status? (Prompts: participant's and other family member's reaction)
- Who else in the family was told about the child's status and what was their reaction? (Prompt: Was permission granted by the foster child to disclose their status to family members, social workers and significant others).
- Have you or the child experienced any discrimination regarding the child's status from the community or other family members?
- What support and training have you received to raise a foster child living with HIV?

- What kind of psychosocial support did you receive from social workers? (Prompts: other social and health care professionals)
- What kind of support would you recommend/suggest that you should receive from social workers?
- What type of support exists in your community for foster parents caring for grandchildren living with HIV?
- What other support systems do you have?

ADDENDUM J: LETTER OF EDITOR

Declaration of Professional Editing

13 November 2024



This letter serves to confirm that Mokgadi Merriam Makgopelasubmitted a dissertaion to me for editing. The dissertaion is entitled, **'FOSTER PARENTS' PERSPECTIVES ON PSYCHO-SOCIAL SUPPORT RECEIVED WHILE CARING FOR FOSTER CARE CHILDREN LIVING WITH HIV AND AIDS.'**

The following aspects were edited:

- Spelling
- Grammar
- Consistency of layout
- Sentence structure
- Logical sequencing
- References (Reference checking involves proofreading and some editing with regards to the simple formatting of the references into the referencing style required i.e. changing the order of the elements - author, date, title, series, place, publisher, journal, volume, issue, pagination etc.)
- Reference cross-checking

My involvement is restricted to language use and spelling, completeness and consistency, referencing style, and formatting of headings, captions and tables of contents. I did no structural re-writing of the content and did not influence the academic content in any way. While comments and corrections are suggested by the editor the accuracy of content and formatting in the final document remains the responsibility of the student.

Should you have any further queries, please do not hesitate to contact me.

Kind regards,

Kim Smit

● Tel: +27 (0)78 493 6554 ● Email: editorialkns@gmail.com
Member of the Freelance panel for the University of South Africa
Associate Member of the Professional Editor's Guild

