HEALTH CAREGIVERS' APPROACH TOWARDS THE REHABILITATION OF HIV AND AIDS PERSONS IN uMHLATHUZE

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HEALTH CAREGIVERS' APPROACH TOWARDS THE REHABILITATION OF HIV AND AIDS PERSONS IN uMHLATHUZE

by

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DECLARATION

I, Cobham, Esien Ikpeme, declare that this research study "**Health Caregivers Approach towards the rehabilitation of HIV and AIDS persons in uMhlathuze"** is my own work and that all sources used have been indicated and appropriately acknowledged by means of complete references.

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Cobham, Esien Ikpeme

DEDICATION

This work is dedicated to God Almighty who through His Son Jesus Christ, I am what I am today. And to all service providers; especially health caregivers who are directly involved in the holistic management of HIV and AIDS persons.

ACKNOWLEDGMENT

I sincerely acknowledge my supervisor, Dr. N.H. Ntombela for her meticulous and intelligent guidance, and support all through this work. Thank you and God Bless.

To my parents and siblings, you are the best anyone could ever wish for. Thank you for your love, prayers and support showered on me. God Bless us all. Amen.

To all my friends, loved ones, relatives, colleagues (who are my superiors in the Department of Social Work), spiritual families both in Nigeria and South Africa, I say Thank You to everyone for making an impact in my life, one way or the other. May God Almighty bless, replenish and up-lift each and everyone accordingly in Jesus name, Amen.

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God Bless.

Cobham, Esien Ikpeme.

TABLE OF CONTENTS

CHAPTER TWO

THEORETICAL FRAMEWORK

CHAPTER THREE

LITERATURE REVIEW

CHAPTER FOUR

RESEARCH METHODOLOGY

CHAPTER FIVE

DATA ANALYSIS AND INTERPRETATION

CHAPTER SIX

SUMMARY OF FINDINGS, RECOMMENDATIONS AND CONCLUSION

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

This study examined health caregivers' approach towards the rehabilitation of HIV and AIDS persons in uMhlathuze, from a social work perspective. The study was necessitated in a bid to know the efficacy of the approaches used in rehabilitating HIV and AIDS persons. In generating data for the study, the descriptive method was utilised to gather data through the administration of the questionnaire and interview schedule. A sample of 50 respondents was drawn from three health centres, namely: Ngwelezana Hospital, Richards Bay Clinic and eNseleni Community Health centre, for the questionnaire method. While the interview schedule was administered on 15 respondents on a face-to-face interview, who were also a part of the 50 respondents that answered the questionnaire: 3 respondents from Richards Bay, 6 from eNseleni CHC and 6 from Ngwelezana Hospital.

A hypothesis was formulated and tested. The result showed among others, that approaches utilised by health professionals have fared successfully in rehabilitating HIV and AIDS infected persons. The set objectives for the study were also achieved. It is recommended that effort be made towards the overhauling of equipment, facilities and man-power, in the rehabilitation process.

CHAPTER ONE

ORIENTATION OF THE STUDY

1.1 INTRODUCTION

The Human Immunodeficiency Virus (HIV) is a retrovirus that belongs to the sub-family lentivirinae, having two distinct types, HIV-1 (divided into Group M (10 subtypes), Group O (9 subtypes) and Group N (new virus), and HIV-2 (6 (A-F) subtypes), are the aetiologic agents of AIDS. It is a lymphocytotropic and neurotropic virus, which means it can be found in almost all body fluids and organs such as semen, vaginal and cervical secretions and blood. The exchange of these body fluids with an HIV infected individual can lead to transmission of HIV to another person (Baveja & Rewari, 2005:6).

HIV-1 is more easily transmissible than HIV-2 and contributes more heavily to the global pandemic, which pose substantial technical problems for vaccine development (Ramamurthy, 2004:27). HIV infects the body's immune system in particular cells called T lymphocytes (T cells) which protect against infection and other threat, as it "kills the infected and uninfected cells by several mechanisms and leads to depletion of CD4 cells" (Baveja & Rewari, 2005:24). With this depletion, opportunistic infections arise such as tuberculosis, meningitis, et cetera, and "the progression from seroconversion to the development of AIDS" (Baveja & Rewari, 2005:59).

Acquired Immunodeficiency Syndrome (AIDS) refers to a clinical definition where an individual's immune system has become progressively weak (Ramamurthy, 2004:27). AIDS was first reported in 1981 in San Francisco

and New York on account of clustering of diseases Pneumoystis Carinii Pneumonia and Kaposi's Sarcoma, amongst young, otherwise healthy adult homosexuals (Baveja & Rewari, 2005:16).

Invariably, HIV is a precipitating factor that leads to AIDS, which "is a contagious, presently incurable disease that destroys the body's immune system. It is caused by HIV which is transmitted from one person to another primarily during sexual contact or through the sharing of intravenous drug needles and syringes" (Zastrow, 2008:487). As "infection with HIV irrespective of type (HIV-1 or HIV-2), subtype and route of infection leads to protracted disease and depletion of CD4 cells in most cases resulting in AIDS" (Baveja & Rewari, 2005:31). The length of time between initial infection of HIV and the appearance of AIDS symptoms is called the incubation period for the virus (Zastrow, 2008:489).

According to Mattheyse in a TB-HIV fact sheet of the South African Medical Research Council (MRC), (2007), in measuring the extent of the HIV and AIDS epidemic, prevalence and incidence are terms frequently used. Accordingly, prevalent cases has been defined as the people who are infected at a particular time, which include, people who have been infected for some time, as well as those who are newly infected. While incident cases are the newly infected people only. In other words, prevalence gives the total number of all cases up till now (less those who have died), whereas incidence tells us how many recent infections have occurred.

The explosive spread of HIV and AIDS is known to have been caused by many factors such as migration; along with urbanisation is also related to the

socio-economic condition of the population where a large scale of the reproductive age group from backward areas migrate to more advanced states in search of employment (Baveja & Rewari, 2005:11).

Violence against women; in settings where violence is regarded as a man's right, women are in a poor position to question their husbands about their extramarital encounters, negotiate condom use or refuse to have sex (Baveja & Rewari, 2005:10).

Better educated people generally have greater access to information than those who are illiterate or uneducated, and they are more likely to make well informed decisions and act accordingly. They generally have better employment and greater access to money and other resources, which can help support healthier life styles (Baveja & Rewari, 2005:9).

The then President Thabo Mbeki at the opening of the 13th International AIDS Conference in Durban, South Africa, June 2000, suggested that the "cause of AIDS is extreme poverty" (Poku, 2005:3), although Mbeki's 'temerity' was not acceptable, it does not rule out the fact that poverty has led many into undesirable activities, as insecure livelihoods, and lack of social protection can increase the likelihood of risky behaviour and undermine capacities to cope with the consequences of infection, creating downward spirals in both vulnerabilities of infection and its consequences (Ramamurthy, 2004:29).

Gender inequality is another factor which makes women and girls particularly vulnerable because they are often compromised in their ability

to negotiate safe sex or to ward-off unwanted sexual attention (Ramamurthy, 2004:28).

Marginalisation is described as the process whereby groups or often entire populations are forced beyond or on the periphery of the social and economic mainstream (White Paper for Social Welfare, chapter 8, section 1:62), groups who are made to live on the margins of society exist in every country although they differ from place to place, and what marginalised groups have in common is an increased vulnerability to HIV (Baveja & Rewari, 2005:10).

Mother to child transmission (MTCT) is yet another risk of transmission from an HIV infected pregnant mother to her baby having been reported to be between 21 and 43%, where various maternal and fetal risk determinants have been reported which play a major role in Mother To Child Transmission of HIV (Baveja & Rewari, 2005:9), as HIV is retrovirus transmitted primarily through sexual intercourse, but also through infected blood and from mother to newborn child (Poku, 2005:52).

This is to mention but a few of such factors, with the resultant effect being the high rate of persons infected and affected by the HIV and AIDS pandemic, “which respects no territorial boundaries, cast, creed, religion or age” (Baveja & Rewari, 2005:1).

Since the discovery of HIV and AIDS, human existence globally, especially in the third world or developing countries have been threatened. As earlier mentioned, from 1981 when this pandemic was first observed among

homosexuals in the United States of America, it posed devastating effect on the socio-economic and man-power development of all nations of the world. “Across the African continent, HIV and AIDS is savagely cutting life expectancy, which is now about twenty less than it would have been without the epidemic, and below forty years in some countries” (Poku, 2005: 51).

1.2 STATEMENT OF THE PROBLEM

According to Spence 1999 in (Parkhurst and Lush 2004:1915), “South Africa similarly saw a radical change to democracy in 1994 with the ascendance of the African National Congress (ANC) under Nelson Mandela and the end of the Apartheid regime.” And about this time of transition from the Apartheid era to democratic rule, the country witnessed “an explosive HIV epidemic with advanced spread of the disease into the general population” (Parkhurst and Lush, 2004: 1915).

With the insurgence of HIV and AIDS, no known scientific attempts at its cure have been successful, which are the greatest challenges facing the health sector, government, policy makers, et cetera, on the way forward in the management of this deadly disease. In an interview with the author NKOSI’S STORY, Dr. Glenda Gray, Director of Peri-Natal HIV Research Unit at Chris Hani Baragwanath Hospital, said “By the time Mandela came out of prison in 1990, we were looking at rates of about three infected women to out of every hundred tested. Now in 2000 we are looking at thirty in every hundred. When you see an increase like that its obvious that no one knows what to do about the epidemic and no one is putting their weight behind it. Its not difficult to control the epidemic, but it takes consistent and solid and good messages” (Fox, 2002:284).

Much has been said and done about this dreaded disease, as it not only affects the infected but also the uninfected, to the extent that according to Walsh et al (2002:107) in (Francis & Rimensberger 2005:87), “the youth of South Africa have been exposed to a fair amount of HIV and AIDS information, so much so, that a general apathy or fatigue in relation to the subject have been recognised,”. In all human sphere one can think of or imagine it appears the issue of HIV and AIDS has been dealt with either squarely, or partially, and yet despite all measures put in place, the rate of HIV and AIDS is on the increase and one is made to wonder, is the increase a case of more infected persons, or a case of more awareness which causes much more people to go for testing?

Also according to Walsh et al (2002:107) in (Francis & Rimensberger 2005:87), while the youth are being exposed to information about HIV and AIDS, they are also receiving messages from the mainstream media about sex and sexuality. Such messages are mediated via youth culture, such as television, magazines, advertising and popular literature. They are sometimes in conflict with the ABC approach (abstain, be faithful, condomise) of conventional AIDS prevention messages. Likewise, according to the South African Medical Research Council 2001, “most AIDS deaths affect adults”, but much of its impact is felt by children who experience the deaths of their parents, other family members, educators and their peers at an increasing rate (Maile, 2003:186).

Against this backdrop, the interest of the researcher is kindled towards understanding the approaches being employed in rehabilitating the HIV and AIDS persons, in the absence of curative and non-effective preventive

medicine, as stated by Campbell (2003:7), "the forces shaping sexual behaviour and sexual health are far more complex than individual rational decisions based on simple factual knowledge about health risks, and the availability of medical services" (Francis & Rimensberger, 2005:87).

1.3 MOTIVATION OF THE STUDY

The explosive rate of the spread of HIV and AIDS across Africa has created one of the greatest crises of modern times (Parkhurst and Lush, 2004:1913). "The world would hardly notice if Africa's entire economy disappeared overnight…" because the combined economic output of the 45 sub-Saharan African countries, including South Africa, is about the same as Argentina's" (Udonwa, Ekpo, Ekanem, Inem, and Etokidem, 2004: 273). Owing to HIV and AIDS, many countries across Africa are now witnessing deterioration in child-survival rates, reduced life expectancy, and crumbling and low over-burdened health systems and fragmenting socio-cultural coping networks, (Poku, 2005:51).

According to a mid-term research report by The International Institute for Child Rights and Development (IICRD 2003), and The Child and Youth Care Agency for Development (CYCAD 2003), "the world is currently witnessing one of the greatest human calamities of all times in the HIV and AIDS pandemic. The disease has cut the largest and the deepest human swathe across the countries of sub-Saharan Africa, where the majority of the 40 million persons now infected by the HIV and AIDS can be found. South Africa is currently experiencing the crushing burden of having the highest number of persons living with AIDS of any country in the world" (IICRD and CYCAD, 2003:3).

A report based on the current estimates of HIV and AIDS on South Africa, according to the then Health Minister, Dr. Manto Tshabalala-Msimang (SABC News at 7.00hrs pm of Monday, 25th August, 2008), "South Africa's HIV and AIDS prevalence rate for 2008 has risen to 29%, as against 23% of 2007". Considering the governments' huge expenditure on treatment, prevention and control of spread, et cetera, it is disheartening to note that HIV and AIDS in South Africa are still on the increase. As asserted by Love Life (2004), South Africa has the highest rate of HIV infection in the world: one in two adolescents is likely to become infected. (Francis & Rimensberger, 2005:87). Likewise, among the provinces of South Africa, KwaZulu-Natal is recorded as having the highest prevalence (Williams et al. 2000:129).

The researcher was motivated to carry out this study based on the increased rate of HIV and AIDS in the KwaZulu-Natal province, which poses a challenge to not just the health care givers, the infected, the affected, the community, the government, the economy, but also a threat to the future generation. Despite the wide publicity being made on the HIV and AIDS pandemic, much more people get to be tested positive while those who are already carriers receive insufficient, inadequate, or no treatment at all, due to either their financial incapacitation, fear of stigmatisation or the careless notion that one will die anyway.

Based on this, and from studies that lay much emphasis on care and support of HIV and AIDS persons, the researcher's interest was veered towards understanding the approaches employed by health care givers, in health

settings, in fostering the holistic and reintegration of HIV and AIDS persons, through rehabilitation, back into the mainstream of the society.

For this study, the researcher was concerned with health care givers' approach towards HIV and AIDS persons in service delivery (this does not down-play the importance and relevance of family members as well as significant others in the management of HIV and AIDS persons, as they all play very relevant roles towards this venture). But for the purpose of the study, focus was on health caregivers in health settings, considered to be medical doctors, nurses, social workers, dieticians, lay-counsellors, physiotherapists, et cetera. Based on this, three health centres within the uMhlathuze municipality were selected for this study; these were the Richards Bay Clinic, eNseleni Community Health Centre and Ngwelezana Hospital.

1.4 RESEARCH QUESTIONS

The questions to be answered in this research are as follows:

1. What are the approaches used by health care givers in the rehabilitation of HIV and AIDS persons in health settings, in the uMhlathuze municipality?

2. What forms of rehabilitative measures have been employed or initiated towards HIV and AIDS persons?

3. What factors have negated the successful rehabilitation of HIV and AIDS persons in health settings, in the uMhlathuze municipality?

1.5 RESEARCH OBJECTIVES

Based on the high prevalent rate of HIV/AIDS in South Africa, this research posed to achieve the following objectives with focus on recent experiences:

1. To examine the actual cases of HIV and AIDS attended to by health caregivers in selected health settings, in the uMhlathuze municipality, between the years 2007-2008;

2. To identify the various specific approaches employed by health caregivers in health settings, in the uMhlathuze municipality towards the rehabilitation of HIV and AIDS persons they attend to;

3. To evaluate the successes and failures of each approach employed by health care givers in the rehabilitation of infected persons within the study area, and

4. To stimulate more researching on HIV and AIDS especially in the area of rehabilitation.

1.6 RESEARCH HYPOTHESIS

A hypothesis was formulated based on the objectives for this study. The hypothesis for this study states that: There is a significant relationship between health caregiver's approach and the success or failure of rehabilitation of HIV and AIDS persons.

1.7 DEFINITION OF CONCEPTS

Conceptualisation is the process by which we specify what we mean when we use particular terms in research, which produces a specific agreed-on meaning for a concept for the purposes of research (Babbie, 2010:130-131 forthcoming). By this definition of concept, terms used as applicable to this study are considered for clarification.

