CHAPTER 5: THE SOCIAL WORKER'S ROLE IN ASSESSING THE HIV/AIDS PATIENT FOR ANTIRETROVIRAL THERAPY UTILISING THE BIOPSYCHOSOCIAL MODEL

5.1   Introduction

The broad framework of the HIV/AIDS and STI strategic plan for South Africa (2007-2011 (South Africa, 2007)) which represents the country's multi-sectorial response to the challenge of HIV infection and the wide-ranging impact of AIDS, focuses on four key priority areas: prevention and treatment; care and support; human and legal rights; monitoring, research and surveillance, by promoting the provision of appropriate packages of treatment, care and support to HIV positive individuals in terms of improving screening and diagnosing and strengthening the implementation of social safety network programmes for people living with AIDS (South Africa, 2006).

The worldwide increase in the prevalence of ARV resistance is of particular concern to all involved in HIV/AIDS matters. Since resistance remains one of the most significant threats to the long-term success of any HAART regimen, practitioners are anxious to learn from past mistakes, translate new knowledge into appropriate treatment strategies, and develop methods to complement the treatment.

The current HIV/AIDS epidemic in South Africa poses major challenges to all professions and, in particular, to the social work profession. The focus of social work falls on the improvement of the social functioning of people in interaction with their environment. Social work deals with the needs and problems that people experience in their effort to cope with the demands of their environment and emphasise the idea of "ubuntu" (namely that people will always need other people to realise their humaneness and individual potential) (Sheafor, Horejsi & Horejsi, 1994:6 in Potgieter, 1998:27).

The social worker, who possesses specialized knowledge and skills, is equipped to be part of the multidisciplinary team that renders a service in an ARV setting. The ability to assess and counsel patients regarding adherence, prior to treatment and while on initiation of ART, is strongly indicated. Continuous assessment, monitoring and support and education are further indicated, since adherence tends to fade over time. The researcher is of the opinion that the social worker can provide a meaningful service as part of the multidisciplinary adherence team in assessing the patient's circumstances, as well as in developing the insight of the patient regarding the implications of treatment and networks with available resources for support.

ART is a complex procedure, which is accompanied by severe biopsychosocial implications as discussed in previous chapters. As a result of this state of affairs, there is a need for a comprehensive service, which will ensure that the patients are able to adhere to ART for life. Literature has shown that, particularly in the field of HIV/AIDS, which is accompanied by a variety of psychosocial implications, the treatment will not be complete without the accompanying social support and counselling services. Karoly (1985:434) argues that the biopsychosocial orientation involves an interdisciplinary systems orientation to health care. This orientation enables the service providers to consider the biological, psychological and environmental information about a patient, in order to make an appropriate diagnosis and develop a treatment programme that encompasses all these three areas.

The researcher is of the opinion that the biopsychosocial model, in recognizing the interaction between the medical, social and psychological dimensions of illness, is the appropriate model to provide the HIV/AIDS patient with a comprehensive service that is responsive to their needs. The aim in this chapter is therefore to explore the territory of the social work profession in HIV/AIDS and ARV matters. The social worker, as a member of the multi-disciplinary team in ARV matters, has a specific role to fulfil, in order to ensure that the patients are adequately assessed for ART and receive a comprehensive service.

5.2   The Social Work Profession

Social workers have been defined by the National Association of Social Workers, in Zastrow (2004;40) as: "Graduates of schools of social work (with either bachelor's or master's degrees), who use their knowledge and skills to provide social services for clients (who may be individuals, families, groups, communities, organizations or society in general). Social workers help people increase their capacities for problem solving and coping and help them obtain needed resources, facilitate interactions between individuals and between people and their environments, make organizations responsible to people, and influence social policies."

Cowles (2000:43) also defines social work as the professional activity of helping individuals, families, groups, or communities to enhance or restore their capacities for social functioning and of creating societal conditions favourable to this goal. Thus, as a profession, social work claims to possess specialized knowledge and skills that better qualify its members, as opposed to non-members, to provide such helping services. The four areas of core knowledge essential for all social work interventions, as identified by Cowles (2000:46), are:

- Human behaviour and social environment;
- Social welfare policy and programmes;
- Social work practice-theory concerning the social work helping process, methods of social work practice, skills, techniques and intervention modalities, values and ethics; and
- Research methods.

Social work in healthcare is defined by the *New Dictionary of Social Work* (1995:39) as follows: "Specialized field in social work practised in hospitals and other health care facilities and aimed at the social and personal implications of sickness and health." Social work in healthcare is also defined by Barker (1991:141) as follows: "Social work in health care is the social work practice that occurs in hospital and other health settings to facilitate good health prevent

illness and aid physically ill patients and their families to resolve the social and psychological problems related to illness."

According to Zastrow (2004:529), the social worker in the health field requires skills and knowledge about how to counsel people with regards to a wide variety of medical conditions. Social workers provide a service with respect to, not only direct casework with patients and their families, but also group work with certain patients, consultation, and training of other professionals. They are also involved in planning and the development of policy within the hospital.

The social worker in the field of health needs to possess knowledge of:
- Client population and pro
- Community and resources;
- Specific intervention modalities and
- Research evaluation and documentation (Cowles, 2000:46).

Social work within the health services will require a broad-spectrum intervention repertoire supported by a complex set of competencies and skills, including administrative, leadership and accountability. The challenge facing social work within the transforming healthcare world is whether a sufficient number of capable social work practitioners will be able to staff the delivery systems and meet the growing recognition of the need for psychosocial care and services or whether other providers will increasingly step in, to meet the expectations and demands presented by HIV/AIDS. Education of social workers for the brave new world of health care is essential (Vourlekis, Kathleen, and Padgett, 2001).

According to Skidmore, Thackeray and Farley (1994:146) social work intervenes with medicine and other related professions in the study, diagnosis and treatment of illness at the point where social, psychological and environmental forces impinge on role effectiveness. The social workers in healthcare employ problem-solving methods for assisting individuals, families, groups and communities in solving health-related problems. Skidmore *et. al.,* (1994:146) further define social work in healthcare as the application of social

work knowledge, skills, attitudes and values in healthcare, where the social worker addresses himself/herself to illness brought about by, or related to, social and environmental stresses that result in failures in social functioning and social relationships.

According to the researcher, social work in healthcare is the delivery of critical, comprehensive social work interventions, to the individuals, families, groups and/or communities who are associated with, or affected by, illness. These medical conditions can be brought about by, or related to social and environmental factors that impose on psychosocial functioning.

The social work intervention should be a holistic approach that could ultimately improve social functioning and quality of life in general, including the prevention of illness and promotion of health by means of education. In acknowledging the physical, mental, emotional, social, economical, cultural and spiritual dimensions of human life and utilizing the biopsychosocial approach, an individualized, comprehensive assessment can be performed (Spies, 2006).

5.2.1 Background

The first social welfare agencies were founded in the early 1800s in an attempt to meet the needs of the people living in urban areas. Prior to 1930, social services were provided primarily by churches and voluntary organizations.

