AN EXPLORATORY STUDY OF SOCIAL WORKERS' EXPERIENCES OF WORKING WITH HIV AND AIDS INFECTED CLIENTS IN THE KHOMAS, KAVANGO EAST, AND OSHIKOTO REGIONS

A RESEARCH THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF

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ABSTRACT

Social workers as professionals largely work within health and social services-related settings. This study explored social workers' experiences in working with HIV and AIDS-infected clients in the Khomas, Kavango-East, and Oshikoto regions. The study adopted a qualitative approach, and a phenomenological design was used. Data collection was done through semi-structured interviews. The study population included state social workers from three different regions of Namibia. Specifically, the Rundu hospital, Windhoek Central hospital, Katutura State hospital, Tsumeb District hospital, Omuthiya hospital, and the Onandjokwe Intermediate hospital. A total of eleven social workers were selected to participate in the study, using the convenience or availability sampling technique. Braun and Clarke's six-step model of thematic analysis was used to analyse the data. The findings of this research uncovered four major aspects: Firstly, most social workers worked in a multi-disciplinary environment. Secondly, social workers perceived their work experience as both negative and positive. Thirdly, the lack of in-service training, poor supervision, human resources management injustices, and compassion fatigue are institutional challenges encountered in their work environment. Fourthly, social workers use coping mechanisms such as debriefing, positive self-talk, and time off from work to mitigate work-related stressors. The study thus proposed the following recommendations: the development and implementation of an in-service and supervision training guide for social workers working at the Ministry of Health and Social Services (MoHSS). Secondly, the implementation of a specialized social work program at UNAM will enable social work students to focus on a specific area of expertise. Finally, the Social Work and Psychology Council of Namibia (SWPCN) should advise the MoHSS on the optimal working conditions for social workers in the public health sector.

Keywords: Social Work, HIV and AIDS, Health, Client, Multidisciplinary, Roles

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
CDC	Centre for Disease Control
CEU	Continues Education Units
CPD	Continues Professional Development
HIV	Human Immunodeficiency Virus
WHO	World Health Organization
UNAM	University of Namibia
TB	Tuberculosis
HCW	Health Care Workers
IEC	International Electro-technical Communication
MGEPESW	Ministry of Gender Equality, Poverty Eradication, and Social Welfare
MoHSS	Ministry of Health and Social Services
NASWA	Namibia Social Workers Association
PLWHA	People Living with HIV and AIDS
SWPCN	Social Work & Psychology Council of Namibia
UNAIDS	United Nations Programme on HIV/AIDS

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DEDICATION

I dedicate this research to my two beloved late sisters, Werveley Kasper and Audrey Clothilde (Samantha Skrywer) Timotheus. May their souls continue to rest in peace.

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I would like to acknowledge the below-stated people and institutions by expressing my sincere gratitude for their contributions towards the successful completion of my studies.

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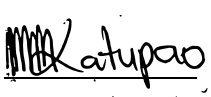
DECLARATIONS

I, Melissa Veronica Petronella Katupao, hereby declare that this study is my own work and is a true reflection of my research, and that this work or any part thereof has not been submitted for a degree at any other institution.

Melissa V.P Katupao		April 2023
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CHAPTER 1: INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 Background of the study

The HIV and AIDS pandemic has been a cause for concern worldwide and has brought many fatalities as well as social problems beyond the control of healthcare institutions (USAID, 2021). HIV is thought to have spread from non-human primates (chimps) to humans in Sub-Saharan Africa, particularly in the continent's west and central regions (Chavan, 2011). The spread was blamed on interactions between humans and animals. On the other hand, the peak of globalism in the early 1990s opened opportunities for human interaction in towns and cities (Chavan, 2011), and this fuelled the spread of the virus. Oramasionwu, Daniels, Labreche, and Frei (2011) assert that the spread of HIV was attributed to the emergence of cities on the African continent, which were characterized by more human interaction through sexual contact, leading to sexually transmitted diseases. The dynamics of society lay in the activities of the city, perhaps, where people could mix and mingle in their numbers (Opeodu & Ogunrinde, 2015). Furthermore, human sharing and reuse of unsterilized sharp objects in jabs and treatment procedures also led to the spread of the virus (Opeodu & Ogunrinde, 2015).

HIV and AIDS have been noted to be a global pandemic, and similarly to the rest of the world, Namibia is also affected by it. Namibia, on the other hand, is one of the countries most affected by the pandemic (USAID, 2021). As one of the worst-affected nations, Namibia joined the rest of the world in partaking in initiatives that would curb the pandemic. The Namibian government has approached the virus from a human rights angle (Ministry of Health and Social Services, 2010). As such, the country has

done commendably well in controlling the virus thus far using both preventative and curative methods (USAID, 2021).

In Namibia, social workers are among the key personnel that work within multidisciplinary teams and settings to help in responding to the HIV and AIDS pandemic. To combat the virus, social workers and other medical personnel collaborate in dealing with clients and the factors surrounding them. This is a multidisciplinary management setting for HIV and AIDS client treatment. The treatment approach is aimed at addressing clients' psychosocial problems that may hinder their medical treatment. Social workers thus look at all systems that impact the client's life and connect the clients to resources in the community to help address some of these needs (Ntshwarang & Malinga-Musamba, 2012). Mthimkhulu (2017) describes a multidisciplinary team in the healthcare environment as one that consists of doctors, nurses, social workers, and other specialists.

When providing treatment to HIV and AIDS-infected clients in a hospital and within a multidisciplinary team, social workers have different experiences of their work with clients as well as the institutional setting they work in (Mthimkhulu, 2017). These include not only negative but also positive experiences. Some of the negative experiences social workers experience are burnout, trauma, fatigue, and work-related stress (Wooten, Kim, & Fakunmoju, 2011; Mthimkhulu, 2017). It is therefore evident that the nature of the work requires exposing oneself to one or more of the above-identified experiences. Despite social workers being among the key personnel responsible for working with people affected and infected by HIV and AIDS, little is known about their experiences and the roles they play in hospital settings, where they

are mostly employed. Against this background, the study sought to explore social workers' experiences of working with HIV and AIDS clients in Namibia, focusing on the Khomas, Kavango East, and Oshikoto regions.

1.2 Problem Statement

Social workers in hospital settings are usually tasked with handling intimate, confidential, and personal matters of HIV and AIDS patients (Brown, Livermore, & Ball, 2015). Tayo and Makofane (2015) found that social workers expressed a range of experiences after working with HIV and AIDS-positive clients. These ranged from feelings of inadequacy due to the training they received about HIV and AIDS, limited infrastructure, and clients' expectations of how social workers should behave or handle themselves during therapy. Thus, working with HIV and AIDS clients can present various challenges for social workers, especially in secondary work settings. Contextually relevant research is needed in this area in each country, given the varied approaches and policies that guide practice in different countries. A review of the literature showed that there was very little research done on the experiences of social workers when they work as part of multidisciplinary teams in the treatment of HIV and AIDS patients within hospital settings. Freeman (2017) acknowledges the fact that, in the Namibian context, there is limited research done around social work services for people living with life-limiting illnesses. Research in this area is critical in informing the training needs and support systems of social workers in hospital settings. Against this background, this study investigated the social workers' experiences of working with HIV and AIDS-infected clients in selected Namibian state hospitals.

1.3 Aim of the Study

This study explored the lived experiences of social workers working with HIV and AIDS clients in public hospitals.

1.4 Research Objectives

The objectives of this study are thus as follows:

- to investigate the roles undertaken by social workers as part of multi-disciplinary teams that work with HIV and AIDS patients in selected state hospitals.
- to investigate social workers' perspectives on how they experience working with HIV and AIDS patients in selected state hospitals.
- to explore the institutional challenges that social workers working with HIV and AIDS patients in selected state hospitals face.
- to explore the coping mechanisms employed by social workers working with HIV and AIDS patients in selected state hospitals.

1.5 Significance of the Study

Given the paucity of knowledge on medical social work, the current study aimed to contribute to the body of knowledge in this area of inquiry. Documenting the experiences of social workers working with HIV and AIDS-infected clients in selected Namibian state hospitals contributes to the literature in an understudied area within social work education and practice in Namibia. Furthermore, this study contributed to the identification of existing gaps in the treatment guidelines for HIV and AIDS and

the role of social workers in hospitals, thus informing practice. The results of this study could also help shape ongoing, small-scale policy changes in medical social work.

1.6 Limitations of the study

Limitations are restrictions that are beyond the researchers' control when conducting research (Du Plooy-Cilliers, Davis, & Bezuidenhout, 2014). The below-stated limitations were experienced by the researcher while conducting the research:

1.6.1. Subjectivity

Based on the nature of the research that was conducted, the researcher acknowledges the level of personal involvement of the researcher. According to Ratner (2002), it is within the realm of subjective thinking that one even decides to research a specific topic. The importance of subjectivity and how it affects objectivity are illustrated. Objectivity means reasoning proven with facts, while subjective reasoning or interpretation merely depends on the personal biases of the researcher. Ratner (2002) notes that researchers' subjectivity is said to negate the possibility of knowing the social world objectively. The world that the researcher then paints or depicts within the research would reflect one's internal values (Ratner, 2002). The researcher, therefore, firstly did an in-depth introspection of their personal biases about HIV and AIDS and, most importantly, towards social workers. Such reflexivity helped the researcher develop more awareness and guard against subjective biases in the analysis of data.

1.6.2. Transferability

The relevance of this study beyond the sample group could have been an issue due to the sample size at which the study was conducted. Small groups seldom do justice when describing a holistic experience. While it was not the aim of the study to generalize findings, Daniel (2012) explains how different methods are used to ensure the practicality of the research beyond the immediate scope of participants. Similar methods as those used to ensure credibility were employed to ensure the relevance of subject matter beyond the confines of the research setting.

1.6.3. Participants

The researcher struggled with getting participants to take part in the study as it was conducted during the COVID-19 pandemic. Appointments were made, but some were cancelled at the last minute. Due to the researcher's determination to conduct the study, he would reschedule, wait for the participants to be ready, and return the following hour or day to collect data.

1.6.4. Distance

The second limitation was that this study focused on social workers within three different regions: the Kavango East, Khomas, and Oshikoto regions. Oshikoto region has three districts that are far apart. The researcher experienced financial constraints as transport, accommodation, and meals were self-funded. The researcher, however, managed to get funding from immediate relatives to help reach the intended destinations.

1.6.5. Population size

This is the entire group of participants or research subjects. However, the minimum number of social workers within a setting was three which was all that could be covered in some regions.

1.7. Delimitations of the study

The study included only social workers that work with HIV and AIDS-infected clients from selected state hospitals as the main research participants.

1.8 Theoretical Framework

The ecological system theory was developed by Urie Bronfenbrenner in 1979. The ecological systems theory, as defined and understood by Bronfenbrenner (1989), as cited in Ettekal and Mahoney (2017), defines and understands human development in the context of the organization of relationships that form the person. The ecological systems theory reveals that the environment is comprised of layers of organizations that interact in complex ways and can affect a person's development (Gabi, 2015). The different layers are as follows: microsystem, mesosystem, exosystem, and macrosystem. Gabi (2015) states that "the microsystem is a layer that constitutes a set of constructions with which an individual has direct contact, and the influences between the acquiring individual and these structures are bidirectional" (p. 22). The microsystem embraces the relationships and interactions that a person has in his or her immediate surroundings, for example, with friends and family members. Concerning the study, the microsystem (social work services) plays a part through direct contact with other smaller systems (HIV and AIDS patients and their families), and they tend

to influence the social attitude of an individual concerning social work services. The exosystem focuses "on those larger social systems in which an individual (social worker) does not directly function, for example, the household of the patient, which has a positive and negative impact on the patient." About the study: social workers have experienced various challenges through interaction and relationships formed between them and HIV and AIDS patients, their families, and communities.

1.9 Organisation of the report

The research report is organised as follows:

Chapter one

Chapter one gives the orientation of the study, focusing on the background, problem statement, research objectives, significance of the study, and theoretical framework that informed the study.

Chapter two

Chapter two focuses on the literature review of the study.

Chapter three

Chapter three discusses the methodological approach adopted by the researcher in carrying out the study.

Chapter four

Chapter four focuses on the presentation and discussion of findings.