1.7.1 Health

Health is the state of complete physical, mental, and social well-being and, according to the *World Health Organization* (WHO), not merely the absence of disease or infirmity (Barker 1999:210-211).

1.7.2 Health Care

Health care is the set of services provided by a country or an organisation for the treatment of the physically or mentally ill (Cambridge Advanced Dictionary 2003:580). Activities designed to treat, prevent, and detect physical and mental disorders and to enhance people's physical and psychosocial well-being. The health care system includes personnel who provide the needed services (physicians, nurses, hospital attendants, medical social workers, and so on); facilities where such services are rendered (hospitals, medical centers, nursing homes, hospices, outpatient clinics); laboratories and institutions for detection, research, and planning; educational and environmental facilities that help people prevent disease; and myriad other organisations and people involved in helping people to become more healthy, stay healthy, return to health, or minimize the consequences of ill health (Barker 1999:211).

1.7.3 Caregiver

A caregiver is one who provides for the physical, emotional, and social needs of another person, who often is dependent and cannot provide for his or her own needs. The term often applies to parents or parent surrogates, day care and nursery workers, health care specialists, and relatives caring for older people. The term also applies to all people who provide nurturance and emotional support to others, including spouses, clergy, and Social Workers (Barker 1999:61).

1.7.4 Approach

This is to deal with something; a way of considering something (Cambridge Dictionary 2003:53).

1.7.5 HIV and AIDS

HIV is defined as Human Immunodeficiency Virus, while AIDS is defined as Acquired Immunodeficiency Syndrome (Gehlert & Browne 2006:538).

The HIV and AIDS are two different but overlapping entities. HIV infects the body's immune system, in particular cells called T4 lymphocytes (T cells), which protect against infection and other threats. While AIDS is the most advanced stage of HIV infection and as defined by (CDC 2001), is a specific group of diseases or conditions that severely suppress the body's immune system (Gehlert & Browne 2006:539).

1.7.6 Rehabilitation

This is restoring to a healthy condition or useful capacity to the extent possible. Social workers usually use this term in the context of helping people who have been impaired through injury, disease or disfunction

(Okorie 2003:68). It is a complex process that depends on interprofessional working and is focused on the individual's goals (Davis 2006:ix).

1.7.7 Social Work

According to the *National Association of Social Workers (NASW*, 1973, pp.4-5), "Social Work is the professional activity of helping individuals, groups, or communities enhance or restore their capacity for social functioning and creating societal conditions favorable to this goal. Social Work practice consists of the professional application of Social Work values, principles, and techniques to one or more of the following ends: helping people obtain tangible services; providing counseling and psychotherapy with individuals, families, and groups; helping communities or groups provide or improve social and health services; and participating in relevant legislative processes. The practice of Social Work requires knowledge of human development and behaviour; of social, economic, and cultural institutions; and of the interaction of all these factors". Social Work is the applied science of helping people achieve an effective level of psychosocial functioning and effecting societal changes to enhance the well-being of all people (Barker 1999: 455).

1.7.8 Perspective

This is a particular way of considering something; to think about a situation or problem in a wise and reasonable way; to compare something to other things so that it can be accurately and fairly judged (Cambridge Dictionary 2003:925).

1.8 RESEARCH METHODOLOGY

This section gives an overview of the research design, target population, sample, as well as the research instruments that will be used in collecting data for the study. Research methodology is what makes social science scientific (Neuman 2003:68).

1.8.1 Research Design

The term research design refers to all of the decisions made about how a research study is to be conducted (Rubin & Babbie 2001:357). Consequently, Babbie (2010:92 forth-coming) states that "social research can serve many purposes. Three of the most common and useful purposes are exploration, description and explanation." For this study, the researcher utilised the descriptive research design. Descriptive, because it "is the precise measurement and reporting of the characteristics of some population or phenomenon under study (Babbie 2010:121 forth-coming). The study also adopted the qualitative and quantitative research methods. Qualitative research focuses on phenomena that occur in natural settings, it is also referred to as field research because it always takes place in the field or wherever the participants normally conduct their activities (Jackson 2008:88). Quantitative research collects and analyses data into numbers which when manipulated represents empirical facts in order to test an abstract hypothesis with variable constructs (Neuman 2003:440).

1.8.2 Population of the Study

A population is the theoretically specified aggregation of study elements (Neuman 2003:259). The population for a study is that group (usually of people) about whom we want to draw conclusions (Babbie 2010:116 forth-

coming), while a study population is that aggregation of elements from which the sample is actually selected (Babbie 2010:199 forth-coming). The study population is fully discussed in chapter four of the research methodology.

1.8.3 Sampling

Sample is seen as representing the subset of people from the population who actually participate in the study, as it is not feasible to survey the entire population (Jackson 2008:97). In choosing respondents for this study, the researcher used the nonprobability sampling procedure. Social work research is often conducted in situations in which it is not feasible to select the kinds of probability samples used in large-scale social surveys, which often make probability sampling impossible or inappropriate, while nonprobability sampling techniques are often more appropriate (Rubin & Babbie 2001:253). This is because non-probability sampling suggests “any technique in which samples are selected in some way not suggested by probability theory. Examples include reliance on available subjects as well as purposive (judgmental), quota, and snowball sampling” (Babbie 2010:192 forth-coming). For the purpose of this study, the purposive (judgmental) sampling was employed because units to be observed were selected on the basis of the researcher’s judgment about which ones would be the most useful or representative (Babbie 2010:193 forth-coming).

1.8.3.1 Sampling procedure

This is the process of selecting observations, although sampling can mean any procedure for selecting units of observation (Babbie 2010:188 forth-coming). Purposive (judgmental) sampling is a type of non-probability

sampling in which the units to be observed are selected on the basis of the researcher's judgment about which ones will be the most useful or representative (Babbie 2010:193 forth-coming). This study is purposive or judgmental because the researcher chose respondents that deal directly with HIV and AIDS persons, meaning not all doctors, nurses, et cetera, were considered for this study, only those health caregivers who are directly involved in the rehabilitation of HIV and AIDS cases.

1.8.4 Research Instruments

The research instruments employed for this study were the structured and unstructured questionnaire. Questions were open-ended and closed-ended, as well as conducting of personal interview (Jackson 2008:96). Due to the fact that respondents were educated, being learned persons from different fields of study, the researcher had no restrain conducting the research in the English language.

1.8.5 Procedure for Data Collection

Data for this study was collected through the use of questionnaires which were administered with the consent of respondents. A structured interview schedule was also used in obtaining data from at least one professional from each of the professional group, preferably the head of the unit, to ascertain the approaches adopted and the team spirit between each of these groups, as applied in each of the health centre under study.

1.8.6 Data Analysis and Interpretation

Qualitative research data are collected in a spontaneous and open-ended fashion, while the quantitative researcher typically starts with a hypothesis

for testing, observes and collects data, statistically analyses the data, and draws conclusion (Jackson 2008:88). Data obtained for this study is presented in simple tables and analysed using simple graphs and figures that are computerised for easy understanding.

1.9 SIGNIFICANCE OF THE STUDY

With the ever increasing interest in the study of HIV and AIDS globally and specifically in South Africa, most research primarily focuses on prevention, treatment and health promotive aspects of persons living with HIV and AIDS. This study is significant because it attempted to examine the various approaches adopted and used by health care-givers towards the rehabilitation of HIV and AIDS persons, in a bid to proffer positive solution(s), in the collective effort to fight against the HIV and AIDS pandemic. The issue on HIV and AIDS has caused a lot of fear, anxiety, nonchalance, confusion, etc, in the present times, as well as a lot of trepidation for the future in the absence of any meaningful cure towards this pandemic.

Therefore, data obtained for this study, would be of significant value to all health care-givers, policy makers, health care planners, researchers, scholars, non-governmental organisations and all who are variously concerned with the care of HIV and AIDS persons in South Africa particularly, and the world in general.

1.10 DISSEMINATION OF FINDINGS

The research findings would be disseminated accordingly where appropriate, and/or possibly published in welfare newsletters, social work journals,

government articles, presented in workshops, health clinics, as well as a copy being referred to the university's library.

1.11 ETHICAL CONSIDERATIONS

The researcher would be careful in being guided by the Code of Ethics of the Social Work Profession. Consent of respondents was formally obtained for the participation in this study, while confidentiality, professionalism and good conduct was the watch word. The researcher ensured the complete anonymity of respondents, as well as maintaining the rights and dignity of the respondents. All information obtained were treated with utmost discretion.

1.12 PRESENTATION OF THE STUDY

This research report comprises six chapters which are as follows:

Chapter 1

This is the introductory chapter that gives an orientation to the study, the motivation for the study, statement of the problem that was researched, the objectives of the study, as well as a general outlay of the entire report.

Chapter 2

Captures the theoretical framework used for the study, and as applicable to the subject under review.

Chapter 3

Reviews literature on rehabilitation and its applicability to HIV and AIDS situation, which enables us appreciate the efforts in the fight against this

pandemic, as well as the role of social work in rehabilitation of HIV and AIDS persons.

Chapter 4

This chapter discusses the research methodology and design of the study, the instrument design and validation, brief profile of the area, sampling technique, as well as the plan of the organisation and data analysis.

Chapter 5

The chapter focuses on the interpretation of the data gotten from the field; presenting the actual field work, administration of the instrument, data presentation and results of the findings of the study.

Chapter 6

This chapter presents a summary of the findings, recommendations, suggestions for future study and conclusions.

SUMMARY

This chapter has given an over-view to the study. Although the study is on HIV and AIDS which has eaten into every sphere of the human existence, it is also broad in nature because of the number of studies carried out on it, and covers virtually every sphere of life as it affects and infects humanity, thus having progressed from a state of being an epidemic, to that of being pandemic. The study's focus is on rehabilitation and its relevance to the management of HIV and AIDS persons, bearing in mind the alarming rate of its spread, causes and consequences, fears, the lack of medicine to bring about its possible eradication, et cetera.

CHAPTER TWO

THEORETICAL FRAMEWORK

2.1 INTRODUCTION

Theory, according to Kerlinger (1986:9) in (Gehlert & Browne 2006:180), is defined as "a set of interrelated constructs, definitions, and propositions that present a systematic view of phenomena by specifying relations among variables, with the purpose of explaining and predicting the phenomena". Accordingly, theories are systematic sets of interrelated statements intended to explain some aspect of social life (Babbie, 2010:44 forth-coming). Social Theory on the other hand, is defined as a system of interconnected abstractions or ideas that condenses and organises knowledge about the social world (Neuman, 2003:42).

The knowledge base of Social Work is vast and constantly growing, and so in this regard, some approaches to Social Work theory and practice shall be considered, with significant focus on Social Work practice in health settings. Considering the focus of this study, HIV and AIDS in relation to rehabilitation, theories to be considered are based on health behaviour.

"Theories of health behaviour have the potential to order the panoply of constructs with which health social workers are faced and provide a conceptual framework that assists in understanding why people behave as they do in terms of their health. These theories provide direction for the helping process and structure for research; they allow us to unite practice and research by providing a shared language for discussing clinical realities" (Gehlert & Browne 2006:179). The theoretical approaches for consideration

here are the Rational Choice-based Theoretical Approaches and the Social Network-based Theoretical Approaches.

2.2 RATIONAL CHOICE-BASED THEORETICAL APPROACHES

This theory holds that human behaviour stems from rational, logical thought processes, as people make choices based on consideration of the costs and benefits of various actions. The theory has two major types, namely the Health Belief Model and the Theory of Reasoned Action, under the theory of Reasoned Action is the Theory of Planned Behaviour (Gehlert & Browne 2006:182).

2.2.1 The Health Belief Model

The Health Belief Model was originally developed to explain why people failed to participate in health screening for tuberculosis, despite accommodations such as mobile vans that came into neighbourhoods (Gehlert & Browne 2006:183). Given this view one can understand why despite information on HIV and AIDS, the rate of the infected is still on the increase.

This model posits two major components of health behaviour, which are the threat and outcome expectations. The threat is the perceived susceptibility to an ill-health condition and the perceived seriousness of that condition. For example, like in the case of risk for acquiring AIDS, the threat would entail believing that one was susceptible to acquiring AIDS and that it was as serious as the medical community portrayed it to be. Outcome expectation: being the perceived benefits of a specified action, such as the use of condoms to prevent the HIV transmission, and the perceived barriers to

taking that action; the benefit of taking action to reduce risk of acquiring AIDS might be staying alive, whereas barriers might be the cost of buying condoms or fear that one will be rejected after asking a partner to use them. This model has been used with a variety of health behaviours and conditions, example, in a study, by Kelly, Mamon, & Scott 1987, in (Gehlert & Browne 2006:183), medication compliance among psychiatric out-patients. As applied to this study, the theory is only relevant to an individual engaging in behaviours which carry a high risk for HIV transmission, such as, commercial sex workers, and exposure through injection-drug users (Ramamurthy 2004:20).

2.2.2 The Theory of Reasoned Action

The Theory of Reasoned Action extends the Health Belief Model to include the influences of significant others in the environment on individual health behaviour. This theory assumes that behaviour is immediately determined by bahavioural intention, which in turn determines a person's attitude toward the behaviour and the influence of significant others in the environment, or social norm. Attitude towards the behaviour consists of (1) an individual's belief that if behaviour is preformed, a given outcome will accrue and (2) how important the individual considers the outcome to be.

This theory has been applied to many health behaviours and conditions, such as, Beck 1981 in his study on substance abuse, Baker 1988 in his study on contraception decision making, and Jemmott, Jemmott, & Fong 1992 in their study on AIDS risk behaviour, as cited in (Gehlert & Browne 2006:184 - 185). As applied to this study, due to the fear, stigma and denial attached to the HIV and AIDS disease, an infected person may be reluctant in disclosing

his/her status because of the perception of family members, the community, as well as the general society (Baveja & Rewari 2004:10), in avoidance of being ostracised. A case of 36-year-old Gugu Dlamini who was stoned and stabbed to death in 1998, by members of her community after disclosing her status on a radio programme (AIDS Guide 2009:84). Although the AIDS stigma appears to be declining in South Africa (HIV & AIDS Strategic Plan 2007-2011:34).

2.2.3 The Theory of Planned Behaviour

The Theory of Reasoned Action was extended to include the perceived control over behaviour. The idea being that intention alone could not predict behaviour if the behaviour was one over which the individual did not have complete control. In other words, a person, for example, who has been unsuccessful at losing weight and has demonstrated a poor control over behaviour, is unlikely to execute it no matter how strong the intentions.

This theory has been widely used to predict behaviours as diverse as the administration of opioids for pain relief by nurses, in a study by Edwards et al 2001, fighting by adolescents, in a study by Jemmott, Jemmott, Hines, & Fong 2001, et cetera, (Gehlert & Browne 2006:185). By the Theory of Planned Behaviour, behaviours are better predicted by the combination of intentions and perceived behavioural control than by intentions alone. As applied to this study, individual's persistence in engaging in high risk behaviour that favours HIV transmission may be due to poverty, while the intention of disengaging from such behaviours may be fruitless in the face of poverty (Baveja & Rewari 2004:11). Although according to Campbell (2003:7) in (Francis & Rimensberger 2005:87), "the forces shaping sexual

behaviour and sexual health are far more complex than individual rational decisions based on simple factual knowledge about health risks, and the availability of medical services". Having access to HIV and AIDS prevention information does not necessarily bring about behaviour change.

2. 3 SOCIAL NETWORK-BASED THEORETICAL APPROACHES

The Social Network-Based Theoretical Approaches was introduced as the Rational Choice-Based Theoretical Approaches did not adequately take into account environmental influences on behaviour. The Health Belief Model, Theory of Reasoned Action and Theory of Planned Behaviour have been criticised as being entirely intrapersonal by failing to acknowledge influences on health behaviour outside the individual's immediate environment.