Richard C. Cabot introduced medical social work at Massachusetts General Hospital in 1905. Gradually, social workers were employed in schools, courts, child guidance clinics and other settings. In 1917, Mary Richmond published the first text to present a theory and methodology for social work. A training school for psychiatric social work was established at Smith College in 1918. What began as social work in healthcare was divided into medical and psychiatric social work around 1920. Following both World War I and World War II thousands of servicemen returned home with psychological as well as physical scars.

Since the inception of social work in the general hospital setting in 1905, social work within the health field has expanded to include practice in a variety of healthcare settings, such as psychiatric and other speciality hospitals, public health agencies, nursing homes and rehabilitation centres, health maintenance organizations, community-based clinics, private medical practices, home care agencies and hospice programmes.

From the 1920s to the 1960s, most social work programmes employed a medical model approach to assess and change human behaviour. In the 1960s, social workers began questioning the usefulness of the medical model. Environmental factors were shown to be at least as important internal factors in causing a client's problems. Social work shifted some of its emphasis to a reforming approach, which seeks to change systems to the benefit of clients, and look beyond the client's presenting problems in order to assess the complexities and interrelationships of the client's life situation.

In recent years, social work has increasingly focussed on using a systems ecological approach, integrating both treatment and reform by conceptualising and emphasizing the dysfunctional transactions between people and their physical and social environments. An ecological model seeks to identify such interpersonal obstacles and then apply appropriate intervention strategies (Cowles, 2000:10 & Zastrow, 2004:45).

5.2.2   The goals of social work

Social work is the professional activity of helping individuals, groups, families, organizations and communities to enhance or restore their capacity for social functioning and to create conditions favourable to their goals. The goals of social work that have been identified by Zastrow (2004:38-58) are to:

- Enhance the problem solving, coping and developmental capacities of people;
- Link people with systems that provide them with resources, services and opportunities;

- Promote the effectiveness and humane operation of systems that provide people with resource and services;

- Develop and improve social policy;

- Enhance human well-being and alleviate poverty, oppression and other forms of social injustice;

- Pursue policies, services, and resources by means of advocacy and social or political actions that promote social and economic justice;

- Develop and use research knowledge and skills that advance social work practice; and

- Develop and apply practice in the context of diverse cultures.

Cowles (2000:14) distinguishes between curing and caring in health interventions. Today the major health problems stem from chronic, rather than acute, infectious diseases. The healthcare delivery system comprises three basic levels of services that represent stages of health status, primary, secondary and tertiary. These stages revolve around prevention, repair and compensation. Curing and caring comprise the two basic approaches to helping within the realm of health and other human problems. Curing refers to efforts to correct the underlying condition, while caring refers to the provision of supportive assistance to:

- Promote healthy growth and development;

- sustain function and relieve distress during a temporary problem episode;

- maximize comfort and function when a problem is permanent or even terminal.

5.2.3   The characteristics and role of the social worker

Barr (1979:106) in Zastrow, (2007:35), identifies the following competencies or core practice skills that social workers should possess:

- Identify and assess situations in which relationships between people and social institutions need to be initiated, enhanced, restored, protected or terminated;

- Develop and implement a plan for improving the well-being of people, based on problem assessment and the exploration of obtainable goals and available options;

- Enhance the problem-solving, coping, and developmental capacities of people;

- Link people with systems that provide them with resources, services and opportunities;

- Intervene effectively on behalf of the populations most vulnerable and discriminated against;

- Promote the effective and humane operation of the system that provides people with services, resources and opportunities;

- Actively participate with others in creating new, modified or improved services, resources, or opportunity systems that are more equitable, just and responsive to consumers of services, and work with others to eliminate unjust systems;

- Evaluate the extent to which the objects of the intervention plan were achieved;

- Continually evaluate one's professional growth and development by assessment of practice behaviours and skills; and

- Contribute to the improvement of service delivery by adding to the knowledge base of the profession as appropriate and supporting and upholding the standards and ethics of the profession.

According to Germain (1984:78), the roles and tasks of the social worker are to assist patients to cope with the stress of illness, injury or disability. Potgieter (1996:42) proposes the following principles when dealing with people. The researcher acknowledges these as relevant.

- Individualisation
- Acceptance
- Controlled emotional involvement
- Non-judgmental attitude
- Self-determination

- Accountability

The said researcher also supports Potgieter's (1998:99) view of the characteristics that the social worker should possess with regards to service delivery, especially concerning ARV matters:

- Acceptance and respect, warmth, trust, congruence and genuineness, empathy, concern for others, commitment and obligation, authority, competence and power, concreteness and objectivity, humour, confidentiality.

When working with individuals, groups, families or organizations, the social worker needs to be knowledgeable and skilful in a variety of roles. Such roles, identified by Zastrow (2004:77-79) are those of:

Table 8:   Roles of the social worker

Enabler	Articulates needs, clarifies and identifies problems
Broker	Links individuals and groups with community
Advocate	An active, direct role, advocates for clients rights
Activist	Seeks change, shift in power, resources to disadvantaged groups
Mediator	Intervention in disputes, finds compromises, reconciles, reaches agreements: a neutral role
Negotiator	Conflict bargaining and compromise: mutually acceptable agreements
Educator	Giving information, teaching adaptive skills, communicator
Initiator	Calls attention to a problem
Empowerer	Helps to increase strengths by improving circumstances
Coordinator	Brings components together in an organized manner
Researcher	Studies literature, evaluates outcome
Group facilitator	Leader of group activity
Public speaker	Informs regarding available resources, advocates new services

Zastrow (2004:77-79)

The present researcher is of the opinion that the above principles and characteristics also relate specifically to service rendering in HIV/AIDS issues. It is important to know that all patients should be accepted as individuals, including all sectors of a community, such as criminals, prostitutes, homosexuals, children, elderly, and adolescents. The patient's personal circumstances and the reason why and how they contracted the HI virus are not important; the important issue is that they are in need of social work intervention, while always bearing in mind the patient's right to self-determination.

The social worker, involved in service delivery in HIV/AIDS and ARV issues, should specifically convey acceptance, warmth, respect, empathy and confidentiality. HIV/AIDS patients not only suffer from the disease but, often, are also subjected to discrimination and disrespect. The social worker should convey confidence, knowledge, competence and commitment. In the past, HIV/AIDS has been notoriously linked with death, homosexuality and promiscuity, thus care must be taken to meet every patient with respect and care.

Individuals diagnosed with HIV/AIDS experience a variety of psychosocial stressors that can negatively affect their lives. One of the stressors that have emerged since the introduction of ART is the awareness that their existence will depend upon being sustained by artificial or chemical means. This understanding raises a number of issues, including unique social and financial pressures, lifestyle and role changes, as well as apprehension regarding the ability to maintain employment and relationship changes. The onset of these stressors usually begins with the diagnosis of AIDS and the necessity for adherence to ART.

5.3 The roles and skills of the social worker in ARV matters

Medical advances alone, no matter how effective in reducing the number of AIDS-related deaths, cannot decrease the number of new infections nor can they support the needs of the many HIV-positive people now regaining health

and lost roles as a result of ARTs. People on ART are doing so with guarded optimism about how long this medication will be effective and feel limited in their ability to live life fully.