Chapter five

Chapter five gives a summary of the study and presents the conclusions as well as the recommendations of the study.

1.10 Conclusion

HIV/AIDS remains a problem within Africa and the Namibian context. Social workers are part of the frontline workers tasked with responding to the psychosocial needs of those affected and infected. This study explored the lived experiences of social workers working with HIV and AIDS clients in public hospitals. It is hoped that insights from the study will contribute to both practice and policymaking, as well as knowledge on social work practice within hospital settings.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter provides a review of the literature on HIV and AIDS and social work intervention in clinical settings. The chapter also looks at literature from the global, continental, and Namibian settings that has to do with social work practice and HIV/AIDS in general.

2.2 Definition of Key Concepts

2.2.1 Client

A client is defined by the Social Work dictionary as a person (i.e., someone affected by a social circumstance that is interfering with their day-to-day functioning and thus approaches the social worker's office); or relative (i.e., a family member of the affected person seeking assistance from the social worker's office); or group/community (i.e., people living in the geographic environment who are the target group of social workers within the same vicinity) requesting or receiving psychosocial support (Garthwait, 2012).

2.2.2 Counselling

This is a rapport that is usually formed between two people or a group of people, and it entails a unique form of contact that seeks to provide assistance by empowering and revealing the client's resources in a confidential setting (Vîşcu, 2013).

2.2.3 Social Work

Social work is a practice-based profession and an academic field that promotes social change, social development, social cohesion, empowerment, and the liberation of people (International Federation of Social Workers, 2021, p. 1).

2.2.4 HIV and AIDS

The World Health Organization (2020) defines the acronym HIV as the human immunodeficiency virus, which attacks the immune system that fights off infections. The virus duplicates rapidly in the human body, defeating cells that protect the body and causing an infected person to be prone to various infections and diseases. If not treated with an antiretroviral therapy (ARV) regimen, the virus progresses to its terminal stage, acquired immunodeficiency syndrome (AIDS).

2.2.5 Micro-Level Social Work

This level of intervention concentrates on assisting the person seeking help, their families, and 3–6 people together, which involves training and providing therapy (Tropman, 2021). Micro-level social work is known to be the most practiced level of intervention. Tropman (2021) further explains that in medical settings, social workers work in conjunction with medical staff.

2.2.6 Macro Level Social Work

This level of intervention caters to the community level and focuses on the achievement of visible and undeveloped goals. This, for example, could involve building cohesion among community members (Tropman, 2021).

2.2.7 Mezzo (Meso) Level Social Work

This level of intervention cooperates with both the micro and Marco levels (Tropman, 2021).

2.2.8 Multidisciplinary Team

Worthington, O'Brien, Myers, Nixon, and Cockerill (2009) said that nurses, doctors, social workers, pharmacists, psychologists, and dieticians all work together in hospitals as part of a multidisciplinary team to help people with HIV get health care.

2.3 The History of Medical Social Work

Social work was first developed in Europe with the realization that social order through social and economic equality was needed in various communities and social settings (Jones & Lima, 2018). According to Bartlet (1975), cited in Kodner (2015), social work has also been attributed to the era of Gabot, a physician caring for clinical patients at a state hospital who realized that patients' medical treatment was affected by their many individual and family problems. Hence, the decision to introduce social workers to the Massachusetts General Hospital to work with physicians on patients' social problems concerning their medical treatment (Kodner 2015). In the 1900s, the need for social workers grew congruently with the rise of new diseases such as syphilis, polio, and HIV and AIDS. This created a need for social workers to bridge the gap between physicians and patients (Beder, 2006). This may have been the era where social work recognition became much more noticeable in communities where the affected and infected resided. Physicians also realized that living conditions and personal problems contributed to the recovery of their patients (Moradi, Mohraz, Gouya, Dejman, and Seyedalinaghi, 2014).

Perez (2012) explains that working with HIV and AIDS in a medical setting consists of a multidisciplinary team comprised of a physician, nurse, psychiatrist, and social worker. The role of the social worker was focused on assessing the client and the roles of the client's relatives, as well as the client's diagnosis and helping the doctors identify possible social and environmental threats that could affect patients' recovery (Mason & Merino, 2013). Thus, the role of social workers in the prevention, spread, and care of patients living with HIV and AIDS and their families cannot be underestimated. In addition to that, the recent noticeable improvement in HIV and AIDS patients and various control measures available through anti-retroviral therapy (ART) have shifted the role of social workers from concentration on health concerns to more chronic social concerns that affect patients and their families (Cain & Todd, 2009). Care for HIV and AIDS patients is now told more from a social than a clinical point of view.

2.4 Social Work in Namibia

The South African colonial rule in Namibia commenced in 1915 and lasted until 1990, when Namibia got its independence (Saunders, 2014). There is evidence that the profession of social work existed during this period, although the services of social workers were not offered to the "black Namibians" (Ananias & Lightfoot, 2012). White privileges were common, and black Namibians were left to pick themselves up, which did not do any justice to their social welfare, let alone their healthcare needs. Also, the white minority's inability to stop abusing social services would make it harder for black Namibians to use the services the state provides as citizens (Ananias & Lightfoot, 2012).

However, this is no longer the case in independent Namibia, which is now a constitutional democracy. Social work and psychology are now disciplines that are regulated by the Social Work and Psychology Council of Namibia, as stipulated in the Social Work and Psychology Act No. 6 of 2004 of the Republic of Namibia. The act is divided into seven sections, which are: (i) interpretation; (ii) establishment, objectives, functions, and powers of the Social Work and Psychology Council of Namibia; (iii) education, tuition, training, qualifications, and registration; (iv) offenses by unregistered persons; (v) disciplinary powers of the council; and (vi) general and supplementary provisions. The division of the act into these sections is to have a holistic act that covers all aspects of the profession and that relates to it.

The University of Namibia (UNAM) is the only institution in the country that provides training for professional social workers through a four-year integrated degree program (Freeman, 2017). This signals a crisis within the social work field as fewer people are trained for the profession, yet the social services provided by social workers are crucial in a country like Namibia with numerous social, health, psychological, economic, and environmental problems. UNAM offers a Bachelor of Arts with Honours in Social Work and a Master of Arts in Social Work (University of Namibia, 2021). Every year, the institution graduates 60–65 social workers (Tjihenuna, 2015). Yet again, the small number of graduates produced per year speaks volumes about the workload social workers face when executing their duties.

Social work training in Namibia exposes social work students to five methods of social work, mainly casework, group work, community work, administration, and research

(UNAM, 2021). It uses the international and continental approach to training, which has its roots in colonialism.

Freeman (2017) indicates that, for persons to practice as social workers in Namibia, they need to be registered with the Social Work and Psychology Council of Namibia. The individual must ensure participation in training accredited by the Council for their continued professional development to keep up with developments in their field of study. By taking this training, the professional will get Continuous Educational Units (CEUs) from training providers registered with the Health Professions Council of Namibia for Continuous Professional Development (CPD) (Freeman, 2017).

The Ministry of Health and Social Services (MoHSS) employs most of the social workers (Tjihenuna, 2015). Social workers in the MoHSS are distributed in hospitals and communities. A total of 500 social workers were reported to be registered with the relevant council in Namibia (Chiwara & Lombard, 2017). The MoHSS had a total of 143 posts allocated for the entire Namibian population (Amakali, 2013). The number of social work posts has increased, and the MoHSS now has a staff complement of 316 social workers across the country (MoHSS, 2020). Currently, within the staff complement of social workers in the MoHSS, the Chief Social Worker is the regional manager, while the Senior Social Worker manages at the district level, where there are three or two entry-level social workers (MoHSS, 2020). According to Freeman (2017), the social welfare and social work scene in Namibia evolved from a medical methodology of service delivery to a much broader-spread problem-solving base aimed at pushing the agenda for socioeconomic development.

2.5 Facets of social work and their challenges

2.5.1 School Social Workers

Social workers in this setting work specifically to provide services to learners enrolled in the school. They focus on issues that affect the learners' educational performance, peer relations, educators, and social lives (Kapur, 2018). Balli (2016) acknowledges that every child has the right to an inclusive education. Therefore, all educational institutions should have school social workers employed to ensure all children have a chance to complete their academics successfully. as "social support is essential for a person's general well-being" (Balli, 2016, p. 175).

Furthermore, Knox, Gherardi, and Stoner (2020) found several challenges faced by school social workers when joining the school after completing their studies at university: (1) They do not have the right skills to meet the needs of children; (2) They do not know enough about the work environment, like how mental disorders affect children and what policies are; (3) They do not have clear roles and responsibilities; (4) They do not get enough hands-on training to help them transition from college to the inclusive education setting; and (5) They do not know enough about policies.

To strive in the new work setting and respond to the different challenges faced, school social workers need to develop and employ some mechanisms. In research carried out by Knox et al. (2020), it was found that participants made use of different platforms to gain knowledge from their peers to catch up with the knowledge they lacked; participants made use of every opportunity on the job to learn from; they, furthermore,

sought for learning opportunities privately to gain knowledge and skills to successfully carry out their work.

2.5.2 Clinical Social Workers

These social workers provide care related to mental health needs, which ranges from information gathering to identifying mental health illnesses and providing therapy to affected clients. Furthermore, the researcher notes that clinical social workers need advanced training in mental health treatment to thrive in the work environment, including mastering mental health illnesses such as emotional, mental, and behavioural disorders, conditions, and addictions (Kapur, 2018, p. 2). Research, however, notes that psychological health in most African countries is an aspect that is largely uncultivated (Luzolo, Ndolo, & Sitawa, 2018).

It was found that clinical social workers help clients through casework, which deals with individual client issues and, when necessary, people in the client's circle who have an effect on the client. This is done by addressing socioeconomic factors, client needs that are needed to better function in communities, the needs of the needy, and other social ills (Kapur, 2018).

In a study by Luzolo et al. (2018), they noted that the profession consists of more female social workers than male social workers, but the male participants held and dominated the senior positions; secondly, the hospitals employed very few social workers; and thirdly, the provision for social work services within the hospital is limited. They further noted that because of the low number of clinical social workers employed in hospitals, social workers face challenges of high workloads and being

overburdened with large numbers of clients. Lastly, they found that social workers employed as clinical social workers did not have specialised training in mental health and that other professionals took up the responsibilities of social workers to lift their burden (Luzolo et al., 2018).

2.5.3 Child and Family Social Workers

Social workers in this area of specialty are responsible for children and families. They do this by providing them with the necessary therapy, addressing issues ranging from academics to socioeconomic needs to poverty-related issues and social factors hindering their well-being as individuals or members of a family unit (Kapur, 2018). Eneh, Nnama-Okechukwu, Uzuegbu, and Okoye (2017, p. 191) state that child welfare services are rendered to pupils aged 18 and below, and these services include "child maintenance, adoption, fostering, and child justice-related services."

2.5.4 Medical Social Workers

Yesudhas, Malar, and Laavanya (2014) describe social work as a specialisation in the social sciences. Through advocacy casework, social workers help clients get a perspective on their illness and the issues that they are facing (Kadarisman, 2019). Medical social workers often work in hospitals, mental health facilities, and clinics. They also work in community health agencies, nursing homes, and drug treatment centres (Dako-Gyeke, Boateng, & Mills, 2018, p. 107). For those that are based in hospitals, social workers deliver as well as aid with the socio-emotional needs of patients, and these needs are believed to have an impact on the client's illness and recovery (Kadarisman, 2019). Medical social workers are acquainted with the possible impact of disclosing the results of chronic illness in a positive and hopeful way to a

patient (Ntshwarang & Malinga-Musamba, 2012). Based on their training in different social and psychological theories, social workers have the knowledge to assist patients in dealing with the impact of disclosure and, in the long run, the conflicting medical prerequisites and socio-cultural values of treatment (Ntshwarang & Malinga-Musamba, 2012). Thus, the social worker`s role, in this case, is that of positivity, optimism, hope, and encouragement.

The WHO (2020) recommends national guidelines as well as a curriculum for all healthcare professionals to incorporate aspects of psychosocial support in the treatment of people living with HIV and AIDS. Social workers should also be proactive in record-keeping, documentation, and evidence-based practises consistent with professional and ethical standards (Wooten, Kim, & Fakunmoju, 2011). This applies to whether they work in a hospital setting or not, but most importantly, it may be imperative for them to work hand in glove with administrative staff in the hospital setting if accurate record-keeping and documentation are to be well maintained.