Based on this, the Social Network-Based Theoretical Approaches, according to Tilly 1984 in (Gehlert & Browne 2006:186), shifts emphasis from the individual mental events to include social relationships, by recognising the social nature of individuals. With this shift, the influence of culture on health behaviour is portrayed. Two approaches are considered under the Social Network-Based Theoretical Approaches, which are the Social Action Theory, by Ewalt 1991, and Behavioural Model of Health Services Use, by Anderson 1968, 1995 as cited in (Gehlert & Browne 2006:186).

2.3.1 Social Action Theory

This theory according to Ewalt 1991 in (Gehlert & Browne 2006:187), represents a marriage of psychological and public health models and principles. The prevailing model in public health is a three-way interaction

between host, agent, and environment. Whereas Rational Choice-based Approaches are concerned exclusively with the host, Social Action Theory encourages a social-contextual analysis of personal change by suggesting pathways by which social and environmental factors influence cognitive processes.

This model contains three dimensions which are self-regulation as a desired action state, a system of interrelated change mechanisms and larger environmental systems that contextually determine how personal change mechanisms operate. The health routines and habits that ensue are entwined with those of others, and how these relationships develop has the potential to either promote or inhibit the goals of individuals or the prescriptions of health providers. For example, a recommended change in the diet of a child with diabetes would require a parent to shop for and prepare different foods or serve two separate meals to the family. This example is very good when considering the nutrition of HIV and AIDS persons, as health decisions are viewed as being embedded in the social network (Gehlert & Browne 2006:187).

By the application of this model, rehabilitating HIV and AIDS persons would be plausible as it would bring about high relationship closeness, favourable attitudes toward condom use, high self-esteem especially in women, as well as improving sexual responsibility especially in men (Gehlert & Browne 2006:188). The process of understanding human tragedy, either individual or collective, invariably occurs within a particular hermeneutic context, which normally provides the appropriate frames of reference for coming to terms with the causes of suffering, in that the

wisdom of a community usually provides both the resources (spiritual, moral, and psychological), as well as the appropriate support structures to help throughout the period of suffering and grief. Even when threatened by the certainty of death, as long as human suffering and death can be explained in a "language" that somehow makes sense, the chances are that one would find the strength to accept whatever fate life may have in store (Cloete 2007:54).

2.3.2. The Behavioural Model of Health Services Use

The Behavioural Model of Health Services Use differs somewhat from the approaches outlined previously in its emphasis on health services use and the outcome of health behaviour. It considers a bigger picture of the influences on health behaviour, such as aspects of the health-care system. This model has gone through three phases since its development in the 1960s as postulated by Anderson 1968, 1995 and Gelberg, Anderson, & Leake, 2000 (Gehlert & Browne 2006:188).

The original model divided determinants of health service use into three groups of variables: predisposing, enabling, and need. Predisposing were variables such as demographic factors and health beliefs and attitudes that influenced an individual's use of health services. Enabling factors included insurance coverage, social support, and family income. Need variables usually included perceived and objectively determined health problems.

The model's second phase by Aday & Anderson 1974 saw predisposing, enabling, and need variables subsumed under the category of population characteristics and the addition of a category of variables, the health-care system, which included policy and resources and organisation of the health-

care system. Consumer satisfaction was included as an outcome of the use of health services. The third phase by Anderson, Davis, & Ganz 1994 brought the addition of the external environment to an expanded category of determinants of health behaviour (Gehlert & Browne 206:188). The use of health services was no longer the end point of the model but was subsumed with personal health practice, under a new category entitled health behaviour (Gehlert & Browne 2006:189).

The Behavioural Model of Health Services Use has been considered for this study because it operates on a broader scope, by not only considering such factors as health beliefs and attitudes that influences an individual's personal health practice but also is interested in significant others, such as insurance coverage, social support, family income, policies, et cetera, one of which is the social disability grant.

SUMMARY

Both the Rational Choice-based Theoretical Approaches and the Social Network-based Theoretical Approaches have been applied to this study by the researcher because both approaches are all embracing and applicable in the total rehabilitation of persons living with HIV and AIDS, as it deals with not only the intrapersonal, but also the interpersonal environment, and the significant others.

CHAPTER THREE

LITERATURE REVIEW

3.1 INTRODUCTION

The trauma of HIV and AIDS is now quite palpable as more men have been killed by the disease than the total casualties of both the world wars taken together. By the end of the 20th century, well over ten million children had been rendered orphans by this disease. The problems encountered by orphans and generally persons suffering from this pandemic are not only of medical nature, but also have associated social and emotional aspects that demand compelling attention and appropriate intervention. The non-acceptance and social discrimination of such persons requires a compaction of medical, social, educational and emotional rehabilitation (Verma, Singh, & Bishmoi 2006:396).

Many families are having fewer children and as more young people migrate from rural to urban area, and from poorer to richer countries, they may not be available to provide care. As women who have traditionally been the givers of care, are pulled into the paid labour force by economic necessity or personal desire, they may be unable to continue providing those services. Their roles are changing in many societies and as they do, questions arise more often as to whether they can be fairly expected to sacrifice their own education and ambition to become caregivers (WHO 2002:1).

As so far no effective treatment exists, and patient's suppressed immune systems make them vulnerable to dying from infections not typically deadly

among young individuals, such as pneumonia, “the obligation of caring for the vulnerable population can not rest on the family alone (WHO 2002:1).

Consequently, according to the Joint United Nations Programme on HIV and AIDS (UNAIDS 2004), at least 20 million people worldwide have died from AIDS since the very first case was reported fewer than 25 years ago. The devastation is enormous, particularly in Southern Africa. In 2003 alone, 2.2 million people in Southern Africa died of AIDS. New, potent antiretroviral AIDS medications are financially out of reach to people in these poorer countries.

Furthermore, rates of HIV continue to increase, as according to Lamptey (2002) in (Gehlert & Browne 2006:539), infections among women result from heterosexual contact, and the remainder are transmitted from mother to child or blood transfusion.

This chapter, therefore, focuses on the holistic approaches towards rehabilitating HIV and AIDS persons. It is aimed at knowing the approaches adopted by health care givers in health settings, with research being conducted in selected health centers within the uMhlathuze municipality.

3.2 HIV/AIDS AND REHABILITATION

Rehabilitation is seen as being an essential part of a patient’s care, as it is here that a person has the opportunity to fulfill his or her potential (Davis 2006:3). To achieve rehabilitation, there is need to involve a group of professionals all working with the same purpose of meeting the individual’s goals, which must involve the individual and their family, as rehabilitation is

synonymous with teamwork since it cannot be achieved by one professional group alone (Davis 2006:13).

Rehabilitation is not only focused on impairment and disability, but also on the individual's participation in the environment and society (Davis 2006:9), as it is basically client-centered and a link between health and social care.

Therefore, rehabilitation of persons with a physical or mental disability can be defined as restoration to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable. To achieve this, a wide range of professionals provide rehabilitation services, such as physicians (medical doctors), nurses, clinical psychologists, physical therapists, psychiatrists, occupational therapists, recreational therapists, vocational counselors, speech therapists, hearing therapists, industrial arts teachers, social workers, special education teachers, and prosthetists. Most of these therapists focus on the physical functioning of the clients, whereas social workers focus primarily on their social functioning (Zastrow 2008:523-524).

A report by WHO (2005), states that the number of people with disabilities is increasing, and classes of such disabilities are from war injuries, landmines, HIV and AIDS, malnutrition, chronic diseases, substance abuse, accidents and environmental damage, population growth, medical advances that preserve and prolong life, are contributors to the increase in disability. And these trends create an overwhelming demand for health and rehabilitation services.

The report went further to state that to ensure equal opportunities and promotion of human rights for people with disabilities, especially the poor, WHO would adopt and implement three of the rules of the United Nations' Standard Rules on the Equalisation of Opportunities for Persons with Disabilities, issued as guidelines for health, education, work and social participation. These are:

Rule 2. Medical care *– States should ensure the provision of effective medical care to persons with disabilities.*

Rule 3. Rehabilitation *– States should ensure the provision of rehabilitation services to persons with disabilities in order for them to reach and sustain their optimum level of independence and functioning.*

Rule 4. Support services *– States should ensure the development and supply of support services, including assistive devices for persons with disabilities, to assist them to increase their level of independence in their daily living and to exercise their rights (WHO 2005).*

From this report, persons with HIV and AIDS have been identified amongst others by WHO, to be beneficiaries of rehabilitation services because they face challenges that demand a holistic approach towards their treatment, as complications resulting from HIV and AIDS radically alter the physiological and psychological well-being of HIV-infected persons.

Treatment with highly active anti-retroviral therapy (HAART) allows HIV-infected persons to live longer, healthier, and more productive lives than was

possible at the beginning of the HIV and AIDS pandemic. However, these life-extending antiretroviral medications often cause side effects that may adversely affect the quality of life.

Medical researchers, such as the South African AIDS Vaccine Initiative (SAAVI) a lead programme of the Medical Research Council (MRC), are continually seeking more effective methods to treat infected persons; a vaccine that effectively prevents HIV infection is the ultimate goal (Dudgeon et al 2004:81). Although, "according to medical establishment, there is currently neither a cure nor a vaccine to neutralise HIV" (Cloete 2007:56).

Accordingly, Clinton Alley (AIDS Guide 2009) asserts that South Africa continues to experience one of the most severe AIDS epidemics in the world. At the beginning of 2008, the number of infected persons living in the country was estimated to be in the region of 5.7million, with almost 1000 AIDS-related deaths occurring everyday. In the absence of an effective medication or vaccine that would decisively deal with this pandemic, and in the face of the changing profile of HIV, where new drugs can now slow disease progression and help people to live longer with improved quality of life, these same new drugs (ARVs) are often very complicated and do cause debilitating side effects. "The success with which a person manages to live with the ongoing stress attached to HIV and AIDS impacts directly on his or her quality of life, with growing understanding of HIV and AIDS, according to Catalan et al (2000) in (Coetzee & Spangenberg 2002:207), researchers and health care professionals recognise that survival time is not only a question of duration, but also of the quality of life."

"Quality of life here, according to Friedland et al (1996) in (Coetzee & Spangenberg 2002:207-208), is the patient's appraisal of his or her overall physical, psychological and social functioning, which impacts directly on his or her morale, happiness and satisfaction."

Accordingly, in an article by Adam Currie (2009) titled 'Spirit of Hope' in (Leadership in HIV/AIDS 2009:47), he asserted that based on a 2007 South African National HIV survey of the nine provinces in South Africa, KwaZulu-Natal still reports the highest percentage of HIV and AIDS. Additionally, the United States Agency for international Development (USAID) has listed KwaZulu-Natal as "the world's highest infected region". The Zululand region is an area where about 35% - 40% of the population is HIV positive, with the North Coast area around Empangeni and Richards Bay as the most severely affected. It has consistently led HIV prevalence rates, and according to an Amangwe Village fact sheet, "infection rates were increasing more rapidly there than anywhere else in the country".

In a bid for the way forward, on the 13-14 May 2009, at the Richards Bay Hotel in Richards Bay, South Africa, a conference was organised by the University of Zululand, with the theme: The HIV and AIDS in Higher Education, 21st Century Challenges, with sub themes: Building a supportive environment; HIV and AIDS Culture and Traditional Medicine; HIV and AIDS and gender; Media as a communication Strategy (Leadership in HIV & AIDS 2009:47).

This conference held, was in line with the purposes of the National Strategic Plan (NSP) 2007 – 2011, one of which is the Operational Plan for

Comprehensive HIV and AIDS Care, Management and Treatment for South Africa in providing comprehensive care and treatment for people living with HIV and AIDS as well as to facilitate the strengthening of the national health system, as well as other agencies working on HIV and AIDS in South Africa, within and outside the government (HIV & AIDS Strategic Plan 2007-2011:53). The goals of the National Strategic Plan 2007 – 2011, are summarised as:

Primary Goals

1. Reduce the number of new infections by 50%

2. Reduce the impact of HIV and AIDS in individuals, families, communities and societies, by expanding access to appropriate treatment, care and support to 80% of all people diagnosed with HIV.

The interventions that are needed to reach the aims of the National Strategic Plan are structured according to the following four priority areas:

1. Prevention;

2. Treatment, care and support;

3. Human and legal rights: and

4. Monitoring, research and surveillance (HIV & AIDS Strategic Plan 2007-2011:56).

The challenge posed by the HIV and AIDS epidemic and by the resurgence of tuberculosis and of other medical conditions, is on how to further shape health care systems to respond to individual and local needs, which is not simply a matter of reacting to conditions but taking advantage of new or emerging therapies. In the context of HIV and AIDS, health systems are expected to develop additional services to HIV and AIDS, some of which are already in place, such as voluntary counselling and testing services (Poku 2005:128), as well as home based care.

Although, as posited by Kaleeba et al (2001:15) in (Poku 2005:129), “home or community care is not about “decongestion of hospital beds”, but about the provision of a comprehensive range of medical, nursing, counselling, spiritual, as well as nutritional care, which must exist from hospital to home, i.e. continuum of care.”

Based on this, the social disability grant has been of much help to ease most of the burdens off infected persons and their family, as it has helped meet certain basic needs. Although “the social grants given to child families are also not enough. They do not cover all the costs like electricity, water and school fees. The grants only take the edge off hunger. Poverty exacerbates the pandemic. Families often demand help from a stricken member because he or she is their “ATM”. If a patient’s viral load improves, relatives force that person to stop taking antiretroviral because they fear that the grant will be taken away” (Real 2008:29).

On this vein, the rehabilitation of HIV and AIDS infected persons shall be considered, such as physical, psychosocial and vocational rehabilitation.

3.2.1 Physical Rehabilitation

The complications resulting from HIV and AIDS radically alter the physiological and psychological well-being of HIV-infected persons. Treatment with highly active antiretroviral therapy (HAART) allows HIV-infected persons live longer, healthier, and more productive lives than was possible at the beginning of the pandemic. However, these life-extending antiretroviral medications often cause side effects that may adversely affect the quality of life (Dudgeon et al., 2004:81). Some of the challenges faced by HIV and AIDS infected persons are caused by changes in the body, which physical rehabilitation play a major role, such as:

3.2.1.1 **Physical therapy** (physiotherapy) is applied by the form of exercises and physical activities through which persons with HIV and AIDS infection, strengthen their muscles, improve movement of the joints, maintain or improve on their flexibility, balance and coordination, as well as gain the ability or stamina to manage pain.

3.2.1.2 **Occupational therapy** helps HIV and AIDS infected persons, learn to manage their daily activities, by making adjustments at home or at the work place, taking into account any physical changes such infected persons may be experiencing. This is mostly done through suggesting changes in their living space to accommodate any physical limitations that may impair their comfort. Assistance would also be offered to help them with the use of a walker, where the need arises, as well as helping them in organising their days in the bid to conserve their energy.

3.2.1.3 **Speech therapy** (Speech-language pathologists) assist persons with HIV and AIDS infection, with issues affecting speech, communication and swallowing.

3.2.1.4 **Audiology** helps in dealing with hearing loss by fitting infected persons with hearing aid or helping them find ways to communicate well despite the hearing loss.

3.2.1.5 **Physiatrist** is a doctor who specialises in physical medicine and rehabilitation, who helps HIV and AIDS persons regain movement or physical functioning they have lost, as well as treat chronic pain. HIV-infected persons have higher incidences of psychiatric disorders than the uninfected ones, the most notable abnormalities being anxiety and depression (Dudgeon et al., 2004:82).

3.2.1.6 **Complementary or alternative therapies** some times, HIV and AIDS persons find the need for such therapies, which include: acupuncture, massage therapy, homeopathy, naturopathy, and aromatherapy. Chiropractic treatments, as well as yoga, mediation, et cetera (Canadian Working Group 2009).

3.2.2 Psychosocial Rehabilitation

Persons living with the HIV and AIDS infection experience depression, anxiety, changes in sleep and appetite, reduced sex drive (libido), self-esteem, as well as affect relationships.