Strug, Grube, and Beckerman, (2002:7) postulate that social workers will increasingly become involved in primary prevention efforts due to the fact that medical intervention alone is insufficient to prevent new infections. Infected persons will need a wide variety of medical and psychosocial support services for long periods of time, since HIV/AIDS becomes a chronic condition for persons living with the disease.

According to the *South African Council for Social Service Professions (SACSSP)* there are 11 803 registered social workers in South Africa, not all of whom are actively involved in service rendering within the profession, or related to HIV/AIDS matters. South Africa has an estimated 5.54 million people living with HIV; of these 5.54 million, 500 000 are estimated to have AIDS and are thus in need of ARVs. If the Government's plan to supply ART to all patients who meet the criteria succeeds, the need for social work intervention in supporting people living with AIDS will be exceeded.

The impact that the various psychosocial needs of millions of HIV/AIDS people living on ART will have on current social structures and services, will challenge the available professional social services. The importance of the social worker being involved in HIV/AIDS and ARV matters, where all the team members will provide the patients with a comprehensive service, cannot be underestimated. Without the involvement of the social worker in ARV matters, there is no other team member who will be able to meet the comprehensive, psychosocial needs of the patient.

Social work interventions and the role of the social worker in the field of HIV/AIDS, which has been primarily, linked with loss and grief, have fundamentally changed with the introduction of ARVs. These interventions need to be shifted to support the millions of HIV/AIDS survivors now living with a chronic disease.

The social worker in ART settings, as a member of the multidisciplinary healthcare team, should possess the necessary experience, knowledge and skills as well as those skills that distinguish it from the other professions. He/she must possess a clear knowledge base of social work in general, as well as social work with regards to health, HIV/AIDS and ART. Rizzo and Abrahams (2002:269) state that social workers are the only professionals who receive professional training in case management and this makes social workers indispensable. Therefore it is necessary to identify gaps in the present system in order to bring about change at policy level and also to allow them to advocate for clients.

Knowledge and skills must be clearly communicated to other team members in order to avoid the blurring of roles amongst the team members, especially counsellors. The present researcher agrees with the viewpoint of Cowles (2000:133), that for the social worker to claim a place in the interdisciplinary team, the claim must be based on expertise. Collaborative skills are essential in order to be recognised, and render a meaningful service. Without this expertise, the role of the social worker will be confused with that of other role players.

Without the involvement of the social worker, the patients are denied the specialized knowledge and skills that would otherwise facilitate their treatment. The researcher would like to apply some of the generic roles of the social worker identified by Skidmore, *et al.,* (1994:151) and Saloner, (2002:154) to the social worker within the healthcare field who deals with HIV/AIDS patients referred for ART.

5.3.1 Caring for and protecting vulnerable populations, social justice and equity

Social work should identify the individuals and groups in society that are most vulnerable and seek to strengthen their potential and capacity by providing protection where this is warranted. Poverty hinders access to a number of services; most people are vulnerable because of their socio-economic conditions and thus are more susceptible to HIV infection. Improving the lives of

poor communities is therefore necessary to ensure that people do not place themselves at risk of infection, for example by prostitution (Viljoen, 2005:82).

Women, in particular, are disproportionately more affected by poverty and HIV/AIDS because of the inequalities in society and a general lack of resources, yet they are traditionally responsible for caring for the sick. They are also more vulnerable to HIV infection due to their inferior position and therefore, often cannot negotiate safe sex and/or resort to selling sex for money or material goods, in order to improve their living conditions.

The establishment of a climate of social justice is one of the purposes of social work in ART practice to enable all members of society to enjoy an equal share in the rights and opportunities afforded by society. The high rate of unemployment and poverty hinders access to a number of services, including adherence to ART.

5.3.2   Healing and caring

It is the function of social work to identify needs and problems that affect the social functioning of people and facilitate actions that might resolve or minimize these. The purpose is to interrupt and prevent the development of social dysfunction by discovering harmful conditions in time and to develop strategies that can control and eliminate problems.

The social worker's role should focus on providing supportive assistance to maximize the comfort and function of persons diagnosed with HV/AIDS. Owing to the introduction of ART, HIV/AIDS is now a treatable and manageable disease, though still incurable.

The introduction of ART has brought unique biopsychosocial needs to patients. Social workers will need to assist greater numbers of families with complex psychosocial matters such as:

- Adjusting to living with a chronic illness of one or more members living with HIV/AIDS; adherence issues; re-evaluation of personal commitments and relationships; re-introduction to employment; discontinuation of disability and social support; and regaining of lost roles and health, for example, sexual roles.

5.3.3 Serve as a broker of community services, providing linkages of patient needs with appropriate resources

Knowledge of HIV/AIDS-related resources is at the centre of successful interventions. The social worker therefore needs to be able to identify resources in any given person-in-environment situation and successfully form network linkages to these services, in order to meet the needs of clients. Social workers cannot deliver effective service without resources. Resource management refers to three kinds of action by the social worker:

- Linking people to resources;
- working with resource systems to make them more responsive; and
- stimulating the development of new resources.

As a broker of community services, the social worker must ensure that the community is provided with resources, mobilize communities, and also identify and network to ensure that resources are responsive to the needs of patients. The community should be equipped with knowledge regarding adherence to ART, by the social worker in the health service. The social worker has to facilitate community services, such as NGOs, to be responsive to the needs of HIV/AIDS patients.

People affected by or living with HIV/AIDS find themselves confronted by stigma and discrimination. People continue to be denied employment, discharged from jobs, denied medical care, ostracized from the community, or even killed, often solely because of their HIV-positive status (Viljoen, 2005:144). Once successfully on ART, people with HIV/AIDS are not so easily identified by their

physical appearance and medical symptoms and can return to lost roles and functioning.

Discriminatory responses to the scourge of AIDS, reactions attributable to society's fear, ignorance and refusal to deal with HIV/AIDS, should be addressed by the social worker as advocate, mediator, negotiator, and if need be, activist for the rights of the HIV/AIDS patient.

5.3.4 Policy and programme development

The social worker who delivers services to HIV/AIDS patients should possess a sound knowledge of HIV-related policies and guidelines. The social work profession's concern for human needs and its commitment towards social justice places it in the forefront of policy and programme development.

For the service to be responsive to the needs of the patients, the need exists to have appropriate policies formulated and implemented to this effect. Bearing this in mind, the researcher is of the opinion that social workers can, and should, play a much larger role in formulating policies regarding HIV matters by means of advocation and social planning.

5.3.5 Professional education and practice development

The provision of professional education and training, as well as the development of practice, are important functions of the social work profession. Even though some social workers may not choose to work directly in the field of HIV/AIDS, it is impossible to avoid the epidemic.