WHO (2020) also acknowledges that social workers are understaffed in hospital settings that provide psychological treatment, as there are not many trained across the world. In a study on HIV service delivery among health professionals in Canada, it was found that 80 percent of the time, most physicians and nurses would refer HIV clients to social workers for psychosocial support services (Worthington, O'Brien, Myers, Nixon, & Cockerill, 2009). Apart from specifically performing duties in hospital settings, the social work profession aims at treating social ills and finding ways to solve these issues by intervening at micro, mezzo, and macro levels of intervention (Mthimkhulu, 2017). Also, when helping a client, social workers don't

just deal with the client; they look at the client as a whole, taking into account the systems in which the client lives (Toner, 2016).

2.6 HIV and AIDS Epidemic and Universal Access to HIV and AIDS Services

HIV and AIDS have been identified as major health challenges around the world, and they have had a significant impact on Africa. The illness has become a global problem that has brought many countries together to jointly fight its eradication (Mutevedzi & Newell, 2014). According to UNAIDS (2017) statistics, about 36,900,000 people are estimated to be living with HIV and AIDS globally, of whom 25% are suspected to be unaware of their status. This can be attributed to the fact that people have a negative attitude towards pre-testing for HIV and AIDS due to fear of the unknown as well as stigma. Since the first case of HIV, globally, a total of 77 300 000 people are estimated to have contracted the virus, of whom 35 400 000 have died as a result (UNAIDS, 2017).

Namibia's first HIV and AIDS cases were recorded in 1986, and at that time, there was a steady prevalence (MOHSS, 2010). According to USAID (2021), currently, Namibia ranks among the countries greatly affected by HIV, with a 14% prevalence rate and an estimated 217 000 people living with HIV and AIDS. due to the high rate of HIV and AIDS infections in Namibia and other factors (MoHSS, 2020). The country has achieved notable progress towards universal access to HIV and AIDS services for infected and affected persons (MoHSS, 2020). Thus, access to HIV and AIDS services has become a human right. The MoHSS (2017) identified strategies to focus on and strengthen for the treatment and prevention of HIV and AIDS in Namibia. The MoHSS (2017) use the combination prevention approach, under which the interventions are

divided into two categories: population-based interventions and service-based interventions. The population-based interventions include services for adolescent girls and young women, prevention programmes for key populations, and male involvement (MoHSS, 2017). The service-based interventions are: prevention of mother-to-child transmission; condom promotion and distribution; voluntary medical male circumcision; prevention of mother-to-child transmission; and pre-exposure prophylaxis (MoHSS, 2017). Furthermore, other strategies include HIV testing services, STI prevention and management, post-exposure prophylaxis, and social behaviour change communication (MoHSS, 2017).

According to the AIDS Law Unit (2009), human rights are universal and inalienable, meaning, firstly, that all human beings have the same rights. Secondly, persons infected with HIV and AIDS should be accorded the rights to health, privacy, non-discrimination, access to information, and education just like other citizens. Stigma and discrimination have long been known to be contributing factors that are limiting people living with HIV and AIDS from seeking healthcare (Ullah, 2011). All patients have the right to be treated with integrity and dignity, meaning they have the right to confidentiality and privacy when seeking healthcare (AIDS Law Unit, 2009). According to Iravani, Esmaeilzadeh, and Parast (2014, p. 212), "the bio-psychosocial model is based on the general systems paradigm and proposes that disease and illness can only be truly understood by evaluating all potential contributing factors, including the social and psychological context." Understanding what social workers have been through and figuring out if they are able to protect their clients' rights under their current working conditions will help the Ministry, its social workers, and their clients a lot.

2.7 Social work and HIV and AIDS

HIV and AIDS treatment goes beyond the use of anti-retroviral therapy, as family involvement is encouraged, as is a proactive change in lifestyle (Beder, 2006). Feelings of worthlessness, helplessness, and a loss of bodily autonomy are experienced by AIDS clients. While feeling this way, clients are forced to trust the medical service providers, whom they could perceive as strangers since they do not know them, which may lead to stigma. But the addition of social work services builds on the idea that social workers train patients' minds to deal with their illness and help patients, doctors, and families talk to each other better (Beder, 2006).

HIV and AIDS patients need as much support as they can get from healthcare workers, families, and the entire community. Hence, there is a need for social work services to help patients (who are infected) and their families (who are affected) accept and cope with the situation at hand through some sort of institutionalised intervention. Given the complex physiological, psychological, and social problems faced by persons living with HIV and AIDS, healthcare providers must work in collaborative teams to provide the best possible care for client groups (Olivier & Dykeman, 2003).

2.8 Role of social workers in dealing with HIV and AIDS clients

The realisation that one has contracted HIV and AIDS has many negative consequences, such as suicide, depression, and stigma. However, social workers are available to help clients with disclosure, acceptance, and coping strategies. Hence, Tayo and Makofane (2015) explain that psychosocial support provided to clients infected with HIV and AIDS comprises therapy and revealing positive results to

patients, which includes the advantages of patients sharing their positive results with those close to them. In terms of the treatment of patients with HIV and AIDS, social workers scale up access to prevention, treatment, and control over patients (UNAIDS, 2017). However, although social workers are an integral part of the treatment process, Ipinge, Hofnie, van der Westhuizen, and Pendukeni (2006) found that social workers did not fully utilise their skills because the hospital setting did not afford them the opportunity. The study also found that patients had little knowledge about the roles of social workers in the hospital setting (Ibid.).

2.9 Institutional challenges faced by social workers with HIV and AIDS patients

Working in hospitals with HIV and AIDS patients has both positive and negative aspects for social workers. Olivier and Dykeman (2003) reported that social workers deal with issues faced by HIV and AIDS patients, such as the death of patients as well as a high workload, stigma, and a lack of resources. Whereas Ntshwarang and Malinga-Musamba (2012, p. 1) found that "the role of social workers in hospitals is often not understood by both the health care workers and the general public." Hence, the misunderstanding of the mandate of social workers weighs heavily on their ability to perform their tasks well, especially when dealing with patients, families, and communities that misinterpret their duties. Social workers often deal with case management problems when dealing with HIV and AIDS patients. Considering the above, a study by Rujumba, Mbasaalaki-Mwaka, and Ndeezi (2010) revealed some challenges social workers face in working with HIV and AIDS patients, children, and caregivers, as they may refuse to disclose to the child that they are HIV positive. It thus becomes difficult for the social worker, as they have a daunting task to convince and mediate between parents and children, as well as offer support services in the

aftermath of status disclosure. In the same way, Nakazibwe (2010) talked about Chernesky's view of casework management in HIV and AIDS, which is based on the ecosystem's perspective of social work. This view says that problems happen when a person's environment doesn't match up with his or her needs, abilities, rights, and goals.

2.10 General Fear and Difficulty Working with HIV and AIDS Clients

Ndou, Maputle, and Risenga (2016) found that although healthcare workers (HCW) received training on HIV and AIDS and HIV and AIDS counseling, they still experienced fear when working with HIV-positive clients. In his research, Kulu (2014) found that people who worked with HIV and AIDS clients said the biggest problems were telling children about their parents' HIV status, people denying they had HIV, being poor, and PLWHA being afraid to tell others because they might be rejected. Ulrich, O'Donnell, Taylor, Farrar, and Danis (2007) found that most social workers felt helpless, surprised, and depressed when a client's problem had ethical implications that made it hard for them to treat the client effectively.

Mthimkhulu (2017) describes a multidisciplinary team in a healthy environment as one that is made up of doctors, nurses, social workers, and other specialists. The health workers in this team aim to provide a holistic approach to treating the client by providing their expertise in the case of the specific client (Spies, 2008). According to Mthimkhulu (2017), Cowles and Lefcowitz (1992) investigated how a multidisciplinary team perceived the role of social workers in health settings.In this study, the researcher found that the multidisciplinary team both questioned the social worker’s capabilities and questioned the use of certain social work models. Although

the research was carried out more than 25 years ago, it shows relevance as the research trends produced similar results. As Limon (2018) found in his recent study with medical social workers, they felt that other health professionals were not familiar with the function of social workers. Spies (2008, p. 127) describes the role of the social worker in a multidisciplinary team as "the major function of the social worker in this context is to improve the quality of life of the patient and his or her social functioning by supporting adherence."

This further raises a concern for social workers and their work experience, as the misunderstanding by their colleagues in health may pose a barrier to them effectively carrying out their work. Gregorian (2005) put forth the idea that social workers in hospitals are not seen as occupying a superior role as team members, and their role is to work in a group to provide a comprehensive treatment service for the client. According to Mthimkhulu (2017), four out of the 10 participants (social workers) reported that their colleagues not only questioned the capacity of social workers but also perceived them negatively. However, Spies (2008) found that the hierarchy in a multi-disciplinary team placed medical doctors at the top, followed by nurses, with other health workers and social workers right at the bottom of the list. Gregorian (2005) concurs with Spies (2008), and he states that being aware of the hierarchy that exists between doctors, nurses, and social workers can reduce irritations that could arise between the professionals. The researchers further found that this ranking also demonstrated how HIV and AIDS are viewed and treated, especially the fact that using medicine to fight the illness is a priority. Studies have found that psychosocial factors determine if the client will adhere to treatment, and as such, it is important to recognise the key role played by social workers in these contexts.

2.11 Gaps in Literature

Cowles and Lefcowitz (1992) conducted a study on the interdisciplinary expectations of medical social workers in the hospital setting. Furthermore, Cowles and Fort (2000) studied social work in the health field, and Freeman (2017) studied social workers' perceptions of their role in providing palliative care to patients with life-limiting illnesses; this was conducted within Namibia. A study like the aforementioned reading is by Rujumba et al. (2010) on the challenges faced by health workers in providing counselling services to HIV-positive children in Uganda. A substantial amount of data still needs to be obtained to understand the specific experiences of social workers working with HIV and AIDS clients, specifically those in the Namibian health care setting. Consequently, this study is expected to add to the knowledge base of the experiences of social workers working with HIV and AIDS clients in Namibian health settings and fill this gap in the literature.

2.12 Conclusion

This chapter focused on a review of the literature on social work in health settings. The researcher discussed the historical background of the profession abroad and within Namibia, focusing on medical settings. The chapter explored the dynamics involved in medical social work practise and the experiences that social workers face as professionals in the helping process. The chapter further explored the gaps that exist in literature. Chapter three, which follows, discusses the research methodology applied to this study.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

The chapter will focus on the methodology that was used to carry out the study. The chapter will go into detail about the research approach, the research design, the research population, the sampling design, the research instrument, the data collection methods, the steps taken to make sure the study is trustworthy and accurate, and the research ethics.

3.2 Research Approach

The researcher used a qualitative approach to be able to get the first-hand facts and "lived" experiences of participants (social workers dealing with HIV and AIDS clients) (Du Plooy-Cilliers, Davis, and Bezuidenhout, 2014), which usually form the basis for accurate accounts of the phenomenon under study.

According to Du Plooy-Cilliers et al. (2014), qualitative research aims to uncover the fundamental attributes of the participants and how they connect those to an event. This approach allowed for the gathering of information from the sources about lived experiences and explanations of how these experiences have impacted them. Because this study aimed to uncover the experiences of social workers working with HIV and AIDS-infected clients, the qualitative research approach was the most suited to conduct this research and for the researcher to document the exact experiences of social workers (participants) in the given hospital settings. Qualitative research mainly depends on the language and the translation of its meaning; therefore, data collection

techniques require close interaction with participants (Du Plooy-Cilliers et al., 2014). resulting in a task of knowledge development rather than testing (Walliman, 2006).

3.3 Research Design

Due to the nature of this research topic, the researcher adopted a phenomenological research design, which Creswell and Creswell (2018, p. 13) described as "deriving from philosophy and psychology, which allows the researcher to define the lived experiences of individuals about a phenomenon as described by participants." This design views people's interactions as a result of how people see the world around them, and this gives the researcher an insider perspective of the participants' world (Mohajan, 2018). In this case, the social workers gave their lived experiences or the experiences they faced in their everyday work with clients with HIV and AIDS, meaning that the information gathered was first-hand, value-laden, and subjective.

