SOCIAL WORKERS’ EXPERIENCES OF HIV AND AIDS INTERVENTION IN BOTSWANA

Lefhoko Kesamang

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Supervisor: Dr B M L Pretorius

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DEDICATION:

This research project is dedicated to Galeboe and Etsozile, my late grandparents who passed on while their grandson was pursuing his studies in a foreign country. The accomplishment of this project is in acknowledgement of the values and ethics they instilled in me as they managed with distinction to hold together the extended family of Kesamang as subsistence farmers and also for their upholding of the importance of education.
ABSTRACT
This study endeavoured to explore and describe the experiences of social workers in their intervention with HIV and AIDS clients within the Department of Clinical Services of the Ministry of Health in Botswana. The researcher undertook a qualitative research study, using an exploratory, descriptive and contextual design to explore these experiences as perceived by the social workers. The method of data collection included semi-structured face-to-face interviews, as this was deemed most appropriate to the nature of the study. Data analysis was undertaken according to the outline of Tesch (1990), as stated in Creswell (1994:155). The findings were reported as themes, sub-themes and categories emanating from the data-analysis process. In ensuring the trustworthiness of the findings, the researcher adhered to Guba’s (1981) model (in Krefting, 1991:251). The research findings were subjected to a literature control, and culminated in the compiling of the research report.

The research findings centred around the following five themes:  
- experiences of intervention with HIV and AIDS clients;  
- challenges in HIV and AIDS intervention;  
- measures to alleviate challenges of HIV and AIDS intervention;  
- intervention strategies utilised by social workers; and  
- suggestions and advice to new social workers.

The recommendations resulting from this research project proposed inter alia that social workers need to be trained in specific and specialised areas related to HIV and AIDS intervention in the health setting, and that the support structures and a holistic multidisciplinary service delivery approach need to be put in place to assist social workers to be able to meet the needs of the clients as well as their own needs.

Key Words: participants, clients/patient, qualitative, HIV and AIDS, experiences, intervention, strategies.
ACRONYMS

AIDS – Acquired Immunodeficiency Syndrome

ARVT – Antiretroviral Therapy

BOCAIP – Botswana Christian AIDS Initiative Programme

CBO – Community Based Organisation

CHBC – Community Home Based Care Programme

FBO – Faith Based Organisation

HIV – Human Immunodeficiency Virus

IDCC – Infectious Diseases Care Clinic

MOH (B) – Ministry of Health (Botswana)

NGO – Non-Governmental Organisation

PMTCT – Prevention of Mother to Child Transmission

RHIVT – Routine HIV Testing

S & CD – Social and Community Development, Department of (Botswana)

STI – Sexually Transmitted Infections
UNAIDS – United Nations AIDS
UNICEF – United Nations Children’s Fund
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CHAPTER ONE

GENERAL INTRODUCTION AND ORIENTATION OF THE STUDY

1.1 INTRODUCTION AND PROBLEM STATEMENT

The advent of HIV and AIDS has proved beyond reasonable doubt that, in spite of the advances made in science and technology human beings have not mastered everything in life. Kain (1989:6) postulates, “AIDS caught the medical profession off guard, coming at a time when epidemiologists believed that infectious diseases no longer posed a threat to the developed world”. He went on to argue that “non-infectious conditions such as cancer, heart disease, and degenerative diseases were thought to pose the remaining menace to the public health”. On the other hand Altman (in Kain, 1989:8), remarks that AIDS changed these assumptions, in turn, creating a major medical catastrophe.

The HIV and AIDS condition was diagnosed in the United States of America in the year 1981 among homosexual communities and continued to emerge as the most lethal pandemic of the century (Van Niekerk, 1999:24). This is generally referred to as the ‘beginning’ of HIV and AIDS. The striking thing about HIV and AIDS is its rapid spread throughout the world from that initial discovery. According to the United Nations AIDS/World Health Organization by December 2004, global estimates were 39.4 million people were living with HIV and AIDS.

In sub-Saharan African countries, HIV and AIDS is the present leading cause of death. In 2004, 25.4 million people were thought to be living with the virus (UNAIDS/WHO, 2004). In the same year, 3.1 million people were estimated to be newly infected, while 2.3 million people were believed to have died of AIDS.

Botswana is one of the countries that have been hardest hit by the worldwide HIV and AIDS epidemic. By the early 1980s, AIDS in Botswana was perceived as a disease that affected male homosexuals in the west and people from other
African countries. During 2004, 260,000 people in Botswana were living with HIV and AIDS according to United Nations AIDS estimates for the end of 2003. This, in a country with a total population of 1.6 million, gives Botswana a prevalence rate of 36.5%, the second highest in the world after Swaziland.

Botswana’s first HIV and AIDS case was reported in 1985 and it was estimated that a significant spread of HIV and AIDS in the country started in the early 1990s, (Botswana Government, 1993:2). Since then, the spread of the virus in the population has been explosive, starting in urban and peri-urban areas, and rapidly extending to rural localities. The HIV and AIDS epidemic, threatens to reverse Botswana’s political and economic gains. The HIV and AIDS epidemic has so far undermined every facet of life in Botswana, including the decrease in “national productivity, the government’s ability to deliver essential services and sustained human development has been weakened, and efforts to promote foreign investment, diversify the economy, and create employment are in jeopardy” (ACHAP, 2005).

The following factors have been identified as exacerbating the spread of HIV and AIDS in Botswana: “alcohol abuse, poverty, the high prevalence of specific STIs, a high proportion of single parents, and widespread early parentage” (ACHAP, 2005). In addition to these factors, four key determinants were identified as well: the low-social standing of women in Botswana society; societal fears of HIV and AIDS and the stigmatization of infected individuals; the mobility of Botswana’s population; and Botswana’s rapid urbanization, which has undermined traditional mechanisms for controlling social and sexual behaviour and has exacerbated sexual exploitation of the poor.

However, on the other hand, Botswana has become one of the first countries in Africa, south of the Sahara, to provide its citizens with free anti-retroviral therapy (ARVT). This has been done in relation to a number of different prevention programmes currently taking place in the country (Compare www. Avert.org/aids
botswana.) A review of the range of programmes available highlighted the following available:

- Public education and awareness (Grunwald, 2002).
- Education for young people (ACHAP- African Comprehensive HIV/AIDS Partnerships)
- Voluntary testing and counselling (Allafrica.com, 2003).
- Antiretroviral therapy programme (ACHAP- African Comprehensive HIV/AIDS Partnerships, 2005)
- Support from the US emergency plan (Daily News Online, 2004).

Social workers in Botswana provide services geared towards the alleviation of social problems experienced by HIV and AIDS clients. Social workers provide the following programmes:

- **Counselling services** for those affected and infected by the disease. The counselling services are provided in Voluntary Counselling and Testing Centres. Some of the clients are attended to in hospitals and clinics where they are counselled and referred to relevant authorities if they need more than counselling services.
- **Material needs** for those who may not provide for their daily needs in the form of food and shelter. There is food basket package for those who are unable to meet their daily nutritional needs as they enrol in ARVT (Revised National Policy on Destitute Persons, 2002).
- **Community Home Based Care Programme** for those clients who may be in need of care within their communities than to be admitted in
hospitals. There are volunteers who provide home based care in their communities at P 100.00 per month.

- **Orphan Care Programme:** this programme caters for all orphans irrespective of the course of their state of affairs. The programme takes care of all orphans who lost their parent(s) or guardian through motor vehicle accidents and other health conditions other than HIV and AIDS. Orphans are registered by social workers and are provided with daily needs (nutrition, clothing, shelter, health, education) until the age of 18 years.

1.2 **MOTIVATION FOR THE STUDY**

Provision of services to HIV and AIDS infected and affected clients pose a challenge to social workers and have not been fully addressed in Botswana. As a social worker and coordinator of the Clinical Social Work Unit in the Department of Social Services in Gaborone, Botswana, the researcher had been mandated to manage and supervise the professional services provided by social workers in sixteen Primary Hospitals, nine District Hospitals as well as three Referral Hospitals. These social workers, among other key duties, provided counselling services to those health service consumers who are HIV and AIDS infected and affected.

The researcher was interested in the social workers’ experiences of their intervention with clients who are HIV and AIDS positive. This was so because HIV and AIDS is a relatively new area of interest to social work where there was lack of basic information, let alone the experiences of social workers intervening with HIV and AIDS.
1.3 RESEARCH QUESTION

According to Creswell (1994:70), a ‘grand tour’ question is a statement of the question being examined in the study in the most general form. The latter proposes that the question should be posed in a general form so as not to limit the inquiry, and follow-up by a number of sub-questions.

Since the qualitative approach is based on the belief that knowledge is socially constructed, the researcher acknowledges that the research participants have their own values and realities, which are diverse and unique. The research method is useful where little is known about the phenomenon to be studied in order to reveal information that goes beyond surface appearances.

The research question, therefore, seeks to explore the insider’s point of view (Holloway & Wheeler, 1996:3). The theoretical framework is not predetermined by the data but derives from it. The method does not seek to establish causal explanations through the testing of hypotheses but to explore the meanings of a phenomenon as narrated by a participant.

The research question posed for this study has been stated as follows:

What are the experiences of social workers in their interventions with clients who are HIV and AIDS positive?

1.4 RESEARCH GOAL AND OBJECTIVES

According to Marlow (1998:62), the term ‘goal’ usually refers to an end product, “the end toward which effort is directed”. Fouché (in De Vos, Strydom, Fouché and Delport, 2002:107) define objective as the steps one has to take, one by one realistically at grass-roots level within a certain time span, in order to attain a dream.
1.4.1 Research Goal

The research goal formulated to guide this research endeavour is:
To explore and describe the experiences social workers had relating to their interventions with HIV and AIDS clients.

1.4.2 Research Objectives

In order to reach the above goal, the following research objectives have been formulated:

- To explore and describe the social workers’ experiences with regard to their interventions with HIV and AIDS clients.

- Based on the findings, to draw conclusion and recommend guidelines for appropriate intervention.

1.5 RESEARCH METHODOLOGY

Research methodology as described by Arkava & Lane (1983:424) is the method or the steps, which the researcher proposes in order to conduct the research. In this research, the qualitative approach or paradigm will be employed to explore and describe the experiences of social workers who intervene with HIV and AIDS clients. According to Denzin & Lincoln (1994:4), the qualitative approach is a multi-perspective approach to social interaction, aimed at describing, making sense of, interpreting or reconstructing this interaction in terms of the meanings the subjects attach to it. Qualitative research focuses on peoples’ everyday life within their culture and environment.
1.5.1 Research Design

According to Kerlinger (in Mouton, 2001:55) “a research design is a plan or blueprint of how you intend conducting the research”. Kumar (1996:74) postulates, “a research design is a plan, structure and strategy of investigation so conceived as to obtain answers to research questions or problems”.

For this research study the researcher elected to use a qualitative, explorative, descriptive and contextual research design. This choice has been influenced by the researcher’s interest in exploring the experiences of the participants relating to their intervention with HIV and AIDS clients.

According to Mouton & Marais (1988:43), the goal that is pursued in exploratory research is the uncovering of the relatively unknown. The researcher will therefore, try to gain new insights into the experiences of social workers in relation to their experiences of providing social services to their clients. The fact that there is a dearth of available literature in Botswana has compelled the researcher to include the explorative component of the research design. Exploratory research design should detail how the researcher plans to collect information and where she or he will look for this information (Terre Blanche and Durrheim, 1999:40).

A descriptive study has the purpose of describing a phenomenon. This study seeks a deeper meaning of the nature of the phenomenon being studied, while the exploratory study seeks a deeper meaning of a relatively unknown topic, with the outcome typically being the development of a new theory or hypothesis about the nature of the phenomenon being studied (Kumar, 1996:9). According to Terre Blanche and Durrheim (1999:40), descriptive studies seek accurate observations, and the research design should focus on the validity (accuracy) and reliability (consistency) of the observations. Descriptive studies aim to
describe phenomenon either through narrative-type descriptions, classification, or measuring relations.

A contextual study aims at describing and understanding events within the concrete natural context in which they occur (Babbie & Mouton, 1998:272). Qualitative researchers argue that, if a person understands events against the background of the whole context, one can truly claim to “understand” the events. Contextual studies study people in their habitat or natural setting in order to understand the dynamics of human meanings as fully as possible.

**1.5.2 Population and Sampling**

According to De Vos et al. (2002:198), “[the] universe... refers to all potential subjects who possess the attributes in which the research is interested”. The universe in this research study was all the social workers who are involved in rendering services to persons living with HIV and AIDS in Botswana. De Vos et al., (2002:198) further define the population as a “term that sets boundaries on the study units. It refers to individuals in the universe who possess specific characteristics”. Therefore, the population with whom the study was concerned is the social workers providing social services in all government health facilities.

According to Arkava & Lane (1983:27), the concept sample is “an element of the population considered for actual inclusion in the study.” The sample included social workers in the following hospitals: Princess Marina, Lobatse Mental, Athlone, Scottish Livingstone, Mahalapye and Sekgoma Memorial.

Kumar (1996:162) defines purposive sampling as “the judgment of the researcher as to who will provide the best information to achieve the objectives of the study. The researcher only goes to those people whose opinions are likely to have the required information and is willing to share”. Strydom & Venter (in De Vos et al., 2002:207) assert that this sample is based entirely on the judgment of
the researcher, in that a sample is composed of elements that contain the most characteristics, representative of typical attributes of the population.

A purposive sampling method was utilized to select social workers deployed to the hospitals selected. Social workers involved in HIV and AIDS in these health institutions were selected irrespective of sex, age, race and rank.

Criteria for sampling included the following:

- Social workers willing to participate in the research study.
- The participants had one year’s experience of intervening with HIV and AIDS clients in Botswana.
- The social workers were deployed to the following health facilities, Princess Marina, Athlone, Good Hope Primary, Scottish Livingstone, Bamalete Lutheran, Deborah Retief, Mahalapye and Sekgoma Memorial Hospitals.

1.5.3 Preparation of Participants

Tutty, Rothery & Grinnell (1996:65) stress that the participants should be clearly informed regarding all aspects of the proposed research. The researcher contacted the supervisors of the identified and agreed participants about the researcher’s intention of requesting the social workers to participate in the study. After gaining access and confidence of the authority, a meeting was arranged to inform the participants who had agreed to take part in the study as to what the research was about. In this meeting, all questions relating to their participation were addressed. The researcher also took advantage of the meeting to make a formal introduction to the participants.
The introduction looked at the following issues:

- how the participants were to be selected;
- advantages of participation;
- what was to be asked in the interview;
- duration of each interview;
- the estimation of interviews to be conducted;
- language preferences;
- what recording devices were going to record data;
- persons who were to have access to the interview data;
- where the transcripts were going to be kept;
- what was to happen to the transcripts after the end of the study and who would verify the data during analysis.

1.5.4 Method of Data Collection

It was initially envisaged that focus groups would be an appropriate method of data collection given that intervention in social work is a shared professional reality and discussion in a group had been considered an available option for this research study. However, given certain practical and logistical constraints the method was altered to suit the contextual realities encountered in the field. The realities included the changed landscape of the composition of the deployment of participants per health institution. Several factors like officer transfers to other duty stations, officers being away on study leave, sick leave and annual leave made it difficult for the researcher to convene a sizeable focus group interview for the purpose of this research study.

The researcher collected data from participants by means of semi-structured interviews using an interview schedule. Creswell (1994:148), mentions the following steps for data collection:
• Setting the boundaries for the study,
• Collecting information through observations, interviews, documents, and visual materials, and
• Establishing the protocol for recording information

Miles and Hurberman (in Creswell, 1994:149), suggests four parameters to be considered in the process of data-collection:

• The setting – where the research will take place
• The actors – who will be observed or interviewed
• The events – what will the actors be observed doing or interviewed about
• The processes – the evolving nature of events undertaken by the actors within the setting.

1.5.5 The Pilot Study

The New Dictionary of Social Work (1995:45) defines a pilot study as a “process whereby the research design for a prospective survey is tested”. A pilot study is a small-scale trial run of the aspects planned for use in the main inquiry and can be viewed as a dress rehearsal for the main investigation. McBurney (in De Vos et al., 2002:210), stresses that a pilot study forms the crux of any successfully completed research project and is especially important in the practical planning of a research project, for example, aspects such as transport, finance, and the appropriateness of the data collection instrument. It is during this exercise that many unforeseen problems can be detected and the necessary improvements can be made in order to ensure effective execution of the main investigation.

The researcher conducted a pilot study in the Thamaga Primary Hospital involving a social worker providing social services to HIV and AIDS clients. This helped to confirm the belief that the research questions provided the necessary quality of information for this research. The interview was transcribed and
analysed. The pilot study interview transcript and analysis did not require any need for the adjustment of the data collection instruments before beginning the study on a larger scale.

1.5.6 Field Notes

In addition to the audio taping of the interviews, field notes were taken in order to reflect on the content of the interview. Greeff (in De Vos et al., 2002:304) mention that the researcher should jot down his impressions of the interview immediately after an interview. This will help him to remember and explore the process of the interview. Flick (1998:170) asserts that “The notes taken in interviews should contain the essentials of the interviewee’s answers and information about the proceeding of the interview”. The researcher had a field notebook to record any noteworthy observations, which may not be captured by other data gathering devices like the tape-recorder.

1.5.7 Methods of Data Analysis

Data analysis is the process of systematically searching and arranging the interview scripts, field notes and other materials that the researcher accumulates to increase understanding of them and to enable him to present what he discovered to others (Biklen, 1992:152). The data collected is termed ‘raw data’. The data has to be reduced to smaller sets of data that can answer the research question. Tutty et al. (1996:360) describe data analysis as a summary of completed observations, which yield answers to the research question. Mouton (2001:108) mentions that “analysis involves ‘breaking up’ the data into manageable themes, patterns, trends and relationships”. Analysis is done in order to understand the personal realities of the participants, including their unique experiences.
The researcher utilized the eight steps provided by Tesch (1990) as quoted in Creswell (1994:155):

- All the transcripts will be read in order to gain a sense of the whole. Perhaps jotting down some ideas as they come to mind.

- Going through one interview document – the most interesting, the shortest, or the one on top of the pile, asking what is this about? The purpose will be to look at the underlying meaning not the substance of the information. All thoughts written on the margins.

- After going through several participants making a list of all topics and clustering similar ones together. Forming these topics into columns of the major topics, unique topics, and leftovers. For example, a topic or category on “feelings experienced”

- Taking the list and going back to the data and abbreviating the topics as codes and writing them next to appropriate segments of the text. Trying out this to see whether new categories and codes emerge. For example category on feelings may be abbreviated “f-e”

- Find the most descriptive wording for topics and turn them into categories. Group topics in order to reduce the total list of categories that relate to each other.

- Making a final decision on the abbreviation for each category and alphabetize these codes.

- Assembling the data material belonging to each category in one place and performing a preliminary analysis.
• If necessary, recoding existing data.

1.6 LITERATURE CONTROL

The literature control was conducted after the data analysis process had been completed and had been used to confirm the data that emerged from the study. The salient data that emerged from the study were compared to available literature in order to note any differences, or provide new insights with regard to the findings.