Social workers should be experienced and have the appropriate skills and knowledge regarding HIV/AIDS and ART matters, factual knowledge concerning the disease, its route of transmission, as well as ART. Saloner, (2002:154) recommends the dissemination of basic social work skills, knowledge and attitudes to other lay and professional team members. Each social worker bears the obligation to ensure that a portion of his/her role involves an education and training component. There are many social workers who lack

various adequacies with respect to their skills, knowledge and attitude with regards to HIV/AIDS and ART matters.

Every social worker has a moral and ethical responsibility to introduce the issue of sexual practices, in relation to AIDS prevention, to particular client groups. According to Woods (1992:37), human sexuality is often a neglected issue in social work curricula, largely because of the:

- Emotive nature of human sexuality; differences in prevailing values and morality; and widespread ambivalence towards the recognition of sexual functioning.

According to Woods (1992:3-47), social workers should gain specific knowledge regarding human sexuality and the act of sexual intercourse (by virtue of its central role in HIV transmission). Woods, furthermore states an increasing number of social workers are indicating an interest in the topic of AIDS and are moving from resistance in dealing with AIDS-related issues to an appreciation of the rewards experienced by those professionals involved in AIDS work.

The Department of Health makes special provision for counselling and social work services (South Africa, 2003), so that much emphasis is placed on counselling related to HIV/AIDS matters. Terms such as voluntary counselling and testing (VCT), prevent-pregnant-mothers-to-children-transmission (PMTCT) and adherence counselling are now well-known terms in the field of HIV/AIDS. Social workers should be aware of these and be skilled in counselling persons infected and affected by HIV/AIDS.

5.3.6   Heightened awareness of ethical and legal issues

The modelling and mentoring role of the social worker regarding basic morals and ethics is very important. The HIV/AIDS epidemic has shown a consistent pattern which indicates that discrimination, marginalisation, stigmatisation and lack of respect for human rights and the dignity of individuals and groups, increase their vulnerability. HIV/AIDS is a condition among humans being driven

by human behaviour and by the nature of relationships between individuals and groups in society. Human rights, ethics and laws enter into almost every aspect of the experience of an individual and community when confronted with HIV/AIDS (HIV/AIDS and the law, 1997).

Issues such as disclosure and confidentiality raise ethical dilemmas in specific HIV/AIDS matters. The South African legal and policy framework, over the years, has evolved to offer some of the best human rights protection in the world. However, the gap between practice and official policy remains a problem (Viljoen, 2006:99). The specific role of the social worker is to advocate for the rights of patients.

Human rights, ethics and law, should be a tool by which the social worker, in delivering service to HIV/AIDS-infected and -affected individuals, empowers and protects human dignity. The social worker should possess a sound knowledge of common law, ethical and professional guidelines, the Constitution as well as National policies and guidelines regarding HIV and ART matters.

5.3.7   Engage in research, to assure a broadening of the knowledge base

In order for social work practice to be responsive to the needs of patients, specifically in HIV/AIDS matters, ongoing research, continuous exploration, and developmental thought, is necessary and critical.

Westerfelt, (2004:237) states: "it is required that social workers educate themselves about antiretroviral medication and side effects. Because of the rapid changes in HIV care, social workers must continually scrutinize medical journals, talk to other health care social workers, pharmacists, nurses and physicians. They also need to learn from clients with whom they work and partake of their expert knowledge." It is evident from the above functions that the social worker involved in ART matters should be experienced and possess the necessary knowledge in order to deliver a comprehensive service.

This must begin with prevention and education programmes, assessment of patient's circumstances, facilitating social work intervention, and include research and policy-making. The social worker, being a member of the multidisciplinary health team, could ensure fulfilment of the above roles.

5.3.8 Collaboration with the multi-disciplinary team in the delivery of services, to assure maximum utilization of skills and knowledge

Due to the difference in knowledge and skills of the team members, especially in the ART clinic, a need exists for collaboration, in order to ensure that the patients are provided with a comprehensive service.

Schlesinger (1985:225) and Erickson and Erickson (1994:8) state that, inherent in the concern for providing good health care by means of collaborative interdisciplinary teams, it is necessary for social work to function as an autonomous profession. With the maintenance of this autonomy, the blurring of roles could be avoided.

Davidson and Clarke (1990:273) are of the opinion that these collaborative skills include the strategies of interpretation, negotiation, marketing and education. With these skills, the social worker enables other team members to understand the psychosocial problems of the patients and the stressful impact of a chronic disease and adaptation. In the health setting, the social workers need to develop collaborative skills in order to be recognised, as well as render a meaningful service.

Cowles (2000:30) states that social workers will be moving away from the traditional tendency of relying on referrals from physicians and nurses. This will allow the selection of the kinds of clients and problems that the social worker should address. This calls for the social worker to make the team members aware of his/her specific roles and functions, specifically regarding the assessment of the biopsychosocial circumstances of the patients concerning adherence to ART.

5.3.9 Counselling

Counselling is defined in the *New Dictionary of Social Work* (1995:15) as comprising "interviewing procedures aimed at guiding the client towards insight, with a view of promoting his social functioning". In the *Dictionary of Counselling* (1994:63), counselling is similarly defined as a "helping process in which one person, a helper, facilitates exploration, understanding and actions about developmental opportunities and problem conditions presented by a helper or client".

The *Social Work Dictionary* (1991:52) in similar vein defines counselling as "a procedure often used by clinical social workers and other professionals from various disciplines in guiding individuals, families, groups and communities by such activities as giving advice, delineating alternatives, helping to articulate goals and providing needed information".

HIV counselling is defined as a confidential dialogue between a client (patient) and a care provider aimed at enabling the client to cope with stress and be assisted in taking personal decisions related to HIV/AIDS (WHO, 2006). Counselling is defined by Van Dyk (2005:200) as a structured conversation, aimed at facilitating a client's quality of life in the face of adversity.

From the above definitions, it can be asserted that counselling is a procedure used by the helping professionals to guide individuals, families, groups and communities towards insight development, with the aim of improving the social functioning of the client.

The South African Government (South Africa, 2003) recognizes the social work profession as part of the multidisciplinary team assisting HIV/AIDS patients on ART and makes special provision for counselling and social work services. Much emphasis is placed on counselling related to HIV/AIDS matters. Patients need to be assessed and counselled, as part of this comprehensive service to ART patients.

Social workers operate within the scope of the multi-disciplinary team, where all the members of the team are concerned with providing the patient with a comprehensive service while assuming the role of counsellors.

The major function of the social worker in this context is to improve the quality of life and social functioning of the patient. It has been established from the literature, that adhering to ARV treatment can be a complex process with severe psychosocial implications for the individual. As a result of this, there is a need for a comprehensive service, which would ensure that the patients are able to adhere to ART for life, while taking all biopsychosocial factors into account, in order to prevent the development of resistance and the spreading of the resistant virus to the community.