3.4 Population

For this study, the population was comprised of state social workers from three different regions in Namibia, specifically the Khomas, Kavango East, and Oshikoto Regions. The Khomas, Kavango East, and Oshikoto regions' social workers were chosen because they worked within hospital settings.

3.5 Sample

A convenience or availability sampling technique was used to select eleven (11) medical social workers from the three regions. Convenient sampling implies selecting participants depending on their availability at the time the interviews are being carried out (Bless, Higson-Smith, & Sithole, 2013). Therefore, the social workers who were

readily available to share their experiences were chosen to participate. These social workers had worked a year or longer for the Ministry of Health and Social Services (MoHSS) and were employed as senior or entry-level social workers. This benefited the research as the participants were well-informed and experienced working within the health setting and with people affected by HIV and AIDS.

3.6 Research instruments

A semi-structured interview guide was used as the main instrument for data collection in the study. The advantage of a semi-structured interview guide is that an interviewer can probe more or diverge so that they can solicit more information on issues of interest that are relevant to the research. (Bless et al., 2013). A pre-test of the research instrument was conducted with the chief social worker from the MoHSS to see if the interview guide yielded the expected results. The chief social worker who took part in the pilot study was not included in the main study.

3.7 Data collection procedures

The researcher collected data through in-depth interviews using a semi-structured interview guide, with English as the mode of communication. Social workers from the Khomas, Kavango East, and Oshikoto regions were contacted before the interviews to let the participants decide on the place and time of the interview. The interviews lasted for approximately 2 hours and were conducted in the offices of the respective social workers. De Vos, Strydom, Fouché, and Delport (2011) say that semi-structured interviews should be used to get a clear picture of the participants' real-life experiences

and worldviews while giving the researcher a chance to ask questions that lead to detailed answers.

The researcher rephrased questions without changing the meaning of the questions to help participants better understand the questions, as noted by De Vos et al. (2011). Furthermore, the participants were perceived as experts and could highlight a problem the researcher may not have thought of. With the participants' permission, the researcher used a voice recorder and took notes during the interviews to make sure they didn't forget anything important that was said.

3.8 Data Analysis

Braun and Clarke's six-step model of thematic analysis, which is one of the commonly used methods of analysis in qualitative research (Howitt & Cramer, 2017), was employed for the analysis of the data collected. The following steps were used in the data analysis process:

Step 1: Become acquainted with the data.

The researcher went through all the collected data by compiling all the field notes and transcribing the recordings. The researcher then read through the compiled complete transcripts several times to familiarise himself with the data.

Step 2: Start coding.

All data were compared and grouped or clustered according to similarities.

Step 3: Create Themes

The grouped information was then labelled, and themes were developed to identify the data.

Step 4: Connect Findings, Literature, and Research Questions

Findings from primary data (the data collected) were connected with the findings from previous research to see if the data answered the initial research question.

Step 5: Justification of Developed Themes

The themes were looked at again, connections between them were made, and quotes were chosen to back up each theme in preparation for writing.

Step 6: Documentation

These themes were then used to guide the write-up phase.

3.9 Trustworthiness and credibility

Since the study was qualitative in nature, the trustworthiness of qualitative research is often questioned because the main scientific constructs are usually depicted numerically to prove validity and reliability. Credibility, dependability, confirmability, and transferability were criteria set to determine trustworthiness (Connelly, 2016). Credibility deals with the congruency of the findings with reality. Proving credibility is one way to enhance the trustworthiness of the research. To ensure the credibility of the research findings, the researcher used multiple participants' accounts. Detailed descriptions of participants' accounts that capture the meanings arrived at during data

analysis were captured in the research report to ensure the credibility and trustworthiness of the research findings.

3.10 Research Ethics

3.10.1 Ethical clearance and permission to conduct research

According to Bryman (2016), the researcher must obtain ethical clearance before conducting a study with human subjects. Ethics clearance was sought from UNAM's Ethics Committee before data permission commenced. Furthermore, permission was sought and granted from the Ministry of Health and Social Services to collect data from social workers.

3.10.2 Informed consent

The researcher explained the research and how the findings would be used to the participants, and the participants agreed to participate in the study (Welman, Kruger, & Mitchell, 2005). The researcher provided all participants with consent forms to sign stating their involvement in the study, when they can withdraw from participation, their voluntary involvement, and how the data will be used. All this was done before conducting the research.

3.10.3 Harm to participants

No potential harm to participants was anticipated in this research. Though the concept of harm to participants cannot be completely identified beforehand, the researcher did identify a few measures to protect the participants and employ some measures for assistance (Bryman, 2016). In this study, the participants were informed of whom to contact if any emotional or physical harm was caused by participating in the study.

3.10.4 Confidentiality

The researcher protected all data gathered within the scope of the project from being divulged or made available to any other person. All information was treated with confidentiality. Therefore, all data is stored on a password-protected computer and will only be discarded after five years from the date of collection. All information was treated with confidentiality, and no one other than the researcher has access to the data. No identifying details of all participants will be included in the final research report or the researcher's notes.

3.10.5 Voluntary participation

Participation was voluntary. No one was forced to take part in the study. Furthermore, the participants were informed that they could withdraw from the study at any time.

3.11 Conclusion

This chapter focused on research methodology. The researcher discussed the research approach which was qualitative in nature in order to get the first-hand facts and "lived" experiences of participants. The chapter further discussed the population, sampling use in the study, the research instruments, the data analysis method and process and lastly the ethical considerations.

CHAPTER 4: FINDINGS AND DISCUSSIONS

4.1 Introduction

In this chapter, the researcher presents and discusses the study's findings. The findings are guided by the objectives of the study. The main themes and sub-themes that emerged during the data analysis process are discussed under the relevant objectives that the study sought to address.

The first part of the chapter presents the demographic details of participants, including their sex, the regional distribution of participants, and the years of experience of the participants. The second part of the chapter presents the themes and sub-themes described above. The themes seek to meet the four main objectives of the study, which are:

- to investigate the roles social workers, undertake as members of multi-disciplinary teams that work with HIV and AIDS patients in selected state hospitals,
- to investigate social workers' perspectives on how they experience working with HIV and AIDS patients in selected state hospitals.
- to explore the institutional challenges faced by social workers working with HIV and AIDS patients in selected state hospitals.
- to explore the coping mechanisms employed by social workers working with HIV and AIDS patients in selected state hospitals.

4.2 Demographic details of participants

Table 1: Demographic details of participants

Participant	Age	Sex	Region interviews took place at	Years of Experience
1. A	31	Male	Kavango East	5 years
2. B	33	Female	Kavango East	2 years 5 months
3. C	25	Male	Kavango East	1 year 3 months
4. D	40	Female	Khomas	7 years
5. E	41	Female	Khomas	10+ years
6. F	48	Female	Khomas	7 years 6 months
7. G	26	Female	Oshikoto	2 years
8. J	27	Female	Oshikoto	3 years 10 months
9. L	32	Female	Oshikoto	10 years
10. M	35	Female	Oshikoto	1 year
11. N	40	Female	Oshikoto	7 years

Table 1: Demographic details of the participants

4.2.1 Age distribution of participants

Participants in this study were aged between 25 and 48 years. These ages fall between the developmental periods of early adulthood and middle adulthood. Figure 1 below indicates that seven of the participants are in the early adulthood stage of development and that four are in the middle adulthood stage of development.

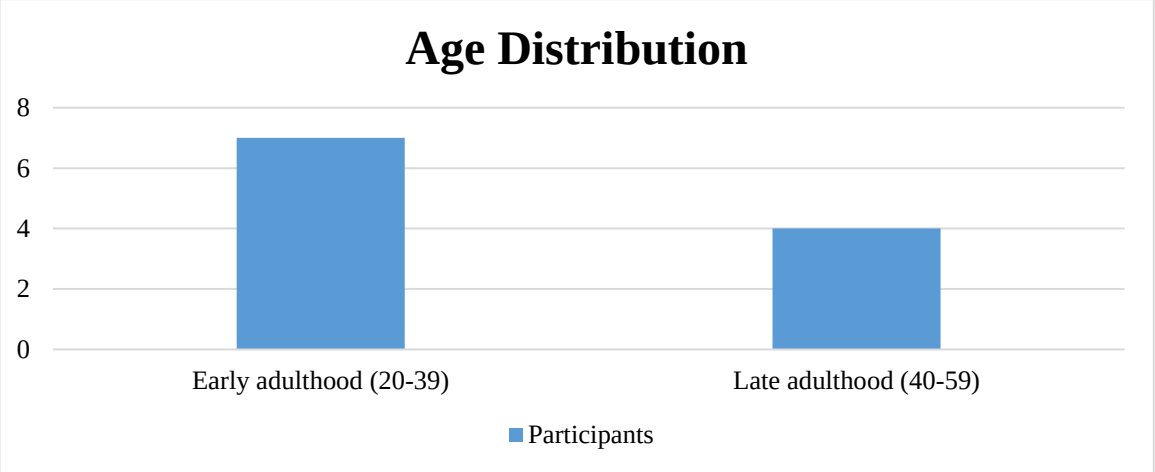

Figure 1: Participant Age distribution

4.2.2 Sex distribution of participants

As indicated in Figure 2, nine out of the 11 participants were female, whereas the other two were male.

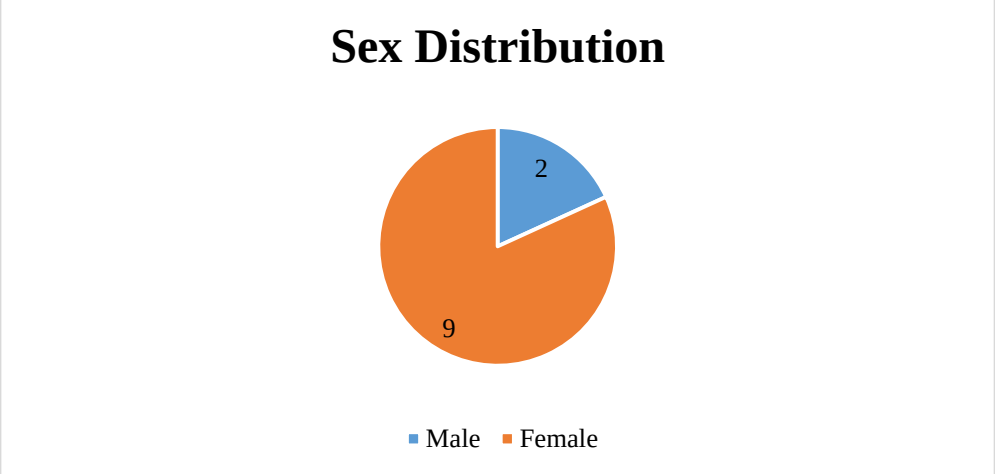

Figure 2: Distribution of participant sex

4.2.3 Years of work experience

Figure 3 shows an indication of participants' years of experience as social workers. Participants that worked for a period of 1 to 2 years in the study were four, whereas one participant had worked for 3 and a half years, one had six years of experience, and five participants had between 7 and 10 years of work experience.

Figure 3: Years of experience

4.2.4 Regional distribution of participants

The pie chart labelled "Figure 4" below indicates the distribution of participants from three major regions. It says that there were five people from the Oshikoto region, three from the Khomas region, and three from the Kavango East region.