1.7 DATA VERIFICATION

This phase ensures that there is accuracy and that information relevant to the findings has been included. For purposes of data verification and ensuring the trustworthiness of the research findings, the researcher will use Guba’s (1981) model of trustworthiness (in Krefting, 1991). This model addresses the following four criteria for assessing the trustworthiness of qualitative research:

• Truth-value
• Applicability
• Consistency
• Neutrality

1.8 ETHICAL CONSIDERATIONS

Ethics are preferences that influence behaviour in human relations. Strydom (in De Vos et al., 2002:63) defines “ethics as a set of formal principles that are suggested by an individual or group, are subsequently widely accepted, and offer rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researcher assistants, and students”. Ethical guidelines also serve as standards and as the
basis on which each researcher ought to evaluate his or her own conduct. In conducting the study, the following ethical conditions were followed:

- **Informed consent or voluntary participation:** According to De Vaus (2001:84, 85), participants should be typically be informed about the purpose of the study and its basic procedures, as well as a statement that participation is voluntary and that each participant is free to withdraw at any time or to decline to answer any particular question.

  During the preparation phase, all potential participants to the research study were briefed on the purpose of the research, the content of the interview, and the implications, both positive and negative. Furthermore, participants were asked to complete a consent form.

- **Anonymity and confidentiality:** Failure to honour promises of confidentiality is an obvious way in which participants can be harmed De Vaus (2001:87). Social science research entails the collecting of personal information which, if made public, could be embarrassing or humiliating or cause harm to participants in one or the other, therefore, it is essential that information be collected in such a way that confidentiality is guaranteed.

  Confidentiality means that information may have names attached to it, but the researcher holds it in confidence from the public (Neumann, 2003:127). The information is not released in a way that permits linking specific individuals to responses.

  Mark (1996:48) suggests that the researcher should keep all information about the participants confidential, unless where participants had given written permission to reveal the information.
• Harm to participants: In some experimental studies, participants are potentially exposed to harm. Where there is a danger of harm to participants the principle of informed consent requires that participants be told of the dangers before participating in the experiment, De Vaus (2001:86). De Vos et al. (2002:25) state that, subjects can be harmed in a physical and/or emotional manner. An ethical obligation rests with the researcher to protect participants against any form of physical discomfort, which may emerge, within reasonable limits, from the research project. HIV/AIDS is a very sensitive issue; therefore, the researcher should make sure that if the participants are emotionally affected during the study, he or she finds means to assist them. The researcher debriefed the participants at the end of the study or as it indicated a need to do so. Those that need further assistance will be referred to professional counsellors for management.

1.9 DEFINITION OF KEY CONCEPTS

• AIDS: Acquired Immune Deficiency Syndrome, a disease that is caused by a virus transmitted in body fluids, in which there is a severe loss of cellular immunity that leaves the sufferer susceptible to infection and malignancy (Concise Oxford English Dictionary, 2004:27).

• Experience is knowledge and skill resulting from observation of or practical acquaintance with facts or events (The Pocket Oxford Dictionary 1992:304).

• Clients: An individual, family, group or community to whom a social worker renders services (New Dictionary of Social Work 1995:10)

• HIV: Human Immunodeficiency Virus, a retrovirus which causes AIDS (Concise Oxford English Dictionary, 2004:27)

• Intervention: Professional behaviour of a social worker to bring about change in the person-environment situation to achieve the objectives of
the agreement cooperation (contract) which has been entered into with the client (New Dictionary of Social Work 1995:35)

- **Programme:** A plan of intended procedure (The Oxford Paperback Dictionary 1988:644)

- **Social Work:** Professional services by a social worker aimed at the promotion of social functioning of people (New Dictionary of Social Work 1995:60).

- **Social Worker:** Person registered and authorized to practice social work (New Dictionary of Social Work 1995:60)

1.10 DISSEMINATION

The findings of this research were reported in the form of a research treatise, and were made available in the Nelson Mandela Metropolitan University’s Library. The results were published in the form of an article in an accredited Social Work Journal. An abridged research report was presented to the Hospital Managers and staff of Social Work Departments of the participating institutions.

1.11 OUTLINE OF CHAPTERS

This research report is divided into the following chapters:

**Chapter 1:** General Overview and Introduction. This section provides the rationale for the study.

**Chapter 2:** Research methodology. This chapter focuses on the researcher’s implementation of the qualitative research process.

**Chapter 3:** Discussion of research findings and literature control. The findings are presented in a narrative form, and compared and contrasted with related existing literature and research.
Chapter 4: Summary, conclusions and recommendations. This chapter provides a summary of the research study, and outlines the overall conclusions and recommendations that emerge from the findings.

1.12 CHAPTER SUMMARY

In this chapter of the research report, the researcher gave a general overview of the research problem that the study seeks to address and provided a brief introduction to the methodology that would be employed. In the next chapter, the focus turns to a discussion of the research methodology and its implementation.
CHAPTER 2

THE RESEARCH METHODOLOGY

2.1 INTRODUCTION

This chapter describes the research methodology followed in order to operationalise this research study. Chapter One of this research report gave a general overview of the research problem that the study seeks to address and provided a brief introduction to the methodology that would be employed. In this chapter, the researcher will describe how the methodology was applied. Strydom (in De Vos et al., 2002: 255) postulates that the purpose is to develop confidence of the reader in the methods used and to spell out the context and purpose for which the collection of data has taken place.

Silverman (2000:89) states that methodology is “a general approach to studying research topics”. To give such an account the following topics will be covered in line with the phases of the qualitative research process suggested by Fouché and Delport (in De Vos et al., 2002:83-86). This structure was chosen as it provides the novice researcher with a user-friendly guide in terms of the sequence of events to be undertaken when undertaking a research project using the qualitative approach. The nine steps suggested by the authors are:

i) Choosing a research problem/topic/theme
ii) Decision on the qualitative research paradigm (mode of inquiry)
iii) Selection of a qualitative research design
iv) Sampling procedure and preparation of participants
v) The pilot study
vi) Data Collection method
vii) Data analysis
viii) Data verification
ix) Report writing

Consistent with the above views, the researcher will outline how the research process of this study has been conceptualised and implemented.

2.2 THE QUALITATIVE RESEARCH METHODOLOGY

According to De Vos et al. (1998:77) the term methodology merely means the way in which one proceeds to solve problems. In the context of research, it means the process one follows to answer the research question or to solve the research problem. Creswell (1994:43) maintains that methodology refers to the entire process of a study. According to Walter, Nutley, Percy-Smith, McNeish, and Frost (2004: xiii) “Research comprises the results from systematic investigations based on planned strategies. This may be primarily research that involves systematic inquiry based on observation or experiment. It may also be secondary research that takes primary research studies as its objects of inquiry.” Mark (1996:209) relates that qualitative research methods assume that there is no single reality, but rather, the nature of reality is defined by the interaction of the researcher with the phenomenon under study.

According to Silverman (2000:89), the “methods used by qualitative researchers exemplify a common belief that they can provide a ‘deeper’ understanding of social phenomena than would be obtained from purely qualitative data”. Denzin and Lincoln (1994:24) add that qualitative research is “multi-method in focus, involving an interpretive naturalistic approach to its subjects”. This means that qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meaning people bring to them. On the other hand, Holloway and Wheeler (1996:45) suggest that “qualitative research is based on the belief that knowledge is socially constructed”. The researcher and the participants have their own values and realities as multiple realities exist. Biklen (1992:227) confirms that researchers who use this
approach are interested in the ways different people make sense out of their lives. In other words, the researcher will be concerned with what is called participant perspectives. That is, in the context of the research study under discussion, the research will endeavour to solicit for the participants’ views and experiences on intervening with HIV and AIDS.

Since the study topic would like to find out the experiences of the participants, this approach sounds relevant. It is a rational decision to adopt the qualitative approach to the proposed study. Therefore, the researcher concludes that the qualitative approach focuses on the quality of human experiences, and that it emphasises the participants’ viewpoint. The importance of this study would be to study and discuss the personal experiences of the participants, as they express them in their everyday lives.

2.3 CHOICE OF RESEARCH TOPIC

Choosing a research topic is the first step undertaken in order for any research project to proceed. According to Fouché (in De Vos et al., 2002:96) our most evident source of a researchable problem is our contact with the external world and direct observation thereof. The other reason may be soliciting research problems from theory, through the testing of theory or generating new theory or hypotheses. One may consult previous research which may include research reports. Curiosity may yet be another source. This refers to the researcher’s inquiring mind and personal interests coming to play. The last source may be the supervisor’s research ideas. Holloway and Wheeler (1996:21) support the views articulated by De Vos et al. and suggest that there are many sources of research problems and state in a general form the very reasons stated by De Vos and others.

The researcher has been influenced by the dearth of research on the topic under discussion in Botswana in spite of the extensive contribution made by social
workers on efforts to control and prevent the spread of HIV and AIDS in the country. This current study envisions adding to the literature and the professional base relating to intervening with the area of HIV and AIDS in a country which is regarded to have amongst one of the highest HIV and AIDS statistics. 37.4% HIV prevalence was reported in 2003 for pregnant women aged 15 – 49 years seeking antenatal care (NACA 2003:2). From personal observation and interaction with colleagues from hospitals, as well as past personal experience in HIV and AIDS intervention, the researcher observed that social workers often expressed that they experience stress in relation to intervention in the area of HIV and AIDS. In order to understand the phenomenon of social workers' experiences with HIV and AIDS intervention, a preliminary literature study was conducted.

In their study on the attitudes of practicing nurses as predictors of intended care behavior with persons who are HIV positive, Laschinger & Goldenberg (1993:441) found that nurses studied presented positive attitudes toward caring for positive patients. They showed that they were likely to care for any positive person to whom they are assigned in a clinical setting. In other study entitled The AIDS Care Dilemma: An Experience in Critical Thinking, Lewis & Eaks (1992:136,137) discovered that the nurses reported that AIDS has been described as 'not a doctors’ disease, but a nurses’ disease, since it is the nursing care that these patients need most.

Faungier & Hicken (1996) in a study entitled, AIDS and HIV: The Nursing Response found out that HIV has presented a great challenge to the nurses’ values, practice and has brought many other ethical dilemmas.

In reviewing available literature, the researcher had not come across any literature that specifically dealt with the subject matter, that is, Social Workers’ Experiences of Intervening with HIV and AIDS Clients. There is a lot written on nurses’ attitudes towards patients with AIDS or knowledge about HIV and AIDS
(Baipidi 2000, unpublished research report). Other study reports browsed through concerned informal caregivers in area of HIV and AIDS. There is no study on record in Botswana done on the Social Workers’ Experiences of Intervening with HIV and AIDS Clients. This might be due to the fact at the onset of intervening with HIV and AIDS concentration has been solely on assisting the clients who were affected and infected by HIV and AIDS at the exclusion of those who are providing social welfare services. The practice has to race against the HIV infection in order to contain it as there is no cure yet.

2.4 SELECTION OF THE QUALITATIVE DESIGN

Grinnell and Williams (1990:138) define research design as “the total plan a researcher uses to aid in answering our research questions. As a part of the plan the researcher decides what the research question should be, what data will be required to answer it, from whom the data will be obtained, and exactly what the best way to gather data is”. Kumar (1996:74) defines research design as a plan, structure and strategy of investigation so conceived as to obtain answers to research questions or problems. The plan is the complete scheme or the program of the research. A research design is a procedural plan that is adopted by the researcher to answer questions objectively and accurately. It is the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose.

For the purpose of this study, the researcher used the exploratory, descriptive and contextual design, because of the interest in the experiences of social workers in terms of their intervention with HIV and AIDS clients.

In referring to exploratory studies, Neuman (1997:19) states that this mode of inquiry is used to explore a new topic or to learn more about issues where little is known. The exploratory study is conducted to gain insight into a situation, phenomenon, community or individual. As mentioned earlier, literature on the
experiences of social workers relating to their intervention with HIV and AIDS clients in Botswana is not available in spite of the prevalence of the problem. The researcher chose the exploratory design because the area understudy is not well developed and therefore no sound theories have yet been put forward.

A **descriptive** design attempts to describe systematically a situation, problem, phenomenon, or provides the living conditions of the community or describes attitudes towards an issue (Kumar, 1996:9). In contrast to exploratory research, the descriptive research presents a picture of the specific details of situation, social setting, or relationship, and focuses on the “how” and “why” questions.

In this study, a descriptive design was used as the researcher interviewed seventeen participants comprising the sample in order to accurately describe their experiences with regard to their intervention with HIV/AIDS clients.

The **contextual** nature of this study refers to the fact that the research seeks to avoid the separation of components from the larger context to which these elements may be related (De Vos et al, 1998:281). According to Terre Blanche and Durrheim (1999: 47), research always takes place in a specific context. The authors acknowledge that every researcher may take a very different attitude towards this context. This is contextual as it was conducted in the natural settings of the participants, at their daily workplace.

### 2.5 PREPARATION OF PARTICIPANTS AND SAMPLING PROCEDURE

Participants in this study comprised qualified social workers employed by the Department of Social Services (Ministry of Local Government) who are presently seconded to the Department of Clinical Services (Ministry of Health), in selected health facilities in Botswana. The research proposal which had been approved by the Nelson Mandela Metropolitan University was submitted to the Ministry of Health to obtain permission to undertake the study. A letter of introduction was
sent to the potential participants and the supervisors of institutions where data was to be collected, after being permitted by the Ministry of Health to proceed with the study. Furthermore, an introductory meeting was arranged with the participants to discuss any queries as well as to inform the participants of their rights to participate in the study.

A non-probability, purposive sampling procedure was used to recruit a sample of social workers in the following health facilities: Athlone, Princess Marina, Scottish Livingstone, Good Hope Primary Mahalapye, and Sekgoma Memorial Hospitals in Botswana. De Vos et al. (1998:198) define a non-probability, purposive sample as a sample that is composed of elements, which contain the most characteristic, representative or typical attributes of the population. In this study, the participants were all social workers with one year’s experience in the field of intervening with HIV and AIDS clients in Botswana.

2.6 PILOT STUDY

De Vos et al. (2002:337) emphasise that it is important to conduct a pilot study, whether it be a quantitative or qualitative study. For this purpose, the participants must possess similar characteristics as those of the main investigation. The authors state further that the pilot study, in qualitative research allows the researcher to focus on specific areas that may have previously escaped scrutiny, as well as to test the questions which guide the data collection process. The testing of the questions in the interview schedule enabled the researcher to make some modifications with a view to undertake quality interviewing during the main investigation.

For the reasons stated above the researcher conducted a pilot study, in order to fine-tune the questions that needed rephrasing.
2.7 PREPARATION FOR DATA COLLECTION

Preparation for data collection involves drawing boundaries or parameters for the study. Miles and Huberman (in De Vos 1998:46) refer to four aspects that need to be attended to in the latter process namely, the setting and the actors, sampling criteria, the events and the process.

- **The Setting**: this is concerned with answering the question “Where will the research take place?” For this study, the setting for both the pilot study and the main data collection phase were the following health facilities, purposively selected in Botswana: Athlone, Princess Marina, Scottish Livingstone, Mahalapye, Sekgoma Memorial, Deborah Retief Memorial, Bamalete Lutheran, Thamaga and Good Hope Primary Hospitals. The researcher lives and works in Gaborone and the selected sites lie at a radius of around three hundred and twenty kilometres to the north and sixty kilometres to the south and provided some convenience and feasibility for the researcher.

The most convenient place for carrying out the interviews was the participants’ workplace offices. An appointment was made not to inconvenience or disrupt the flow of work. The aim was not to remove the participants far away from their workplace, as well to avoid after work appointments which may had interrupted their personal life. In a case where there were clients to be attended to the other social workers would attended to them. Where this proved impossible, the participants were interviewed in a pre-arranged place like a public or school hall or a similar venue which however did not violate the participants’ ethical rights for example, the right to privacy and anonymity.
All the participants were deployed to the health facilities sampled and were engaged in intervening with HIV and AIDS among other duties they had to execute. The participants

- **The Actors**: refers to the people who were interviewed or observed according to the sampling procedure and sampling criteria. Kerlinger (in De Vos et al., 2004:198), defines sampling as taking any portion of a population or universe as representative of that population or universe. Mason (1998:83) broadly defines the sampling and sampling selection procedures as the process used to “identify, choose, and gain access to relevant units which will be used for data generation by any method”. In this study the actors were social workers intervening with HIV and AIDS clients in health facilities in Botswana.

- **Sampling Criteria**: A sample, according to Mark (1996:105) is a portion of a population selected for study. A subset of the observations selected from a population. The sample was selected from those providing direct service to customers facing HIV/AIDS challenges in the selected areas. A non-probability sampling technique, namely, purposive sampling was employed. According to De Vos et al. (2004:207), this is based entirely on the judgement of the researcher, in that the sample is composed of elements that contain the most characteristic, representative or typical attributes of the population. The researcher hand picked the sample according to the nature of the research problem. The selected participants were contacted by phone and an introductory letter was faxed to inform them of the purpose of the research study, what it would entail, and that the interviews were to be tape-recorded in order to gain precise accounts of their experiences.

Follow up was done telephonically during the data collection phase in order to check on social workers’ willingness to participate in the research study. An
appointment for completing the consent form was arranged for those agreeing to take part in the study. All the selected participants willingly participated in the research study.

- **The events**: The participants were expected to relate their personal experiences relating to their intervention with HIV and AIDS clients. The participants related personal experiences in relation to their intervention with HIV and AIDS clients in Botswana. For a detailed discussion on this, the reader is referred to Chapter One (see Section 1.5.4).

- **The process**: this refers to the data collection process and included the contact and contract phases of recruiting the potential participants taking part in the study. Data were collected by means of semi-structured interviews with the aid of an interviewing guide. The interviews were at the most sixty minutes in duration in an individual setting, depending on the participant’s accounts of his or her experiences. The use of in-depth semi-structured interviews allowed for the collection of more extensive and detailed data from the participants through enabling them to air their views and experiences in an expended manner. This allowed the researcher to examine the phenomenon in context.

The interview guide is a form of questionnaire written to guide interviews, and is known as an interview schedule. Greeff (in De Vos et al., 2002:302) remark that the interview schedule provides the researcher with a set of predetermined questions that can be used as an appropriate instrument to designate the narrative terrain. The researcher is prepared before going into the field with a set of questions to cover. In this way difficulties as well as sensitive areas of the project may be anticipated before going into the main data gathering exercise. The same author further states that, “in general, [the] researcher uses semi-
structured interviews to gain a detailed picture of a participant’s beliefs … perceptions and accounts. The method [interview schedule] gives the researcher and participants more flexibility”. On the other hand, Holloway & Wheeler (1996:55), states that the semi-structured or focused interview questions are contained in an interview guide (used only by the researcher, not the predetermined questionnaire completed by the participants). The interview guide will however, ensure that the researcher collects similar types of data from the participants.

Thus, in this research study, the semi-structured interview gave the researcher an opportunity to gain a detailed picture of the social workers’ experiences relating to their intervention with HIV and AIDS clients. The interview solicited the experiences of the participants’ interactions with their clients. The questions were constructed to trace intervention over time from the first to current experiences. Interviewing provides an appropriate avenue of inquiry bearing in mind the aforementioned nature of the study which has to elicit the meaning the social workers attach to their intervention experiences with HIV and AIDS clients.