In ART matters, counselling is focussed on adherence to ART. Adherence counselling can be defined as: A structured conversation aimed at facilitating the treatment process. The ultimate goal is to develop patients' insight into adherence to ARV medication, in order to review their problems, options and choices and make adjustments to facilitate life-long medication, articulate recourses and provide required information and education to individuals, families, groups and communities. Counselling people with HIV/AIDS is an ongoing process. Skills in comprehensive HIV and AIDS counselling encompass all aspects of counselling

- Voluntary counselling and testing (VCT), which includes pre- and post-test counselling, has been established as being critical, in order to identify HIV infection in individuals. Since the advent of the HIV/AIDS pandemic the concept of voluntary counselling and testing has gone far beyond the mere testing of people.
- Prevent-pregnant-mothers-to-children-transmission (PMTCT)
- Adherence counselling can include crisis intervention, palliative care, family therapy, counselling.

- Ongoing counselling of HIV-positive patients becomes mandatory cornerstones in the long-term management of HIV/AIDS (South Africa, 2004).

The present researcher is of the opinion that counselling should not be labelled and fragmented. The needs of patients often exceed the indicated counselling, for example pre- and post-test counselling. Patients do experience various biopsychosocial needs that should be addressed by a qualified and experienced professional.

A comprehensive assessment by an experienced counsellor and knowledge of resources is often needed. Counsellors should be able to render a holistic and comprehensive service in assessing patients. In such an instance, the social work profession, with its specialized skills, could play an important role in assessing the patient and rendering the necessary therapeutic interventions where necessary. The counsellors should possess knowledge of community resources and networking with organizations, and assist the family to co-operate with treatment, and to support the patient's utilization of medical services.

The role of the social worker in counselling the patient's family (with the consent of the patient) would be to develop insight into the patient's situation to provide him/her with the necessary support. If the family of the patient are not made aware of the need for adherence and the possibility of developing resistance to ART, they would not be able to assist and remind the patient regarding ART. The social worker could play a role in motivating the patient to disclose their HIV status to at least one family member, friend or support system in order to provide him/her with the needed support with regards to their ARV treatment, which could influence their adherence. The social worker could facilitate co-operation, so that the patient could ultimately benefit from the treatment as well as the support from his/her family. To take ARV medication in secrecy can contribute to patients being anxious, demotivated and possibly non-adherent, with devastating results not only to the individual, but also to society as a whole.

The researcher concurs with Cowles (2000:30), that social workers will have to move away from the traditional tendency of relying on referrals from physicians and nurses, and be actively involved with all patients at the ART clinic.

Assessment, reassessment and continuous assessment are, collectively, the cornerstone of social work intervention in ART adherence issues, since adherence is not a static process and the circumstances of the patients change, they can influence adherence.

The social worker can provide a meaningful service not only during the assessment stage prior to initiating ART, but throughout treatment, since patients usually need continuous counselling. By assisting patients to develop goals with regard to behavioural change, the social worker can enhance adherence to ART by means of motivational training. The aforementioned refers to inducing a state of readiness to change (Taylor, 2003:479).

5.4 Assessing the HIV/Aids Patient for Adherence to ART - Utilizing the Biopsychosocial Model

5.4.1 Assessment

According to Cournoyer (2000:231), assessment is a fundamental process in professional social work practice. Assessment is defined as a process (ongoing); assessment involves gathering, organising, and making judgements about information. As a product, assessment is a verbal or written statement of the functioning of the group (client) and its members, which is useful in the development of intervention plans.

Skidmore, *et al.,* (1994:151) postulate that the social worker must make a thorough assessment of the patient's psychological and environmental strengths and weaknesses, so as to enable the team to understand the patient better, which is necessary for the patient to be provided with appropriate treatment The role of assessment of the patient's circumstances is in agreement with, and applicable to, assessing HIV/AIDS patients for adherence.

It is necessary for the team to work toward the goal of, developing a better understanding of the motivation of the patient, taking into account all the psychosocial issues, the factors affecting a patient's ability to cope with his/her illness; and to interpret behaviour and provide recommendations. For the social worker, in ARV matters it might be difficult to perform the traditional psychosocial assessment, since the patient may refuse to discuss his concerns, fearing that what he says will be used against him; the patient may also refuse to have his family contacted, because he had not disclosed his HIV status. All staff members are encouraged to provide input regarding the functioning of the patient.

An individual treatment plan must be developed, including

- potential problematic situations;
- behavioural expectations;
- patients' needs and motivations;
- staff intervention; and
- consequences for the patient

The patient seeking ART experiences various difficulties; not only suffering from AIDS-related symptoms, but also suffers from psychological and social implications, would benefit from a comprehensive service. As has already been indicated, social work professional knowledge and skills equip the social workers to provide this most needed assessment to ensure that all the aspects pertaining to clients' circumstances will be attended to. Shannon's (1989:32) view that the social workers, as the primary providers of psychosocial care, can close the gap between physical and mental health, applies specifically to the ART clinic.

Without this understanding, the patient will be provided with an incomplete assessment, with various aspects not being attended to, which could lead to treatment failure. This is the reason why the researcher is of the opinion that the biopsychosocial model is the most relevant model to be used in assessing the

patient at the ARV Clinic. All interventions planned are based upon a comprehensive assessment. The researcher is of the opinion that assessing the HIV/AIDS patients "readiness" to commence ART is an important factor. Westerfelt (2004:237) asserts that the transtheoretical model is appealing in assessing individuals' readiness to change

It is argued by Green and Shellenberger (1991:19) that the biopsychosocial approach to health and wellness is viewed as the result of the interaction of biological, psychological and social factors. This implies that no wellness can be attained without utilising all three dimensions. Green and Shellenberger (1991:19) further indicate that the biological factors include genetics, environmental factors and behaviour that affect biological functions, whilst psychological factors include personality, feelings, stress management, life goals, perceptions of health and sickness behaviours, and social factors include social values, customs and social support. Of importance here is to note that the interaction of these factors impacts on the person's wellbeing. If only one aspect is attended to and the others are neglected, wellness cannot be attained.

5.4.2   The Biopsychosocial Model

Since 1907, after the work of Ida Cannon at the Massachusetts General Hospital, the underlying theoretical perspective of social work in the health field has been that physical, psychological and social environmental conditions tend to influence one another and must be taken into account in order to understand and help clients and their families in health settings. The person-in-environment-, biopsychosocial-, and general systems theories all view a person's health status as reflecting the interdependency of physical, psychological and social environmental systems. The general systems theory holds that all levels of organization in nature are inked so that change in one affects change in the others (Cowles, 2000:12).

As discussed above, it is important for health practitioners not to deal with human beings in a fragmented manner. Every human being, who seeks medical attention, must be seen as possessing the three components, namely

biological, psychological and social dimensions, which are in constant and continuous interaction with each other. It must be remembered that it is this interaction that determines the state of health of a person. The biopsychosocial model recognizes the interaction between the medical, social and psychological dimensions of disease and illness in order to provide the patient with a service that is responsive to his/her needs.

Engel (1980:535) asserts that the biopsychosocial model is based on the systems approach. The biopsychosocial model is further defined by Engel (1980:535), as a scientific model constructed to take into account the missing dimensions of the biomedical model, which has governed the thinking of most health practitioners for the last 300 years. The biomedical model disregards the interaction between the medical, psychological and the social aspects in illness or human behaviour.