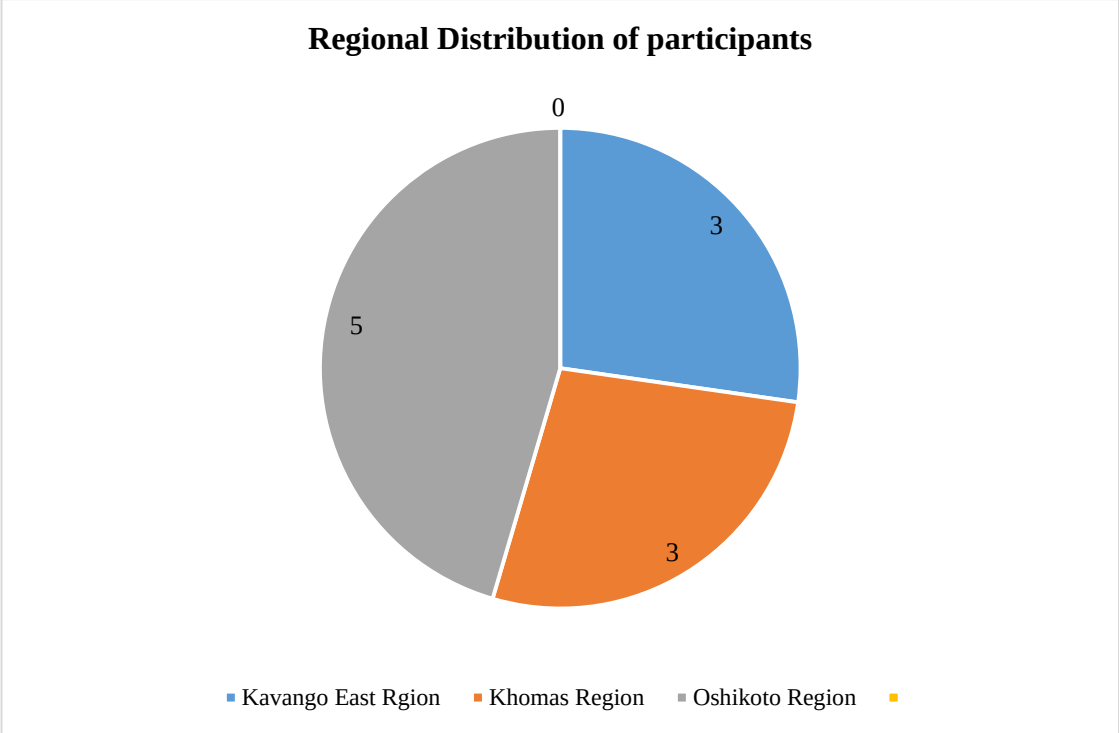

Figure 4: Regional distribution

4.3 Themes and Sub-themes

Table 2 shows the study's results, which are then talked about in terms of themes and subthemes.

Objectives	Themes and Sub-themes
4.3.1 Objective 1: ROLES UNDERTAKEN BY SOCIAL WORKERS AS PART OF A MULTI-DISCIPLINARY TEAM WORKING WITH HIV AND AIDS PATIENTS IN SELECTED STATE HOSPITALS.	4.3.1.1 Theme: Facilitator role 4.3.1.2 Theme: Educator role 4.3.1.3 Theme: Linkage role 4.3.1.4 Theme: Assessor role 4.3.1.5 Theme: Psychosocial Support 4.3.1.6 Theme: Mediator 4.3.1.7 Theme: Advocate role
4.3.2 Objective 2: PERSPECTIVES ON HOW SOCIAL WORKERS EXPERIENCE WORKING WITH HIV AND AIDS CLIENTS IN SELECTED STATE HOSPITALS	Theme: Positive Experiences 4.3.2.1 Sub-theme: Medical social work has an enriching learning environment. 4.3.2.2 Sub-theme: Diversified working environment 4.3.2.2 Sub-theme: Opportunity of Learning from Other Professionals 4.3.2.4 Sub-theme: Compassion Satisfaction Theme: Negative experiences 4.3.2.5 Sub-theme: Medical Social work is mentally demanding.

	4.3.2.6 Sub-theme: Medical social work can lead to trauma. 4.3.2.7 Sub-theme: Medical social work causes burnout. 4.3.2.8 Sub-theme: Medical social workers to question their usefulness in carrying out their work
4.3.3 Objective 3: INSTITUTIONAL CHALLENGES THAT SOCIAL WORKERS WORKING WITH HIV AND AIDS PATIENTS IN SELECTED STATE HOSPITALS FACE	4.3.3.1 Theme: Lack of relevant policies and guidelines on social workers working with HIV and AIDS affected clients. 4.3.3.2 Theme: Lack of office space, furniture, and equipment 4.3.3.3 Theme: Poor supervision 4.3.3.4 Theme: Lack of in-service training, workshops, and formal training 4.3.3.5 Theme: Lack of resources for case management and community activities 4.3.3.6 Theme: Social workers suffer human resources management injustices
4.3.4 Objective4: COPING MECHANISMS EMPLOYED BY SOCIAL WORKERS WORKING	4.3.4.1 Theme: Case review/Debriefing 4.3.4.2 Theme: Supportive Colleagues 4.3.4.3 Theme: Positive self-talk

WITH HIV AND AIDS PATIENTS IN SELECTED STATE HOSPITALS.	4.3.4.4 Theme: Taking time off from work 4.3.4.5 Theme: referring to colleagues. 4.3.4.6 Theme: Spirituality 4.3.4.7 Receiving therapy

4.3.1 Objective 1: Roles undertaken by social workers as part of a multi-disciplinary team working with HIV and AIDS patients in selected state hospitals

The first objective of the study was to explore the role of social workers working in multi-disciplinary teams at state hospitals dealing with HIV and AIDS-infected clients in the Kavango East, Khomas, and Oshikoto regions. The following themes emerged from the study:

Theme: Facilitator role

Theme: The role of the educator

Theme: The role of linkage

Theme: Assessor role

Theme: Psychosocial Supporter/Counsellor Role

Theme: Mediator

Theme: Advocacy role

4.3.1.1 Facilitator role

Social workers in hospitals play a vital role in client medical treatment by facilitating client-doctor or nurse relationships. This role consists of social workers nurturing the client-practitioner relationship, making sure the client's voice is heard, and taking into consideration the client's psychosocial needs. The participants narrated their role as facilitators in fostering the client-practitioner relationship, along with why they play the facilitator role. Participants also indicated that this role is mainly carried out when dealing with clients who are in default. Participants also said that as social workers, they help a client who is being treated by a team of experts from different fields.

Participant D*: "We facilitate the treatment process between the patient and other professionals." Social workers have to provide counselling to clients who have missed a number of sessions before we can recommend that they start their treatment again. "We facilitate the treatment process between the patient and other professionals."*

Participant E*: "We facilitate the relationship between medical staff and patients as well as the interaction for information to be shared in the right manner."*

Participant F*:* "We facilitate the *treatment process of patients between patients and the multi-disciplinary teams, especially those that are chronic defaulters as well as the drug-resistant patients." When someone tests positive at the CDC, the CDC staff refers the client to me. I assess if they are ready to take the medication there and then; we call it "initiation." Or if they need time to talk to their spouses or simply think about it, but normally I don't give an open period of time. I have to be specific. because remember, this person could go and start spreading the virus). So, I give them two*

days at most. If you do not come, I will call and ask you to come to the hospital, so we can discuss again. Because of the availability of mobile communication providers, our HIV clients can easily change their phone numbers. And at times, when I follow up, the number is no longer reachable.

Social workers in selected state hospitals that work with HIV and AIDS-infected clients indicated that they use the role of a facilitator within their practice. The role comprises social workers facilitating communication between health care providers and HIV- and AIDS-infected clients. Social workers use the role of a facilitator to ensure that clients' backgrounds are better understood by the medical staff, especially the medical staff that are directly involved in the treatment process of the affected client. It also aims to make sure that clients' treatment plans are tailored to suit the HIV- and AIDS-infected client's treatment needs. Facilitation for social workers initially starts after the patient is diagnosed. The patient, after receiving their positive results, receives brief counselling at the Centre for Disease Control and is then referred to the social worker for further assessment and a recommendation for treatment, either immediately or later. The social workers do follow-up calls and counselling until the patient is ready to start their ART treatment. Social workers indicated that the process is a delicate one given that some patients, out of shock or psychological dilemma, could go and further spread the virus if they are not helped to accept the situation and embrace having to live positively. The role of the facilitator in social work is to link clients and medical staff in the treatment management of HIV (Spies, 2008). In other words, social workers are members of the multidisciplinary treatment team, and they

are the ones who facilitate communication between the client and other medical personnel (Mason & Merino, 2013).

4.3.1.2 The role of the educator

Another important role that participants identified is that of an educator. Social workers educate their clients on health-related issues surrounding HIV/AIDS and treatment. Furthermore, they also educate other professionals on psychosocial factors that may hinder client treatment plans. Participants noted that they carry out the task of an educator by providing their clients with information about HIV and AIDS to encourage them to adhere to treatment and reduce the risk of them defaulting on treatment. The role is further used to help professionals within the multidisciplinary team get an understanding of their clients and give insight on their circumstances that may hinder or foster treatment. The following quotes from participants give an account of social workers' roles as educators:

Participant A: *"We get clients that are defaulting. It is not necessarily because they want to default. But it is actually because of a lack of understanding. They do not understand the need for them to take their medication. So, the social worker comes in, and we try to educate them on the importance of adhering to their medication and why they should take their medication on time.*

Participant B: "We also carry out the role of an educator." We provide information on the treatment so that they can understand why it is necessary for them to take their medication. And if they do not take their medication, then what happens? So, we educate them in all those areas. And even with family members, we also inform them why it is necessary for this person to come for follow-up updates at the hospital. And

if the person doesn't come back, what will be the consequences of that? So, we educate both the family and the client. You find that sometimes the nurses just give medications, but they won't necessarily explain them. Then they come to your office and ask you about medication. Then you call the nurse to come over and explain how the medication works and how to take it. The patient realises that taking this medication helps with this and that.

Participant M: *"Health education is part of our work." So, after conducting your assessment, we identify that clients do not understand why they are taking their medication. So, you educate them and make them understand why it is important. "We also educate other professionals to get an understanding of the client's psychosocial background."*

Participant E: "We get referrals from the medical team about patients who have psychosocial issues that impact their treatment plan. So, what we basically do is try to investigate the root of the problem so that they can adhere to treatment. It also has to do with explaining to patients their diagnosis in a way that they can understand and the changes they need to make for the treatment plan to work. "For the multi-disciplinary team, we educate the team on the impact of psychosocial conditions on health and the treatment plan."

Upon diagnosis, most clients do not know about their illness or the meaning of their diagnosis, and health practitioners such as doctors and nurses do not have the time to thoroughly explain to the client and at the same time deal with the emotional needs of the client at that time. It is, therefore, the role of social workers to educate clients about their diagnosis and treatment while providing therapeutic as well as psychosocial counselling to them. The findings indicate the educator's role is to educate patients

about their diagnosis, the disease, and the treatment thereof. In doing so, social workers help clients gain an understanding of the disease, which will help them adopt lifestyle changes that will impact their lives positively. In addition to that, the findings indicate the role is used to educate other professionals within the multi-disciplinary team. This is for them to get an understanding of the client and the factors surrounding the client's treatment. This is aligned with the literature, which indicates that the educator's role in social work comprises equipping clients or community members at large with the latest and most relevant information as well as fostering behaviour change (Mthimkhulu, 2017).

4.3.1.3 Linkage role

Linking clients to stakeholders to help them receive goods and services was identified as a role played by social workers in health settings. Participants narrated that the main reason they link their clients affected by HIV and AIDS to other service providers is due to a lack of food and that they not only make use of hospital-based stakeholders but also those outside the hospital's walls. Most clients are not aware of the other services they can get outside of the hospital setting to help with their welfare and well-being. In this regard, social workers are a critical resource, linking clients to other organisational systems and resources.

Participant A describes their role as a linker: *"Linking patients to needed services; let's say, for example, the person is suffering from a social ill and is on HIV treatment, but the person is not taking their tablets because they lack food. So, link them to either the ministry of poverty or gender to be registered for social grants, or alternatively, we*

ask for sponsors around other NGOs to assist our clients with the necessary food and services that the client may need."

Participant B: *"You will find that clients are not taking their medication, and it could be that there is no support system at home or that there is a lack of food." And if there is a lack of food and you discover that the client is under the age of 18, has national documents, but is not receiving social grants, "we always link them to the gender ministry so that they can obtain the social grants."*

Participant E: *"We link patients to services from a variety of service providers within the ministry and outside the ministry." For example, mostly in health with regards to linkage, I like sending people to the mental health unit, the psychiatric unit, or the ministry of gender when children with HIV are involved and are struggling with their health. Though HIV is not a disability, some complications lead to disability, though they are not eligible for disability grants. And in other cases, at the ministry of labour and social welfare, many of our patients have chronic, long-term health issues, so we refer them for disability grants. We then use local NGOs for food and material supply. We also work with churches that would like to help their members. And also, the community at large. "We have a lot of support from the community in terms of donations" and "family members to help the sick patients."*

Participant E: *"We link patients to different service providers within and outside the hospital." Within the hospital, we link patients to mental health services—the psychiatric unit, ministry of gender, and child welfare—especially for children living with HIV and AIDS who are struggling with their health. HIV is not a disability, but*

sometimes there are complications that can cause disability, though they are rare. We also connect patients to labour ministry and social welfare services, particularly for chronic patients with long-term health issues who qualify for disability grants. as well as local NGOs for food and material supply, as well as churches whose members we are treating and the community at large. "We have a lot of support from the community in terms of donations and family members in terms of sick relatives."