3.2.2.1 **Psychotherapy** provides mental health counselling, family care and support groups, memory books, cultural and age-specific approaches for psychological care, identification and treatment of HIV-related psychiatric illnesses, and bereavement preparedness (Care for People 2008). The psychotherapy plays a major role through the services of psychiatrists, psychologists, psychotherapists and mental health counsellors. They assist by providing therapy or counselling, they also suggest and employ strategies and techniques to relieve anxiety and stress, they connect HIV and AIDS persons with peer support groups and prescribe medication, if necessary by psychiatrists only (Canadian Working Group 2009).

3.2.2.2 **Social supports** such as friends, family, cultural and other community organisations provide help by giving emotional and practical support. (Canadian Working Group 2009). Social care supports community mobilisation , leadership development for people living with HIV and AIDS, legal services, linkages to food support and income-generating programmes, and other activities to strengthen the health and well-being of affected households and communities (Care for People 2008).

3.2.3 Vocational Rehabilitation

This is concerned in the area of assisting HIV and AIDS persons stay in the workforce, or return to the workforce after a period of illness, as reintegration into the society may pose a challenge due to complications arising from disease. Such concerns maybe perception of how one may be treated at the disclosure of ones status or the challenge may be in scheduling work time, from maybe fulltime to part-time to accommodate stamina,

another concern may be about income or health benefits if an HIV and AIDS person had been on long-term disability.

Vocational rehabilitation programmes provides training and employment counselling, job search and interview skills, counselling about income support, health and disability benefits, information about infected persons legal rights, as well as advocate on their behalf (Canadian Working Group 2009).

3.3 RELEVANCE OF SOCIAL WORK IN HEALTH CARE

Social Work in health care settings is practiced in collaboration with medicine and also with public health programmes. It is the application of Social Work knowledge, skills, attitudes, and values to health care. Social Work addresses itself to illness brought about by or related to social and environmental stresses that result in failures in social functioning and social relationships. It intervenes with medicine and related professions in the study, diagnosis, and treatment of illness at the point where social, psychological, and environmental forces impinge on role effectiveness (Farley, Smith, & Boyle 2006:173).

Medical Social Work is shaped and guided by the attitude, beliefs, knowledge, and acceptable ways of doing things by professionals serving in health care institutions and by the philosophy and practice of modern medicine. It requires knowledge of illness and of the psychological and social impact of disease on the individual, the family, and the family interrelationships; it calls for the application adaptation of Social Work

concepts, principles, and ideas to the special needs of hospital and clinic clientele (Farley, Smith, & Boyle 2006:176).

Social Workers in health care services use the problem-solving method in assisting individuals, groups, and communities in solving personal and family health problems. Social Work is involved at various levels of prevention:

Primary- health education, encouraging immunisations, good mental health practice in families, prenatal and postnatal care;

Secondary- early screening programmes for detection of disease, checkups, encouraging treatment;

Tertiary or rehabilitation- preventing further deterioration of a disease or problem (Farley, Smith, & Boyle 2006:175).

The functions of Social Work in the hospital include:

1. Assess the patient's psychological and environmental strengths and weaknesses.

2. Collaborate with the team in the delivery of services to assure the maximum utilisation of the skill and knowledge of each team member.

3. Assist the family to cooperate with treatment and to support the patient's utilisation of medical services.

4. Identify with a cadre of other professionals to improve the services of the hospital by an interdisciplinary sharing of knowledge.

5. Serve as a broker of community services, thus providing linkages of patient need with appropriate resources.
6. Participate in the policy-making process.

7. Engage in research to assure a broadening of the knowledge base for successful practice (Farley, Smith, & Boyle 2006:178-179).

3.3.1 ROLES OF SOCIAL WORK IN REHABILITATION

Rehabilitation for people with a physical or mental disability has been defined as restoration to the fullest physical, mental, social, vocational and economic usefulness of which they are capable. Services rendered are on vocational training, vocational counselling, psychological adjustment, medical and physical restoration, and job placement, although these are administered based on client's needs for such services (Zastrow 2008:523).

Social work in the medical or health setting is basically practiced in the hospital. With a wide variety of problems and situations encountered, social work in the health field is dynamic and requires continued study, as the dramatic expansion of new therapy approaches for medical conditions poses a challenge (Zastrow 2008:503). Social workers provide 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 policy development within the hospital and with various health agencies (Zastrow 2008:501).

One of the emerging fields of practice for medical social work is combating AIDS. Social workers are getting involved in advocating for programmes that would assist in reducing discrimination against persons with HIV and AIDS, they are also involved on counselling and in providing services in hospitals, residential treatment centers, nursing homes, and hospices to those that are positive. Social workers also serve as case managers for many people with AIDS. The case manager works with the affected persons, their loved ones, providers of care, and payers of health care expenses to make certain that pressing medical, financial, social, and other needs are met and to ensure that the most cost-effective care possible is provided.

In serving persons affected, the trend is to have more and more of the medical care delivered outside the hospital or nursing home, often at the person's home or in an outpatient clinic (Zastrow 2008:504). As cited by Kaleeba et al., (2001:15) in (Poku 2005:129), 'home or community care is not about "decongestion of hospital beds" but about the provision of a comprehensive range of medical, nursing, counselling, spiritual, as well as nutritional care which must exist from hospital to home, i.e. continuum of care'. Invariably, one of the most difficult tasks of doctors, nurses, social workers, and other allied professionals in the health field is to help a terminally ill patient deal with dying (Zastrow 2008:505). And to achieve this, social workers generally function as members of a team, and they need to learn to work with those in charge.

Medical treatment teams are increasingly dependent on social workers to attend to socio-psychological factors that are either contributing causes of illnesses or side effects of a medical condition that must be dealt with to

facilitate recovery. As a member of a medical team, social workers have an important role in diagnosing and treating medical conditions. Social work in the health setting needs skills and knowledge about how to counsel people with a wide variety of medical conditions, which requires a high level of emotional maturity, a well-thought-out identity, and a high level of competency in counselling (Zastrow 2008:508).

In rehabilitation services, social work services are various, such as counselling clients, counselling families, taking social histories, serving as case managers, serving as liaison between the family and the agency, being a broker, as well as doing discharge planning (Zastrow 2008:523-524).

SUMMARY

In conclusion, this chapter has discussed the efficacy of rehabilitation in the treatment of HIV and AIDS persons, as well as the different rehabilitative services available for any of the various ailments or opportunistic diseases that attack infected persons. The role of social work in rehabilitation has also been considered.

CHAPTER FOUR

RESEARCH METHODOLOGY

4.1 INTRODUCTION

This chapter explains how the research was conducted and how data was collected. More background information is added to the research design, as qualitative and quantitative research designs will be broadly discussed.

Therefore, a methodology section delineates in precise terms the designs of the study including the logical arrangements, sampling and data collection procedures, and the measurement approach used (Rubin & Babbie 2001:108). In this chapter therefore, the researcher explains how the study was undertaken in data collection in terms of the objectives for the study, i.e. the description of the methods used and the procedure in the research exercise.

4.2 RESEARCH DESIGN

Social research can serve many purposes. Three of the most common and useful purposes are the exploration, description and explanation. Although a given study can have more than one of these purposes (Babbie 2010:92 forth-coming). This study can be said to have an element of the exploration because the study on rehabilitation with HIV and AIDS, although relatively new, is not so new in practice. The study also has an element of the explanation because it tends to explain phenomena, and so this study has elements of all three research purposes (Rubin & Babbie 2001:125). But for this study, the use of the descriptive research design was utilised by the researcher.

4.2.1 Descriptive Research Design

Descriptive research design begins with careful observation (Jackson 2008:14). The researcher observes and then describes what was observed, because scientific observation is careful and deliberate, scientific descriptions are typically more accurate and precise than casual description (Rubin & Babbie 2001:124). In using the descriptive research design for this study, was to ascertain the correlation that exists between the approaches employed by health care givers, the target of the research which is on rehabilitation, and the incessant increase on the prevalence rate of HIV and AIDS infected persons. This was to enable the researcher gain insight and increase knowledge on the phenomenon under study, and make appropriate description and analysis.

In this regard, both the quantitative and qualitative research methods were employed. In quantitative descriptive studies, the objectivity, precision, and generalisation of the description are of paramount concerns (Rubin & Babbie 2001:124). While in qualitative studies, description is more likely to refer to a thicker examination of phenomena and their deeper meanings (Rubin & Babbie 2001:125). Invariably, there are three types of descriptive methods, namely, the observational, case study and the survey methods. In obtaining data for the study, the survey method was employed, which relies on questioning individuals on a topic or topics and then describing their responses. Surveys can be administered by mail, over the phone, on the internet, or in a personal interview (Jackson 2008:17). For this study, the survey method employed was the personal interview.

4.3 POPULATION OF THE STUDY

The researcher's target population for this study was comprised of health caregivers involved in the rehabilitation of HIV and AIDS persons in three selected health centres within the uMhlathuze municipality, namely: The Richards Bay Clinic, eNseleni Community Health Centre and Ngwelezana Hospital.

4.3.1 Brief profile of the area under research

South Africa, as the name applies is situated in the southern part of Africa. She got her independence in the year 1994 and is made up of nine provinces. Of these provinces, KwaZulu-Natal is of interest here, as the research was conducted in one of her municipalities, the uMhlathuze municipality. The City of uMhlathuze is one of six local municipalities situated within the uThungulu District Council area. The area comprises urban settlement, rural settlements, rural areas, farms and nature reserves. The majority of rural settlements are located within Tribal Authority areas. The area has a deep-water port, which is connected by national roads and railway line to the economic heartland of South Africa (City of uMhlathuze's Annual Review 2007/08:51).

The uMhlathuze Municipality is a strategically placed aspirant metropolitan, situated on the north-east coast of KwaZulu-Natal, and was established on 5 December 2000, after the demarcation process and local government elections of that date. As such it encompasses the towns of Empangeni, Richards Bay, eSikhaleni, Ngwelezana, eNseleni, Vulindlela and Felixton, as well as the rural areas under Amakhosi Dube, Mkhwanazi, Khoza, Mbuyazi and Zungu. uMhlathuze is home to the country's largest deep-

water port and enjoys the associated economic spin-offs as well as a diverse natural environment. It is a progressive municipality, which appreciates the need to achieve a successful balance and synergy between industry, its rich environment assets, and the community. Richards Bay is considered to be the industrial and tourism hub, while Empangeni is the initial commercial town and eSikhaleni the largest black suburb.

The name uMhlathuze is derived from the uMhlathuze River, that meanders through the municipal area and symbolically unifies the towns, suburbs and traditional areas. According to legend, the river was strong in currents and was infested with crocodiles and, therefore, could not be used by locals. The name uMhlathuze broken up has the following meaning: Mhlathi – 'jaw', Mthuzi – does not 'chew'. In other words, the uMhlathuze River was like a jaw that could not chew. The uMhlathuze Municipal Council consists of 60 councillors, of whom ten are full-time and serve on the council's Executive Committee. The Council has adopted a portfolio committee approach and interacts with its community using the Ward Committee system. Administratively, the Municipality has almost 1 900 full-time staff members led by the City Manager and his team of professionals, with offices in Richards Bay, Empangeni, eSikhaleni, Ngwelezana, eNseleni and Vulindlela (Culled from City of uMhlathuze's Annual Review 2007/08:2).

For this study, the towns of interest are Richards Bay, eNseleni and Ngwelezana, with particular interest on three health centres situated in these towns which are; The Richards Bay Clinic, eNseleni Community Health Centre and Ngwelezana Hospital.

4.3.1.1 Richards Bay Clinic

The Richards Bay Clinic, also referred to as uMhlathuze Municipality Clinic is situated at the civic centre in Richards Bay Central Business District (CBD). The clinic is sited 5kilometres from the Richards Bay Airport, 8kilometres from N2, and 17kilometres from Empangeni.

The clinic is staffed by basically nurses and lay counselors. Among services rendered at the clinic are the management and care of persons living with HIV and AIDS. Voluntary counselling and testing services for HIV and AIDS are available on a daily basis; such counselling services are rendered to assist clients in understanding and dealing with the effects of the disease. CD4 cell assessment is done at the Richards Bay Civic Centre Clinic on Thursdays.

4.3.1.2 The Enseleni Community Health Centre

Enseleni CHC is a 16 bed rural health centre situated between Empangeni and Richards Bay at uMhlathuze Municipality under uThungulu Health District forming part of the Lower Umfolozi sub-district. Enseleni CHC is 22kilometres away from Empangeni and it is 14kilometres from Richards Bay. The catchment's population area of eNseleni CHC is 103,262. The population is mainly comprised of rural and squatter camps and few from the urban areas. They also serve five Residential Clinics, which are Cinci Clinic, KwaMbonambi clinic, Sappi clinic, Sokhulu clinic and Nhlabane clinic. Enseleni CHC is about to incorporate other two clinics of which is Dondotha clinic and uCilwane clinic, currently under Ngwelezana Hospital.

Enseleni Community Health Centre has achieved different certificates of which amongst them there is a certificate of recognition for the implementation of comprehensive care plan for the prevention, treatment, care and support of HIV and AIDS, STI and TB in KwaZulu-Natal. It is also accredited to provide antiretroviral treatment. Enseleni CHC is committed to quality service delivery based on Batho Pele principles with the acknowledgement of the Patients Rights Charter.

4.3.1.3 Ngwelezana Hospital

Ngwelezana Hospital is a 554-bedded hospital. It provides District, Regional and Tertiary Services to communities from uThungulu, uMkhanyakude and Zululand Districts. It is situated at Ngwelezana, a suburb which is 5kilometres away from Empangeni. While Empangeni is about 20kilometres from Richards Bay Industrial area, harbour, beaches and airport.

The vision of the hospital strives for excellence in providing Optimal Health and Status and Customer Care in Service Delivery. While the mission seeks to provide a referral service for adults and children (excluding maternity) to District Hospitals of DC26,27,28 and a District level service to Lower Umfolozi Sub-District through coordinated cost effective, quality service in line with Batho Pele principles and the patients charter.

4.4 SAMPLING

Sampling is the process of selecting observations, while specific sampling techniques allow the researcher determine or control the likelihood of specific individuals being selected for the study (Rubin & Babbie 2001:250).

The study's focus was on the approaches being used by health care givers in health settings, towards rehabilitating HIV and AIDS persons. In conducting this research, the researcher visited the three health centres under study frequently for a number of times, so as to observe and gather appropriate data for the study.

The researcher made use of the non-probability sampling procedure, with specific focus on the purposive (judgmental) sampling. By being specific and selective of the population to be studied, only health care workers directly involved in the rehabilitation services to HIV and AIDS infected persons were considered qualified for the study. Based on this, questionnaires were issued out and received purposefully from 50 respondents: 11 copies from Richards Bay Clinic, 16 copies from eNseleni CHC and 23 copies from Ngwelezana Hospital. In conducting the personal interview, the survey, which is one of the methods of the purposive (judgmental) sampling, was adopted as each health profession was represented by one health professional where available, for the face-to-face interactional interview (Neuman 2003:294).

4.5 DATA COLLECTION

For the data collected to be both reliable and valid, the researcher must carefully plan the survey instrument. The type of questions used and the order in which they appear may vary, depending on how the survey is ultimately administered (Jackson 2008:91). In this study, the researcher has utilised both the questionnaire and the interview schedule. Both of which shall be explicitly discussed as applied to the study.

4.5.1 Questionnaire

Questionnaires are used in connection with many modes of observation in social research. Although structured questionnaires are essential to and most directly associated with survey research, they are also widely in experiments, field research, and other data collection activities (Babbie 2010:262 forth-coming). By definition, a questionnaire is a document containing questions and other types of items designed to solicit information appropriate for analysis. Questions to be asked are either open-ended or closed-ended (Babbie 2010:256 forth-coming). In generating information for this study, the researcher made use of both the open-ended and closed-ended questions.

Open-ended questions

These are questions for which participants formulate their own responses

Closed-ended questions

These are questions for which participants choose from a limited number of alternatives, questions are written in clear, simple language to minimise confusion (Jackson 2008:91).