Brannon and Fiest (1992:11) argue that a systems approach emphasises the mutual dependence of each system within the whole and suggests that a change in one system will produce changes in the others. The systems approach is not a necessary component of the biopsychosocial model but it helps one to understand the interaction among the biological, psychological and social components of disease and wellness.

The term biopsychosocial is also defined by Barker (1991:23) as "a term applied to phenomena that consist of biological, psychological and social elements." It becomes evident that the biopsychosocial model came into being after the realisation that, in order for the person's illness to be understood, it is necessary to consider these three dimensions in his/her life.

Kaplan, *et al.*, (1994:1) further indicate that Engel, a psychiatrist, is the most prominent proponent of the biopsychosocial model, in looking at the patient as a whole. This is vital in treating the patient as a unity, with all the aspects that are relevant to his/her situation taken into consideration. Kaplan, *et al.,* (1994:1) further argue that Engel's model does not assert that the medical illness is a direct result of a person's psychological or socio-cultural makeup, but rather

encourages a comprehensive understanding of disease and treatment. Kaplan, *et al.*, (1994:1) in addition stress an integrated systems approach to human behaviour and disease, because of the continuous interaction between the individual's body, mind and social context.

As mentioned, the researcher is further of the opinion that it is clear that the biopsychosocial model is the most relevant model when assessing patients for ART, to ensure that all the circumstances of the patient are evaluated. This model enables the medical team to understand the patient, which leads to designing an appropriate treatment plan that is responsive to the needs of AIDS patients considered for ART and ultimately improvement of quality of life.

The researcher acknowledges Boyer and Indyk's view (2006:151), that there is a tendency to treat clients' maladies in accordance with two basic premises: the medical needs of the client (as perceived by the clinician) can be successfully addressed by focussing solely on that aspect of the client's life and if the client is not able or ready, then there will be someone in the client's support system to take responsibility for administering the prescribed therapy. In many cases these assumptions hold true, but for certain sub-populations they do not:

- Individuals with substandard/chaotic lives; and
- Those with multiple, confound diagnosis who possess neither personal adherence ability nor adequate support systems.

The researcher would like to add, however, that there are individuals, despite substandard and chaotic lives, who are able to adhere due to specific personality traits, and a strong motivation to live.

Successful adherence can only be accomplished by rethinking what constitutes care and tailoring that care to the individual. Adherence requires the interweaving of three sets of needs, namely:

- needs perceived by the client,

- client's needs (motivation) as observed by an objective recorder (counsellor) and assessed for impact on the client's ability and willingness to be adherent
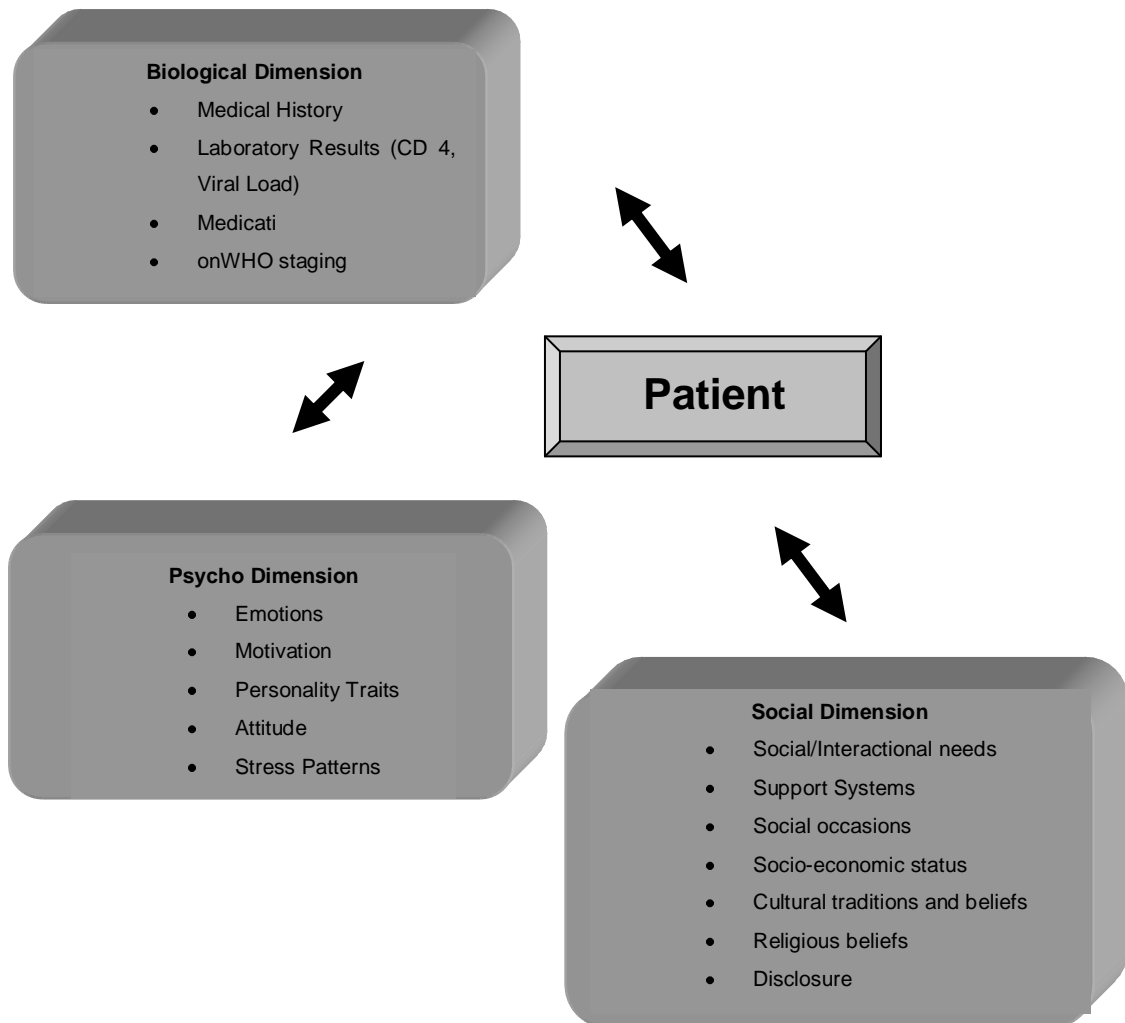- medical needs as identified by a clinician

The process of adherence is not static, but is constantly being affected by external factors. (Childs and Cincotta, 2006:189). The researcher will explain the role and task of the social worker regarding the biospsychosocial matters as follows:

Bio - A physically weak, ill bed-ridden patient would have difficulty adhering without social and practical support: for example, to fetch medication, water, or prepare food. The social worker's task would be to facilitate appropriate care. Such a person could be institutionalized for a period or home-based care could be arranged.

Psycho - A negative, unmotivated or depressed patient would possibly not adhere. The social worker's task would be to motivate such a person, or to refer such a patient to the necessary resources such as a psychologist or psychiatrist for therapy.