According to the study findings, social workers in health settings have very few to no resources to offer their clients in order to mitigate client issues and improve client circumstances that may be detrimental to the client treatment process. Social workers therefore value stakeholder relations, as they play a major role in the successful treatment of most of their clients. Linkage is defined as "the connecting of resources, services, groups, or organisations to serve a client or client system" (Garthwait, 2012, p. 35). This is a very important role for social workers, as it enables them to identify resources within the community and connect their clients to the services and resources that they need. It was also found that food resources are the scarcest in the community and that most referrals or linkages to stakeholders are for food-related needs. These findings corroborate Okafor, Onalu, Jecinta, and Okaye's (2020) study, which also found that social workers in health settings carry out the linker role to assist clients and their families by getting them access to resources.

4.3.1.4 Assessor role

The findings of the study also show that one of the most important roles in medical social work is that of assessing the client and their situation. By assessing the client,

social workers can provide a service best tailored for the specific client. Through assessment, social workers can understand how clients are affected and what course of treatment ought to be provided to them. The participants identified the role of an assessor as that which social workers in state hospitals carry out with HIV and AIDS-affected clients. Initial assessment equips social workers with the necessary information that they can use in drawing up clients' treatment plans and with the necessary recommendations to be made to the multidisciplinary team. Below, participants A, C, D, and J describe how their role as an assessor is carried out:

Participant A: *"Assessment is very important, especially when it comes to the home environment of the clients that are defaulting or are just not coping." We are responsible for doing home assessments to see the situation and what is really happening. In most cases, a client is HIV positive and contracts TB; as a result, they are admitted to the ward. So, before they are discharged, it is expected that the social worker do the home assessment at home by assessing the home situation and recommending discharge if everything is okay.*

Participant C narrated the following: *"We do assess the situation before we make any possible referral." We assess the social situation, financial background, and just the home environment. We assess if the patient is fit to live in that setting and if it is really conducive for the patient to take their medication in that setting. You find out that in some homes, patients are neglected; their caretakers do not even mind if they take their medication or not. So, in situations like that, we always work with the doctors and the CDC clinic, as they always make sure to monitor the viral load of our patients. So should they detect that some patients are really lacking or not taking their*

medication, we are always involved as a matter of urgency to help patients get back on track. "So, we go home and assess the situation and discuss the way forward."

Participant J: Sometimes, or most of the time, we have clients that default on their treatment. We want to understand why this client defaulted. What is their condition at home, and in that manner, how do we assess why the client is defaulting? Perhaps there is a food issue; perhaps we can refer the client to the councillor's office as a broker. And say, "Let's connect this person to the counsellor's office; maybe they can get food; maybe they are allegeable for the food parcels and do not know about it." "The assessment allows you to know what the problem is and what services they need, which we can refer them to."

Participant D: "Number one is to assess the living condition of this patient, so let's say this patient defaulted." You need to assess the support, and you also need to empower them to nominate a support person in treatment. We believe that if a patient has a support person in their treatment, they can be guided and supported, as well as check their cards to find out when their next appointment is. When a patient has someone who is very supportive, it is unlikely for them to default on their treatment. You find cases where someone has defaulted for three years, and upon assessment, you find out it is because they do not have a support person. The treatment is lifelong, and when faced with challenges, most patients default. That is why the role of a support person is important, especially for motivation. Furthermore, patients who have fallen behind on their treatment must attend a series of sessions with a social worker before

they can be reinstated. So, we assess the person's seriousness and willingness before you can recommend treatment initiation. "We assess the reason for defaulting and try to avoid having patients default for the same reasons after a month of reinitiating."

The role of an assessor was found to be another important role identified by all participants. It was found that this is one of the core roles of social work. The findings indicate that the role helps social workers identify gaps or problems that are faced by clients. which enables social workers to tailor psychosocial treatment plans for the specific client. Iravani et al. (2014, p. 211) note that "social workers can thoroughly assess psychological aspects of an HIV-infected person, his or her life story, and create an environment that will increase the person's understanding and thus strengthen the ability to cope with the stress and sufferings and to adapt to the complex reality of life." According to the study's findings, this role allows social workers to successfully carry out their work and assist their clients in better coping with their circumstances and illnesses.

4.3.1.5 Psychosocial support

One of the important roles played by social workers in hospitals is that of a counsellor. This role is a major function of the social worker, as it influences the client's life and impacts the treatment plan. The participants identified this role and indicated that it is through counselling that they can address issues that pose a hindrance to the client's treatment adherence. Participants E, G, and L below identify their role as a counsellor:

Participant E: *"We get referrals from the medical team about patients who have psychosocial issues that impact their treatment plan. So, we investigate the root of the problem so that we can help the patients find ways to deal with their problems. This*

also has to do with explaining to patients their diagnosis in a way that they understand and the changes that they need to make for the treatment plan to work. "Patient treatment does not happen in a vacuum; it is impacted by the socio-economic situation of patients." "As a result, patients who lack adequate food and shelter, as well as a lack of family and social support, are unemployed and in denial about their illness." "We try to medicate the effects of the difficult psychosocial circumstances."

Participant G: *"Provide counselling and psychosocial support for acceptance of status.*"

Participant L: "*Our role as social workers is highly valued, because sometimes even if you give them the treatment but there is no social support that is rendered, the treatment won't work." Simply encouraging and supporting them (clients) while providing medical care can make you feel as if you are not doing enough for this patient. So, that's why the nurses and doctors refer to the social workers: "They know that if they are given the necessary social support they need, it will also assist them in achieving the adherence outcome that they want for this patient*."

Another core role that was found is that of providing psychosocial support, which can also be defined as providing counselling. It was found that providing psychosocial support is one of the most important roles carried out by social workers working in state settings with HIV- and AIDS-infected clients. It was found that psychosocial support forms part of the core process of working with clients, as the role uncovers most of the information needed to address client issues that might hinder the treatment plan or process. The role enables social workers to draw up plans and find

interventions suited for a specific client. Namibian client treatment plans are hindered mainly by socioeconomic circumstances, a lack of family support, and denial of HIV status. Psychosocial support uncovers these issues and allows social workers to address them by referring to services that provide food and grants, while social workers deal with the counselling aspect. Tayo and Makofane (2015) and Beder (2006) explain that the psychosocial support provided to clients infected with HIV and AIDS comprises therapy and allows for the disclosure of results in a positive and encouraging way to patients, including sharing their positive results with those close to them. The UNAIDS (2017) report emphasises that psychosocial support makes clients stay committed to taking their medication while attending all hospital appointments and receiving help with all psychosocial problems. According to UNAIDS (2017), psychosocial support is one of the most important interventions for all clients that social workers work with; it brings about positive change in clients' lives and encourages clients to stick to their ART treatment for the long term. HIV and AIDS patients need as much support as they can get from healthcare workers, families, and the entire community. It is therefore noted that there is a need for social work services to help patients (infected) and families (affected) accept and cope with the situation at hand in some sort of institutionalised intervention, and this was found to be carried out by all social workers working in the identified state hospitals that work with HIV and AIDS-infected clients. Moreover, the role of social workers as psychosocial supporters indeed contributes highly to client treatment, as it targets the clients' psychosocial well-being. Okafor, Onalu, Jecinta, and Okoye (2020, p. 137) state that "social workers pull their experiences and knowledge together to ensure that patients receive inclusive care, consisting of medical and psychosocial elements." Clients that are affected by HIV and AIDS need a holistic approach to their treatment, as a positive status weighs

heavily on a patient. This role was therefore found to be most holistic, crucial, and inclusive within the social work context pertaining to HIV and AIDS treatment plans for clients.

4.3.1.6 Mediator role

The role of mediator or advocate is another important one carried out by social workers. The role creates an environment in which clients can open up to their relatives or loved ones. In this study, participants identified scenarios in which the role of mediator is carried out by social workers in hospitals. They indicated the sensitive nature of the disease and the discomfort of disclosure by clients to their relatives. Below are the participants' responses when asked about the roles of a social worker in the treatment of a client affected by HIV or AIDS who works in a multi-disciplinary team.

Participant C: "*We play the role of a mediator." Sometimes you find out that this patient is caught up in this situation. This could be a situation of rejection within the family setup. Now, as the social worker, you have to stand in the middle. You have to explain to the family their role in supporting the patient. And you also have to explain to the patient what is expected of them. A practical example is one of my 16-year-old clients who approached my office. She had just discovered that she was HIV positive, and in the home setting, she was the only one who was to be placed on the ARV medication. So, the family was in a state of denial that they did not want her. We had to travel to their village to reconcile and work together. When we returned, we had to engage the*

family in family therapy to reconcile and work together as a team. "Nobody wakes up and looks for HIV; it happens unexpectedly."

Participant E: *"People are scared to tell their relatives or partners (about their HIV status). I then mediate the process. "I also take part when patients are put on second-line treatment and the medication side effects are severe*."

Participant A: "*And there are some clients that find it difficult to disclose their status to their partners." They are in a relationship, and they are so much in love with this person that they fear that if I disclose my status to this person, how will this person feel? Probably I am going to lose them, or the person might overreact, and they might harm me. So, they approach the social worker's office, and then they do the disclosure. "We assist them through the process of making the disclosure to their partner."*

Another role discovered is that of a mediator. It was found that this role comprises social workers creating a safe place for clients to share and resolve conflict. It was also found that clients fear sharing their diagnosis and need the intervention of a mediator. Interestingly, findings indicate that the participants carry out this role of go-between to manage family and client relations. Participants noted that upon diagnosis of a positive HIV status, clients in relationships find it difficult to share this with their partners. Through mediation, social workers can assist clients to share their status and mediate any issue that might arise during this session and with the client's relationship

going forward. Participants further noted that conflict arises when a client's status is known by the relatives, and most relations are broken. In these instances, social workers also mediate to restore family ties in conjunction with other applicable roles. The use of this role positively impacts the client's treatment plan as they are then able to have support and acceptance from family members, which encourages positive living and adherence to ART treatment for many. Kadarisman (2019) notes that the role of a social worker as a mediator focuses on fostering understanding, finding resolution, seeking ways to amicably solve grievances, and intervening in the conflict. The role was discovered to be assisting clients in fostering peaceful relationships and in finding amicable ways to resolve conflict between the client and their relatives, as well as with other health care providers.

4.3.1.7 Advocacy role

Advocacy was identified by participants as a role carried out by social workers in health settings. The participants further shared that the role allows them to get their clients the necessary treatment from other health professionals. The role was further explained as one that is carried out not only within the hospital but also with external stakeholders.

Participant A: "*Within a hospital setting, the social worker acts only when the doctors have noted that there is a client that is experiencing social problems." A referral is made to the social worker. When there is a critical case, we sit as a team, like nurses, doctors, social workers, and sometimes the TB coordinators as well. And we discuss*

everyone's role in the client's situation. So once everyone has a role, the social worker acts as an advocate, for example. "They advocate for the rights of the patients."