4.5.2 Interview schedule

This is a data-collection encounter in which one person (interviewer) asks questions of another (a respondent). Interviews may be conducted face-to-face or by telephone (Babbie 2010:274 forth-coming). In collecting data for this study, a face-to-face interview was conducted with each health profession being represented by one health professional from each of the three health centres: 3 respondents from Richards Bay Clinic, 6 respondents

from eNseleni and another 6 from Ngwelezana Hospital. The researcher was guided by a structured interview schedule, which brought about uniformity in questions asked. In all, 15 health care workers were interviewed for the study (except an occupational therapist though they were part of the general questionnaire process), which brought about more insight into the study, as the interview generated a higher and more explicit response rate as compared to the questionnaires method (Babbie 2010:274 forth-coming).

4.6 CONCEPT OF MEASURES

Measurement means careful, deliberate observations of the real world for the purpose of describing objects and events in terms of the attributes composing a variable (Babbie 2010:125 forth-coming). Measurements can also be made with varying degrees of precision as precise measurements are superior to imprecise ones (Babbie 2010:150 forth-coming). Precision and accuracy are obviously important qualities in research measurement, and they probably need no further explanation when social scientists construct and evaluate measurements. However, they pay special attention to two technical considerations: validity and reliability.

4.6.1 Validity

This refers to the extent to which an empirical measure adequately reflects the real meaning of the concept under study consideration (Babbie 2010:153 forth-coming). In simple terms, validity refers to whether a measuring instrument measures what it claims to measure (Jackson 2008:71). The questionnaire was constructed and used as an instrument in data collection. The instrument was divided into two, section A and section B. While section A was on demographic data, section B was on phenomenal data. Similar

results were yielded on the majority of responses received from the use of the instrument.

4.6.2 Reliability

This refers to the quality of measurement method that suggests that the same data would have been collected each time in repeated observations of the same phenomenon (Babbie 2010:150 forth-coming). Simply put, reliability refers to the consistency or stability of a measuring instrument. Invariably, the measuring instrument must measure exactly the same way every time it is used (Jackson 2008:67). To ascertain the reliability of the study, the three health centres under study were served the same questionnaires differently and responses received were similar to a large extent. A test – retest was also conducted through a face-to-face interview of 15 health care workers, which served as a retest on the questionnaires already conducted.

4.7 DATA ANALYSIS

Data collected is analysed and results should be understandable and presented in a way that enhances credibility and impact. Data analyses for both quantitative and qualitative methods are considered.

Babbie (2010:422 forth-coming) posits that quantitative analysis is the numerical representation and manipulation of observations for the purpose of describing and explaining the phenomena that those observations reflect. Qualitative analysis, on the other hand, is the non-numerical examination and interpretation of observations for the purpose of discovering underlying meanings and patterns of relationships (Babbie 2010:394 forth-coming).

For this study, quantitative data were analysed by the use of closed items, which made use of tables and graphs. While for the qualitative data, open-ended items were analysed using the descriptive analysis method.

4.8 ETHICAL IMPERATIVES

Social workers and other professionals who conduct research that involves human subjects confront questions about the ethics of their proposed investigations. These questions must be resolved, not only to meet with their own ethical standards, but also to meet the standards of committees that have been set up to review the ethics of proposed studies and to approve or disapprove the study's implementation from an ethical standpoint (Rubin & Babbie 2001:73).

As applicable to this study, before the researcher commenced research, approval to conduct research and ethical clearance were received from the concerned committees of the researcher's institution. With these, request to conduct research were forwarded to the Richards Bay Clinic's management, eNseleni Community Health Centre's management, Ngwelezana Hospital's ethics and research committee, as well as the KwaZulu-Natal Department of Health; Provincial Health Research Committee. They all gave their consent and approval for the study to be conducted in the respective health centres.

In conducting this research, the researcher took into cognisance the rights and privacy of participants, as well as their consented participation in the study was sought and granted. The researcher made certain to observe, as much as was possible, all ethical considerations and conduct attached to a study considered to be of a very high sensitive nature.

SUMMARY

In this chapter, the researcher has attempted to fully outline the research methodology and identified the types of instruments that were going to be used in collecting the data, the method of sampling used and why that type of sampling was selected. The procedures required in collecting data were outlined so that a clear picture of how data was collected is provided. The researcher made use of open-ended and close-ended questions that were easy to answer and that avoided wastage of time on the part of the respondents. These were made to be easy for the respondents not to waste time trying to answer the questionnaires.

CHAPTER FIVE

DATA ANALYSIS AND INTERPRETATION

5.1 INTRODUCTION

In this research, findings are presented, analysed and discussed. The findings are presented to data collected from the Richards Bay Clinic, eNseleni Community Health Centre and Ngwelezana Hospital. In all, fifty questionnaires were completed by health care givers. While personal interviews were conducted with health caregivers in each of these health centres representing the different departments, four from Richards Bay, five from eNseleni and six from Ngwelezana Hospital. The main aim of the study was to find out the approaches of health care givers towards the rehabilitation of HIV and AIDS persons in the uMhlathuze municipality, from a social work point of view.

5.2 DEMOGRAPHIC DATA

Demographic data were obtained from respondents in the three health centres under study who are involved with rehabilitating HIV and AIDS persons, i.e. Richards Bay Clinic, eNseleni Community Health Centre and Ngwelezana Hospital. In this section, only aspects of gender, age, marital status, educational qualifications, designation of health caregiver and religious affiliation were covered and regarded to be of important factor in determining the different professionals who practically make up the rehabilitation team in service delivery within the area under study.

5.2.1 Gender of the respondents

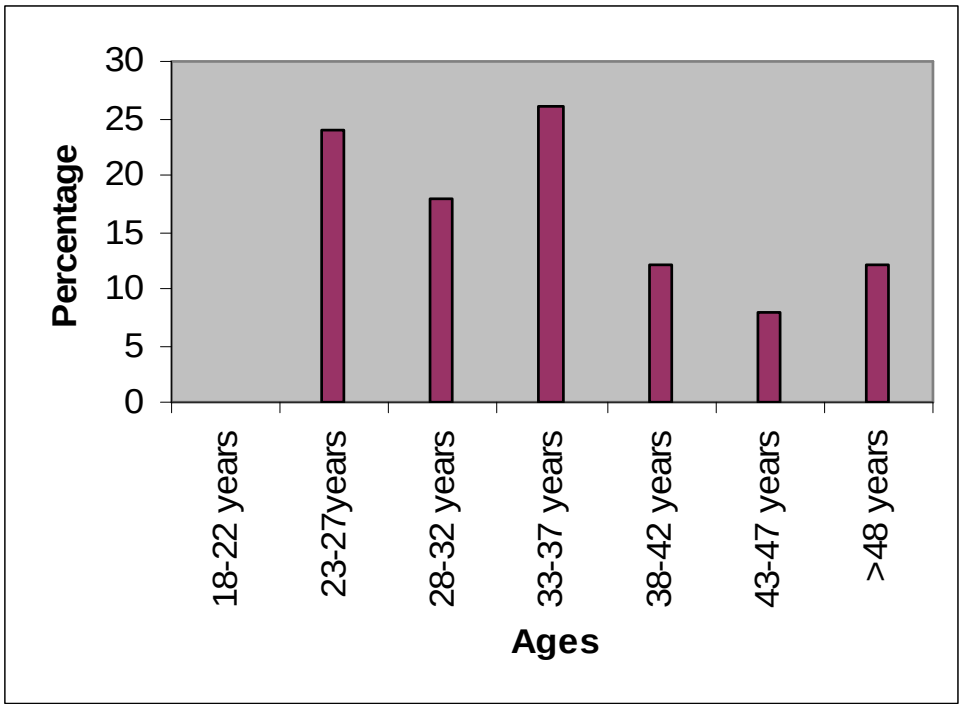
Table 5.1

Gender	Number of respondents	Percentage
Male	10	20%
Female	40	80%
Total	50	100%

As reflected in table 5.1 above, the majority of respondents which comprised 80% (40 respondents) of the total sample, were females, while 20% (10 respondents) were males. The rationale for asking this question was to ascertain that both sexes were involved in rehabilitating HIV and AIDS persons, because the disease affects both the male and female gender alike.

5.2.2 Age Distribution

Figure 5.1



From figure 5.1 above, the majority of respondents aged 33-37 years comprised 26% (13 respondents), followed by 12 respondents aged 23-27 years which comprised 24%, 9 respondents were aged 28-32 years which comprised 18%, 6 respondents were aged 38-42 which comprised 12%, 4 respondents were aged 43-47 which comprised 8%, while 6 respondents were aged 48 years and above comprising 12%. None of the respondents were aged 18-22 years.

5.2.3 Marital Status

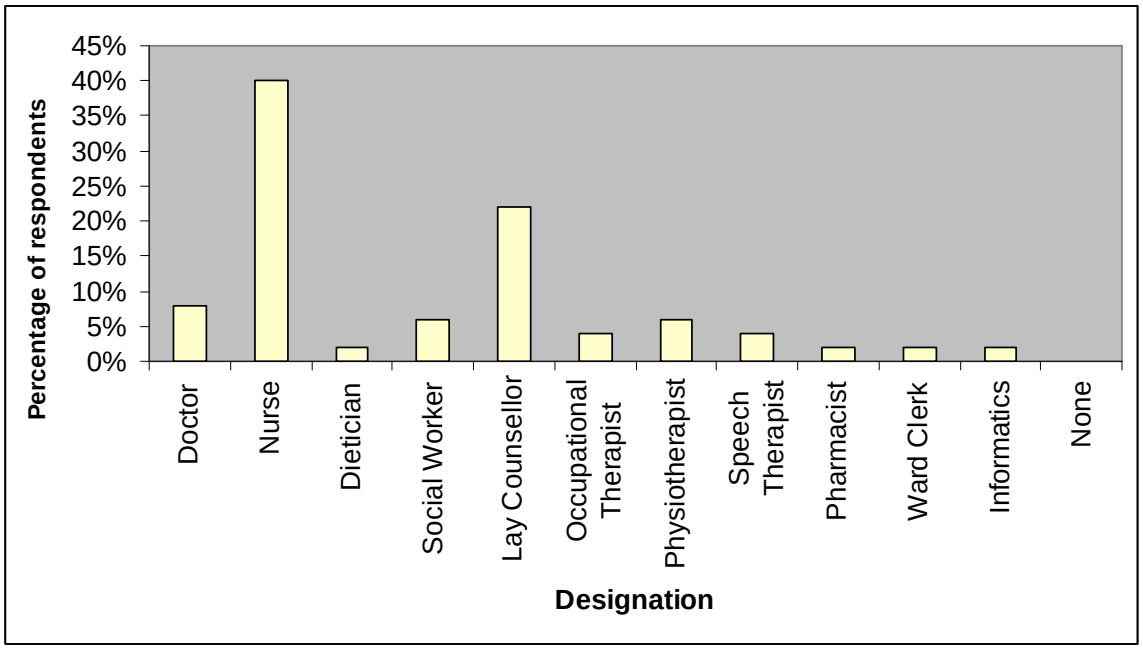
Table 5.2

Marital Status	Number of Respondents	Percentage
Single	20	40%
Married	26	52%
Separated	0	0%
Divorced	0	0%
Widowed	4	8%
Total	50	100%

As reflected in table 5.2 above, majority of respondents were married which comprised 52% (26) respondents of the sample, followed by 40% (20) respondents indicated being single, while 8% (4) respondents of the total sample were widowed. None were either separated or divorced.

5.2.4 Designation of respondents

Figure 5.2



As indicated in figure 5.2 above, nurses made the majority of health care givers in this study, being 40% (20) respondents of the total sample, 22% (11) respondents were lay counsellors, 8% (5) respondents were medical doctors, 6% (3) respondents were social workers, 6% (3) respondents were physiotherapists, 4% (2) respondents were Occupational therapists, 4% (2) respondents were speech therapists, 2% (1) respondent was a dietician, 2% (1) respondent was a pharmacist, 2% (1) respondent was a clerk, as well as 2% (1) respondent was an informatics specialist. This was to determine health care givers involved with HIV and AIDS person's treatment.

5.2.5 Religious Affiliation

Table 5.3

Religion	Number of Respondents	Percentage
Christianity	42	84%
Traditional Religion	1	2%
Islam	2	10%
None	5	4%
Total	50	100%

From table 5.3 above, Christians made the majority of health caregivers which comprised 84% (42) respondents of the total sample, the Islamic Religion was represented by 10% (2) respondents, while 2% (1) respondent represents African Traditional Religion. In all, five respondents made no indication about their religion.

5.3 PHENOMENAL DATA

The phenomenal data were obtained from respondents based on the subject under study. In this section, a set of introductory questions were asked in relation to the study, before questions that deals decisively on the subject matter were asked. This was to determine the understanding, knowledge-base, experiences and approaches of health care givers in the rehabilitation of HIV and AIDS persons.

5.3.1 Is HIV/AIDS a terminal disease?

Table 5.4

Response	Number of Respondents	Percentage
Yes	28	56%
No	19	38%
None	3	6%
Total	50	100%

From the above question as indicated in table 5.4, 56% of respondents (28) indicated that the disease is terminal, 38% of respondents (19) indicated that the disease is not terminal, while 6% of respondents (3) made no indication.

5.3.1 Is there a definite cure for the HIV/AIDS disease?

Table 5.5

Response	Number of Respondents	Percentage
Yes	4	8%
No	46	92%
None	0	0%
Total	50	100%

From table 5.5 above, majority of the respondents (46) represented as 92% were of the strong opinion that there is no definite cure for this terminal disease HIV and AIDS, while 8% of respondents (4) indicated a yes to the

question. By the majority response, it affirms the assertion that "AIDS is a disease for which no effective cure is available as yet" (Baveja & Rewari 2004:167).

5.3.3 Does HIV/AIDS cut across gender, age, colour, culture, religion, etc?

Table 5.6

Response	Number of Respondents	Percentage
Yes	23	46%
No	27	54%
None	0	0%
Total	50	100%

As indicated in table 5.6 above, majority of respondents (27) represented as 54% answered no to this question, while 46% respondents (23) affirmed that the disease cuts across every sphere of human existence. Although majority of the respondents answered no this question, it is evident that the HIV and AIDS affect every aspect of human existence.

5.3.4 In recent times, are HIV/AIDS cases on the increase?

Table 5.7

Response	Number of Respondents	Percentage
Yes	45	90%
No	1	2%
None	4	8%
Total	50	100%

From table 5.7 above, 90% of respondents (45) answered in the affirmative to the question, while 2% represents the only respondent with a negative opinion. The rationale for this question was to affirm the reports given in the literature review that the prevalence rate is still on the increase.

5.3.5 Rehabilitation has been called the third phase of medicine, is this relevant in the HIV/AIDS situation?

Table 5.8

Response	Number of Respondents	Percentage
Yes	40	80%
No	8	16%
None	2	4%
Total	50	100%

From table 5.8 above, 80% of respondents (40) answered yes to this question, 16% of respondents (8) indicated no to the question, while 4% of

respondents (2) made no response to the question. The rationale of this question was to check the relevance of rehabilitation to treatment.

5.3.6 Rehabilitation requires teamwork; do health caregivers work as a team?

Table 5.9

Response	Number of Respondents	Percentage
Yes	48	96%
No	2	4%
None	0	0%
Total	50	100%

As indicated in table 5.9 above, the majority of respondents which comprised 96% (48) respondents answered yes to the question that health care givers engage in team work, while 4% of respondents (2) were of a negative opinion. The rationale for this question was to check if indeed rehabilitation was being practiced by health workers, as rehabilitation is synonymous with teamwork since it cannot be achieved by one professional group alone (Davis 2006:13).

5.3.7 Have you been involved in the treatment of an HIV/AIDS person?

Table 5.10

Response	Number of Respondents	Percentage
Yes	46	92%
No	4	8%
None	0	0%
Total	50	100%

From table 5.10 above, 92% of respondents (46) have been involved in the treatment of HIV and AIDS persons, while 8% of the respondents (4) indicated that they have never been involved. The reason for this question was to establish the fact that respondents were involved in treatment.