Social - A socially isolated, homeless patient with no income would find it difficult to adhere. The social worker's task would be to facilitate support regarding financial matters, transport, grants and nutrition.

Figure 4: **The different dimensions of the bio-psychosocial model can be illustrated as follows:**

Biological Dimension
- Medical History
- Laboratory Results (CD 4, Viral Load)
- Medicati
- onWHO staging

Patient

Psycho Dimension
- Emotions
- Motivation
- Personality Traits
- Attitude
- Stress Patterns

Social Dimension
- Social/Interactional needs
- Support Systems
- Social occasions
- Socio-economic status
- Cultural traditions and beliefs
- Religious beliefs
- Disclosure

5.4.2.1 Assessing the biological/ physiological dimension

Kaplan, *et al.,* (1994:1) postulates that the **biological** system emphasises the anatomical, structural and molecular substrate of disease and its effects on the patient's biological function. According to Bernard and Krupal (1994:13), the biological aspects include the person's genetic predisposition, physiological reactivity, pathogens and immune responses.

This aspect of the person is the place where the medical practitioner always begins when consulted by a patient (Engel, 1980:538). This happens within the doctor-patient relationship and the medical practitioner will collect the data that

will enable him/her to reach a diagnosis. The symptoms of HIV/AIDS are the biological aspects. The service provider, usually a hospital or clinic, is approached because of the patient's biological condition (suffering from a illness), and in taking into consideration the other 2 dimensions (psychological and social) that are related to the condition will contribute to a more comprehensive assessment.

The researcher has found from her own experience that the following aspects should be assessed in adherence matters regarding the bio dimension.

- Gender
- Age
- Performance status
- Medical history
- Laboratory tests such as CD 4, viral load
- WHO staging of illness
- Side effects
- Symptoms
- Opportunistic infections
- Physical functioning in general
- General appearance

The researcher believes that the physical wellness or performance status of respondents will influence adherence. The Karnofsky Scale can be utilized in an attempt to try and measure the more subjective side of a patient's functioning. The scale relates purely to physical ability and covers 11 points, from normal health to death, each scored as a percentage:

http://www.cancerbacup.org.uk/Qas/AboutcancerQAs/AllQAs/related_faqs/Qas/993:28.02.2006

The researcher is of the opinion that biological or physical matters cannot be ignored in adherence matters. The service provider comes to know the patient because of the biological condition and the presentation of symptoms or AIDS-related diseases, but in understanding the psychological and social dimensions

of the disease, certain aspects of the biological dimension could be addressed more effectively.

Golub, Indyk and Wainberg (2006:167) assert that non-adherence is framed as a "treatment problem" and explain that barriers to adherence are constructed in terms of the patient's experiencing of the medication regimen itself. Framing of adherence as a treatment problem forces a distinction between the experience of treatment and the experience of illness. Practitioners talk about the cost of non-adherence in terms of illness, relapse and recovery but few talk about the cost of adherence to the patient in terms of her/his quality of life and identity.

For HIV-positive people, treatment becomes part of the process of living with a chronic illness. The ultimate goal of intervention should be to enhance the quality of life of patients. HIV/AIDS challenges the patient's body image and identity, and their sense of self-change, their social and familial relationships and life roles are also affected. Meanwhile they are obliged to deal concurrently with psychological distress, physical pain, prolonged medical treatment and increasing interference in or restrictions of their daily performances and activities.

5.4.2.2　Assessing the psychological dimension

The adoption of the biopsychosocial model in ART settings will make it possible for the patient's feelings and perceptions regarding their biological state to be attended to. In this way his/her coping capacity and adherence can be improved. Engel (1980:538) argues that in collecting data regarding the biological aspects of the patient, it is crucial also to explore her/his psychological being, because the course of the illness and the care of the patient may be importantly influenced by processes at the psychological level. This dimension forms an important component of the biopsychosocial model, in the sense that it assists the medical practitioner to understand the patient's perceptions of his/her condition and the extent to which he/she is motivated towards receiving help. When using the biomedical model these aspects are neglected, with a negative impact on the patient.

Kerns and Curley (1985:150) further argue that the individual's cognitive, affective and behavioural functioning greatly influences the extent and meaning of perceived psychological and social losses, as well as the person's coping with or adapting to these losses.   This clearly shows that an individual's condition cannot be successfully treated with the biomedical model that is, disregarding the interaction among the biological, psychological and the social dimensions of his/her condition.

According to Kaplan, *et al.,* (1994:1), the psychological dimension emphasises the effects of psychodynamic factors, motivation and personality on the experience of illness and the reaction to it. This dimension forms an important component of the biopsychosocial model, in the sense that it helps the medical practitioner to understand the patient's perceptions of his/her condition and the extent to which he/she is motivated with respect to help.

The researcher has in her experience found that the following psychological matters could impose on adherence positively or negatively and should be addressed in rendering service to the HIV/AIDS patient in adherence matters.

- Psychological comprehension
- Personality
- Intelligence
- Feelings
- Personality traits: sense of responsibility, self-discipline, organization
- Emotions and emotional stressors (adolescence), negative feelings, grief, denial, guilt, anger, anxieties, bargaining, sadness, loss
- Attitudes towards medical care, health and illness
- Knowledge and understanding
- Health beliefs: concerning threats to health, regarding efficacy of action
- Stress pattern
- Fears
- Motivation or lack of motivation
- Ongoing or past psychiatric illness, such as mood disorders

- Psychologically ready and willing

In exploring the patient's feelings, the social worker will be able to understand the patient's needs and motivations in perspective. It is evident that during this period the patient is overwhelmed with a variety of emotions, because of the treatment. If the patient's emotions are not explored and attended to, they could find themselves with emotional problems that will affect adherence. Exploration of these feelings will assist the patient to identify them and deal with them.

Friedland (2003:35) broadly defined motivation as including all variables that encourage or discourage adherence. These might include attitudes and beliefs with respect to HIV treatment and a specific medication, social support, trust in the physician, the patient's psychological status, and the presence of competing priorities in the patient's life.

The researcher further identifies with Meyer, Moore and Viljoen, (2003:296) view on motivation: "Instead of attributing motivation to specific motives or drives, the social cognitive learning theorist regards motivation - as the result of two processes, namely interaction and learning. Their basic idea here is that individuals are not motivated only by specific intrapersonal drives, nor are they motivated only by external stimuli. They are motivated by the interaction between individual and situation".

By helping patients develop behaviour-change goals, the social worker can enhance adherence to ART through motivational training, which refers to inducing a state of readiness to adhere." (Taylor, 2003:479). The researcher believes that motivation is a very strong determent for adherence.

The researcher is of the opinion that the patient's needs are a strong determinant of adherence. The researcher is further of the opinion that Maslow's hierarchy of needs, as described in Louw, van Ede & Louw (1998:68) is very applicable to HIV/AIDS patients. That is, if the basic needs such as hunger, thirst, sex and the maintenance of the internal state of the body are not

fulfilled, respondents will not be aware of higher psychological needs, such as emotional needs.