The following questions would form part of the interview guide:

1. Please tell me about your experiences in intervening with HIV and AIDS clients?

2. What was your first intervention experience?

3. Have your experiences been different since your first intervention experience?

4. What are the current challenges you encounter in intervening with HIV and AIDS clients?
5. Which intervention strategies do you apply in your intervention with HIV and AIDS clients?

6. Are there any programmes available to assist you in dealing with HIV and AIDS clients?

7. What suggestions or advice could you give to other social workers who are about to enter the area of HIV and AIDS intervention?

The questions were open-ended as evidenced above. This allowed the researcher to probe relevant areas with a view to facilitate a process whereby participants were free to relate their personal intervention stories. There were no changes in the pilot study.

The following interviewing techniques in De Vos et al. (2002:293-296) were taken cognisance of to ensure effective interviewing: most of the talking was done by the participant; questions were clear, brief, single, and truly open-ended; sensitive and leading questions were avoided; experience/behaviour questions were asked; questions were sequentially arranged; general questions were used to open the logjam; questions were asked when there was no understanding on the side of the researcher; key questions were repeated throughout the interview; pauses were allowed in the interview; a return to incomplete points and the use of creative allusions were done.

The following communication techniques will be utilised as they provide mutual attentiveness, monitoring and responsiveness (Greeff in De Vos et al. (2002:294, 295).

- **Minimal verbal response**: that which correlates with occasional nodding.
- **Paraphrasing:** it involves a verbal response in which the research will enhance meaning by stating the participant’s words in another form with the same meaning.
- **Clarification:** this embraces a technique that will be used to get clarity on unclear statements.
- **Reflection:** on something important that the person has just said in order to get him to expand on that idea.
- **Encouragement:** encourage the participant to pursue a line of thought.
- **Comments:** inject own idea or feeling to stimulate the participant into saying more.
- **Spur:** say something to spur or challenge the participant into saying more.
- **Reflective summary:** summarise participants’ ideas, thoughts and feelings verbalised so far to see if you really understood what he was saying.
- **Listening:** have a superb listening skill.
- **Probing:** the purpose is to deepen the response to a question, to increase the richness of the data being obtained and to give cues to the participant about the level of response that is desired. It is a technique to persuade the participant to give more information about the issue under discussion.

The following are probing methods (Greeff in De Vos et al. 2002:295).

- **Contradicting:** it entails deliberately giving an opinion opposite to that of the participant, in an attempt to arouse his further comments.
- **Linking** up the participant’s comment with the information that the researcher wants to know.
- **Faking puzzlement:** pretending to be confused, indicating that elaboration was needed.
- **Challenging:** demanding more information to prove the validity of the participant’s claims.
- **Showing understanding and allowing time for elaboration:** letting the participant know that his comments are understood and treasured and allowing him time for further comments.
- **Acknowledging** repeating the participant’s comment to show attention.
- **Direct question:** asking questions to get more information.
- **Procuring details:** asking questions to see if more information can be obtained.

For the purpose of this research study, interviews were recorded on tape and the field notebook.

### 2.8 DATA ANALYSIS

According to Mouton (2001:108-109), data analysis involves ‘breaking up’ the data into manageable themes, patterns, trends and relationships. The aim of analysis is to understand the various constitutive elements of one’s data and to see whether there are any patterns or trends that can be identified or isolated, or to establish themes in interpretation. Kvale (1996:187) however, states that “there is no magical tool for finally uncovering the meaning which lies hidden in pages of opaque interview transcripts”.

For the purpose of this study the researcher used the eight steps of Tesch (in Creswell 1994:155).

1. In order to get a sense of the whole of the transcripts were carefully read and ideas were jotted down as they came to mind.

2. Then a transcript, namely, an eighth one was chosen as it had rich information. This could be the longest or shortest. Thoughts and ideas that came to mind were jotted down in the right margin of the transcript.
3. After the above task was completed for the several transcripts, the researcher then made a list of all the topics, clustering the similar topics together in three columns: major topics, unique topics and leftovers. For example, topics on feelings, training needs, lack resources, impact of HIV and AIDS, stress and depression and suggestions and advises to a new social worker were grouped together, in order to draw a picture of the development of the thoughts from the analysis process..

4. Then the researcher returned to the data (transcripts) and wrote appropriate codes next to the appropriate segments of text. Then new codes emerged as a result.

5. Thereafter, themes were grouped together, named and categorised. Lines were drawn between categories to show interrelationships. For example, themes were developed as follows: Experiences of Intervention; Impact of HIV and AIDS Intervention; Measures to Alleviate Impact of HIV and AIDS on Social Work Intervention; Intervention Strategies; and Suggestions and Advices to New Social Workers

6. A final decision on the abbreviation for each category was made and codes were alphabetized. For example, all feelings pertaining to the initial intervention experiences were coded Ei/MixF (Experiences of Intervention – Mixed feelings).

7. Then the researcher used a flipchart sheet to place data pertaining to each code in one category.

8. A recoding was performed in order to make sure that the coding system made sense. For example, the category ‘Lack of information’ under the sub-theme ‘Initial Intervention Experiences’ was coded Ei/LInfor, but after thorough thought the coding was changed to ‘Ei/LOInfor’
The researcher employed the services of an independent coder experienced in the field of qualitative research. The independent coder came up with themes which were related to the experiences of social workers intervening with HIV and AIDS clients. Consensus was reached between the independent coder, the research supervisor and the researcher after an analysis of the transcripts during a joint consensus meeting. The themes, sub-themes and categories which emerged will be reported in Chapter Three as the research findings.

2.9 DATA VERIFICATION METHOD

The researcher used Guba’s model of trustworthiness (Krefting 1991:215-221), for the purpose of data verification in order to ensure the trustworthiness of the research findings. The four general criteria proposed by Guba (1981) for assessing the trustworthiness of qualitative data are truth-value, applicability, consistency, and neutrality. The four components are discussed below as they were employed in this study.

For a full detailed theoretical discussion on the above refer to Chapter One (section 1.7)

- **Truth-Value** asks whether the researcher has established confidence in the truth of the findings for the participants, and the study context. The researcher was interested in the experiences of social workers in their intervention with HIV and AIDS clients. To achieve truth-value, the researcher employed the strategy in data verification. Credibility in this study was achieved through the following:

  - **Triangulation** is a strategy for enhancing the quality of the research and is the best way in which to enhance validity and reliability. In this study, the researcher used the triangulation of data resources in order to verify data by endeavouring to interview
a number of different research participants in an individual interview setting.

- **Peer-examination** is the discussion that the researcher holds with regard to the findings and problems encountered in the research with impartial colleagues who have experience in qualitative research (Krefting 199:220). The research study supervisor and the independent coder were used in this regard. The use of interviewing skills mentioned in section 2.8 (Preparation for Data Collection) were employed by the researcher to further enhance the credibility of the research findings.

- **Applicability** is “the degree to which the findings can be applied to other context, settings, or with other groups.” In other words, this is the ability to generalise from the findings to larger populations. The strategy employed to attain applicability is that of **transferability**. Transferability, therefore, was achieved by a detailed description of the research methodology employed in this research study, as well as the research findings on the experiences of social workers in relation to their intervention with HIV and AIDS clients.

- **Consistency** according to Krefting (1991:216) refers to whether the findings would be consistent if the inquiry were to be replicated with the same participants or in a similar context. The strategy to measure consistency is that of **dependability**. The following was used to achieve dependability.

  - **The use of an independent coder**: the researcher and the independent coder analysed data in order to identify themes and categories that emerged from the data collected, after which we engaged in a consensus discussion with the research study
supervisor in order to finalise themes, sub-themes and categories.

- **Peer examination**: as discussed under truth-value, peer examination was employed to enhance the trustworthiness of the research findings.

- **Triangulation**: as discussed under truth-value section, triangulation of data sources was utilised.

- **Code and recode procedure**: the researcher coded data obtained from the semi-structured interviews and then allowed some time to pass in order to have a fresh look at the coding again. The process was repeated again in order to assess the applicability of the initial coding process as well as to make the necessary changes (Krefting 1991:221).

- **Neutrality**: Guba (in Krefting 1991:215) defines neutrality as the “degree to which the findings are a function solely of the informants and conditions of the research, and not of other biases, motivations and perspectives.” **Confirmability** is the strategy used to confirm neutrality. Triangulation of data sources as discussed under “truth-value,” was used to achieve conformability.

2.10 REPORT WRITING

According to De Vos et al. (1998:48), report writing is the last phase in the qualitative research process, and this document represents the product emerging during this phase.

2.11 CHAPTER SUMMARY

In this chapter, the researcher described the qualitative research process using the structured outline suggested by De Vos (2002:85-92), as follows:
The first phase involved the selection of the research problem which provided the foundation for the entire research process. The research problem was discussed in Chapter One (see Section 3) and pointed to the paucity in the indigenous literature about the experiences of social workers relating to their intervention with HIV and AIDS clients as discussed extensively in Chapter One.

The Selection of the qualitative research paradigm constituted the second step. The researcher opted for the qualitative research due to the dearth of research and literature available on the topic, as well as the explorative nature of the study.

In Selecting the qualitative research design, an explorative, descriptive as well as contextual research design was employed in an attempt to explore, describe and understand the meaning ascribed by social workers to their experiences relating to their intervention with HIV and AIDS clients.

In the Selection of the data collection method, the researcher was involved in making decisions as to where the research was to take place, who the participants were, the method of data collection, and the researcher’s role during the study. The setting was eight government hospitals in Botswana. The participants were social workers who are currently involved with the HIV and AIDS programme in these health facilities. Semi-structured interviews were conducted with a non-probability sample of participants who voluntarily participated in this study.

Pilot study: was conducted prior attempting the main study

The researcher selected to implement the eight steps proposed by Tesch (in Creswell 1994:155) in order to systematically analyse the data gathered during the interviews.

In Selecting the tool for data verification, Guba’s model of trustworthiness (in Krefting 1991:215-221), was chosen and the following
four criteria – truth-value, applicability, consistency and neutrality - was applied to enhance the trustworthiness of the research findings.

The theoretical and implementation of the research study was discussed in this chapter. The research design, method and the sampling criteria was the focus in this section of the report. Data collection was done by taping individual interviews using a semi-structured interview schedule.

In Chapter Three, the discussion will focus on the research findings as they emerged during the process of data analysis.
CHAPTER THREE

RESEARCH FINDINGS AND DATA VERIFICATION

3.1 INTRODUCTION

In Chapter One of this research report the researcher discussed the relevance of the research topic and the dearth of literature on social workers’ experiences of intervening with HIV and AIDS clients in Botswana. The choice of the qualitative approach and its appropriateness in answering the research question was covered in Chapter Two. The latter chapter also provided a full description of the research design and methodology implemented in order to answer the research question framed for the study, namely:

What are the experiences of social workers in their interventions with clients who are HIV and AIDS positive?

Seventeen semi-structured interviews were undertaken to collect data from social workers who participated voluntarily in this study. The interviews were guided by the following questions:

1. Please tell me about your experiences in intervening with HIV and AIDS clients?
2. What was your first intervention experience?
3. Have your experiences been different since your first intervention experience?
4. What are the current challenges you encounter in intervening with HIV and AIDS clients?
5. Which intervention strategies do you apply in your intervention with HIV and AIDS clients?
6. Are there any programmes available to assist you in dealing with HIV and AIDS clients?

7. What suggestions or advice could you give to other social workers who are about to enter the area of HIV and AIDS intervention?

In this chapter, the researcher will deal with presenting two phases of the research process, namely, reporting the findings emerging from the process of data analysis and verification of the findings by means of a literature control. A literature control in qualitative research should be used in a way that is consistent with the methodological assumptions of the research paradigm. Creswell (1994:20) contends that in qualitative research literature should be used inductively. In other words, the research findings must be compared and contrasted with the established literature.

For this reason the researcher used literature sparingly in the initial stages of the research study, in order to ensure that there would be no contamination of the study by prior knowledge. Furthermore, this ensures faithfulness to an inductive design in which literature does not guide and direct the research. In this section of the research report the narratives of the participants will be presented in support of identified themes and sub-themes. The findings will be compared and contrasted with existing theories and previous research reports (De Vos et al., 1994:48).

The following format will be used to discuss the research findings: firstly, the professional profile of the research participants will be presented and briefly discussed. Secondly, the themes, sub-themes and their categories as identified during the data analysis and consensus discussion process will be presented and discussed in a narrative format and supported by relevant quotations from the transcribed interviews.
### 3.2 PROFILE OF PARTICIPANTS

The table below displays a summary of the professional profile of the research participants.

<table>
<thead>
<tr>
<th>IDENTITY</th>
<th>SEX</th>
<th>EDUCATION</th>
<th>COMMNENCEMENT DATE AS SOCIAL WORKER</th>
<th>INSTITUTION</th>
<th>SPECIAL -ISED TRAINING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant 1</td>
<td>F</td>
<td>BSW</td>
<td>23/12/02</td>
<td>District Hospital</td>
<td>No Training</td>
</tr>
<tr>
<td>Participant 2</td>
<td>F</td>
<td>MSW</td>
<td>01/06/05</td>
<td>District Hospital</td>
<td>No Training</td>
</tr>
<tr>
<td>Participant 3</td>
<td>M</td>
<td>BSW</td>
<td>05/02/02</td>
<td>District Hospital</td>
<td>Kitso Training</td>
</tr>
<tr>
<td>Participant 4</td>
<td>F</td>
<td>BSW</td>
<td>01/09/99</td>
<td>District Hospital</td>
<td>HIV/AIDS Counselling</td>
</tr>
<tr>
<td>Participant 5</td>
<td>F</td>
<td>BSW</td>
<td>16/08/99</td>
<td>Primary Hospital</td>
<td>Community Home Based Care</td>
</tr>
<tr>
<td>Participant 6</td>
<td>F</td>
<td>DSW</td>
<td>Unavailable</td>
<td>Mission Hospital</td>
<td>Kitso Training</td>
</tr>
<tr>
<td>Participant 7</td>
<td>F</td>
<td>DSW</td>
<td>06/10/97</td>
<td>Mission Hospital</td>
<td>HIV/AIDS Counselling</td>
</tr>
<tr>
<td>Participant 8</td>
<td>F</td>
<td>DSW</td>
<td>03/08/99</td>
<td>District Hospital</td>
<td>PMTCT, CHBC &amp; Kitso Training</td>
</tr>
<tr>
<td>Participant 9</td>
<td>F</td>
<td>BSW</td>
<td>23/07/01</td>
<td>District Hospital</td>
<td>No Training</td>
</tr>
<tr>
<td>Participant 10</td>
<td>F</td>
<td>BSW</td>
<td>01/11/00</td>
<td>District Hospital</td>
<td>Couple HIV Counselling</td>
</tr>
<tr>
<td>Participant 11</td>
<td>M</td>
<td>BSW</td>
<td>01/11/00</td>
<td>District Hospital</td>
<td>No Training</td>
</tr>
<tr>
<td>Participant 12</td>
<td>F</td>
<td>BSW</td>
<td>15/03/82</td>
<td>District Hospital</td>
<td>No Training</td>
</tr>
</tbody>
</table>
From the sample recruited for this study it became clear that the experience of intervening with clients who are HIV and AIDS positive is shared by all social workers regardless of the length of experience after completing studies. The sample for this study comprised seventeen participants, two males and fifteen females. Data were saturated as evidenced by the repetition of themes during data analysis and the coding process.

The profile of participants was evident of the following characteristics:

- The participants were all social workers working for the Botswana Ministry of Local Government under the Department of Social Services. All the
participants are on secondment to the Ministry of Health and work under the Department of Clinical Services.

- It is important to note that all the participants are graduates of the University of Botswana with one exception where a social worker has undertaken post-graduate studies outside Botswana.

- Twelve of the participants have a first degree in social work; three have a Diploma in Social Work, while two hold Masters Degrees, one from Botswana and the other from the United States of America with an emphasis on clinical social work.

- Nine of the participants had initial experience with the Department of Social and Community Development (S & CD). Four were recruited directly from graduate school while the remaining four were either deployed from within the Department of Social Services to the hospitals or recruited from non-governmental organisations (NGOs).

3.3 DISCUSSION OF THEMES, SUB-THEMES AND CATEGORIES

Five themes with accompanying sub-themes and categories resulted from the process of data analysis and consensus discussion between the independent coder, the researcher and the research supervisor.

Table 3.2 below is presented in order to provide an overview of the themes, sub-themes and categories.
Table 3.2 Overview of themes, sub-themes and categories

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In the remainder of this chapter, each of these themes with their accompanying sub-themes and categories will be presented and discussed by providing excerpts from the interviews and verified against existing literature to support the themes, sub-themes and categories.

3.3.1 THEME 1: SOCIAL WORKERS’ EXPERIENCES OF INTERVENTION WITH HIV AND AIDS CLIENTS

The first identified theme is the experiences of social workers in intervention with HIV and AIDS clients. This theme is divided into two sub-themes which highlight the range of feelings experienced by the participants as a result of their HIV and AIDS intervention: These are the initial and subsequent experiences. The first sub-theme includes the following categories: Initial intervention with HIV and AIDS clients is an emotionally loaded experience, the lack of specialised training, the lack of resources, lack of information and the impact of HIV and AIDS has on life in general. The second sub-theme includes the following categories: specialised training, practical experiences, supervision/colleague support, and ARVs provide hope for clients.

The narratives which led to the emergence of this theme with its inherent sub-themes and categories were elicited by asking participants questions on their general experiences of intervention with HIV and AIDS clients with emphasis on their initial and subsequent experiences.

It is important for the reader to understand that the initial intervention experiences were mostly negative in nature, while the subsequent intervention experiences were generally positive. By then the participants had gone through the trauma of HIV and AIDS intervention and gained practical experience.
3.3.1.1 Sub-theme: Initial Intervention Experiences

The participants were requested to recount their initial experiences in intervening with HIV and AIDS clients. Various responses that included the following mixed feelings were expressed by the participants: trauma, struggle, sorrow, shock, pain, anxiety, pity, emotion, stress, crying/tears, tiredness, fear and guilt. The participants expressed the foregoing feelings as it was their first direct encounter with HIV and AIDS related clients as part of their professional intervention.

This sub-theme is divided into the following categories:

- Initial intervention with HIV and AIDS clients is an emotionally loaded experience

The participants reported that their knowledge on HIV and AIDS intervention had been minimal as they dealt with the scourge at a theoretical level without doing practical intervention while they were undertaking undergraduate studies. Participants who have been in the field for some length of time articulated experiencing fear, anxiety, distress, depression, helplessness, hopelessness, meaninglessness and loneliness when confronted with clients who suffer with HIV and AIDS.

Counselling people who are HIV positive produces intense feelings in the counsellor. Dreyden (1995:47) states that many of the stresses experienced by the counsellor are the indirect result of the stressors operating in the client. Winiarski (1991:134) suggests that psychotherapy is a difficult enough profession. Its powers and difficulties lie in the two-way emotional bonds between client and therapist. Psychotherapy is enhanced by the gift of empathy to enable practitioners to feel the client’s pain and confusion, and the client to understand and feel that his or her story is heard and appreciated. Winiarski further says that the empathetic attachment to clients in pain guarantees that practitioners will also
feel pain. HIV and AIDS work is difficult because it deals with a chronic and life-threatening disease and its stresses, with concerns regarding a shortened life, and the waxing and waning of hope.