5.3.8 If yes, was there an aspect of rehabilitation to the treatment?

Table 5.11

Response	Number of Respondents	Percentage
Yes	36	72%
No	8	16%
None	6	12%
Total	0	100%

From table 5.11 above, 72% of respondents (36) affirmed treatment was of a rehabilitative nature, 16% of respondents (8) were of a negative opinion,

while 12% of respondents (6) made no indication. This question was asked as a follow up to the previous one.

5.3.9 As a health caregiver, is caring for the HIV/AIDS person a difficult task?

Table 5.12

Response	Number of Respondents	Percentage
Yes	17	34%
No	17	34%
None	16	32%
Total	50	100%

From table 5.12 above, respondents were of equal opinion that the task of caring for the HIV/AIDS person was difficult in nature, as 34% of respondents (17) indicated yes to the question, another 34% of respondents (17) indicated no, while 32% of respondents (16) made no indication.

5.3.10 Can family and community members be considered as health caregivers?

Table 5.13

Response	Number of Respondents	Percentage
Yes	47	94%
No	3	6%
None	0	0%
Total	50	100%

From table 5.13 above, the majority of the respondents (47) comprising 94% were of the opinion that family and community members are considered as health care givers, while 6% of respondents (3) indicated no. The rationale behind this question was in line with NSP 2007-2011 assertion that families and communities care for their infected ones, in one way or the other, as they are directly affected by the pandemic (HIV & AIDS Strategic Plan 2007-2011:43).

5.3.11 If yes, are they being incorporated into the rehabilitative team?

Tables 5.14

Response	Number of Respondents	Percentage
Yes	39	78%
No	6	12%
None	5	10%
Total	50	100%

From table 5.14 above, 78% of the respondents (39) were of the opinion that family and community members are a part of the rehabilitation team, 12% of respondents (6) indicated no, while 10% of the respondents (5) made no indication. The rationale for the question was to determine the involvement of significant others in treatment.

5.3.12 Does the rehabilitation of an HIV/AIDS person have an end point?

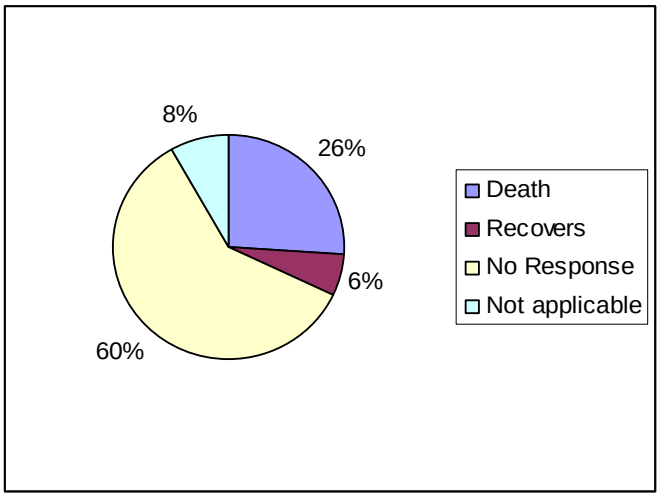
Table 5.15

Response	Number of Respondents	Percentage
Yes	16	32%
No	33	66%
None	1	2%
Total	50	100%

From table 5.15 above, 66% of respondents (33) indicated that there is no end to treatment of HIV/AIDS persons, 32% of respondents indicated that treatment does have an end, while 2% (1) respondent made no indication. The rationale for this question was to determine if treatment does have an end point.

5.3.13 If yes, when does it end?

Figure 5.3



From figure 5.3 above, 60% of respondents (33) made no indication to this question, 26% of respondents (13) indicated at the point of death, 8% of the respondents (4) indicated not applicable, while 6% of respondents (3) indicated that treatment ends when the infected recovers. The rationale for this question was to determine the end point.

5.3.14 Does the process of rehabilitation help them live above stigmatisation?

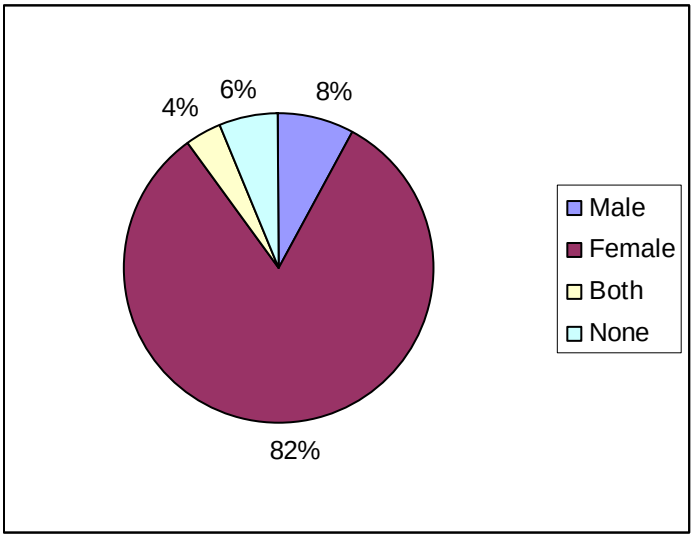
Table 5.16

Response	Number of Respondents	Percentage
Yes	43	86%
No	4	8%
None	3	6%
Total	50	100%

From table 5.16 above, 86% of respondents (43) were positive that rehabilitation does help reduce stigma, 8% of respondents (4) were of a negative view, while 6% of the respondents (3) made no indication. The rationale for this question was based on the premise that if care is rehabilitative, i.e. incorporating every sector, then stigmatisation will be a thing of the past because it is apparent everyone is either infected or affected.

5.3.15 What gender has the most prevalence rate?

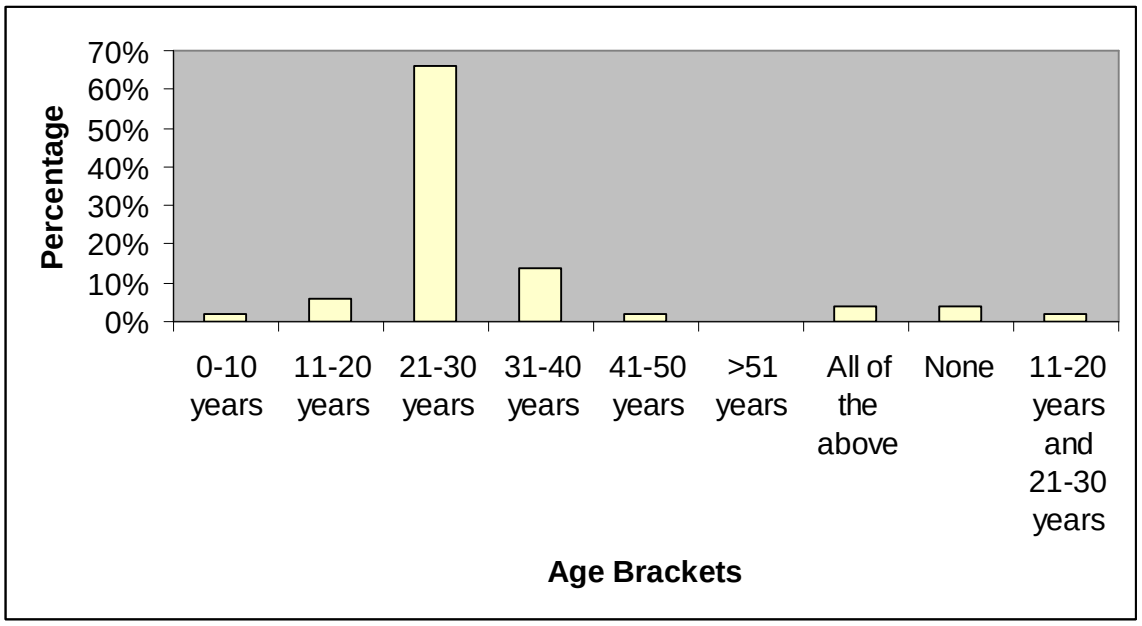
Figure 5.4



According to figure 5.4 above, 82% of respondents (41) were of a high opinion that the female gender were most infected, 8% of respondents (4) indicated the male gender, 6% of the respondents (3) made no indication, while 4% of the respondents (2) indicated both genders. The rationale for this question was to confirm the assertion that the female gender has the highest prevalence rate (HIV & AIDS Strategic Plan 2007-2011:33) bearing in mind they make more of those that provide care for the infected.

5.3.16 What age bracket is most infected?

Figure 5.5



As indicated in figure 5.5 above, the most affected age group is young persons between the ages of 21-30 as indicated by 65% of respondents (33), 15% of respondents (7) indicated the age group of 31-40, 6% of respondents (3) indicated the age group of 11-20, 4% of respondents (2) indicated all age group, another 4% of respondents (2) made no indication, 2% of response was received from 1 respondent by indicating the age group of 0-10,1 respondent represented by 2% chose the age group of 41-50, another 2% representing 1 respondent indicated the 11-20 and 21-30 grouping, while no indication was made on the age group of 50 and above.

5.3.17 Between 2007 and 2008, will you say the number of HIV/AIDS persons attended to is on the increase?

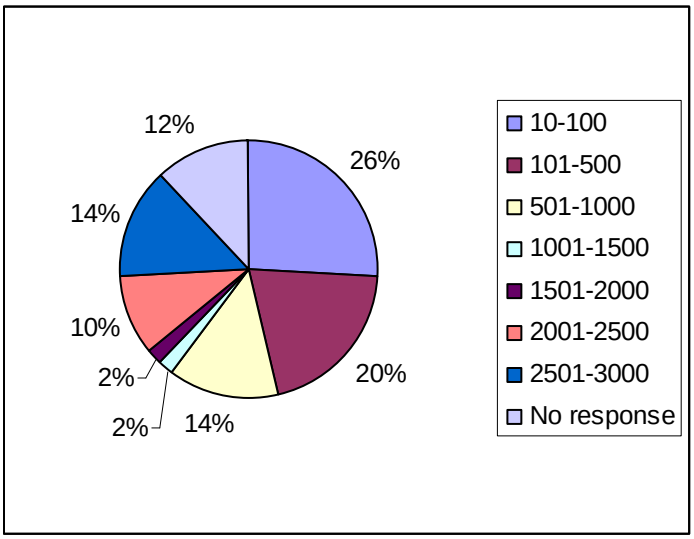
Table 5.17

Response	Number of Respondents	Percentage
Yes	45	90%
No	3	6%
None	2	4%
Total	50	100%

From table 5.17 above, 90% of respondents (45) affirmed positively to the question, 6% of respondents (3) indicated no to the question, while 4% of the respondents made no indications. The rationale for the question was to assess the prevalence rate in the health centres where study was conducted, and this was in line with the then Minister for health's statement Dr. Manto Tshabalala Msimang (SABC News 2008), as well as the millennium development goal for 2015 to reduce the rate by 50% (HIV & AIDS Strategic Plan 2007-2011:56). And also, the question was asked in line with the first (1st) objective of the research, which was "to examine the actual cases of HIV and AIDS attended to by health caregivers in selected health settings, in the uMhlathuze municipality, between the years 2007-2008.

5.3.18 How many patients are you attending to on a monthly basis?

Figure 5.6



From figure 5.6 above, 26% of respondents (13) indicated that between 10-100 patients, 20% of respondents (10) indicated between 101-500, 14% of respondents (7) indicated 501-1000, another 14% of the respondents (7) indicated 2501-3000, 12% of respondents (6) made no indicated, 10% of respondents (5) indicated between 2001-2500, 2% of respondents (1) indicated between 1001-1500, while another 2% of the respondents (1) indicated between 1501-2000.

5.3.19 Mention the different approaches employed by health caregivers in the rehabilitation of HIV/AIDS persons in your establishment.

Table 5.18

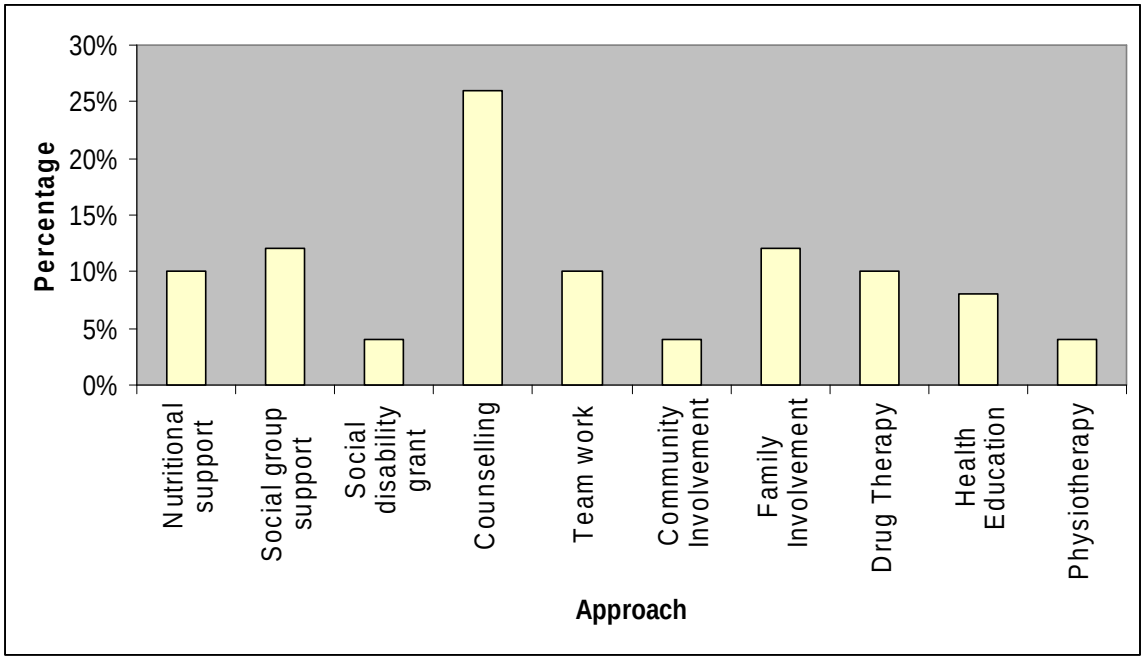
Responses	Number of Respondents
Pharmacological approach (Drug Therapy)	25
Social group support	26
Nutritional support	15
Family Therapy	17
Vocational Rehabilitation	5
Physical Rehabilitation	8
Health Education	17
Psycho Social Rehabilitation	5
Social Disability Grant	15
Referral	10
Occupational Therapy	2
Speech Therapy	4
Community Involvement	2
Counselling	4

From table 5.18 above, is a list of approaches used by health caregivers in the rehabilitation of HIV and AIDS persons as provided by respondents. The table shows that more of the respondents listed such approaches as pharmacological approach (drug therapy), social group support, family

therapy, health education, nutritional support, social disability grant, referral, physical rehabilitation, vocational rehabilitation, speech therapy, counselling and community involvement. The table above shows the number of respondents that made mention of each of these approaches. This question was posed to give answer to the first (1) research question which states: what are the approaches used by health caregivers in the rehabilitation of HIV and AIDS person in health settings, in the uMhlathuze municipality?

5.3.20 Which approach or approaches are most effective?

Figure 5.7



From figure 5.7 above, 26% of respondents (13) ranked counselling to be the most effective approach utilised by health care workers, followed by the

social group support which was indicated by 12% of the respondents (6), same as the family involvement which also had 12% respondents (6). Nutritional support, drug therapy and team work, each had 10% of respondents (5), health education was listed by 8% of respondents (4), while social disability grant, community involvement and physiotherapy each had 4% of respondents (2).

5.3.21In your opinion, what are the successes or failures of these approaches that have been in use?

This question was posed to answer the third (3) research question which states, what factors have negated the successful rehabilitation of HIV and AIDS persons in health setting, in the uMhlathuze municipality? The following responses were received from respondents.