Participant C: *"We advocate for additional services apart from the ones that we are rendering at the hospital." The Ministry of Gender should provide something for families, especially minors. "Because the main issue we pick up from our patients on ART treatments is that, though they come for their follow-up treatments and have the medication, they do not have enough food, and therefore we advocate on their behalf to help them adhere to their treatment."*

Another role that is found to be carried out by social workers in health care is that of advocacy. The role was found to be important as it enabled social workers to get their clients the treatment, services, and resources they needed to thrive in their treatment. Without advocacy, social workers within the context would not be able to create a space in which clients would be treated fairly and receive everything they need to adhere to their ART treatment. The Australian Association of Social Workers (2020, p. 4) highlighted that "in their commitment to human rights and social justice, social workers advocate for the rights of patients and their families/carers, as well as against discrimination, exclusion, and abuse experienced at times." Literature further states that advocacy is at the forefront of social work, as the profession fights for the rights of the members of the community while fostering the attainment of resources through the persuasion of stakeholders about the necessities and rights of those in the community (Sesane & Geyer, 2017). Sesane and Geyer (2017) further explain that social workers are mainly fruitful with issues affecting voiceless community members. Social workers can be advocates for social justice and welfare for patients, their families, and the communities they live in (Brown et al. 2015). Most clients do not

know what is within their rights; it is therefore the social worker's duty as a social justice agent to advocate for their clients' rights.

4.3.2 Objective 2: Social Worker's Experiences while working with HIV and AIDS Clients in Selected State Hospitals

The second objective of this study was to investigate the social workers' perspectives on their experiences of working with HIV and AIDS-affected clients in the Kavango East, Khomas, and Oshikoto regions. In this section, social workers' perceptions of their experiences were investigated, and the participants identified both negative and positive experiences. Geoffrion, Morselli, and Guay (2016) acknowledge that working in a space where there is human interaction has its benefits and drawbacks and can be both satisfying and traumatic. The following themes emerged from the study:

Theme: Positive Experiences

Sub-theme: Medical social work has an enriching learning environment.

Sub-theme: Diversified working environment

Sub-theme: Opportunity to Learn from Other Professionals

Sub-theme: Compassion and Satisfaction

Theme: Negative experiences

Sub-theme: Medical Social work is mentally demanding.

Sub-theme: Medical social work can lead to trauma.

Sub-theme: Medical social work causes burnout.

Sub-theme: Questioning the usefulness of medical social workers in carrying out their work.

Theme: Positive Experiences

In this section, the researcher looks at the positive experiences of social workers working with HIV and AIDS-infected clients in selected state hospitals.

4.3.2.1 Sub-Theme: Medical Social Work Has an Enriching Learning Environment

Social workers also experience problems like their clients, and dealing with clients' issues gives them an opportunity to learn from their experiences and ways of managing their issues. This is a very enriching and empowering experience for social workers. Below, participants share that by working with their clients through their circumstances, they can acquire life lessons.

Participant A: *"It helps you to grow personally as you are helping the client sort out or deal with their social problems." You are also learning from that. When you or the doctors are educating the clients, you are also learning. "It is a profession in which you learn something new every day."*

Participant B: *"I do not regret being a social worker because, in the same process, you are also learning." It is also a learning process for you; you are also learning as a health worker. It helps you deal with your own problems. Because you are putting yourself in that person's shoes. You grow in your level of understanding and maturity. These are difficult and negative issues that we are dealing with. It is also a learning process. If there are no problems, we will not grow or learn to deal with them. Life is like a book; if there is a chapter of sadness, go through that. At the end of the day, there will be something that you learn. In the next chapter, everything will be okay. And then again, you go through life."*

In this area, it was found that participants find their working environment to be enriched with knowledge as they are exposed to working with different professionals and with cases of different nature. Findings also indicate that the knowledge gained by participants is not only for the benefit of the clients but also for the social workers' personal life experiences. Most participants in the study valued this aspect of their work environment. In a study by Perriam (2015), it was found that participants defined knowledge that they had acquired in the service while performing their duties as social workers as "informal knowledge." And participants regarded informal knowledge as being very important to them. In another study, this kind of knowledge was identified as an aspect of lifelong learning and described as knowledge or information gained from clients during their sessions (Jivanjee, Pendell, Nissen, & Goodluck, 2015).

4.3.2.2 Sub-theme: Diversified Working Environment

Working in a hospital setting allows you to perform a variety of tasks and interact with a wide range of clients who are affected by a variety of circumstances. Each case is unique and requires different interventions. Participants felt that working within the hospital setting broadened their practise experience and allowed them to work with diverse population groups that have different experiences and needs. Participants shared that their daily exposure to these cases helped them grow, which they found enriching. Below, participants B, C, and D share their experiences:

Participant A: *"In the ministry of health, there are a variety of activities for social workers, as you are not limited." You do presentations, research, administrative duties, assessments, group work, community work, and so forth. "If you want to learn something new, this is the best platform for you to work on." "Unlike other ministries where you are limited,"*

Participant B: *"Growth is there, as this is a referral hospital." "We receive clients from different hospitals and clinics." "You are not only dealing with similar cases but with cases from different areas and needs."*

Participant C: *"Working in the hospital setting, our scope is broad." You have a lot of cases to work on; it is not like you are in a work environment where you are just focusing on a specific issue. We deal with a lot of cases of suicide, TB, HIV, and other*

health-related issues, as well as social issues. As a result, you will be exposed to every possible situation or case. As a result, more learning opportunities have arisen. Room for growth attracts social workers to health settings because, at the end of the day, exposure really matters. So, the more you are exposed to a lot of social work activities or cases, the greater the room for you to grow as a professional. Because this setting equips you to be able to work in any work setting, So, working within the MoHSS, we have an opportunity to work with other organizations. We make referrals to different organizations. And it allows us to have an understanding of different stakeholders and the importance of teamwork. So, it is a great opportunity; hence, social workers, especially those on entry-level, prefer coming here for exposure before they go and specialise for a broader understanding and knowledge.

Participant L*: "What attracted me to the hospital setting is the diverse learning environment." "Because with the ministry of health, you deal with all types of cases as compared to other ministries like gender, where your focus is mainly on kids,*"

Participants identified working within an environment that is diverse, which exposes them to working with different client populations and circumstances, as another positive aspect of their work setting. It was found that the hospital setting is a space in which social workers are expected to work with cases of diverse nature, with both inpatients and outpatients, as well as in multidisciplinary teams. Social workers are also expected to report on their activities, run and represent their departments, and work within the surrounding communities. The hospital setting exposes social workers to an environment in which they work with clients infected or affected by HIV, TB, or other health-related cases, as well as with clients affected by different social ills.

Participants found this to be a positive aspect of their work setting. Participants noted that the possibility of being exposed to a diverse workload was one reason most entry-level social workers joined the ministry. On the contrary, a study on the perceptions of health workers about conditions of service in Namibia found that, although social workers are an integral part of the treatment process, they did not fully utilise their skills as the hospital setting did not accord them an opportunity (Ipinge et al. 2006). Though the hospital setting allows for a broad scope of practice, other factors such as high workloads and understaffed departments could hinder the quality of and time for practise for most social workers.

4.3.2.3 Sub-theme: Opportunity to Learn from Other Professionals

Social workers who work within the hospital setting work in multi-disciplinary teams to provide holistic care for their clients. This creates an environment in which social workers must keep up with different illnesses and trends in health care services. By working within a multi-disciplinary team, social workers get to learn from other professionals who are experts in their fields of practice. Participants identified that working with other professionals provides a learning environment for them about HIV and AIDS, which affect their clients, among other illnesses. Below are quotes from participants B, D, and L:

Participant B: "*We also learn from the nurses about the treatment by asking them about the treatment part." They explain to us about the first-line, second line, and third-line treatments. So, when the patient is not on the third line, it means that the medication*

that person is taking is the last line of treatment. So, we inquire as to what this means. Some clients are scared to ask the nurses, so we call them in for further explanations.

Participant D: *"I used to work at the CDC clinic, and there it was very nice. When doctors and nurses are sitting, I would become part of the discussion. And we would discuss the treatment—for example, the current treatment guidelines that are being used and the regime—and I learned so much from that. "Different treatments are given to children and adults." "You really get to understand, and you get to know about every new treatment that is in place; you even get to learn about the different side effects." "You learn that when patients are put on treatment and do not respond well to it, their treatment changes."*

Participant L: *"When it comes to HIV, I would say that it is one of the specialised fields in social work." "Because it is one of the areas in which we specialise as social workers, we feel our role is not there or that we are not that involved." So, in dealing with these cases now, we are also learning in the process. And as we are learning, we are also finding or, rather, strengthening our roles through practice. It is a good feeling, though at times you feel you do not have all the necessary information, especially when it comes to understanding the treatment and the possible side effects. That is where I sometimes feel challenged, but with the relationship that we have with the multi-disciplinary team, we can always go back to them for clarification.*

It is clear from the above verbatims that participants identify learning from other professionals as a positive aspect of working in a hospital setting. Given the complex

physiological, psychological, and other social problems faced by persons living with HIV and AIDS, healthcare providers must work in collaborative teams to provide the best possible care for client groups (Olivier & Dykeman, 2003). So, the hospital setting is ideal for social workers to learn from their colleagues who have specialised in different disciplines. Participants noted that they learn about the disease/virus, treatment thereof, and the developments that surround the illness. This in turn helps the participants provide better services for their clients as they understand their illness. Working with multiple professionals from various fields was also found to enrich one's worldview and contribute to vital social networks that can be beneficial to the overall well-being of social workers.

4.3.2.4 Sub-Theme: Compassion and Satisfaction

The practise of social work in dealing with clients and their problems also provides benefits to its practitioners. HIV was known to be a deadly virus at the peak of the pandemic; however, with so much advancement in treatment, people now live longer and healthier lives. This requires clients to adhere to treatment, meaning social workers need to play a vital role in making sure that the client's psychosocial needs are addressed. Participants noted that helping clients deal with their psychosocial issues and adhering to their treatment gives them some joy and satisfaction. Seeing clients cope, recover, and continuously adhere to treatment because of the support from social workers was noted to make participants feel good about themselves. Below, participants share their experiences with how clients who struggled after being diagnosed with treatment improved and lived healthily, as well as how encouraging and mood-lifting it is to work with a client and have a positive outcome. Below are quotes from participants D, E, J, and M:

Participant D: *"It makes me feel good, especially for those who are born with HIV and especially when young people get to university." It makes me feel very happy. At the onset of diagnosis, they tend to have a negative attitude, blaming their parents. But once you sit this child down, you see the results at the end of the day: this child adheres to treatment. "We have a lot of them who are even professionals today."*

Participant A: "*The reason I decided to join social work was to see a change in people's lives." So, when you find someone that was defaulting, for example, and then you speak to them, these people will understand, and then they will start to take their medication and live a healthy life, a normal life. You feel like saying, "Yeah, I have done something; I have managed to help this person become who this person is today." Or when you help couples whose marriages or relationships were on the verge of failing and you see them reconcile and live happily ever after, "It's really that feeling that, yeah, I managed to change or help someone change their life."*

Participant E: *"It is always very encouraging to see how someone who was very sick is now healthy and also appreciative of the service."*

Participant J: "Y*ou feel that you have done something, and it makes you happy because you brought about change in someone's situation or life. Sometimes you feel that you didn't do something, but it makes you happy because you brought about change in*

someone's situation or life. Sometimes you feel that you didn't do much, but the clients come back after a while to thank you. "It makes you do some self-reflection."

Participant M: *"It makes me feel good when a client's circumstances are improved, and I always encourage them to come back." "Because for me, if I help someone and they open up, even if something affects you and I am far away, you can still contact me so we can talk and solve this one."*

Participant C: "Self-gratification is there; I like using the Ubuntu philosophy, "I am because we are." When you help others, you tend to feel good. You know that you have played a very significant role in someone's life. That's how it's supposed to be. So, when we help our clients and their situations change for the better, we always feel good. We now understand that we are carrying out a divine mandate.

It is evident from the verbatims above that social workers find satisfaction in cases that have positive outcomes. It was found that participants felt good when given positive feedback about their interventions by clients. as well as seeing the transition in their clients from the first session into the process and beyond. This was found to give them meaning and some form of compassion and satisfaction for their long-term clients. Collins and Long (2003) note that compassion satisfaction is a vital part of the practise as it creates stability within the practise and the self. Compassion satisfaction is experienced because social workers find pleasure in providing services that improve their clients' livelihoods (Radey & Figley, 2007). Harr, Brice, Riley, and Moore (2014, p. 236) pointed out that "compassion satisfaction has been defined as the pleasure that

a helper gets from doing his or her work well and the ability to contribute to the well-being of others." Findings within this area indicate that feeling some sense of satisfaction from helping clients is very beneficial to social workers' well-being and motivation within their profession. An interesting observation within this area was that all participants shared their responses with a smile on their faces and with so much enthusiasm.