The mixed feelings experienced by the participants are thus confirmed by Dreyden (1995) and Winiarski (1991).

The participants verbalised their first encounter with HIV and AIDS in the following manner:

“*It is traumatic. At times we come across very painful stories/cases, especially those of children.*”

“*The first experience was so tough for me, as I had been recruited from the Local Authority, with no experience at all on HIV/AIDS.*”

“As we were talking, it was very painful as it was my first experience to come across a case of a full-blown AIDS. I was overwhelmed with emotion without knowing where to start.”

“So some of the experiences we have here, hit very close to home. Sometimes you may feel that you are actually addressing your fears and problems and concerns when attending to a patient. This may trigger depression in you.”

From the above statements, the participants’ feelings can be attributed to empathy and their lack of knowledge as will be discussed later. The participants were overwhelmed by the reality of HIV and AIDS as well as the lack of resources as there were no drugs to deal with the effects of HIV and AIDS.

- Initial intervention with HIV and AIDS clients highlighted lack of specialised training

HIV and AIDS intervention presents challenges both in the medical and social dimensions of life. The condition evokes a range of feelings and makes it difficult for the client to cope with the infection status. The professional thus has to be
well equipped with information that can assist the client to deal with the disease. Social workers should educate themselves about the stages of the illness and how its progression may present (Aronstein & Thomps on, 1998: 36). Coughlin, Coughlin and Jameson (1996:255), express the view that professions such as social work that are not addressing the AIDS question effectively need to be equipped with knowledge that will enhance effective involvement in HIV and AIDS. HIV and AIDS are new diseases, which everyone is trying to understand. They require adaptation in practice (Bennett, Miller and Ross, 1995:262).

According to Macklin (1989:75, 76) professionals, whether they are health-care providers or educators, have a special need for education on AIDS. Thus, education for professionals must begin by providing accurate information about the epidemiology, transmission and prevention of HIV infections.

The participants expressed the lack of special training in the following narratives:

“No skills at all in relation to HIV/AIDS intervention. I had to acquire them from my involvement with clients at work. ”

When asked of the importance of training in HIV and AIDS one participant said:

“It is important because dealing with HIV/AIDS is not the same as having to attend to other social problems. They suffer from an incurable illness which has a lot of emotions and feelings surrounding it.”

- **Initial intervention with HIV and AIDS clients highlighted an evidence of lack of information**

Participants’ perspectives on their initial experiences of intervening with HIV and AIDS clients highlighted a lack of information for both the client and the professional. Clients presented with a lack of basic information on HIV and AIDS. On the other hand, since the professional was not trained, he or she lacked intervention skills as well as any basic medical understanding of the terminology surrounding HIV and AIDS intervention. This will be reflected differently in the
subsequent sub-theme 3.3.1.2 as the participants articulated contrasting experiences after acquiring training and practical experience.

Aronstein and Thompson (1998: xxi) postulate that while HIV/AIDS shares many of the characteristics of other life-threatening conditions, HIV/AIDS is also very different, thus calling for the development of new knowledge, skills, and strategies. An effective response to HIV thus requires a range of skills: flexibility, creativity, and a willingness to follow the problem wherever it might lead.

The participants in this study expressed their lack of intervention knowledge and skills in different ways, which reflected their personal experiences with HIV and AIDS intervention. Their experiences are expressed in the following statements.

“There were times when I used to go blank without knowing what to do and say.”

“To be honest I did not possess any of them [intervention skills and knowledge] when I came here, because where I was, I was dealing with other social problems other than HIV/AIDS.”

“I did not have any skills.”

“I would say that the problem is the accessibility of information.”

- Initial intervention with HIV and AIDS clients highlighted lack of resources

The participants mentioned challenges related to lack of material resources such as lack of antiretroviral therapy (ARVT) and transport as major setbacks during their initial intervention experiences. This resulted in their inability to deliver the much needed basic intervention services to their clients. According to Nelkin, Wills and Parris (1999:1), AIDS is costly in terms of resources – both people and money – are required for research and medical care.

This experience was expressed by the participants as stated below.
“When I started, Antiretroviral Therapy (ARVT) was not yet available. People then were encouraged to test for HIV, but the question was always, why should I test while you cannot help me with treatment?”

“There is lack of transport to be able to make home visits. We usually manage to make home visits once a month in order to check on our CHBC Programme patients.”

“Two compounding issues were that, there were no drugs and I was not yet trained in HIV/AIDS Counselling.”

“Some challenges include situations where one has to deal with cases where there are hardly any resources to address the problem...Sometimes the supplies and resources may have run out.”

Accessing resources has always been a challenge in the war against HIV and AIDS. Good social service intervention is essential to provide families, especially poor families, with basic information regarding employment, finances, housing, and medical issues.

- **Initial intervention with HIV and AIDS clients highlighted impact HIV and AIDS has on life in general**

HIV and AIDS affect the whole society in ways that are felt in the social, economic, security and political make-up of every nation. The issues surrounding AIDS strike deep at the heart of well-entrenched values at all points along the political continuum and is likely to engender controversy at all levels of society, Macklin (1989:130). Factors that influence the impact are the number of people affected, the term to death, the rate of the spread of the disease, the highest level it reaches, the income and skills levels, and available support systems (Barnett and Whiteside 1999). At the level of the workplace the epidemic will affect productivity, competitiveness and/or profitability and service delivery (Bruton, 2002).
The views of the authors reflected above with respect to the impact of HIV and AIDS in life are consistent with those of the participants.

“I know that HIV/AIDS is a big problem in this country… it affects people, families, individuals as well as communities… the country’s economy, and it takes away the country’s productive force ranging from the age of 16 to 49 years.”

“The rate of unemployment makes it difficult for some able-bodied persons to supply their daily nutritional needs.”

“When people are told that, they are HIV positive they immediately think of death. They conclude that as long as they are HIV positive they are already sick. They quickly give up on the will to live. It is difficult for them to cope with the HIV-positive results.”

As one may deduce from the above, the participants and the reviewed literature are in agreement on the impact of HIV and AIDS. Poverty, socio-economic inequality and high levels of unemployment, dislocation of the family and male dominance are among some of the factors that seem to exacerbate the epidemic (MOE, Botswana 2002: 5).

3.3.1.2 Sub-theme: Subsequent Intervention Experiences

The second sub-theme was termed subsequent intervention experiences. Subsequent interventions here refer to those experiences a participant has had after intervening with HIV and AIDS for some time and subsequently had either in-service or formal training in HIV and AIDS. The subsequent intervention experiences of social workers are presented in the following categories: specialised training, practical experience, supervision/collegial support, and ARVs provide hope for the client.
- **Subsequent intervention with HIV and AIDS clients highlighted the benefit of specialised training**

In recounting their subsequent experiences of intervention with HIV and AIDS clients, participants referred to the benefits derived from specialised training which included Community Home-Based Care Programme (CHBC), community capacity building, HIV and AIDS counselling, Kitso Training, Prevention of Mother to Child Transmission (PMTCT), and Couple HIV Counselling. It is important for all health-care workers to undergo service-related training in order to deliver quality intervention in response to the needs of the participants. Cremin (in Van Dyk, Nel, Loedolff and Haasbroek 1997:226) articulate that the concept of education is a deliberate, systematic, and sustained effort to transmit, evoke or acquire knowledge, attitudes, values, skills and sensibilities, and any learning that results from the effort, intended or unintended. Training on the other hand is a learning experience in that it seeks a relatively permanent change in an individual that will improve his or her ability to perform on the job (De Cenzo and Robbins in Van Dyk et al., 1997:227; Ostrow 1990:363, 364). Staff motivation, workloads and staff turnover are important areas that need to be addressed in order to ensure that staff can effectively use their training to improve programme effectiveness (MOH, Botswana, 2004:40).

The following quotations demonstrate the importance participants attached to specialised training in intervening in the context of HIV and AIDS.

“We were lucky to have attended a two weeks training in a Community Home-Based Care (CHBC) Programme which incorporated some skills that came in handy to deal with my first experiences.”

“The skills that I have acquired from an HIV/AIDS Counselling course I attended at IDM have helped me.”

“I had done Prevention of Mother to Child Therapy (PMTCT) Counselling, as I was involved with the Community Home-based Care Programme (CHBC).”
“I have attended Couple HIV/AIDS Counselling at IDM for a week.”

The literature reviewed substantiates the views held by the participants that, in comparison to their first experiences as already discussed and expressed, the relevant training is critical in making an impact on the HIV and AIDS intervention experiences of social workers.

- Subsequent intervention experiences with HIV and AIDS clients highlighted the benefits of supervision/collegial support

As with all intense clinical work, supervision provides essential support and perspectives into the many difficult issues presented in HIV and AIDS intervention. It may be difficult for the professional to balance the demands of work and his or her personal life (Aronstein & Thompson, 1998:522). After undergoing training, it is important that health workers obtain supportive supervision in order to reinforce the training on site. There is a need for supervisors to be thoroughly trained in intervention strategies in order for them to offer effective support and supervision (MOH Botswana, 2004:44).

Supervision is very critical in providing HIV and AIDS services to the clients. This is due to the fact that some social workers join the health-setting sector where their immediate supervisors are medical doctors with very little understanding and appreciation of social work as a profession.

“Our supervisors need to motivate and encourage us than it is the case now. They need to appreciate the conditions we are working under.”

“My colleagues have also imparted invaluable skills and knowledge to me.”

“I did not have any knowledge; however, fortunately I had assistance from my supervisor we used to do counselling together and this eased my anxiety. She was so helpful.”

“I was interested more in knowing about HIV/AIDS related issues, so I had to rely on reading and consultations with my colleagues. I also had to rely on my attendance to adherence counselling with nurses to acquire more information.”
Supervisors must ensure that social workers under their care receive all the information necessary to function as effectively as possible (Carrell, 1998:209). They are facilitators of subordinates rather than order givers (Kreitner and Kinicki, 1998:412). Supervisors have delegated authority to guide and control subordinates. They have to enrich the job of their subordinates (Hellriegel, Slocum and Associates, 2001: 264, 270; Bennett et al., 1995:267).

From the aforementioned discussion it becomes clear that supervision and collegial support are very important in intervening with HIV and AIDS.

- **Subsequent intervention with HIV and AIDS clients highlighted that ARVs provide hope for client**

While the race for discovering a cure for HIV or an AIDS vaccine continues, there are presently drugs on the market that are used to treat AIDS-related conditions. It is an ongoing research challenge to find the most suitable combination of drugs for different groups of patients, to eliminate treatment failure and to determine the risk of resistance to antiretroviral drugs (Van Dyk 1999:82). Antiretroviral Therapies (ARVs) provide treatment to reduce the amount of replicating virus to as a low a level as possible, thereby preventing infection of new cells and further damage to the immune system (Jocelyn, 2003:156). According to Evian (2003: 79), this in turn, will result in less immune damage and will reduce any continued decline in the health status of the patient. It is therefore effective in delaying the onset of AIDS. [Compare also Barnett et al. in Bowler, 2003:30.]

The above literature perspectives support the views expressed by participants as is evidenced in the following quotations:

“People used to be sick from opportunistic diseases with nothing to help them. The introduction of ARVs has brought such a tremendous relief to the sufferers as well as caregivers.”
“But now the introduction of ARV Therapy, as well as other programmes like Isonite Prevention of TB (IPT) has taken this hope to a different level.”

“Today there is hope. People have hope. … Now with the introduction of ARVs, the family members play their role in the care of the patient by even taking them to the hospital, unlike before where they would neglect them and give up on hope.”

“There is a lot of difference as there is now hope. This was not the case before the introduction of ARV Therapy.”

The Botswana Government has committed itself with the increased access to ARVs to substantially reduce illnesses and deaths among HIV infected people (MOE, Botswana 2002:9).

3.3.2 THEME 2: CHALLENGES IN HIV AND AIDS INTERVENTION

The second theme focuses on the challenges in HIV and AIDS intervention for both clients and professionals. The theme is divided into the following sub-themes: support systems, service provision gaps, professional challenges, ethical and practice challenges and client challenges. The first sub-theme is divided into the following categories: lack of human and infrastructural resources and challenges of responding to clients’ material needs. The second sub-theme is informed by the following categories: collaboration and networking. The third sub-theme includes the following categories: lack of specialised skills and knowledge, work-related stress and depression, underlying social problems, the challenges with attitudes of professionals, the need for professional counselling, the need for professional contribution, lack of professional supervision and challenges with discordant couples. The fourth sub-theme includes the following categories: practice and practice principles, routine HIV testing, infection control. The fifth sub-theme includes the following categories: HIV results disclosure, client denial, eligibility criterion, adherence to treatment, women and HIV and AIDS, the client’s behavioural change, couple and family relationships, client abuse and neglect, illiteracy and ignorance and cultural beliefs and practices.
3.3.2.1 Sub-theme: Support Systems to Facilitate HIV and AIDS Intervention

The first sub-theme in factors in HIV and AIDS intervention with clients participants refer to lack of human and infrastructural resources, social and economic impact and treatment accessibility. This label for the sub-theme refers to and includes external factors, systems or resources that enable and facilitate HIV and AIDS intervention.

Care and support are efforts that aim to improve the quality of life and life expectancy of people living with HIV/AIDS and persons affected by HIV/AIDS (Jocelyn, 2003:156).

- Lack of human and infrastructural resources in challenges of support systems to facilitate HIV and AIDS intervention

Factors reported by participants relating to human resources arise from the fact that there are few professionals per health institution as well as trained staff members, while those related to infrastructural resources refer to shortage of office space, furniture and transport. Capacity constraints in the SADC region, both in terms of the skills for mainstreaming HIV and AIDS and the gender of the people who could undertake these activities are a challenge. This has left most of the coordinating units overburdened with what could be considered their role functions and it has been difficult to create adequate opportunities for mainstreaming HIV and AIDS (Chirambo & Caesar, 2003:44).

For the PMTCT programme to run efficiently there is a need to train health workers in order to arm them with specific knowledge and skills specific to the challenge. Regarding their experiences of the lack of human resources the participants had the following to say:
“But we are quite few in relation as service providers to the number of patients we have to attend to.”

Transport is important to transfer clients to tertiary institutions for specialist medical care in cases of emergency (Altman, 2004:254). Stanhope and Lancaster (1992:370) state that access to health services is frequently a problem, particularly because of transport difficulties. Ambulances are usually used for the inpatients and/or the outpatients have to use alternative transport such as buses and minibuses/taxis.

Participants raised the lack of transport among the challenges of infrastructural needs in the following manner:

“One other problem is transport. People are unable to come for refills due to lack of transport. They do not have money to hire or pay travel fares to points of treatment...The distances from the treatment centre are one of these.”

“There is lack of transport to be able to make home visits. We usually manage to make home visits once a month in order to check on our CHBC Programme patients.”

Some participants recounted a lack of infrastructural resources:

“One of the challenges refers to those who have been transferred for medical reasons to a hospital like Nyangagbwe Hospital for tertiary treatment. Some of them presented with financial problems.”

“There is a shortage of resources like ... direct telephone lines to easily communicate with our clients and stakeholders. Computers are also important for office management purposes.”

On the office space participants mentioned the following challenges:

“The second need is office space. We need other resources like the telephone to access our patients and other networking requirements.”

“We need office space for ease of providing quality service. Lack of counselling rooms sometimes makes us do a shoddy job as we have to speed up intervention in order to give others a chance to see their patients.”
From the participants' narratives it is clear that staff shortage and poor dissemination of information are posing problems that affect the degree of involvement of social workers in HIV and AIDS management.

- **Challenges of support systems to facilitate HIV and AIDS intervention in responding to client's material needs**

Poverty is the single common factor related to the transmission of HIV. Economically deprived people usually have little access to education, social and health-care services and other forms of social and financial support. As a result they end up being forced into becoming sex workers or in bartering sex for food and supplies (Barnett and Whiteside in Bowler, 2003:2; Whiteside & Sunter 2000).

Participants expressed concern about the lack of resources to respond to clients' material needs:

“Most of the people that I see here are very poor to go on treatment without some form of assistance. Some come from surrounding villages, which are poverty stricken. Some are from very large families and unemployed.”

“They present with some of the problems that I do not have a solution for. Especially, material needs which are beyond my capacity. That is someone’s area of competency and the same individual may see it in another way.”

“Nutrition poses yet another problem. People complain of their nutritional needs.”

“They also face the challenge of poverty. This mainly affects those who were on temporary or informal employment. They are the ones who come for assistance with the food basket.”

“There is the challenge of the food basket. I do not know how to handle it, as everyone wants to be registered for the food basket, as soon as they start their treatment.”

**3.3.2.2 Sub-theme : Service Provision Gaps Impacting on Intervention**

This sub-theme refers to and includes the challenges encountered in collaboration and networking between HIV and AIDS-service providers. This
includes limited clarity on the roles of various role players and sectors at national level, limited commitment by key sectoral officials and inadequate communication between sectors and specifically unresolved coordination between health setting social workers and their counterparts in the community.

- **Challenges of service provision gaps impacting on intervention in collaboration and networking**

This category emerged from the experiences of participants relating to poor internal and external referral systems, poor discharge planning, and lack of service provision coordination and level of cooperation amongst service providers.

The HIV and AIDS problem requires a dynamic intersectoral collaboration by all sectors of society to fight it. Social workers in their intervention efforts are expected to work in cooperation and partnership with other sectors of the society (Potgieter, 1998:70; Integrated Business Plan for HIV and AIDS, 2000:5). Schurink (1990:20, 21) alludes to HIV and AIDS as involving professionals from different disciplines and voluntary organisations. This collaborative, multidisciplinary, intersectoral structure involves the government, a community network of voluntary organisations that involves churches, hospitals and other voluntary organisations.

A number of participants highlighted poor working relationship with those they liaise with internally, that is, in the hospital.

“But at times they fail to play their part (other hospital professionals). Some just refer cases that are beyond the competency of social workers.”

“The other challenge involves the discharge planning process. It becomes difficult where a home environment assessment has to be undertaken to make sure that the family is ready to receive the patient without stigma and discrimination.”
Participants’ experiences with external referrals had been expressed as bad.

“My experience with the external referral is very bad. We usually refer to Social and Community Development (S&CD). My experience is that they do not readily attend to patients in time.”

“No, they do not refer to us neither give us any feedback on the cases that we refer to them (S&CD). This sometimes makes it difficult to carry out our work.”

A contracting voice among participants’ highlighted experiences with their internal colleagues has been expressed as being positive as stated below:

“The relationship with nurses, medical doctors, pharmacists and dieticians is very good. We are able to approach them and discuss issues of concern.”

“We have a good working relationship with those in the community …We work well with our Social and Community Development (S&CD) counterparts… We visit each others’ offices.”

“…. However, the relationship with other service providers like Botswana Christian AIDS Initiative Programme (BOCAIP) is just fine. The same applies to the Botswana Police Services.”