SUCCESSES:

1. Occupational therapy offers job adaptation and retraining.

2. Disability grant offers financial relief and support to the very poor.

3. Family support very therapeutic.

4. Physiotherapy provides devices for ease of mobility.

5. Nutritional support provides food parcels for patients and relatives.

6. Nurses assist patients by checking their viral loads and blood.

7. Doctors prescribe medication and ensure best health of patients.

8. One-on-one counselling very effective for patients.

9. Referrals very effective, depending on the patients need or challenge at a particular time in the course of treatment.

FAILURES:

1. Difficult to follow-up on out-patients due to shortage in staff, as well as poor staff funding.

2. Group therapies not as effective as some patients refuse participation.

3. One-on-one counselling although effective is time consuming.

4. Disability grant although effective, is faulted because it is episodic. It terminates every six months for renewal so patients default treatment to get grant.

5.3.22 Are there limitations to the successful rehabilitation process for persons living with HIV/AIDS?

Table 5.19

Response	Number of Respondents	Percentage
Yes	29	58%
No	15	30%
None	6	12%
Total	50	100%

From table 5.19 above, 58% of respondents (29) indicated yes, that there were limitations, 30% of the respondents (15) indicated no, while 12% of respondents (6) made no indications.

5.3.23 If yes, what are these limitations?

1. Lack of knowledge by health workers on factors that constitute medical and social disability.

2. Lack of guidelines and the correct process on how to access social disability grant.

3. Lack of resources for proper rehabilitative services.

4. Lack of personnel to offer rehabilitative services.

5. Lack of space to effectively rehabilitate persons who need it and also to be monitored.

6. Poor management of resources.

7. Limited resources; staff, equipment, medicines and general funding.

8. Non-compliance of patients to attend rehab, due to fear of being seen which may lead to being stigmatised and discriminated against.

9. Limited access to properly monitor patients, especially when the CD4 count gets above 200 patients tend to refuse treatment because of fear that the disability grant will stop.

10. Negative attitude of some health caregivers towards persons infected with HIV and AIDS.

5.3.24 As a health caregiver will you say there is room for new measures of caregiving?

Table 5.20

Response	Number of Respondents	Percentage
Yes	32	64%
No	12	24%
None	6	12%
Total	50	100%

From table 5.20 above, 64% of respondents (32) were positive, 24% of the respondents (12) indicated no, while 12% of the respondents (6) made no indications.

5.3.25 If yes, what would you suggest?

Suggestions made by respondents were as follows:

1. The need to motivate for more available posts or vacancies for more qualified staff to be employed.

2. Specific ARV dietician to work with ARV clients and also prescribing ARV budget for nutritional supplement.

3. Employment of more trained professionals in the different fields, as well as in-service training for staff on duty.
4. More space for efficient service delivery.

5. More commitment of family and community involvement.

6. Set measures in place, such as better paid salaries and incentives so professionally trained persons do not opt out of the country for greener pastures, or opt for the private services only when the bulk of the work lies with the public service.

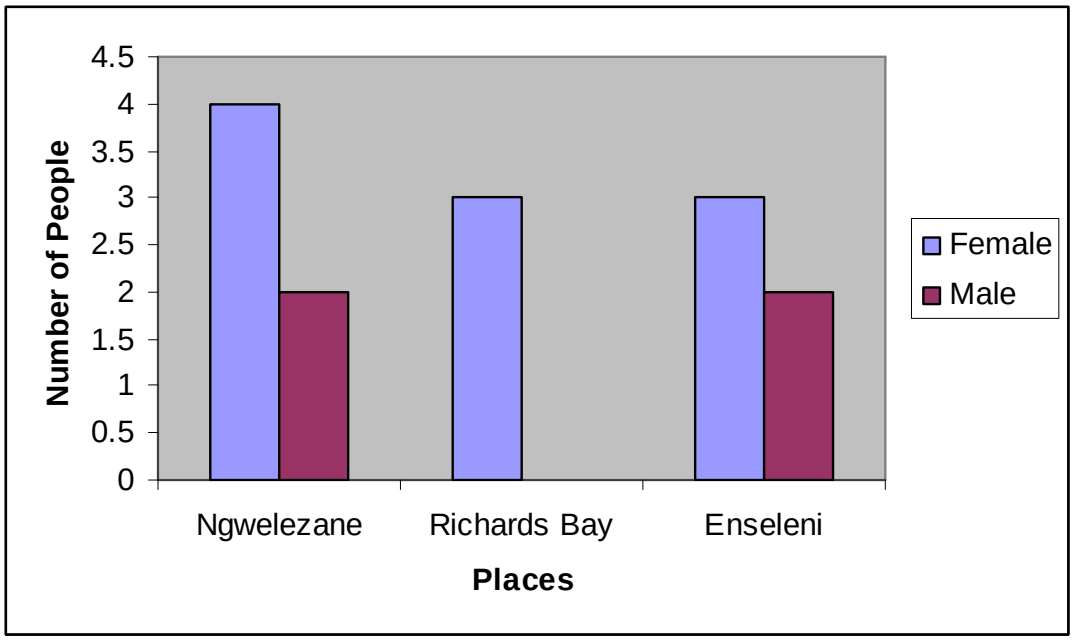
5.4 INTERVIEW SCHEDULE

A face-to-face interview was conducted on health caregivers, and this was done by interviewing each health profession, which was made possible by a representative where possible from each profession. These were made up of medical doctors, nurses, social workers, dietician, physiotherapist, lay counsellors, health counsellors, speech therapist and a pharmacist, except an occupational therapist because of the tight schedule on which they work with and a lack of sufficient time, although they participated in answering the questionnaire. The essence of this interview was to gather more in-depth information.

The researcher was guided by a planned interview schedule, which brought about uniformity in questions asked in the three health centres and also tailored information received, which were asked on the basis of the objectives for the study.

5.4.1 Gender of respondents from the three health centres

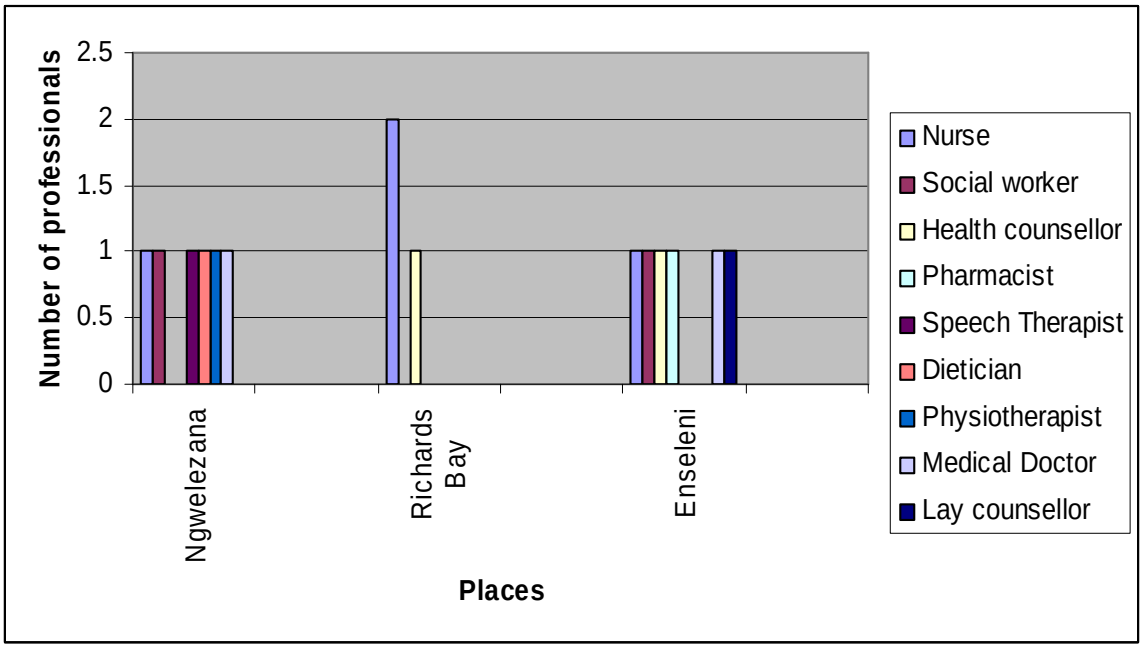
Figure 5.8



From figure 5.8 above, the graph shows the gender of health workers that were interviewed by the researcher based on their location. From Ngwelezana, there were 4 females and 2 males. Richards Bay had only 3 females no males. while eNseleni had 3 females and 2 males.

5.4.2 Professions of the respondents interviewed from the three health centres

Figure 5.9



From figure 5.9 above, the graph shows the professionals that were available to be interviewed from the three health centres. Ngwelezana had 1 nurse, 1 social worker, 1 speech therapist, 1 dietician, 1 physiotherapist and 1 medical doctor. From Richards Bay, there were 2 nurses and 1 health counselor, while eNseleni had 1 nurse, 1 social worker, 1 health counsellor, 1 pharmacist, 1 medical doctor and 1 lay counsellor.

5.4.3 Is the prevalence rate on the increase?

Table 5.21

Place	Response
Richards Bay Clinic	Yes
Enseleni Clinic	Yes
Ngwelezana Hospital	Yes

From table 5.21 above, it was unanimously agreed by all respondents that the prevalence rate is still on the increase.

5.4.4 Is rehabilitation appropriate in the management of HIV/AIDS patients?

Table 5.22

Place	Response
Richards Bay Clinic	Yes
Enseleni Clinic	Yes
Ngwelezana Hospital	Yes

From table 5.22 above, again an emphatic yes was received from all respondents, when the question on rehabilitation being appropriate in the management of HIV and AIDS persons was asked.

5.4.5 Are you sufficiently staffed for the challenges?

Table 5.23

Place	Response
Richards Bay Clinic	No
Enseleni Clinic	No
Ngwelezana Hospital	No

From table 5.23 above, respondents from the three health centres where study was conducted were in agreement that they are not sufficiently staffed in the face of the challenges posed on them from the HIV and AIDS crisis.

5.4.6 Would you say the ratio of health care givers is balanced to that of HIV/AIDS patients?

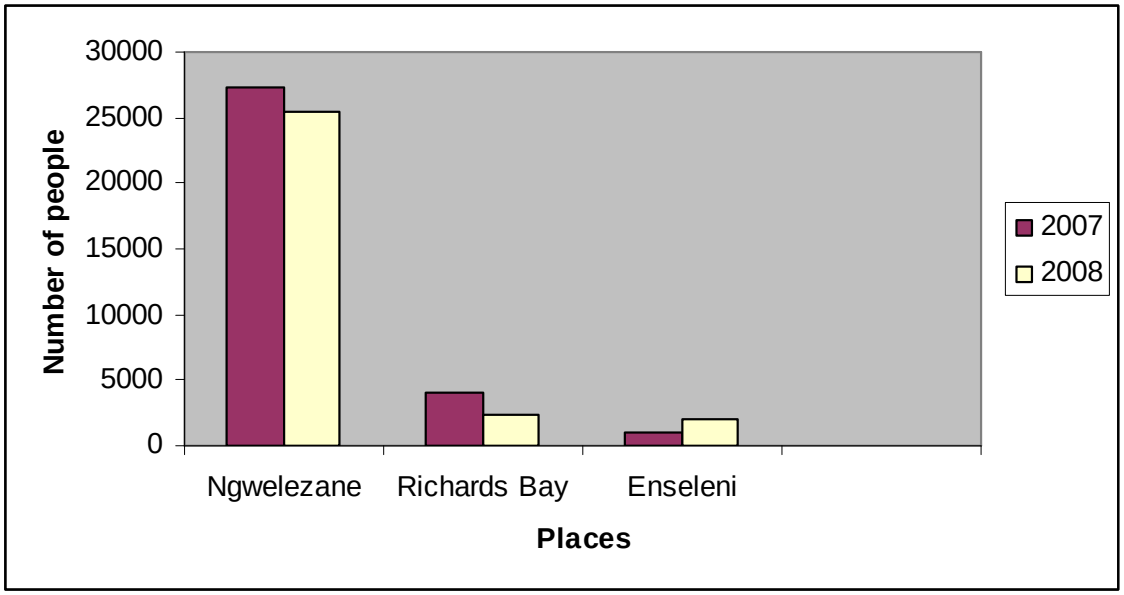
Table 5.24

Place	Response
Richards Bay Clinic	No
Enseleni Clinic	No
Ngwelezana Hospital	No

Again, according to table 5.24 above, all respondents from the three health centres had the same response, that due to shortage of staff, the ratio of infected persons was on a very high proportion, as compared to health caregivers.

5.4.7 Number of cases recorded in the three health centres

Figure 5.10



From figure 5.10 above, the graph shows the total number of infected persons that were attended to in the years 2007 and 2008. From Ngwelezana, the total number of infected persons attended to was 27,277 (2007) and 25,506 (2008), from Richards Bay, the total number of infected persons attended to was 4,400 (2007) and 2,299 (2008). While, the total number of infected persons attended to from eNseleni was 1,065 (2007) and 2,051 (2008). The rationale for this question was to give answer to the first objective of the study which states: to examine the actual cases of HIV and AIDS attended to by health caregivers in selected health settings, in the uMhlathuze municipality, between the years 2007-2008.

5.4.8 Would you say that your approaches have been successful?

Table 5.25

Place	Response
Richards Bay Clinic	Successful
Enseleni Clinic	Very successful
Ngwelezana Hospital	Very successful

From table 5.25 above, responses received shows that from the three health centres, approaches employed by health caregivers have fared successfully so far towards the rehabilitation of HIV and AIDS persons. This question was asked respondents in line with the hypothesis which states that: there is a significant relationship between health caregivers' approach and the success or failure of the rehabilitation of HIV and AIDS persons. By the response received, this means the hypothesis is true and accepted.

5.4.9 In your establishment are all who make up the rehabilitation (multidisciplinary) team represented?

Table 5.26

Place	Response
Richards Bay Clinic	No
Enseleni Clinic	Fairly
Ngwelezana Hospital	Yes

From table 5.26 above, Richards Bay clinic respondents were emphatic about not being well represented, eNseleni were fairly represented, while in Ngwelezana Hospital they were of the opinion that they were well represented, although short staffed.

5.4.10 Do you have an end point for the treatment of HIV/AIDS?

Table 5.27

Place	Response
Richards Bay Clinic	No
Enseleni Clinic	No
Ngwelezana Hospital	No

From table 5.27 above, the response received from respondents on the question as stated above indicated that from the three health centres there is no end point to treatment as it is a continuous process.

5.4.11 Would you say this study is relevant towards the holistic management of HIV/AIDS persons?

Table 5.28

Place	Response
Richards Bay Clinic	Very relevant
Enseleni Clinic	Very relevant
Ngwelezane Hospital	Very relevant

From table 5.28 above, all respondents from the three health centres were of the opinion that the study was very relevant towards the holistic management of HIV and AIDS persons' treatment.

CHAPTER SIX

SUMMARY OF THE FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

6.1 INTRODUCTION

This study was descriptive and utilised both the qualitative and quantitative research approaches. Data was collected by the use of both the questionnaire and interview schedule. While the sample was drawn from the Ngwelezana Hospital, the Richards Bay Clinic and the eNseleni Community Health Centre, all within the uMhlathuze municipality.

This chapter presents the findings of the research based on its stated objectives. In discussing the findings, responses from the questionnaire and interview schedule have been used simultaneously. The total number of respondents was fifty (50) in number, while from amongst this fifty, fifteen (15) respondents were interviewed on a face-to-face interaction to generate relevant and precise information based on the objectives of the study, which are to be reviewed.

Consequently, recommendations that are presented in this chapter are based on the findings presented. A conclusion of the study is thus drawn from the presented findings.