5.4.2.3   Social dimension

The social environment refers to the quality and characteristics of one's life situation, including interpersonal relationships, resources for meeting one's needs and one's position, roles and participation in the society. Social institutions or social systems denote the economy, politics, the family, education, health care, transportation and religion, functioning in social roles. According to (Cowles, 2000:11) including attitudes, feelings, values, beliefs, behaviour, mental and physical health status, it constitutes the person-in-environment perspective.

Engel (1980:543) points out that in using the biopsychosocial model, the medical practitioner is able to identify and evaluate the stabilising and destabilising potential of events and relationships in the patient's social environment. Furthermore, neglecting the destabilising effects of the patient's illness on others may rebound as a further destabilising influence on the patient. This argument emphasises the importance of the patient's social environment as regards his/her health and illness. This is an indication of the need to belong in a social and familial sense and to be accepted and affiliated to others, and could include the need to reach self-fulfilment.

Kaplan, *et al.*, (1994:1) also argue that the social dimension emphasises the cultural, environmental and familial influences on the expression and the experience of illness. It is important to note that these social aspects of the person's life not only affect mental health but also health in general, which illustrates the important role played by the social system in as far as an individual's health and mental health is concerned.

Patients diagnosed with life-threatening diseases are usually smothered with sympathy and support, yet the diagnosis of HIV/AIDS is often characterised by stigmatisation, subsequently social rejection and emotional isolation. This

stigmatisation reminds us of the rejection that met a person diagnosed with leprosy in the biblical period (Holy Bible: Luke 17:12 and Leviticus 13).

Adherence to therapies has been shown to be influenced by behavioural difficulties such as substance abuse (e.g. alcohol and mood-altering drugs) and social isolation. In her experience the researcher has found that the following social/environmental matters could affect adherence positively or negatively.

- Accommodation: housing, rural/urban, prisoners
- Substance abuse: alcohol/drugs abuse,
- Relationships: familial, support systems, marital status, sexual matters, disclosure
- Rape and incest
- Social stability
- Social occasions
- Literacy; knowledge/education,
- Socio-economic status: financial circumstances, employment/pension/ income, poverty
- Nutrition
- Ethnics, cultural traditions and religious beliefs
- Transport

Healthcare providers must achieve a level of cultural competence in their practice, to be able to develop adherence intervention strategies that take into account cultural differences between clients. Cultural competency addresses the ability to recognise, understand, and be sensitive to ethnic and lifestyle differences. Cultural diversity influences perceptions of illness and wellness as well as of healing beliefs and practices. Understanding these variations is critical to developing culturally competent HIV treatment and care.

Ross and Deverell (2004:16) are of the opinion that cultural considerations definitely affect whether members of a population choose to participate in prevention campaigns and whether they choose to believe, internalise and

accept the messages propagated by such campaigns as adhering to antiretroviral treatment.

As defined by Leininger (1978), culture refers to patterns of learned behaviours and values which are shared among members of a designated group and are usually transmitted to others of their group through time." Culture includes, but is not limited to geographic origin, language, traditions, values, religion, food preferences, communication, education, and lifestyle. Cultures consist not only of racial and ethnic groups but also of groups of individuals who share common lifestyles.

The researcher is of the opinion that traditional beliefs and values should be taken into account regarding adherence, as culture has been identified by various sources as one of the primary barriers to preventing the spread of HIV/AIDS. Culture and specific cultural beliefs, values and traditions could also influence treatment and adherence to therapy (Friedland, 2002:35-40).

The social elaboration of HIV/AIDS and poverty is endorsed by Mashologu-Kuse (2005:378) as well as Strydom, Cronje, Roux, Strydom, and Wessels (2005:68), confirming that poverty and the high level of unemployment, coupled with families being headed by women, no support from their partners, leading to almost total dependency on child support grants, are an indication of the plight of disadvantaged families. The researcher endorses this view and also the view of Abdool Karim and Abdool Karim (2005:381) that whilst there is a general relationship between poverty and poor health, there is also a specific relationship between HIV and poverty.

Friedland (2002:37) postulates that social isolation predicts poor adherence levels and he therefore encourages patients to have supportive family members accompany them to clinic visits. Regarding adherence and age, Friedland (2002:35-40), also states the following: "With regard to patient related characteristics, the literature in the developed world indicates that age and race consistently predict adherence. Older adults are likely to be more adherent. In the USA studies have found that the black race and people with low literacy

levels are associated with poorer adherence. Whether this finding will hold in Africa remains undetermined".

To disclose HIV status in an effort to obtain adherence support is another matter of concern. Disclosure appears to be used as a form of punishment rather than a mechanism to provide such support (Venter, 2005:22). The researcher is of the opinion that disclosure cannot be forced, as this would go against the individual's right to privacy and confidentiality, as well as the basic social work principles, such as actualising. The social worker's role here is to assess patients regarding disclosure or not and refers to alternative support and networking.

It is therefore clear that the biopsychosocial model, which takes into account all three dimensions of a person, is appropriate when assessing and monitoring HIV/AIDS patients on ART, to ensure that all the aspects pertaining to the patient's condition are considered. This model enables the service providers to understand their patients, which leads to designing an appropriate treatment plan that is responsive to the needs of the latter, specifically the AIDS patients on ARV. If a provider has a significant bias that could potentially affect the helping relationship, another team member may need to intervene Saloner (2004:41).

It is clear that HIV/AIDS patients are struggling to adapt to the confusion and conflict of being cast in the "sick/not sick" role. Unfortunately, the recognition of the life paradox of such persons is only the beginning. Neither the healthcare team nor the patients themselves can, by individual effort, hasten the tedious process of assimilating this new role, produced by chemicals, into the social order: we are still mapping behaviour topography, emotional currents and role boundaries. Social frameworks must become restructured in order to accommodate millions of HIV/AIDS people living on ART. A task shared by health team, professionals, family and the community as a whole.

The researcher consequently proposes an adherence assessment schedule, **(Appendix 7)** to be used as a standard tool, in assessing the patient's

circumstances as discussed above. The schedule makes provision for assessment of all three dimensions of the Biopsychosocial model. The schedule was introduced to other professions supporting adherence. The said schedule has been successfully implemented by the researcher, in assessing HIV/AIDS patients for ART, at the ARV clinic, Tshwane District hospital. Specifically, lay counsellors, with no formal training and little experience, found the schedule to be extremely helpful. If a problem which they cannot address is identified by the counsellors, a referral to an appropriate service providers or multidisciplinary team member is done.

5.5   Summary

If the social work profession could have fabricated a condition, imposing on all aspects of human functioning, to challenge and test social workers' service delivery regarding knowledge and skills; goals and roles; norms and values; characteristics and principals – on individuals, groups or communities - it would have been called HIV/AIDS – and seemed rather far fetched…

In the following chapter the researcher will offer a brief discussion of the research methodology and the research findings, which are presented according to the subsections in the questionnaire used for the quantitative part of the study, in terms of the biographical, medical and psychosocial data. The qualitative part of the study is presented throughout the discussion wherever applicable, including the narrative relating to the themes and sub-themes.