For social workers to exercise their intervention role in HIV and AIDS effectively there should be harmony with all concerned stakeholders and/or role-players. In the light of the above narrations, participants hold different views with respect to the relationship experiences they have had with others.

3.3.2.3 Sub-theme: Professional Challenges in HIV and AIDS Intervention

During the interviews the participants were probed for possible solutions to the challenges they experience in intervening in HIV and AIDS. One participant mentioned the lack of a professional organisation for social workers as a concern. The participant mentioned the Botswana Nurses Association is able to cater for their own in times need.
“The nurses have the Botswana Nurses Association which caters for their needs; while social workers do not even have a professional association. When your supervisor or professional colleagues are not supportive you are left on your own.”

- Challenges in HIV and AIDS intervention highlighted professional challenges with the lack of specialised skills and knowledge

The attention of the reader is drawn to the fact that this challenge emanates from participants’ own previous experiences and thus has already been the focus of discussion in previous themes or sub-themes. Therefore, the reader is referred to the earlier discussion and only where unique or new information is introduced, new literature is included. This links to 3.3.1.2 where participants highlighted their own experiences associated with the lack of specialised training.

The views that were raised by the participants included issues such as child abuse and neglect, age of consent and disclosure of results to children who are HIV positive. Children are affected and infected in almost the same way their adults’ counter-parts are impacted by HIV and AIDS.

The participants recounted the following challenges pertaining to the aforementioned issues:

“Working with minor children always poses a great challenge. It is difficult to counsel and disclose the results to a child.”

“Personally I do not have child-care skills. I do not think we are equipped as social workers.”

“We obviously lack training. We need a lot of information as we have to give people a lot of information relating to their queries relating to HIV/AIDS.”

“First of all, I would like to mention training. We should not take it for granted that since we are qualified social workers, we know everything. We also need specific training to deal with HIV/AIDS.”
• HIV and AIDS intervention highlighted professional challenges with work-related stress and depression

The participants mentioned that stress resulted from workloads, death of clients, clients’ general problems and ARVT illegibility (immigrants). Frustration at work leads to demotion which manifests in things like perceived stress, job performance, absenteeism and others. All human service and health care providers face the challenge of coping with stress and burnout. Today the challenge is even greater than ever, when we must work with increasingly complex client needs in an era of diminishing resources. This creates the classic conditions for stress – when the demands exceed the individual’s ability to respond (Schoen in Aronstein & Thompson, 1998: 527).

Many counsellors are likely to experience burnout under the stress of repeatedly telling their clients that they are HIV positive. There is need for managers and experienced counsellors to share their positive experiences that can motivate counsellors (MOH, Botswana, 2004:50). This will motivate them so that they are providing a worthwhile service to the community. [Compare also Aronstein & Thompson, 1998: 527.]

Some clients die young and the illness itself can be ravaging. These incidences affect the professionals who intervene in HIV and AIDS as is evident from the narratives below:

“Sometimes it can be very busy in the office, where one may be left with no time to rest and reflect on the cases he/she has been attending to. It is very stressful.”

“There is some depression that we experience due to the nature of our job. Death is a reality when you work with HIV/AIDS patients. It is painful to lose patients through this way. You end up blaming yourself and wondering may be you did not intervene well.”

“HIV/AIDS affects our families, therefore, when you see your patients going through all these painful experience it reminds you of your relatives and it becomes stressful.”
• **HIV and AIDS intervention highlighted professional challenges with underlying social problems**

During the interviews the participants mentioned the following as underlying problems that make HIV and AIDS intervention a challenge: opportunistic infections and many other psychosocial problems that come about due to HIV and AIDS. Van Dyk (2001:4) states that HIV is a virus (a disease-causing virus). AIDS is a syndrome of opportunistic diseases, infections and certain cancers, each or all of which has the ability to kill the infected person in the final stages of the disease. [Compare also Giberman, 1995:148; Bowler, 2003: 30.]

Similar sentiments were expressed by participants as can be seen in the following statements:

"There are also some social problems that develop due to HIV/AIDS, so you have to tap from your other intervention skills."

"What I would like to add is that HIV/AIDS has a lot of social issues connected to it."

"The challenges are not only HIV/AIDS related but also everything about being ill."

"Adherence is not only about treatment. Some of these patients have social problems that are not attended to through adherence as it is done today. Nurses only address the medical part and the social is not addressed."

Many clients are coping with multiple hardships in addition to HIV – poverty, mental illness, drug use, and discrimination (Aronstein & Thompson, 1998: 527).

• **Challenges in HIV and AIDS intervention highlighted challenges with attitudes of professionals**

The participants mentioned professional challenges related to behavioural changes as stereotypes, stigma, discrimination, labelling, name-calling and breach of confidentiality.
Marks and Goldblum (in Aronstein & Thompson 1998: 33) state that the use of anonymous testing is the most frequently endorsed protections against HIV-related discrimination. HIV and AIDS conjure some emotional issues that affect the professional caregiver and raise fears of contracting HIV and becoming sick (MOH, Botswana, 2000:6-2). These cause the professional to discriminate against people living with HIV and AIDS. Caregivers witness friends and family members dying from AIDS-related conditions. Social workers witness the fear, stigma, isolation, marginalisation and discrimination that their clients experience. Witnessing such attitudes and being part of the community leads some of them to treat such people in a similar manner. [Compare also Van Dyk, 2005:100.]

The participants recounted the following as challenges with their attitude in intervening with HIV and AIDS clients.

“Even my perception on HIV/AIDS has changed for the better since when I started. Before that I had a lot of stigma towards people who were HIV positive, which makes me feel guilty today when I look back. I was imposing my own feelings on them. This led me into trying to change their lifestyle according my conviction. ”

“There is some change of attitudes towards HIV/AIDS patients. I do not know whether it is due to the fact that I have met the patients on a more regular basis than before.”

- Challenges in HIV and AIDS intervention highlighted professional challenges with need for professional counselling

There is considerable evidence to suggest that nurses, midwives and other counsellors themselves need ongoing support and care, since caring for the sick and dying is very stressful. Unless there is adequate education, supervision, counselling and other support services available for caregivers, the result can be ‘caregiver burnout’ (MOH Botswana, 2000:6-2).
Macklin (1989:163/64) states that it is important to emphasize the need for psychotherapy support for the professionals who deal directly with persons with AIDS and HIV infection. Staff find themselves increasingly overburdened, and many “burnout” as a result of their efforts to serve those clients/patients who otherwise might “fall between the cracks” in traditional service delivery settings.

The following quotations highlight the views of participants:

“I think programmes like the Staff Emotional Support Programme will help.”

“There is a need for staff group support systems to help relieve stress in times of depression. This will help us to discuss and share our experiences with our colleagues to learn how they cope in their area of work.”

“We need to be counselled as well. Our patients’ conditions affect us too. Their conditions change so drastically that we are drained when they just suddenly die. Their stories live in us.”

“I believe as a counsellor you need to go through counselling as well, especially after attending to a patient.”

- HIV and AIDS intervention highlighted the need for professional contribution

The professionals expressed the need for professional contributions including involvement in research and policy making. Research can provide information critical for formulating effective policies for effective programming that can increase policy initiatives that can increase the capacity of countries to meet the challenges of the HIV and AIDS epidemic (Linge & Porter, 1997:136). Grinnell (1988:301) supports this view by stating that confronting such issues as abuse of the elderly, the ageing, mentally handicapped and more recently clients with AIDS requires one to conduct exploratory studies.
“Since the policy that is used to assess their needs is the Revised National Policy on Destitute Persons… The policy is silent on those who are needy due to their sickness.”

“Social workers in a health setting need to be involved in research. Grants need to be made available to encourage us to carry out research. Research will give us information in order to make well-informed decisions in our intervention strategies.”

“I do not think that there are any challenges. However, we need to be involved at the Hospice and the Infectious Diseases Care Clinic (IDCC).”

- HIV and AIDS intervention highlighted professional challenges with discordant couples

Family relationships offer a stable source of support during chronic illness, despite the disruptions that the illnesses causes to family continuity (Kalichman, 1998:281). Kalichman continues that on the other hand the stigma of AIDS can create insurmountable obstacles to accessing family support. Families may assume greater responsibilities for caregiving, particularly at the later stages of AIDS. They assume instrumental support such as assistance with shopping and housework (Takigiku, Brubaker & Hennon in Kalichman, 1998:281).

The participants felt that it was important to disclose to relatives and caregivers because this would help when they have to provide community home-based care as well as in discordant cases. The spouse has to be counselled as he or she is equally affected, and may assist in ensuring adherence to treatment.

“Discordant results involving couples is a challenge; it has proved so difficult for some couples to understand that it is a normal experience to have discordant results. It is quite a challenge to me as a social worker to try to explain to a couple the reasons behind discordant results. The information is not easy to explain as it is more medical and scientific.”

“I have seen quite a number of them. This sometimes raises conflict in the relationship between the couple.”
“They are not easy to handle. They are very difficult. But it always comes out positively after counselling with them. The condition has a lot of information gaps that makes it difficult for us to deal with.”

3.3.2.4 Sub-theme: Ethical and Practice Principles’ Challenges In HIV and AIDS Intervention

In this sub-theme participants perceived their role in HIV and AIDS intervention as bringing to the forefront social work practice prescripts. Reynolds (in Green and Ephross, 1991:1) argues that social work like any other social practice is “always shaped by the needs of the times, the problems clients present, the fears they generate, the solutions that appeal and the knowledge and skills available”. Social work practice is characterised by unified approach methods, which emphasize the commonalities among types of direct practice, whether with individuals, families or groups (Weyers, 1997; Middleman & Goldberg, 1997). Northen (1995:21) asserts that these approach methods are also called major specialisations and they include social and community organisations as well. Davis and Aroskar (1983:5) describe a right as a ‘legal obligation, which one ought or ought not to do’. [Compare also Bandman & Bandman 1985:57-58.]

“We need to learn more on infection control and on the opportunistic diseases as well as how they may be transmitted from one person to another. We need to know this in order to avoid offending the patients by our unintended acts.”

- Challenges to practice values and principles in HIV and AIDS intervention

Values are an important determinant of the social worker’s selection of knowledge for purposes of assessment and treatment (Northen, 1999:65). They include beliefs and ideologies, appreciative and aesthetic preferences and moral and ethical principles. Translated into ethical principles of conduct, values guide the practice of a profession. Van Niekerk (1999:91-102) argues that AIDS is an ethical problem, which requires an ethical approach. Currently the confidential
status in respect of HIV and AIDS still exists and disclosure of information on the health status of an HIV and AIDS person is a violation of human rights and can lead to legal prosecution (Underwood, 2001).

Throughout the interviews the participants showed an acknowledgement of the social work’s overarching values and principles of human dignity, worth and social justice in their intervention with HIV and AIDS clients. However, they also point out the conflict that arises as these are practised in an environment like a hospital where issues of routine HIV screening and occupational exposure are critical.

“There is a challenge with legal issues. What to do when parents have given consent for sixteen year olds to undergo an HIV test poses a problem on the legal ramifications in case she may raise an objection afterwards?"

“HIV/AIDS affects all of us; even as professionals you cannot dissociate yourself from the challenge. It challenges even your stand on empathy.”

“I later discovered that the child has been tested without her consent and results came out HIV positive.”

One other important social work principle which came out more than once has been the client’s self-determination where one has to make a decision as to whether to undergo an HIV antibody test as well as enrolling in the ARVT programme when the CD4 count is lower than the accepted level (Barker in Northen, 1996:69; Potgieter, 1998:44).

“But at the end of the day it all boils down to one thing, the choice still belongs to the one being educated.”

“The fact is that, it is up to the patient as to whether she/he wants to reveal his/her HIV positive status.”
• Challenges associated with routine HIV testing

In a similar vein to the latter category, participants voiced concern about the challenges raised by HIV testing.

Macklin (1989:139, 140) argues that the questions surrounding mandatory and routine testing for HIV antibodies reflect significant conflicts between the tradition of respect for human rights and civil liberties and public health concerns for protection of non-infected persons.... Routine testing refers to situations in which all persons are tested for antibodies to HIV either as part of standard operating procedures or as part of a standardized assessment or treatment protocol. Thus, routine antibody screening can occur when persons seek treatment at sexually transmitted infections disease (STI) clinics, drug detoxification programmes, and hospitals.

“Since the inception of the Routine HIV Testing (RHIVT), people are not counselled well to make sure that they are able to cope with the outcome of the results. Now it seems the exercise (RHIVT) tramples on people’s rights.”

“Unless in cases where a routine test was done against the will of the patient. If the results come out HIV positive they just write in the patient’s Out-Patient Department Card that she/he should come up to us for post-test counselling.”

• Infection control challenges in HIV and AIDS intervention

Infection control includes the use of barrier protection such as eyewear, facemasks, gloves, gowns and careful handling of needles and other sharp instruments. Workers observe recommendations for prevention of infection by any means in order to protect themselves from injury and infection. These precautions are called universal as they are used in all situations – even if there appears to be no risk involved (Aronstein and Thompson, 1998: 14, 15).
Participants’ views were expressed as follows:

“Some of these patients develop TB and as they cough around, it is scary as I do not know whether it will be passed on me.”

“The mouth mask interferes with the flow of communication. The patient may interpret it as a sign of rejection due to their condition … So, wearing a mouth mask does not look right.”

“The challenge is that it is not easy to speak with someone with a mouth mask as this may convey a wrong message which may lead to stigma.”

“We come here not knowing the infection control precautions. We need to take care of when we work in such a place. We walk in and out of the medical wards without washing our hands or putting on protective clothing.”

3.3.2.5 Sub-theme: Client Challenges in HIV and AIDS Intervention

One of the aims of HIV and AIDS intervention is to provide psychosocial support to both the infected individual as well as those affected. In order to achieve these objectives, intervention should seek to help infected persons make decisions about life, boost their self-confidence, and improve family and community relationships and the quality of life. HIV and AIDS intervention must also provide support to the families and loved ones of infected persons, so that they in turn can provide encouragement and care for those with HIV infection.

- Challenges in HIV results disclosure

Clients are always faced with the challenge of having to disclose to significant others like their next of kin, other caregivers and their partners or spouses. ‘Coming out’ or ‘going public’ refers to voluntarily disclosing one’s HIV-positive status to other people. Going public plays a crucial role in the fight against AIDS … but coming out as HIV positive should never be forced (AHRTAG in MOH, Botswana 2001:5). Sharing HIV-positive status is, according to UNAIDS (2001:40), not only important in enabling people to receive emotional support from spouse, family and friends but also crucial to future decision making. It also
reflects people’s ability to understand and accept their HIV status. In Chaing Mai, Thailand, it has been proposed that post-test counselling should be carried out in a family setting to facilitate disclosure and hence long-term support and normalisation (UNAIDS, 2002:43; Fitz, 1998:46; Almond, 1996:127).

The participants felt that it was important for clients to disclose their status to relatives because it will reassure them if they know what is wrong with them. These views were expressed in the following statements:

“Some of them used to refuse to disclose to their caregivers-to-be while they were up and about.”

“One particular challenge I would like to mention involves children who are HIV positive. In most cases these children are not informed why they have to take ARV Therapy. They are not told of their HIV-positive status.”

“One other thing that I learnt is that, patients are afraid to disclose their HIV-positive status to their partners.”

- Challenges of HIV and AIDS intervention in client denial

Another sub-theme which emerged from the participants’ narratives was the denial surrounding HIV and AIDS as people were reported to be denying the existence and the reality of HIV and AIDS by attributing their condition to traditional rituals or practices. HIV is surrounded by a conspiracy of silence and denial. People are afraid to be tested for HIV or to admit to their HIV status because they fear discrimination, violence, stigma and isolation.

Van Dyk (2001:33) states that there are truly some horrifying myths that are circulating in communities around HIV and AIDS, such as: AIDS will be cured if you have sex with very fat women, virgins or very young boys and girls. The said myths continue to be perpetuated in the media (SATV.SABC 1 7/2/02 on baby Tshepang’s rape by eleven Upington men). Denial of the diagnosis and its implications is common among HIV and AIDS patients (Land, 1992:41; UNAIDS,
“Like I mentioned, it was not at all easy for people to accept their HIV/AIDS status. It was very hard for them to accept that they have HIV.”

“They have a battle of having to accept themselves, as well as their HIV-positive status. They reluctantly start on programmes meant to alleviate the HIV/AIDS pandemic out of desperation, but not really doing it with a positive mindset.”

Social workers can help support and counsel people to be HIV tested and to be open about their HIV status.

- **Challenges of HIV and AIDS intervention in eligibility criterion**

An eligibility criterion for accessing the HIV and AIDS programme is being a citizen of Botswana. This automatically excludes non-citizens like residents and undocumented immigrants. The main services provided include the food basket and ARVT drugs. The food basket is a monthly ration of food provision offered to people who are on ARVT and in need of nutrition to continue with their treatment. The food basket is provided free by the government under the Revised National Policy on Destitute Persons of 2000. The food basket is determined by the nutritional needs as assessed by the health institution’s dieticians. An assessment for eligibility is determined by the area social welfare officer, who has to do a thorough social inquiry report and come up with a recommendation for or against assistance.

There is always a challenge relating to the eligibility for the food basket, which is offered to HIV-positive people who cannot supply their own nutritional needs.

“They feel that the food basket system is not supporting the combat against HIV/AIDS as it does not register people who need to have a certain level of nutrition in order to benefit from the ARV Therapy.”
“There is a challenge of the food basket. I do not know how to handle it, as everyone wants to be registered for the food basket, as soon as they start their treatment.”

“Nutrition poses yet another problem. People complain of their nutritional needs.”

- **Challenges of HIV and AIDS intervention on couples and family relationships**

Participants mentioned the following factors as challenges for HIV and AIDS intervention with clients: discordant couples, both unmarried and married couples also and women. The following reasons were mentioned as the main cause of HIV-infected women falling pregnant even after a positive HIV test: the need for children; fear of losing a partner; and the fear of stigma and discrimination. The participants further expressed concern about the impact of a test result, especially the HIV-positive results, on clients, families and on society at large. The individual has to be prepared during the pre-test counselling for the eventuality of the bad news. The possibility of a positive result could lead to a situation where the client suddenly finds himself or herself in a crisis. Where families can be involved in counselling, it can be of great benefit in helping the person with HIV to be more accepted and supported by his or her family (Lipmann and James in UNAIDS, 2004:41).

According to Perelli (1991: 30, 38), the crisis of AIDS spills over onto those affected with the disease as well as those who are associated with those with the disease and the feelings of fear take a toll on all members of the family. The family with AIDS will face many issues of bereavement and will take many steps on their way to acceptance of this illness and preparation for death. [Compare also Nelkin, Wills and Parris, 1999:1, 2, 7, 5; Macklin, 1989:104, 135.]

Women are highly infected and affected by the HIV virus for various reasons. Their low social status in many societies subjects them to poverty, lack of education, poor access to health care and jobs, and social practices expose them to a lack
of power and control over decision making. Gender discrimination which is a result of denial and a neglect of a girls and women’s human rights, gives young women little access to socio-economic opportunities (MOH Botswana, 2000:6-2).