6.2 DISCUSSION OF FINDINGS BASED ON THE STUDY'S OBJECTIVES

Based on empirical evidence, the findings of the study are presented as follows:

1. **To examine the actual cases of HIV and AIDS attended to by health caregivers in selected health settings, within the uMhlathuze municipality, between the years 2007 – 2008.**

From the study conducted, health caregivers interviewed were able to supply the researcher with the total number of infected cases attended to between the years 2007 and 2008. From Richards Bay Clinic, the total number of infected persons attended to were 4,400 in 2007 and 2,299 in 2008, from eNseleni Community Health Centre the total numbers were 1,065 for 2007 and 2,051 for 2008. While for Ngwelezana Hospital the total numbers of infected persons attended to were 27,277 for 2007 and 25,506 for 2008. In line with this, the question was posed on the questionnaire, considering the number of HIV and AIDS persons attended to, thus considering the statistics for 2007 and 2008, it was noted that the prevalence rate was on the increase.

Based on this, 90% of the respondents responded yes to the question posed, 6% said no, while 4% of the respondents made no response. A follow-up question was posed on how many patients were attended to by them on a monthly basis. The response here was quite pathetic, as most of the respondents had to handle more patients than they can easily deal with at a time.

From this, the researcher was able to find out that health caregivers in these health settings sacrifice a lot to give their humanitarian services, as Richards Bay Clinic is basically made up of nurses and lay-counsellors. There are no medical doctors, social workers, dieticians, dentists, physiotherapists and the rest, and so they do have a huge challenge in service delivery. For example, when referrals are made for a patient, the patient most often does opt out of treatment because of the change in treatment environment, this is mostly due to the fear of not wanting their status to be exposed, which brings about a high standard of confidentiality to be upheld.

From eNseleni CHC, the health team is fairly represented but with only one social worker to attend to all patients, whether HIV and AIDS infected or not. There are no dieticians, speech therapist, physiotherapists, occupational therapists, and the rest.

Ngwelezana Hospital is a much bigger hospital with basically all the health professionals, who are well represented to provide rehabilitative treatment to infected persons. Within the hospital, there is a special unit by the name Thembalethu Clinic where HIV and AIDS adults are treated.

Also, from the three health centres, despite the huge number of infected persons being attended to, they face a similar challenge of a shortage of skilled persons, as well as a lack of insufficient space to contain the number of infected persons they have to deal with especially on their clinic days. And so, even the issue of complete confidentiality cannot be adhered to, as infected persons can easily be identified on the long queues that are formed on each clinic days. Therefore, the objective of the study here was achieved.

2. **To identify the various specific approaches employed by health caregivers in health settings in the uMhlathuze municipality towards the rehabilitation of HIV and AIDS persons they attend to**

This objective was achieved because the respondents were able to mention the various approaches with which HIV and AIDS persons were rehabilitated within their health setting, as well as providing the pitfalls of these approaches, which also gave input to the presiding objective. From information gathered, the researcher was able to identify the various approaches employed in the holistic treatment of HIV and AIDS persons, as well as the involvement of significant others, such as the family, the community, the government and other stakeholders with keen interest on the HIV and AIDS issues.

The various approaches mentioned by respondents were the pharmacological approach (also known as the drug therapy), the social group support, family therapy, nutritional support, vocational rehabilitation, physiotherapy, health education, psychotherapy, social support grant, referrals, occupational therapy, speech therapy, community involvement, and counselling.

The findings of the study revealed that although health caregivers from Richards Bay Clinic were basically made up of professional nurses and lay counsellors, as well as being short staffed, they are faring very well with such approaches as counselling, drug therapy and health education. They also check the viral load of infected persons, and were there is a challenge, referrals are done.

The findings from eNseleni CHC revealed that although health caregivers were made up of medical doctors, nurses, a social worker, and pharmacists, they were still very short staffed, even though they employed the peer support group and family/community support which have fared very well in boosting the morale of infected persons. Basically, the approaches employed here are the psycho social, social/peer group support, nutritional support, vocational rehabilitation, counselling, health education, community involvement and the social disability grant, which is described as being episodic because it has to be reviewed after every six months just as the HIV and AIDS disease is episodic.

The findings which were gathered from Ngwelezana Hospital revealed that although health caregivers were made up of medical doctors, nurses, social workers, psychologists, psychiatrists, physiotherapists, occupational therapists, speech therapists, lay counsellors, and one dietician, others such as audiologists, dentists, pharmacists and infection control were also identified by the researcher as being involved in the rehabilitation of HIV and AIDS persons, even though they were not a part of the study, yet this establishment is short staffed considering that there is only one dietician in the hospital, one full time speech therapist and two part time. Even social workers are but a hand full. With the number of infected persons to be treated, most times the bulk of the work rests especially on the nurses, the lay counsellors and the social workers.

In using the speech therapy, language and feeding are dealt with in the sense that the muscle might get weak and with this weakness, the infected person becomes disabled which leads to speech and feeding disability.

Physical rehabilitation is another relevant approach, as it improves the patient's movement to function properly, this is mostly utilised at the chronic stage.

Nutritional support is also very relevant, as its role is basically to choose the right type of food or nutrition for the infected.

Based on much intake of several drugs, i.e. the antiretroviral drugs, infected persons most often suffer depression, dementia, anxiety, et cetera, in reaction to this intake. Psychiatrists, psychologists, social workers, et cetera, play a major role in treatment here, and also in bridging the gap about reintegrating infected persons back into the society.

3. **To evaluate the successes and failures of each approach employed by health caregivers in the rehabilitation of infected persons within the study area**

The objective of the study was achieved, as respondents were able to not only describe the different approaches utilised, but were also able to explain the successes and failures experienced with each of these approaches.

Family support has been viewed as very successful from all three health centres and is much encouraged, though much is still expected from family and community support. On the issue of the social disability grant, this seems to pose a huge problem to treatment phase, due to the fact that infected person's are prone to stop treatment when their CD4 count goes above 200 so as to continue benefiting from the disability grant, as has been

asserted earlier that, “the social grants given to child families are also not enough. They don’t cover all the costs, like electricity, water and school fees. The grants only take the edge off hunger. Poverty exacerbates the pandemic. Families often demand help from a stricken member because he or she is their ‘ATM’. If a patient’s viral load improves, relatives force that person to stop taking antiretroviral because they fear that the grant would be taken away” (Real 2008:29).

This conception on the social disability grant as opined by health caregivers is one of such shortfalls that are detrimental to the rehabilitation of HIV and AIDS infected persons.

4. **To stimulate more researching on HIV and AIDS especially in the area of rehabilitation**

From the interview conducted, each respondent was of the opinion that much still needed to be done on the HIV and AIDS issue, especially in the area of rehabilitation.

From the Richards Bay Clinic, the general notion was that as KZN still has the highest rate of prevalence, much still needs to be done, in consideration to culture and ignorance, despite information from the media and the general awareness.

From Ngwelezana Hospital, respondents suggested that more researching needs to be done in the area of rehabilitating HIV and AIDS persons, due to the escalating increase in the number of persons infected; as poverty is a problem and education do not change people’s attitude and behaviour as the

most common means of getting infected is through heterosexual relationships.

From eNseleni CHC, respondents agreed that researching on approaches utilised by health caregivers towards the rehabilitation of HIV and AIDS persons, was very necessary, as the prevalence rate is alarmingly on the increase, either due to new infection or more awareness that would require prompt testing.

6.3 RECOMMENDATIONS

Based on the research findings as obtained from the study, the following recommendations are suggested:

1. Continuous support from the government, by formulating and implementing policies that would effectively bridge the gap between strategies on achieving set goals and the achievement of such set goals.

2. A community based rehabilitation unit or centre with outreach should be set up; this would serve as one of the measures to effectively bridge the gap.

3. Rehabilitation teams would need to visit primary health clinics, homes, on daily basis to offer services.

4. There is a crucial need for more qualified professional personnel to be employed in health centres.

5. There is also a crucial need for health social workers to be employed in the public health service where their expertise is evidently needed and not only in the social development service.

6. There is also need to have an increase of staff in health setting to meet up with the challenges faced in the treatment of HIV and AIDS persons.

7. Implementation of expertise to the various specialised fields is required, as well as in-training for health professionals to meet up with the ever changing and innovative trends of therapies towards the rehabilitation of HIV and AIDS persons.

8. Funding for community based rehabilitation is essential to the growth and development of such communities.

9. Improvement on community or home based rehabilitation is very necessary as the provision of continuous physical and psychological care and support from the community and government agencies serve to extend fruitful life as much as possible (Baveja & Rewari 2004:253).

10. Spiritual involvement and recreational approach is also of very high relevance.

11. Expansion of multidisciplinary team to involve complementary therapies.

12. Establishment of more male HIV and AIDS Care Programmes in all private and public health centres.

13. There is requirement for adequate space in health centres for much more effective service delivery and the provision of incentives to health workers.

14. Improvement on home care education is very necessary, as professional expertise and home based care are of vital importance.

15. There is further need for the provision and proper maintenance of hospital facilities and man-power, as well as the availability of such services, where and when needed.

6.4 SUGGESTIONS FOR FUTURE RESEARCH

Based on findings from the study, the researcher wishes to suggest that for future researching on HIV and AIDS:

1. Concentration would be veered towards health care workers, as much has been said and done on the infected, because if appropriate measures are not put in place, there will be a human disaster as all health workers are also endangered.

2. It would also be suggested that strategies to incorporate and maintain more health workers in public health service, thereby minimising the shortage of staffing to be evaluated.

CONCLUSION

According to Steiner et al (2002) in (Davis 2006:ix),rehabilitation is defined as a complex process which depends on interprofessional working and should be focused on the individual's goals. HIV and AIDS is a chronic ailment that is described as being episodic as it fluctuates between a state of wellness and illness, and "for intervention to be effective, the consideration of the cultural explorations and people's perceptions of illness, disease and well-being are as important as knowledge of biomedical facts" (Williams 2000:131). Based on this, the Rational Choice-based and Social Network-based Theoretical Approaches were applied to this study, as presented in chapter two, towards the holistic treatment of HIV and AIDS persons in the society, as these approaches embrace every aspect of health care in treatment.

According to a World Health Organisation report (2000), governments have been urged to recognise that they are ultimately responsible for a country's health system though care may be provided by a combination of private, non-profit and public agencies, "governments must be the prime mover." Likewise, states are to be responsible for anticipating the needs associated with home-based, long-term care, which extend beyond the provision of health care services, and for ensuring that resources are available and are distributed efficiently and equitably (WHO 2002:2). This can only "be achieved in situations where all the care methodologies are delivered appropriately in adequate quality and quantity" (Baveja & Rewari 2004:253).

This is not just providing care, but the dissemination of expertise or professional skills, starting from the health settings to the home, which will go along way to end child-headed families and the deprivation of family members not attaining their goals in life because of giving care to a sick family member, et cetera, as well as meeting with the National Strategic Plan (NSP) 2007-2011.

In conclusion, “any real society is a caregiving and care-receiving society, and must, therefore, discover ways of coping with these facts of human neediness and dependency that are compatible with the self-respect of the recipients and do not exploit the caregivers” (WHO 2002:44).

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RESEARCH QUESTIONNAIRE

Department of Social Work
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Private Bag X1001
Kwadlangezwa 3886
Kwazulu-Natal Province
South Africa

Dear Respondent

I am a Masters student of the above-named Department, conducting a study on: "**HEALTH CAREGIVERS' APPROACH TOWARDS HIV/AIDS PERSONS' REHABILITATION: A SOCIAL WORK PERSPECTIVE."** This research is basically on academic grounds, not being instigated by political, social, economic and/or cultural underpinnings.

You are please requested to complete this Questionnaire to your best knowledge, as your responses shall be analyzed and tested against the study's hypothesis. All ethical considerations and confidentiality of information will be adhered to.

Thank You

Yours Sincerely

Miss. EI Cobham (200814175)

SECTION A: DEMOGRAPHIC DATA

Instruction: Please tick (√) the correct answer as appropriate to the following questions. You may be required to provide your answers to some of the questions.

1. GENDER: Male [ ] Female [ ]

2. AGE: 18-22yrs [ ] 23-27yrs [ ] 28-32yrs [ ] 33-37yrs [ ] 38-42yrs [ ] 43-47yrs [ ] 48yrs & above [ ]

3. MARITAL STATUS: Single [ ] Married [ ] Separated [ ] divorced [ ] Widowed [ ]

4. EDUCATIONAL QUALIFICATION: ----------

5. POSITION HELD: ----------

6. DESIGNATION OF HEALTH CARE GIVER: Doctor [ ] Nurse [ ] Dietician [ ] Social Worker [ ] Lay-Counsellor [ ] others (please specify) ----------
   ----

7. RELIGIOUS AFFILIATION: Christianity [ ] African Traditional Religion [ ] Islam [ ] others (please specify) ----------
   ----

SECTION B: PHENOMENAL DATA

1. Is HIV/AIDS a terminal disease? Yes [ ] No [ ]

2. Is there a definite cure for the HIV/AIDS disease? Yes [ ] No [ ]

3. Does HIV/AIDS cut across gender, age, colour, culture, religion, etc? Yes [ ] No [ ]

4. In recent times, is HIV/AIDS cases on the increase?
   Yes [ ] No [ ]

5. Rehabilitation has been called the third phase of medicine, is this relevant in the HIV/AIDS situation? Yes[ ] No[ ]

6. Rehabilitation requires team work; do health caregivers work as a team? Yes[ ] No[ ]

7. Have you been involved in the treatment of an HIV/AIDS person? Yes[ ] No[ ]

8. If yes, was there an aspect of rehabilitation to the treatment? Yes[ ] No[ ]

9. As a health caregiver, is caring for the HIV/AIDS person a difficult task? Yes[ ] No[ ]

10. Can family and community members be considered as health caregivers? Yes[ ] No[ ]

11. If yes, are they being incorporated into the rehabilitative team? Yes[ ] No[ ]

12. Does the rehabilitation of an HIV/AIDS person have an end point? Yes[ ] No[ ]

13. If yes, when does it end? ----------
---

14. Does the process of rehabilitation help them live above stigmatisation? Yes[ ] No[ ]

15. What gender has the most prevalence rate? Male[ ] Female[ ]

16. What age bracket is most infected? 0-10yrs [ ] 11-20yrs[ ] 21-30yrs[ ] 31-40yrs[ ] 41-50yrs[ ] 51yrs & above[ ]

17. Between 2007 and 2008, will you say the number of HIV/AIDS persons attended to are on the increase? Yes[ ] No[ ]

18. How many patients are attended to by you on monthly a basis?

---

19. Mention the different approach or approaches employed by health caregivers in the rehabilitation of HIV/AIDS persons in your Institution ----------
---

---

20. Which approach or approaches is/are the most effective, and why? ----
---

---

21. In your opinion, what are the successes or failures of these approaches that have been in use? ----------
---

---

22. Are there limitations to the successful rehabilitation process for persons living with HIV/AIDS? Yes[ ] No[ ]

23. If yes, what are these limitations? ----------

---

24. As a health caregiver will you say there is room for new measures of care giving? Yes[ ] No[ ]

25. If yes, what would you suggest? ----------

THANK YOU.

INTERVIEW SCHEDULE

1. PERSONAL DETAILS

1.1 Gender

Male	
Female	

1.2 Name of establishment

1.2 Professional inclination

1.3 Position in your establishment

---

2. Briefly, what are your views on the HIV/AIDS pandemic?

---

3. Considering the cases of HIV/AIDS attended to in this establishment, would you say the prevalence rate is on the increase?

---

4. In your opinion, what do you understand by the concept rehabilitation?

4.1 Do you think it is appropriate for consideration in the management of HIV/AIDS patients?

4.2 If yes, what aspect of Rehabilitation are you directly involved in and how relevant is your approach?

---

5. Would you say, you are sufficiently staffed for the challenges faced in the management of HIV/AIDS persons?

5.1 If no, what would you suggest as the way forward?

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6. Would you say the ratio of health caregivers is equal to that of HIV/AIDS persons?

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7. Would you say your approaches have been successful?

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8. In your establishment are all who make up the rehabilitation (multidisciplinary) team represented?

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9. As a health care giver, do you have an end point to treatment?

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10. Would you say this study is relevant towards the holistic management of HIV/AIDS persons?

Thank You and God Bless!