Macklin (1989:63, 64) states that “Almost three quarters of women with AIDS are poor, in the minority and from the inner city. The particular goals of AIDS education for women include helping them protect themselves when their partners are HIV-infected and helping them prevents HIV transmission to their unborn children… Some women who insist on condom use have been raped, battered, or threatened with the loss of their relationship”.

“Sometimes couples do not disclose their HIV-positive status to each other, due to fears of being rejected and so on.”

“Married people are easy to handle because they are committed to their relationship”

“The negative partner always thinks that he/she was cheated on.”

“We do receive clients with suicidal tendencies, marital problems, divorce, and orphans. I think these are crisis situations. People go through loss and bereavement.”

“I find it difficult to stomach cases of women who fall pregnant while they are on ARV Therapy. This creates a lot of problems in spite of the availability of the Prevention of Mother to Child Transmission (PMTCT) Programme. Does this mean that the message is not reaching home?”

“They respond by saying that they need to have children also. Some attribute this to just a mistake”.

“Their main concern has always been that they are afraid to be dumped by their partners, as well fearing to be killed or harmed”.

- **Challenges of behavioural change of clients**

The participants highlighted the need for behavioural change by clients as a prevention strategy for HIV infection, including safe sex practices. High-risk
behaviour includes activities that increase a person’s risk of transmitting or becoming infected with a disease. Macklin (1989:48) states that “AIDS is a behaviour-bound disease, spread primarily by high-risk behaviours and not by membership in any particular risk group”. In the absence of a cure it is clear that a (sometimes radical) change in lifestyle is the most important way to provide protection from the disease and its fatal consequences (Van Niekerk, 1991:15). Behaviour modification includes a series of activities in which helpers and clients engage. These activities, however, have value only to the degree that they lead to valued outcomes in client’s lives (Egan, 1994:6).

“The greatest challenge is the ability to make an impact on the individual and to instil behavioural change.”

“Some report that they default on treatment as they do not see the reason for continuing when they still engage in unprotected sexual intercourse.”

- **Challenges related to intervention with HIV-positive children**

Social workers who participated in this study verbalised specific challenges they experience with regard to intervention with children who are HIV-positive.

“The other challenge involves orphans on ARV Therapy. Orphans sometimes face the prospects of being moved from one caregiver to another. And along this migration they lose touch with their treatment schedule. It frustrates a lot.”

“One other challenge involves HIV-positive children who spend a long time in the hospital as their parents do not want to take them home after being discharged.”

“Some of these children are verbally abused at school due to their HIV-positive status.”

“The other challenge was where the next-of-kin were not willing to take the patient home after being discharged.”
• Challenges of intervention in the face of illiteracy and ignorance

Knowledge of HIV status, according to UNAIDS (2001:37, 38), can enable people to seek appropriate emotional support. According to Aronstein and Thompson (1998: xxiii), most people who are infected do not know that they are HIV positive because they have not been tested.

“Some people fail to differentiate between HIV and AIDS and so one needs to be as simple as possible.”

“Most people from outlying areas work as farmhands and are illiterate. They do not have much exposure like their urban dwellers.”

“As I have already mentioned, some people are illiterate, this causes a problem of bringing the message to their level of understanding.”

“Some people do not have a good grasp of issues related to HIV/AIDS.”

• Challenges of HIV and AIDS intervention in cultural beliefs and practices

During the interviews some participants articulated that the clients’ personal beliefs may differ from the scientifically held understanding of HIV and AIDS. Cultural, sexual, religious, and legal influences often make discussion about sexual practices, preferences, sexual desires, the number and type of sexual partners, and the use of birth control difficult. Such subjects are taboo and are associated with embarrassment, shame, guilt and rejection. The same feelings may be experienced by caregivers as well. Some societies do not sanction, religious leaders, the use of condoms as a means to control birth and disease transmission by (MOH Botswana, 2000:7-2).

According to Haralambos (1997:3), culture is a way of life of its members; the collection of ideas and habits which they learn, share and transmit from generation to generation. Culture defines accepted ways of behaviour for members of a particular society. Kain (1989:151) defines culture as attitudes,
values, and beliefs that influence self-perception, self-expression, and perception of others. To a large degree, culture determines how members of a society think and feel it directs their actions and defines their outlook on life. [Compare also Nelkin, Wills and Parris 1999:53; and Macklin 1989:93.]

“Furthermore, what you may understand about HIV/AIDS may be running against your patient’s beliefs.”

“… It is traumatic working with adults as well. Some believe that they do not suffer from HIV/AIDS, but from a different ailment, unrelated to HIV/AIDS. They call HIV/AIDS by its street name ‘Disease of the Radio’.”

For current interventions to prevent HIV and AIDS to be effective there is a need to address myths and home and community environments that create risks regarding HIV and AIDS need to be addressed. There is a need for an effective approach to dealing with cultural issues in order to address the breakdown of certain cultural norms which are challenged by modernisation without being replaced (MOE Botswana, 2002:22).

3.3.3 THEME 3: MEASURES TO ALLEVIATE CHALLENGES OF HIV AND AIDS INTERVENTION

The third theme focuses on the measures to alleviate challenges of HIV and AIDS intervention. The theme is divided into the following sub-themes: coping strategies and education and training. The first sub-theme is divided into the following categories: stress management and outdoor activities. The second sub-theme is informed by the following category: specialised training.

One participant mentioned that professionals need to confront their personal challenges as a way to alleviate their fears and anxieties about intervening with HIV and AIDS clients. The professionals have to test themselves in order to establish their HIV status. Other measures included the deployment of more
human resources, provision of professional supervision and a revisit to intervention strategies.

“It depresses when you have to attend to patients when you have a similar experience. For instance, if you did not deal with your trauma from loosing a relative in similar circumstances it can be depressing and stressful. Some of us are either affected or HIV positive.”

3.3.3.1.1 Sub-Theme: Coping Strategies in Alleviating Challenges of HIV and AIDS in Intervention

Burnout is a stress-induced problem common among members of helping professions such as teaching, social work, nursing and law enforcement (Kreitner and Kinicki, 1998:535-537). It is a condition that occurs over time and is characterized by emotional exhaustion and a combination of negative attitudes. Kreitner and Kinicki mention that emotional exhaustion is fuelled by too much work, role conflict and interpersonal interactions encountered at work. To prevent burnout, managers can remove job and organisational stressors by buffering their effects. This simply means applying resources and making administrative changes such as the provision of extra staff, support from top management and time off for personal development or rest.

Coping can be defined as the efforts we make to manage situations we have appraised as being potentially harmful or stressful (Kleinke, 1998:2). Lazarus and Folkman (in Kleinke, 1998:2) mention three features of coping as involving a certain amount of effort and planning; no assumption that the coping outcome response will always be positive; and that the emphasis being that coping is a process taking place over time. Coping in relation to HIV and AIDS is particularly important in the light of the devastating knowledge that there is no cure for the disease with victims facing certain death.

“I managed to cope through the discussion that I had at work. I used to ask my colleagues how they cope with the situation.”
“The way I am handling cases today is far much better than before. I do have more confidence and trust myself than before.”

“I am now comfortable with the issue of HIV/AIDS. I am now open to discuss the issues around the problem. I have managed to do away with the shock, anxiety and questions that I had prior to the present experiences.”

“Over time I got used to the stress related to work and I devised my own coping strategies. I read many relevant books here at work and at home.”

- **Stress management on alleviating challenges of HIV and AIDS intervention**

The following authors have defined stress as an unsettling reactive experience to external factors, arousal of mind and body in response to demands made upon them, as well as a response by people to demands made upon them (Pargman 1986:66; Schafer, 1992; Her Majesty Stationery Office, 1987:7). Ostrow (1990:361) postulates that a consistent recommendation for health care settings that provide services to HIV-affected patients has been to establish support groups that can give workers an opportunity to ventilate feelings, to share resources, and to deal with the untimely death of their patients.

“The best way is to discuss the depressing issue with others and find the best way to handle it. This may assist in ventilating your system. Meeting with some professionals from outside your workplace may also assist in dealing with stress.”

“There is AIDS in the Workplace Committee and Staff Emotional Support Committee which also deals with HIV/AIDS in the workplace.”

- **Outdoor activities to alleviate challenges of HIV and AIDS on intervention**

Ostrow (1990:362, 363) states that there is a need for “… commitment to changing some of the behaviours that contribute to burnout, such as overwork, insufficient attention to personal needs including recreation, outside interests,
companionship, diet and exercise, unmanageable caseloads, and taking on too much responsibility, often by setting limits or prioritizing."

“Other activities like social retreats may also help relieve stress.”

“We need programmes, even a gym for that matter, so that when we are through with our daily work we may go there to ventilate and reduce stress. And be able to meet a professional counsellor to have a one-on-one attention.”

“I believe social clubs may help a lot... Social clubs will assist in the sharing of experiences and ideas, which will help one to cope.”

3.3.3.2 Sub-theme: Education and Training

To mitigate the effects of HIV and AIDS, education and training have been mentioned by all the participants. Education for some of the participants meant formal training on a long-term basis, while training referred to short-term training which targeted the relevant needs of the service.

- Specialised training to alleviating challenges of HIV and AIDS intervention

The attention of the reader is drawn to the fact that the need for specialised training emanates from the participants’ own previous experiences and this has already been the focus of discussion in previous themes or sub-themes. Therefore, the reader is referred to these latter discussions and only where unique or new information is introduced, new literature is included. This links to 3.3.1.1 where participants highlighted their own experiences associated with the lack of specialised training.

Ostrow (1990:365) states that, in training health-care providers to work with the psychiatric aspects of AIDS, a one-day session with ongoing support as a follow-up is ideal.
“We need new skills which we do not have. I do not know how to attend to a ten year old presenting with HIV/AIDS related problems. Service delivery on children who are on ARV Therapy is difficult.”

“May be the challenge we have is to make sure that we educate those that we work with that they should not only look at HIV as a medical problem. There are other related social problems that both of us can work on together.”

3.3.4 THEME 4: INTERVENTION STRATEGIES UTILISED BY SOCIAL WORKERS

The participants recounted the following as strategies to intervene with the challenges of HIV and AIDS intervention with clients: pre- and post-test counselling, supportive counselling, couple HIV counselling, routine HIV testing, Prevention of Mother to Child Transmission, group and family intervention, internal and external referrals, Community Home-Based Care Programme, health education (IEC) and community capacity building.

HIV and AIDS has brought with it a reorganisation in many segments of contemporary life and this concerns such varied spheres of life as conduct in intimate sexual relations, needle sharing by drug users, administration and content of health education, and funding of social services and research. One of the social services’ responses to the HIV epidemic has been the setting-up of counselling services for people whose lives have been touched by HIV and AIDS (WHO 1988:21).

Silverman (2000:5) defines counselling as the skilled and principled use of relationships, which develop self-knowledge, emotional acceptance and growth, as well as personal resources. The World Health Organisation (1997:10) adds that counselling attempts to help people define for themselves the nature of the problems they face and make realistic decisions about what they can do to reduce the impact of those problems on themselves, their family and their friends.
The fourth theme: Intervention Strategies employed in responding to HIV and AIDS has been subdivided into two sub themes with their supporting categories

3.3.5 Sub-Theme: Counselling Services (Psychosocial Support)

Numerous studies suggest that good counselling assists people to make informed decisions, cope better with their health condition, lead more positive lives, and prevent further transmission of HIV (MOH Botswana, 2000:7-2). Carbello and Miller (in Peraklya, 1991:2) mention that HIV counselling on the one hand seeks to prevent the transmission of the virus through addressing both non-infected and infected groups, while on the other hand, it seeks to provide psychosocial support for those affected by HIV and AIDS, either carriers of the virus or their family members, friends and relatives. In doing this, it seeks to encourage and enhance the self-determination and self-confidence of the concerned, and to improve family and community relations. [Compare also Peraklya, 1991:3, 4; and Litwack, Litwack & Ballou, 1980:10.]

• Pre- and post-test counselling as an intervention strategy

The aim of pre-test counselling is to provide information to the individual about the technical aspects of testing and the various implications of being diagnosed as either HIV positive or negative. The up-to-date information given must outline the implications of taking and receiving the test results, as well as communicating in a manner that is easy to understand. Post-test counselling on the other hand, involves the revelation of either the negative or positive HIV results to the client (NACA 2005:14).
The HIV test is a blood test that enables individuals to find out whether they have been infected with the Human Immunodeficiency Virus (HIV). The test is actually used to detect the presence of antibodies that the human immune system produces in response to the presence of the virus in the blood stream (Rubenstein, Eisenberg & Gostin, 1996:21). Post-test counselling involves giving the test results and addressing their implications for the person and others who may be connected with him or her. In the situation of an HIV-positive test result, the counselling process will ensure that the patient’s immediate needs and concerns are addressed, and helping him or her to plan his or her future life (UNAIDS, 2002:179; Aronstein & Thompson 1998: 36; Peraklya, 1991:4).

During the interviews the participants mentioned pre-test and post-test counselling as one dimension of the range of intervention strategies they use to intervene with HIV and AIDS clients.

“As mentioned we do pre- and post-test counselling.”

“Then I went for Kitso Training which added more on pre-counselling and post-test counselling and the general information on HIV/AIDS.”

“We were trained in pre-counselling and post-test counselling.”

From the above excerpts the researcher deduced that the participants engaged in individual counselling of clients from a social work point of view based on their particular needs.

- **Supportive counselling as an intervention strategy**

Further counselling and support following the initial meeting is needed by the HIV-infected person and his or her family. Such support helps their quality of life as well as to enhance their ability to cope and make informed decisions about ongoing care (MOH Botswana, 2000:7-2).
Whether a test is positive or negative, people need access to counselling after receiving an HIV-test result. People need support to plan for a test and to cope with the result, positive or negative, so they can respond appropriately (UNAIDS, 2002:179; UNAIDS, 2001:37, 38). According to Addison (in Bowler, 2003:30) sympathetic counselling and support are necessary since the complex personal, social and economic problems associated with being HIV positive cause enormous distress, contributing to the decline of health. [Compare with Land, 1992:33.]

“This is then followed by supportive counselling, which involves the family and the significant others in order to establish the support system in place.”

“We make follow-up cases that we have referred to them. We then follow up those who did not go to their offices after being referred from here.”

“We empower the clients to stand through their predicament.”

Social workers also serve as a source of emotional support to those who are neglected in the hospital by their families due to their illness.

- **Couple HIV Counselling as an Intervention Strategy**

Knowledge of HIV and AIDS, according to UNAIDS (2001:37, 38), can enable people to seek appropriate emotional support. The psychological challenges to couples are considerable; they often change over the course of the infection and are coloured by the unique characteristics of the relationship and the two individuals (Aronstein & Thompson 1998: 183). Couples work provide the social worker working with HIV an encounter with a wide range of issues and problematic situations. [Compare also Abramowitz & Cohen in Aronstein & Thompson 1998:185.]

“We are in the process of starting the Couple HIV Counselling and Testing (CHCT) strategy. We are planning to do this in cooperation with those responsible for CHBC Programme in the community.”
“I have attended Couple HIV/AIDS Counselling at IDM for a week. Afterwards I briefed the Lay Counsellor as he is the one dealing with married couples.”

- **Routine HIV testing as an intervention strategy**

Pregnant women receive pre-test education and HIV testing during antenatal care. They all participate in prevention group discussion on mother-to-child transmission or they are educated individually when they miss a group session (MOH, Botswana 2005:7, 16).

“The introduction of the Routine HIV/AIDS Testing (RHIVT) changed the trend.”

“RHIVT brought a lot of challenges as people go through a lot of trauma when they are told results as they were not pre-test counselled to prepare them for an HIV positive outcome. People are suffering untold damage as they have to try to deal with their HIV positive status without assistance. It does not afford patients on-going support counselling. Some end up being referred to us when they have already gone through the worst.”

- **Prevention of Mother to Child Transmission (PMTCT) as an intervention strategy**

Mother-to-child transmission (MTCT) or vertical transmission is one of the major causes of HIV infection in children (Van Dyk, 2005:31). HIV can be transmitted from an infected mother to her baby via the placenta during birth, through blood contaminated during childbirth, or through breastfeeding. Macklin (1989:99, 100) states that “The occurrence of HIV in women is a special concern and the infected mothers are the major source of infection for infants”.

Macklin (1989:102, 103) further argues that, as the disease spreads to women, the number of children with AIDS is increasing, especially among minorities. When a baby has AIDS, the human service professional is always dealing with a dying system. Both parents are at a risk and both may die. Siblings may be forced to take on responsibilities far beyond those appropriate for their age....
Many babies who are born with AIDS remain in the hospital because their families cannot provide care.

“I had done Prevention of Mother to Child Therapy (PMTCT) Counselling, as I was involved with the Community Home-Based Care Programme (CHBC).”

“Programmes like Prevention Mother to Child Treatment (PMTCT) have brought this hope when they were not available. The fact that people can now survive brings hope.”

- **Group and family intervention as an intervention strategy**

People Living with HIV and AIDS (PLWA) should be encouraged to join a peer support group to learn where and how to access services, to find educational resources, and to obtain treatment during counselling and support. Group counselling must consider material resource concerns and care for the family after the breadwinner’s death. Where families can be involved in intervention, this can be of great benefit in helping the person with HIV to be more accepted and supported by his/her family (Lipmann et al., in UNAIDS, 2001:41). The authors cited a project from Ukraine that demonstrated that by involving families of people who are HIV-positive they were better able to accept and understand the problems of their HIV-positive family members and to help the members to cope following counselling. [Compare also Miley, Melia, and Du Bois, 2000:331.]

“We have the Vision Support Group, which is mainly for people who are HIV positive. But it also caters for those who are HIV negative.”

“We do group counselling using videos to facilitate the presentation. This gives us the opportunity to clear out the myths and misconceptions associated with HIV/AIDS. These presentations are conducted in association with other colleagues like nurses.”
• **Health education as an intervention strategy**

Health education is one of the strategies employed to empower clients during ward rounds, morning clinic health talks and community home visits. The education and information dissemination to clients and other members of the community in HIV and AIDS is crucial and has to be offered as a matter of priority. Education is concerned with the development of sound reasoning processes to enhance one’s ability to understand and interpret knowledge (De Cenzo and Robbins in Van Dyk et al., 1997:227). AIDS as a communicable disease can be confined with primary prevention like education. It is important to know factors controlling people’s behaviours such as group norms and personal responsibility. The social worker has to assist families to support HIV and AIDS persons by disseminating educational information on HIV and AIDS, resource mobilisation and case management (Giberman, 1995:152; Macklin, 1989:39, 40).

“...I am presently a facilitator on PMTCT training.”

“There is a challenge in educating people on HIV/AIDS. Some people present with very limited knowledge of HIV/AIDS, while some do not know anything at all. And you need to provide information.”

“Our role is taking part in educating the community about HIV/AIDS. We disseminate information on condom use.”

“We basically provide information through counselling, workshops, seminars or health education talks in the hospital. We make follow-ups of our patients in the community.”

Prevention initiatives include the following: General HIV and AIDS awareness and Information, Education and Communication (IEC), condom distribution, Sexually Transmitted Illnesses (STI), the expansion of Voluntary Counselling and Testing (VCT). The above substantiate the participants’ perspectives as well as the literature consulted.
Community capacity building as an intervention strategy

Macklin (1989:137) states that “community support for HIV infected individuals and their families may be an important determinant of the degree to which persons with AIDS are able to cope with the vicissitudes of the disease itself. AIDS education efforts must be directed at informing the entire community about the modes of HIV transmission, and the psychological and the emotional costs of the disease for the infected and their loved ones. The information provided in these education efforts should be accurate, current, sensitive to the concerns of those directly affected by the epidemic and non-sensational in style”.

Empowerment is a process of increasing personal, interpersonal and collective power, which allows individuals, families, groups and communities to maximise their quality of life (Potgieter, 1998:216). Social workers enable these groups to gain the capacity to interact with their environments in ways that enhance their gratification, well being, satisfaction, self-esteem, support systems and individuals’ actions in concert with others to lead to improvements of their lives (Hepworth & Larsen in Potgieter, 1998:216; Gaitley & Seed, 1998:101). People who are empowered are more than likely to implement effective HIV prevention programmes.

“We only sensitize the community at the Out-Patient Department (OPD) as well as in the medical wards. We provide them with Information, Education and Communication (IEC) materials.”

“There is a need to once in a while get out of the hospital and conduct community health education.”

“Like I said, we sensitize the community by speaking about HIV/AIDS through health talks. Through this process, we use the influential members of the community, as well as Non-Governmental Organisations (NGOs) within the community, to assist us.”
3.3.4.2 Sub-Theme: Client Referrals as an Intervention Strategy

Doel and Shardlow (1998:56) state that “…most people have been referred on to social work agency, formally or informally, by friends, relatives, neighbours or other professionals.” Referral is both internal and external. The external referral refers to other service providers outside the hospital like the Department of Social and Community Development and the internal referral refers to other departments or units within the hospital like medical wards.

- Internal and external referrals as an intervention strategy

Referral to relevant service providers is critical, especially in the area of orphan care. The care can include direct physical care, being an advocate on behalf of the child, and helping to influence the policy changes to respect the rights and dignity of the children. It is important to develop a relationship with a specific individual at the test site whom you can refer a client to with confidence.

The participants reflected the need for the multidisciplinary approach to a client who is HIV positive.

Referrals were meant for the food basket as stated below.

“We liaise with social workers in the Local Authority (Social and Community Development – S&CD) for needs like the food basket and shelter.”

Some of the referrals were from the medical clinics and/or wards to the social worker, while others originated with the social worker to the clinics or self-referrals as stated below.

“I would safely say it is okay, because referrals are done smoothly for the attention of the social worker.”
“We sometimes call the medical doctors or nurses to assist with the information. Infectious Disease Care Clinic (IDCC) also assists with information.

“Some do come here as self-referrals after they have learnt of our services. Friends or acquaintances refer some. Others may have difficulties in accepting their results, so they come here for supportive counselling.”

The social worker needs to know where anonymous and confidential HIV testing is available in his or her community in order to make a referral when appropriate (Aronstein & Thompson 1998: 33).

- **Community Home-Based Care Programme as an intervention strategy**

Community based care is by nature a service rendered by different disciplines and volunteers to its target from within the community itself. Relying on the strengths of family and community networks, Community Home-Based Care (CHBC) has emerged as an effective method of providing cost-effective, compassionate care to those infected and affected by HIV/AIDS (Pathfinder International – Fact Sheet, 2004).

“The only programme was the Community Home-Based Care Programme (CHBC).”

“We were lucky to have attended a two weeks training in Community Home-Based Care (CHBC) Programme which incorporated some skills that came in handy to deal with my first experiences.”

“…What we did was to make sure that they receive adequate care at home. And we would just educate the family on the importance of testing.”

Care and support initiated by the Botswana Government includes Community Home-Based Care Programme (CHBC), treatment protocols, the expansion of counselling services, and a plan of action for orphans. According to WHO (1987:1) home care refers to any form of care of people in their homes.
CHBC is not a replacement for hospital care, but instead is part of a comprehensive continuum of prevention, care, treatment, and support services that include the family, the community, and various levels of health care providers. In addition to providing support to families coping with HIV/AIDS, CHBC also contributes to prevention efforts. By involving community members in prevention, care, and support efforts, CHBC brings issues surrounding HIV/AIDS into the open, creating opportunities to clarify myths, reduce stigma, empower those infected and affected by HIV/AIDS, and influence peoples’ willingness to know their HIV status and change risky behaviours (Pathfinder International – Fact Sheet, 2004).

3.3.5 THEME 5: SUGGESTIONS AND ADVICE TO NEW SOCIAL WORKERS

The attention of the reader is drawn to the fact that many of the suggestions emanate from participants’ own previous experiences and thus have already been the focus of discussion in previous themes or sub-themes. Therefore, the reader is referred to the latter discussions and only where unique or new information is introduced, new literature is included.

3.3.5.1 Sub-Theme: Professional Development

The participants mentioned professional competency, the need for continuous learning and specialised training as important aspects for the newly recruited social worker in the field of HIV and AIDS intervention. He has to keep these in mind. This links to 3.3.1.1 where participants highlighted their own experiences associated with the lack of specialised training.

- Specialised training and continuous learning was highlighted as suggestions and advice to a new Social Worker

For literature and discussions on this category, refer to 3.3.1.1.
“One has to go for training before she/he goes into the field of work.”

“He/she should keep learning. In the health setting you learn for the rest of your life. Try to learn from everyone despite a person’s position.”

“She/he must be prepared to learn from others.”

“Be willing to learn new things, more than the basics. Be prepared for surprises as some patients will come knowing more than you do.”

- Professional Competency was highlighted as suggestions and advice to a new Social Worker

All clients have a right to privacy, a right to have what they have shared to be held in confidence by the practitioner and protected by the agency (Miley, et, al. 2000:57). As an ethical principle, confidentiality guides professional behaviour and forms the basis for trust in a professional relationship. Almond (1996:127), states that AIDS and confidentiality pose a dilemma to those involved in helping the affected group.

“She/he should be patient. She/he should be dedicated towards her/his work. There is need for commitment to what you are doing, and you have to like your work.”

“They should be ready to live what they teach and say. They need to walk the talk.”

“In addition, they should be faithful to the education and teaching they received, as well as sticking to treatment. This calls for lifestyle change.”

3.3.5.2 Sub-theme: Personal Development

Individual participants mentioned the following in relation to the need for the new social worker to function at his or her optimal capacity.
• Emotional stability was highlighted as suggestions and advice to a new social worker

For reference and discussions on this category the reader is referred to 3.3.1.1

“I will share with him/her the requirements of being a social worker in a hospital as well as the possibility of being stressed out due to the environment.”

“Since some of the challenges are going to be very familiar to their life experiences, they need to be emotionally stable, as these may push you to the edge.”

“She/he must be emotionally strong. She/he should be versatile to work under different and difficult circumstances.”

“They must have a strong personality, to be able to withstand the challenges related to HIV/AIDS intervention.”

• Personal stereotypes was highlighted as suggestions and advice to a new social worker

For an in-depth discussion on this the reader is referred to 3.3.1.

“They should not differentiate a sufferer of HIV/AIDS from those that suffer from other illnesses. The difference is that HIV/AIDS has the connotation of stigma and discrimination.”

“Be prepared to experience some change in your attitude and your professional outlook as well as your personal perceptions.”

3.4 CHAPTER SUMMARY

In this chapter, the research findings were presented, and were subjected to literature verification. The researcher began with providing a biographical profile of the participants in order to provide the reader with contextual information. The five themes that emerged from the process of data analysis were discussed. They were:
Experiences of intervention with HIV and AIDS clients.
Challenges in HIV and AIDS intervention.
Measures to alleviate impact of HIV and AIDS on social work intervention.
Intervention strategies employed by social workers.
Suggestions and advice to new social workers.

The discussion of the themes was supported by providing evidence in the sub-themes and categories that reveal that the participants were overwhelmed by their first encounter with HIV and AIDS clients. Lack of training, limited resources and the emotionally loaded nature of intervention were identified by social workers as the main factors influencing experiences with HIV and AIDS clients. The participants’ subsequently experience showed some improvement from their first encounter as they attained specialised training in HIV and AIDS intervention with clients, acquired practical experience, received collegial support, and the introduction of Antiretroviral Treatment These brought a measure of hope both to the professional and the client.

Challenges accompanying intervention with HIV and AIDS clients included lack of support systems such as human and structural resources. The participants also experienced service-provision gaps in the sense of poor collaboration and networking with other service providers. Professional challenges included lack of specialised skills and knowledge to intervene with HIV and AIDS clients. Professionals had to deal with personal challenges like work-related stress and depression.

Ethical values and practice principles proved a challenge as the participants had to deal with the challenges of infection control and routine HIV testing. These challenges reminded participants of their unique social work ethics that are undergirded by human rights approach. On the other hand clients were faced with challenges of having to deal with their HIV-positive status. HIV-positive results brought overwhelming challenges to the clients and highlighted the lack of resources to assist them to live a productive life.
Stress management and changes in the mindsets of professionals were recounted as measures to alleviate the impact of HIV and AIDS intervention. The other strategies included acquiring relevant skills and knowledge. Intervention strategies available and utilised in mitigating HIV and AIDS were counselling services, referrals to other service providers and empowerment of the community through health education. Lastly, professional development in the form of training and personal development in the form of changing one’s mindset were suggestions and advice mentioned for the newly recruited social workers who were about to enter the field of HIV and AIDS intervention.

Based on the themes, sub-themes and categories presented in this chapter, the next chapter documents the limitations of this study, draws conclusions from the findings, and proposes recommendations and guidelines in enhancing the professional intervention of social workers in mitigating the effects of HIV and AIDS in Botswana.
CHAPTER 4

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

4.3 INTRODUCTION

In this final chapter the summary, conclusions and recommendations of this research report will be presented. Chapter One of this research report gave a general overview of the research problem that the study sought to address and provided a brief introduction to the methodology.

In Chapter Two a description of the research methodology was provided. This was followed in order to operationalise this research study. The qualitative research process employed by the researcher to explore the identified research problem was discussed according the specific phases of the qualitative research approach proposed by De Vos (in De Vos et al., 2002:83-86). In Chapter Three, the research findings on the social workers’ experiences of intervening with HIV and AIDS clients in Botswana were discussed using the interview narratives of the participants and verifying them against literature.

Seventeen semi structured interviews were analysed and the themes, sub-themes and categories that emerged during the process of data analysis were presented. The purpose of this fourth chapter is firstly, to provide a brief summary of the main points of the above-mentioned chapters. Then conclusions derived from these chapters will be outlined. Lastly, these will be complemented by recommendations. Before presenting the discussion, the reader will be reminded of the objectives of the research study as well as the semi-structured interview schedule that was used to attain the purpose of the project.

The objectives initially formulated for the research study were:
To explore and describe the social workers’ experiences with regard to their interventions with HIV and AIDS clients.

Based on the findings, to draw conclusions and to recommend guidelines to ensure appropriate social work intervention to HIV and AIDS clients.

The researcher believes that the above objectives were attained through the completion of this research study.

The ensuing discussion will be presented under the following headings:

- research methodology: summary, conclusions and recommendation;
- the findings regarding the social workers’ experiences intervening with HIV and AIDS clients: summary, conclusions and recommendations; and
- Conclusions and recommendations.

4.4 THE RESEARCH METHODOLOGY

4.4.1 Summary

The research process implemented to effect this study followed the seven phases of the qualitative research framework as outlined by De Vos (in De Vos et al., 2002:84).

- Choosing a research problem/topic/theme

The research problem that formed the central focus of this study was stated as follows: No previous research has been undertaken to investigate social workers’ experiences of intervening with HIV and AIDS clients in Botswana.
This research endeavour would enable the participants themselves to articulate their practice experiences of intervening with HIV and AIDS. Based on such information, the social workers in collaboration with the Department of Social Services would be able to initiate appropriate intervention strategies, in order to enhance services to the clients. The hope is that these insights will enhance our professional knowledge.

- **Decision on the qualitative research paradigm (mode of inquiry)**

The research was planned within the qualitative paradigm, as the intention of the study was to explore and describe the experiences of social workers’ experiences in the context of their intervention with HIV and AIDS clients in Botswana. The qualitative research was deemed as being best suited for this research study as it focuses on under researched topics. The approach was found appropriate as there was limited empirical research and literature available on the topic of social workers’ experiences of intervention with HIV and AIDS clients in the context of Botswana. Literature and journals in the Nelson Mandela Metropolitan University and the University of Botswana libraries were accessed and there was a dearth of any direct literature.

- **Selection of a qualitative research design**

A qualitative, exploratory, descriptive and contextual research design was used in this research study. Explorative studies attempt to investigate unknown areas of research by emphasising an open, flexible approach (Terre Blanche and Durrheim, 1999:39). Descriptive research is concerned with how, what is, or what exists, are related to some preceding event that has influenced or affected a present condition or event, as well as to describe the what that has been explored (Best in Cohen and Manion, 1994:67). Contextual studies endeavour to understand participants within their specific context Schurink and De Vos (in De Vos et al., 1998:281).
• **Preparation for data collection**

During the preparation for the data-collection phase a number of decisions were made. The setting was delineated as all the Botswana Government health facilities where social workers render a service to clients who are HIV and AIDS positive. Purposive sampling was used to identify the seventeen participants. The sample consisted of two males and fifteen females. For the sampling criteria the reader is referred to Chapter One (see section 1.5.2). Each participant was invited to take part in the study by inviting him or her by first making a phone call. This was later followed by an invitation letter which explained in detail the nature of the study and the rights of the participant to decline the invitation to participate. The interviews were carried out in the participants’ offices as had been pre-arranged with them.

• **Data collection and analysis**

A semi-structured interview schedule was used to conduct interviews with each individual participant to collect the data. The semi-structured interviews were audio-taped and transcribed verbatim. The data were then analysed according to the eight steps proposed by Tesch (in Creswell, 1994:154, 155).

• **Data verification**

Data verification was carried out according to Guba’s (1981) model of trustworthiness (in Krefting 1991:215). This model identified four criteria and their related strategies to ensure trustworthiness of this qualitative research endeavour. The study was assessed against these criteria, namely: truth value, applicability, consistency, and neutrality.
4.4.2 Conclusions and Recommendations

This section deals with the conclusions and recommendations based on the researcher’s experiences with regard to the implementation of the specific research methodology. The researcher drew the following conclusions and proposes the following recommendations based on these conclusions:

- Qualitative paradigm

The qualitative paradigm was an appropriate choice for this research study, as it is concerned with a subjective exploration of the phenomena. The paradigm was well suited for the topic under investigation as by nature it is suitable for the topic under investigation since this is not well researched and documented. Subjective exploration refers to an exploration with those who can give a first-hand account of their experiences (experiences of intervention with HIV and AIDS clients, the impact of HIV and AIDS intervention, intervention strategies in place, challenges related to HIV and AIDS intervention, measures taken to alleviate the impact of HIV and AIDS, and suggestions and advice to a new social worker).

It is advisable, as a recommendation, that novice qualitative researchers consult various texts on the qualitative paradigm to gain a better understanding of the principles of this approach. It is further recommended that one interested in this approach should consult more experienced researchers to enhance his or her understanding of the research process. This should enhance the trustworthiness of such research studies. The well-experienced researchers will help the novice qualitative researcher to manoeuvre the maze of these nuances of the qualitative research paradigm with confidence. This researcher found that this is not as easy as it may seem from the outset.
• The explorative, descriptive and contextual design

This qualitative research design was concluded to have been suited to the goal and objectives of this research study. The researcher was able to interpret the participants’ narratives ascribed to their experiences. It is recommended that this design be utilised when dealing with people’s subjective experiences of their situations where the researcher endeavours to gain in-depth information. This proved useful as the participants were able to express their views and experiences without being restricted by a rigidly structured format of data collection.

• Recruitment of participants

It is recommended that future researchers study and identify the most suitable time to implement data collection to avoid a situation where either the participants are transferred, are on sick leave, on study leave or out of station due to training.

• Gatekeepers

It is also recommended that the researchers should establish the requirements from the gatekeepers on the rules and policies that apply before one is granted permission to gather data. This will go a long way in saving time and resources. Even if the researcher is aware of the procedures in place, it has proven wise to enquire beforehand and to verify expectations as standards and systems change without warning. Each gatekeeper has his or her unique requirements; therefore, it is advisable to make sure that the researcher has the prerequisites in writing. These should be made available to the supervisors as well as the University’s Advance degree Committee to enable such additional requirements to be factored into one’s research proposal.
• **Time management**

From the researcher’s personal experience it was concluded that the research study requires one to have skills in time management, as encounters with gatekeepers and participants may change the time scheduled. Time management skills become handy when the researcher has to factor in the challenge of having to adjust the schedule bearing in mind that he or she has to complete the study within the allotted time. The time for the interviews plays an important part in ensuring that one gets more from the interview encounter with the participant. It would be recommended that interviews are scheduled for the time of the day where there will be no other patients, as in the afternoon.

• **Relationship with research participants**

It is vitally important for the researcher who conducts a research study in their own workplace to bear in mind the ethical principles which they set at the beginning of the research study. This is recommended in order to keep the relationship with the participants at a researcher-participant level. There is a temptation to either provide supervision or counselling as the participants relate emotional stories of their intervention experiences. One other recommendation is to have a clear idea of the place for conducting the interviews and to enquire whether electricity is available for the tape recorder.

• **Undertaking a pilot study**

The researcher undertook a pilot study prior to embarking on the main study to try to identify possible deficiencies in the data-collection instruments, and improve the success and effectiveness of the research study. A pilot study is highly recommended as it provides the opportunity for the novice researcher to obtain feedback from the study’s supervisor regarding the appropriateness of interviewing and probing techniques.
• In-depth interviews using a semi-structured interview schedule

The utilisation of semi-structured interviews allowed the researcher flexibility for further exploration providing space to probe for more information. Therefore, it can be concluded that semi-structured interviews, as a method of data collection, worked effectively in answering the research questions set in the interview schedule.

This method of data collection is recommended for use by the novice researcher who does not feel confident about conducting totally unstructured interviews.

• Audio-taping interviews

Interviews conducted were recorded (see section 2.7). The recording of the interviews reduced the potential for error during the process of transcribing data. This also allowed the researcher to capture the essence of the participants’ stories and enhanced the completeness of the research, as it provided access to the nuances (such as pauses) during the interviews. It is important for the researcher to test the recording device before the interview as the device may malfunction or it may be a little too sophisticated for one to operate with ease. The use of a tape recorder for qualitative research is recommended with the permission of the research participants. It is further recommended that the researcher should be conversant with the technical operation of the recording device he or she is using prior to the commencement of data collection.

• Tesch’s eight steps for data analysis

These steps prescribe a clear structure that allows for a systematic analysis of data and were clear for the researcher to follow. This method is recommended for novice qualitative researchers, as this framework was found to facilitate the analysis of data in an ordered and comprehensible manner.
• Guba’s model of trustworthiness

This model was helpful for ensuring and establishing the trustworthiness of the research study as it provided clear criteria and strategies that could be implemented in the research process. It is recommended for future use by researchers, as the model assist in limiting any biases which might affect or complement the credibility of the results of the study and their trustworthiness. It is recommended that the services of an independent coder be utilised, as this enhances neutrality and hence the trustworthiness of the research findings.

4.5 FINDINGS OF THE RESEARCH STUDY

4.5.1 Summary

This study emanated from the fact that social workers’ intervention with HIV and AIDS is a relatively new strategy in social work services provision in Botswana. Social work services in the health care setting are relatively new. The participants through their narratives informed the researcher that they experienced challenges during their initial or early intervention experiences. The challenges of these experiences somehow lessened as social workers gained practical experience as well as appropriate and specific training. Evidence drawn from interviews with social workers as well as from the literature review indicates that there are challenges in intervening with HIV and AIDS clients in a health-care setting.

In Chapter Three, the research findings were discussed, as the themes, sub-themes and categories that emerged during the data analysis process. These themes, sub-themes and categories were described and supported with quotations from the transcripts, as well as verified against relevant literature and related research documents.
The themes that emerged during data analysis were: experiences of intervention with HIV and AIDS clients, the challenges in HIV and AIDS intervention, measures to alleviate the challenges of HIV and AIDS in social work intervention, intervention strategies employed by social workers, as well as suggestions and advice to new social workers.

Each theme was further divided into sub-themes and categories. The **first theme**, *experiences of intervention with HIV and AIDS clients*, was divided into the following sub-themes: initial intervention experiences, which included emotionally loaded (mixed) feelings on the lack of specialised training, lack of knowledge and skills, lack of resources, impact of HIV and AIDS and subsequent intervention experiences, which included specialised training, practical experiences, supervision/colleague support and ARVs provide hope for clients.

The **second theme** was labelled *challenges in HIV and AIDS intervention*. Based on the feelings and views which were experienced by the participants, the theme was sub-divided into the following five sub-themes: support systems which included lack of human and structural resources, social and economic impact and treatment accessibility; service provision gaps included collaboration and networking; professional challenges included lack of specialised skills and knowledge, work-related stress and depression, underlying social problems, professional’s attitude change, need for professional counselling, need for professional contribution, need for professional supervision and challenges with discordant couples; ethical and practice principles challenges included practice values and principles, routine HIV testing and infection control; client challenges included HIV results disclosure, client denial, eligibility criterion, clients’ behavioural change, couple and family relationships, HIV positive children, illiteracy and ignorance and cultural beliefs and practices.

The **third theme**, *measures to alleviate the challenges of HIV and AIDS on intervention* was based on the challenges faced by participants as they
intervened with HIV and AIDS clients. This theme is divided into two sub-themes, namely, coping strategies, which included stress management, out-door activities; and education and training included specialised training,

*Intervention Strategies employed by social workers* formed the focus of the *fourth theme*. The following sub-themes were identified by the participants as strategies they used to intervene with HIV and AIDS clients. Counselling services included the following: pre- and post-test counselling, supportive counselling, couple HIV counselling, routine HIV testing, Prevention of Mother to Child Transmission and group and family intervention; referrals included internal and external client referrals of Community Home-Based Care Programme; community empowerment included health education (IEC) and community capacity building.

The *fifth* and last *theme* that emerged related to *suggestions and advice to new social workers*. The theme was comprised of two sub-themes, namely, professional development which included specialised training and continuous learning and professional competency; and personal development which included emotional stability and confronting personal stereotypes.

Taken together, these themes constituted the narratives of social workers’ experiences in intervening with HIV and AIDS clients in Botswana. The conclusions that can be made based on the research findings and the literature verification are as follows:

◊ The participants were overwhelmed by the demands of intervening with HIV and AIDS clients as a novice in HIV and AIDS intervention practice.
Lack of relevant training in HIV and AIDS related issues was a core issue in affecting social workers’ feeling about providing relevant services to clients.

Lack of both human and material resources, had a negative impact as HIV and AIDS were not only a medical challenge, but a social tragedy as well, demanding a political as well as a social response from everyone to prevent and control their spread and devastation.

Some of the challenges included the support systems and service provision gaps. These hampered effective intervention as various sectors of the care giving efforts were perceived to be not well coordinated and thereby resulting in the poor utilisation of resources and creating unnecessary tensions and animosity. This in turn affects the client as he or she would lose the attention to his or her needs.

The professional caregiver was faced with challenges ranging from lack of skills and knowledge, emotional stress and depression and a need for counselling. Without proper mechanisms to look after the professional caregiver, service provision would suffer as absenteeism, staff turnover, sick leave and dissatisfaction with the job as well non-motivation to do one’s work would be the result.

The participants experienced ethical and legal challenges as a result of intervening with HIV and AIDS. Any new challenge to a profession would come with new challenges to established ethics and practice values. Participants expressed their concern with issues of confidentiality in the face of clients’ disclosures to other caregivers as well as their own protection for possible infection by their daily contact with HIV-positive clients.
The clients experienced challenges in dealing with their HIV-positive status. Some of these challenges were the disclosure of their HIV-positive results to caregivers; denial of their HIV-positive status; adherence to treatment; abuse and neglect as well as illiteracy and ignorance. Participants expressed that they were affected by what their clients were experiencing, especially when they had to adjust to a life of knowledge of their HIV-positive status. Death of a client was also mentioned as one reason for these feelings in the professional.

Measures to combat the impacts and challenges of HIV and AIDS on the participants were stress management strategies; outdoor activities; training and case-conferencing. Participants reported that without these self-initiated strategies, it would have been difficult for them to cope with the challenges of intervening with HIV and AIDS clients.

Participants reported that the intervention strategies they used in their daily work involved the provision of counselling services, referrals to relevant service providers as well as community empowerment through education and capacity building.

The participants mentioned the following as the suggestions and advice they would give to a new social worker who was about to begin intervention with HIV and AIDS clients: Professional and personal development in the knowledge as well as skills in dealing with HIV and AIDS and confronting/addressing personal stereotypes.

Based on these conclusions the following recommendations are made:
- **Training in HIV and AIDS intervention**

It is recommended that every social worker who is assigned to intervene with HIV and AIDS clients be well trained to be able to provide relevant services in order to meet the client’s basic human needs specific to HIV and AIDS clients. This training may be long term as in the case of undergraduate and postgraduate training.

The most important and manageable is the short-term training like in-service training, which may target shortcomings experienced by the professional. Training should address the stigma, misconceptions and lifestyle skills among other challenges related to HIV and AIDS intervention. [Compare Aronstein & Thompson, 1998: 36; Bennett et al., 1995:262; Coughlin et al., 1996:255; Macklin 1989:75, 76.]

- **Resources – material and human**

It is recommended that the Revised National Policy of Destitute Persons of 2001 be urgently revised to address the HIV and AIDS clients’ needs in a more integrated and holistic manner. The policy should spell out clearly how the unique needs of the clients should be addressed as the policy is meant to cater for the destitute person. [Compare Nelkin, Wills & Parris, and 1999:1.]

- **Professional supervision**

In an effort to assist the professionals in managing the challenges of their daily encounters with HIV and AIDS clients, there is a need to ensure that the supervisors are well versed with the basic knowledge of what a social worker’s intervention world entails. It is therefore recommended that supervisors participate regularly in in-service training that will introduce them to the world of clinical social work in order to equip them for effective responses to the needs of
the social worker in their daily service provision. [Compare Aronstein and Thompson, 1998:522; MOH Botswana, 2004:44.]

- **Support systems**

It is recommended that a new look be taken at both the internal and external referral systems of intervening with HIV and AIDS clients and these be urgently revisited. Both referral systems should facilitate the clients’ assistance to have access to services and goods. It is further recommended that there should be integration in collaboration and networking between different service providers in order to utilise the limited resources.

- **Recreation, health and wellness facilities**

It is recommended that the employer should consider incorporating recreational facilities for the future development and upgrading of health-care facilities. These facilities will help the participants to cope with their work-related stress and depression. Wellness or Employees Assistance Programmes will be important to enable the infected and affected to deal with the stresses created by intervention with HIV and AIDS clients. [Compare Ostrow, 1990:362, 363.]

- **Inter-sectoral coordination at all levels**

It is recommended that there be coordination between hospital-based social work and other community-based service providers like the NGOs, CBOs, FBOs and other relevant Government Departments responsible for mitigating HIV and AIDS.
• Future research

Finally, it is recommended that further research study be done in following areas:
The effects of work-related stress on social workers who intervene with HIV and AIDS clients in Botswana; the role and perceptions of social workers providing HIV and AIDS intervention to clients; and a model on the multidisciplinary approach to home-based care for HIV and AIDS clients.

4.6 CONCLUDING REMARKS

In an article in the City Press Newspaper (5 November 2005), Rapitso highlighted that caregivers need care too as they look after the sick and are often on the receiving end of their patients’ suffering. For the caregivers, AIDS has raised many ethical and moral issues, especially relating to proper professional conduct and fair treatment of people with HIV and AIDS. Health-care workers are being asked to provide both physical and emotional support and care for those who are dying (Evian, 2003:313).


9. Baipidi, C.S. 2000. Experiences and Needs of Nurses Caring for People Living with HIV and AIDS In Nyangagbwe Hospital, Francistown. (Dissertation)


77. Pathfinder International' [http: www. pathfind.org-accessed](http: www. pathfind.org) 27/12/06


APENDIX A – LETTER REQUESTING PERMISSION TO CONDUCT STUDY

Nelson Mandela Metropolitan University
P. O. Box
Port Elizabeth
South Africa

The Permanent Secretary
Ministry of Health
Private Bag 0038
Gaborone
Botswana

11th September 2005

Dear Sir,

REQUEST TO CONDUCT RESEARCH ON THE SOCIAL WORKERS’ EXPERIENCES RELATING TO THEIR INTERVENTION WITH HIV AND AIDS CLIENTS

This letter serves to request permission to conduct the above study in Botswana, in the following health facilities Mahalapye, Seckgoma Memorial, Princess Marina, Scottish Livingstone, Thamaga Primary and Athlone Hospitals. I am currently enrolled for the Master’s degree in Clinical Social Work in the Department of Social and Development Professions at the Nelson Mandela Metropolitan University in Port Elizabeth.

As part of the requirement in this Master’s degree, I have to engage in a research project, and for this reason I have decided to do an inquiry on the experiences of social workers intervening with HIV and AIDS clients in the health facilities mentioned above.

Please find attached a letter of approval from the Advanced Degrees Committee.

Yours Faithfully,

Lefhoko Kesamang
APPENDIX B - INFORMATION AND INFORMED CONSENT FORM

TITLE OF THE RESEARCH PROJECT:

SOCIAL WORKERS’ EXPERIENCES OF INTERVENING WITH HIV AND AIDS CLIENTS IN BOTSWANA

REFERENCE NUMBER: …………………………………………………………….

PRINCIPAL INVESTIGATOR: Lefhoko Kesamang

ADDRESS: Nelson Mandela Metropolitan University
         Village # 7 Flat # 3
         P. O. Box 1600
         Port Elizabeth
         600

CONTACT TELEPHONE NO: 0820807634

DECLARATION BY OR ON BEHALF OF PARTICIPANT:

I, THE UNDERSIGNED,……………………………………………..(name)

[I.D. No:………………….…..] The participant in my capacity as
……………………………………of the participant
[I.D……………………….
of
………………………………………………………………………
…..
………………………………………………………………………….(a
dress).

A. HEREBY CONFIRM AS Follows:

I/The participant was invited to participate in the abovementioned research project which is being undertaken by Lefhoko Kesamang of the Department of Social Development Professions in the
Faculty of Health Sciences of the Nelson Mandela Metropolitan University.

2. The following aspects have been explained to me the participant:

2.1 Aim: The investigators is studying: Masters of Clinical Social Work

The information will be used to identify the specific needs of social workers intervening with HIV and AIDS clients in order to develop guidelines for their intervention

1.1 Procedures: I understand that

1.2 Risks: I will not be exposed to any form of physical risk or harm. Should I experience any emotional distress from telling my experiences, I agree that the researcher would refer me to an appropriate resource.

Possible benefits: As a result of my participation in this study
<table>
<thead>
<tr>
<th>New insights or understanding about the specific needs of social workers intervening in HIV and AIDS problems.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidentiality: My identity will not be revealed in any discussion, description or scientific publications by the investigators.</td>
</tr>
<tr>
<td>Access to findings: Any new information / or benefit that develop during the course of the study will be shared with me.</td>
</tr>
<tr>
<td>Voluntary participation / refusal / discontinuation: My participation is voluntary. My decision whether or not to participate will in no way affect my present or future medical care/ employment / lifestyle.</td>
</tr>
<tr>
<td>2. The information above was explained to me / the participant by Lefhoko Kesamang. In English and Setswana. I was given the opportunity to ask questions and all these questions were answered satisfactorily.</td>
</tr>
<tr>
<td>4. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalization.</td>
</tr>
<tr>
<td>5. Participation in this study will not result in any additional cost to myself.</td>
</tr>
</tbody>
</table>

<p>| B. I HEREBY CONSENT VOLUNTARILY TO PARTICIPATE IN THE ABOVEMENTIONED PROJECT. | Initial |</p>
<table>
<thead>
<tr>
<th>Signed / confirmed at .......................... on</th>
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<tr>
<td>........................................ 20...</td>
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<tr>
<td>(place)                                      (date)</td>
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<tr>
<td>.........................................................</td>
</tr>
<tr>
<td>Signature or right thumb print of participant  Signature of</td>
</tr>
<tr>
<td>witness</td>
</tr>
</tbody>
</table>


Example of Statements and Declarations:

**STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S):**

I, Lefhoko Kesamang declare that

- I have explained the information given in this document to  
  ........................................
  (name of the participant) and/or his/her representative  
  ........................................
  (name of the representative);
- he/she was encouraged and given ample time to ask me any  
  questions;
- this conversation was conducted in English and Setswana and no  
  translator was used ..........................
  (language) by..........................................................  
  (name).

Signed at .................................................. on  
........................................  20......  
(place) (date)

..........................................................
..........................................................
Signature of investigator / representative Signature of  
  witness

**DECLARATION BY TRANSLATOR:**
(name), confirm that I

- translated the contents of this document from English into [language] (indicate the relevant language) to the patient/the patient’s representative/participant;
- explained the contents of this document to the patient/participant/patient’s representative;
- also translated the questions posed by [name], as well as the answers given by the investigator/representative; and
- conveyed a factually correct version of what was related to me.

Signed at ________________________________ On ________________________________

(place) (date)

_______________________________
Signature of translator

_______________________________
Signature of witness
IMPORTANT MESSAGE TO PATIENT / REPRESENTATIVE OF PATIENT / PARTICIPANT:

Dear patient/representative of the patient/participant,

Thank you for your/the patient’s participation in this study. Should, at any time during the study,

• an emergency arise as a result of the research, or
• you require any further information with regard to the study, or
• the following occur

……………………………………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………………………

(indicate any circumstances which should be reported to the investigator) kindly contact ……………………………

(name) at telephone number ………………………………………

(it must be a number where help will be available on a 24 hour basis).
APPENDIX C – LETTER REQUESTING FOR PARTICIPATION OF POTENTIAL PARTICIPANTS

Nelson Mandela Metropolitan University
P. O. Box
Port Elizabeth
South Africa

The Social Worker
Princess Marina Hospital
P. O. Box 258
Gaborone

Dear Participant,

INVITATION TO PARTICIPATE IN A RESEARCH STUDY ON SOCIAL WORKERS’ EXPERIENCES INTERVENING WITH HIV AND AIDS CLIENTS IN BOTSWANA

This letter serves to kindly request you to participate in a research study, which will be conducted in your hospital. My name is Lefhoko Kesamang and I am currently enrolled for a Master’s degree in Clinical Social Work in the Department of Social Development Professions at the Nelson Mandela Metropolitan University in Port Elizabeth.

As part of the requirement for this Master’s degree, I need to engage in a research project and for this reason I have decided to do an inquiry on the experiences of social workers intervening with HIV and AIDS clients. The ultimate goal of the project is to explore and describe the experiences of social workers intervening with HIV and AIDS clients, with the view to make recommendations on strategies to address factors identified by social workers.

The project will require semi-structured interviews with participants in a focus group. These interviews will be tape-recorded, the researcher, therefore, request for permission to use the equipment during the interview. This will assist me to pay attention to the interview process than to writing during the interview. Your responses will be kept strictly confidential, since your name will be quoted as a code allocated and thus your name will not appear in any of the documents reporting on the research. Copies of the transcripts will be kept under lock and key and will be destroyed on completion of this study. In the final report of the study, some responses will be provided as quotes, but these will remain anonymous, therefore participants will not be recognised.

I would like to point out that you have a right to withdraw from the research project at any time and that your decision will be respected and no pressure placed upon you. If you are willing to participate, first, please read and sign the attached consent form. Your help in this research project will be greatly
appreciated. If you have questions about the research project, you may call me at (+27820807634 or 72722538).

Yours Sincerely,

Lefhoko Kesamang
APPENDIX D – REQUESTING FOR PERMISSION TO CONDUCT STUDY IN SAMPLED HEALTH INSTITUTION

Nelson Mandela Metropolitan University
P. O. Box 77000
Port Elizabeth
6031
South Africa

Chief Medical Officer
Mahalapye Hospital
P. O. Box 49
Mahalapye
Botswana

Dear Sir/Madam

REQUEST TO CONDUCT RESEARCH ON THE SOCIAL WORKERS’ EXPERIENCES OF INTERVENING WITH HIV AND AIDS CLIENTS IN BOTSWANA

This letter serves to inform you of the permission granted by the Ministry of Health for the writer to conduct a study on Social Workers’ Experiences of HIV and AIDS intervention in Botswana. Find enclosed a document from the Ministry of Health.

My Name is Lefhoko Kesamang and I’m currently enrolled for a Master’s degree in Clinical Social Work in the Department of Social Development Professions at the Nelson Mandela Metropolitan University in Port Elizabeth. I hope the study will not interfere with the day to day hospital business, as this will be factored in when starting the study.

May you please send your responses to the following address as I am in Botswana:

Department of Social Services
Private Bag BO 180
Gaborone

Fax: 397 1866

Tel. 39 39 215(H) or 72 72 25 38 (Cell).

Your timely response will be highly appreciated as time is not on my side.
Thank you.

Yours Faithfully

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Lefhoko Kesamang
APPENDIX E – PERMISSION FROM THE MINISTRY OF HEALTH (BOTSWANA)

REFERENCE No: PPM&E 13/18 PS Vol I (23) June 19, 2006

Lefhoko Kesamang
P/Bag BO 180
Gaborone

Research Permit: Social Workers Experiences of Intervening with HIV and AIDS clients in Botswana

Your application for a research permit for the above stated research protocol refers.

The application form, protocol and consent form have been reviewed and found to be ethically and scientifically appropriate. Permission is therefore granted to conduct the above-mentioned study. This approval is valid for a period of 1 year, effective June 19, 2006.

This permit does not however give you authority to collect data from selected institution without prior approval from the management of the institution. Similarly, consent should also be sought from all the participants prior to undertaking data collection.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal will need to be resubmitted to the Health Research Unit in the Ministry of Health.

Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research Unit, Ministry of Health within 3 months of completion of the study. Copies should also be sent to relevant authorities.

Approval is for academic fulfillment only.

Thank you,

S. El-Halabi
For Permanent Secretary Ministry of Health