Theme: Negative Experiences

In this section, the negative experiences of social workers that were identified by participants will be discussed.

4.3.2.6 Sub-Theme: Medical Social Work Is Mentally Demanding

Working with a client who has similar problems on a daily basis and working in an environment that lacks resources to meet client needs is mentally demanding for many participants working in state hospitals. Most participants indicated that social work is a profession in which one is most likely to suffer from stress, and they are victims of it. Participants shared how complicated client issues are as well as how the lack of resources to assist clients causes them mental strain. Participants also noted that the workloads are very high, and this contributes to their stress. The most hurtful and stressful of all is the death of a client. Below, participants C, D, and L share their experiences:

Participant C: "Work-related *stress is there; there are always complicated cases." For example, in the male ward, we had two cases of two boys in the same age group of 15 years, from two different villages. We conducted several home visits for both and did our assessments and interventions, but the situation never changed. As we speak, we lost both those boys in the same month they passed on. They used to come for follow-ups and collect their medication; however, the family support was not there. So, it's stressful for social workers because you're trying to help these boys. We tried, but it felt like we were failing somewhere somehow, and we wonder where we failed. It was sad to find out that they died; we wish we could have done better. "Things like that contribute to stress.*"

Participant D: "*Stress is there; what stresses me the most is the lack of resources in the community, to be honest." Because you find this mother at your office saying, "I have defaulted because I don't have food." Here you are busy giving counselling, and the person is talking about food. Speaking of resources, we do not have food resources in the community to refer this mother to. We all know that with ARV medication, you need to take food because this medication is very strong. So, at the end of the day, I really feel useless as a professional because, if I assess myself, I will be like, "What did I do?" and it is very sad.*

Participant L: "*Burnout and stress are part of our work, which are the working conditions we find ourselves working under." So obviously, when you have a lot of clients that maybe need adherence or that need you to do home visits, you find yourself stressed or burned out. Okay, it is different clients or patients, but with the same problem, so in the process, you also get stressed out.*

It is clear from the above narratives that participants found the working environment to be stressful, as there is a lack of resources to holistically meet clients' needs, which in turn has a negative impact on their treatment plan. Participants further noted that the death of a client has a negative bearing on them, which affects them, and it is mentally draining for them. They also noted that most clients suffered from a lack of food to eat, and there are not many resources within the hospital or community to address this issue because they are helpless in that regard. This would add to their stress. Wooten et al. (2011) acknowledge that social work professionals are exposed to a working environment that makes them prone to being faced with elevated intensities of stress. This is because the working environment that social workers find themselves in comprises many duties and requires them to deal with sensitive information, emotional moments, as well as ridicule from communities, among other unpleasant experiences. Similar to this finding, a study by Mthimkhulu (2017) found that social work was a profession prone to stress because social workers directly work with clients and get first-hand accounts from clients on the issues they face or experience.

4.3.2.7 Sub-Theme: Medical Social Work Can Lead to Trauma

Social workers work with clients who are diagnosed with chronic illnesses, and working with this population can be traumatic. Participants noted that their work was traumatic, and they suffered from it. Participants also noted that the most affected by trauma are the newly graduated staff, as their exposure to traumatic cases, if not well supervised, can have a negative impact on them. Participants also stated that if they were exposed to trauma and did not receive treatment, they would cause more harm to their clients. Below are quotes from the research participants C, E, and G:

Participant C acknowledges that trauma could be experienced by a social worker, as narrated below: *"It can cause trauma, as you do sometimes get flashbacks when confronted with similar cases."*

Participant E: *"New and student social workers, if not well supervised, can experience trauma; being exposed to traumatic events can have that secondary effect."*

Participant G: *"Some cases are traumatizing, and that can cause us to cause more harm than good to our clients."*

It was found that social workers who worked in health care settings were traumatised by their jobs. It was also found that participants felt that the effects of trauma were mainly experienced by new graduate social workers if they were not well supervised. Participants also acknowledge having experienced trauma and, as a result, would have flashbacks when confronted with a similar case. It was also found that the people who took part knew that if they did not get help for their trauma, they would hurt their clients more. Trauma is a term used to describe health workers' exposure to ubiquitous and harmful work environments that arise because of working with distressing client issues (Michalopoulos & Aparico, 2012). Participants noted that the work environment exposed them to distressful cases, and this indeed caused them trauma. Similar to the findings in this study, Mac-Ritchie and Leibowitz (2010) found that counsellors who work daily providing trauma counselling are more susceptible to secondary traumatic stress.

4.3.2.8 Sub-theme: Medical Social Work Causes Burnout

Burnout is another inevitable experience for medical social workers, as these are mostly state hospitals, and the workload is usually overwhelming. Furthermore, working during a pandemic can also contribute to exhaustion. Participants narrated that the work environment contributed to their exposure to burnout, along with the nature of their work as social workers. Participants also noted that burnout was a major contributor to social workers' leaving the ministry. Below, participants B, E, and F share their views:

Participant B: "*Burnout is definite; we are understaffed, and our caseload is very high." At times, you just want to stay home because both your mind and body are telling you that they are tired. I then find a strategy to deal with the workload and sometimes avoid being burned out. You won't be able to help your clients if you are burned out*.

Participant E: "*Burnout is one of the reasons social workers are leaving the ministry."*

Participant F: "*Burnout is inevitable, especially when clients are not cooperative and their CD4 count drops, and as a result, lives can be lost." This is regardless of the efforts made by the social worker. "It is depressing and saddening*."

It was found that participants felt that they experienced burnout as service providers within the hospital setting. That is inevitable given the working circumstances for social workers within health care. It was found that social workers in most hospitals are understaffed and, as a result, overworked. Just as Ananias and Lightfoot (2012) discovered that social workers are more vulnerable to burnout, participants in this study stated that they are more vulnerable due to the nature of their work as well as the setting in which they work. Participants identified that clients can be reluctant and resistant when it comes to their treatment. Burnout can have a negative bearing on the service delivery of social workers, and as noted by participants, finding ways to deal with or treat trauma is in the best interest of the social worker and client. Gregorian (2005) states that because of the multi-disciplinary setting that social workers are expected to provide treatment in, they are at risk of being drawn in all over and losing focus. Social workers, therefore, need to acquire strong interpersonal and professional boundaries for effective service delivery and to avoid burnout.

4.3.2.9 Sub-theme: Medical Social Work Causes Social Workers to Question Their Usefulness in Carrying Out Their Work

Social workers are also humans, and unfortunately, their working environment does not provide solutions to all their clients' needs. Most clients affected by HIV and AIDS are poverty-stricken, and the main social problem that leads to them defaulting on treatment is a lack of resources, mainly food. When a social worker must see clients that have a need and there are no resources within or outside the hospital setting, this can cause a great deal of uncertainty about the impact of one's role within society. Participants shared the same sentiment and narrated how there is a lack of resources to assist clients, how clients leave the office unsatisfied as the social worker could not

give them the food they need, and how all that leads to social workers questioning their impact and contribution to clients' needs. Below are quotes from participants A, G, and M about their experiences:

"Without family cooperation, the child has no treatment supporter completely; the child has to come alone to come and take the medication," Participant A explains. *And then go back home alone; there is no supervision at home, whether the child is taking medication or not. So, when family issues are investigated, you realise it's either a family dispute or the child is an orphan without a mother or father and that the person who takes care of them is probably in Angola or somewhere else. And there is nothing much you can do there; as much as you try to assist, you just find yourself at a dead end. It makes me feel bad because, as I said before, I became a social worker to help. "And when you come to a point where you have done everything in your power, but you reach a point where there's nothing you can do further,"*

Participant G: *"Some clients walk out not satisfied, as they expressed food as an issue, but we do not give food other than counselling." "The feeling of "I could do a little more" overshadows me and creates self-doubt when there is no change in the client's situation."*

Participant M: "*It really makes me feel bad if someone is not changing, and I have done more interventions." Sometimes I feel like letting me refer them to someone else*

might make a difference. I can even refer them to someone, and they might have a better understanding than me. It makes me feel very bad that I am not doing well. Or maybe whatever I am doing is not what I am supposed to do."

The above verbatims from participants show how they question their usefulness in carrying out their work. Participants noted that this was mainly because the main reason for joining the profession was to help and make a difference in people's lives. And when confronted with client circumstances in which they feel they have done all they could, but the required outcomes are not met, it can be disheartening and can make one feel powerless and doubtful of their impact. Participants said that their clients' main problem, which is that they don't have enough resources like food, is that they don't have enough resources like food. This made participants wonder if they were useful in helping their clients get better.

Shaufeli and Greenglass (2001), as stated by Marais and van der Merwe (2015), noted that when a social worker feels that they are not capable of carrying out their work duties, this may contribute to social workers experiencing negative feelings. Self-doubt can be identified as a negative experience. This can have a negative bearing on cases for participants and affect the services. When social workers are faced with cases that do not change or show an aspect of improvement, this could cause them to experience negative feelings, such as doubting their usefulness in carrying out their work. The researcher notes this to be the cause of social workers losing motivation within their practice. In a study by Marias and van der Merwe (2015), participants questioned their capabilities and wondered what they were doing wrong when their cases did not have favourable outcomes; the phrase some participants used was "*I don't know what I am doing,*" which is a similar feeling participant in this study expressed.

4.3.3 Objective 3: To Explore the Institutional Challenges that Social Workers Working with HIV And AIDS Patients in Selected State Hospitals Face

The third objective of this study was to explore the institutional challenges social workers face while working with HIV and AIDS-affected clients in the Kavango East, Khomas, and Oshikoto regions. The following themes emerged from the study:

Sub-theme: Lack of relevant policies and guidelines for social workers working with HIV and AIDS-affected clients.

4.3.3.1 Theme: Lack of relevant policies and guidelines for social workers working with HIV and AIDS-affected clients.

Theme: Lack of office space, furniture, and equipment

Theme: Poor supervision

Theme: Lack of in-service training, workshops, and formal training

Theme: Lack of resources for case management and community activities

Theme: Social workers suffer injustices in human resources management

4.3.3.1 Theme: Inadequate Policies and Guidelines for Social Workers Working with HIV/AIDS Patients

The lack of policies and guidelines on social work-related work was another issue that was highlighted by participants. Participants noted having no knowledge of HIV and AIDS policies or guidelines for social workers and acknowledged that this affected

their practice. Participants also shared that most policies are outdated and that most of these documents are more relatable to medical personnel than to social workers. Below, participants D, E, M, and C's quotes are shared:

Participant D: *"The lack of guidelines hinders our work." If there is a clear layout of what to do when you get a client who defaults and is referred to the medical social worker, then I see this patient, and after that, I refer that patient to the district social workers to continue with the need for services like ongoing counselling. As a result, I believe that having a guideline that outlines the work process can help illuminate the work. Now there is no guideline; you just do what you think is best. Even the way we are doing adherence counselling, we are just trying to Google, but there is no clear guideline.*

Participant A: "*We have policies and guidelines that guide us," such as the policy on HIV that I was reading recently and then the clinical handbook that we usually use, and there is a policy on HIV disclosure, something like that. They are there, but, as you know, we live in a world where things are constantly changing. As a result, some of these policies are out of date; others were written when HIV was a pandemic and extremely lethal. And many of these policies were never reviewed; they are outdated, and when you try to use them, they are not effective at all.*

Participant M: "*Some of our new social workers do not have experience as they are coming straight from school." They must be instructed on how to handle cases. "I feel the ministry can develop guidelines and policies; it will improve our work."*

Participant L: *"The policies of the guiding documents that we are using focus more on the medical aspect and less on the psychosocial issues." That's why I say our role was possibly ambiguous, or I'm not sure. "But we need more of the guiding documents that emphasise social welfare aspects and not only the medical part."*

It was found that there is a lack of policies and guidelines on social work, in particular HIV and AIDS, within the hospital setting. Participants felt that the lack of these documents negatively affected their service delivery. Furthermore, it was found that when working in a hospital setting and in an organisation that employs new graduates, having guidelines and policies is important. It guides the social workers, and it also protects both the clients and practitioners. In the absence of these, social workers may become overburdened while attempting to find the best possible solutions to a problem. Meanwhile, new graduate social workers might struggle to handle specialised cases. WHO (2020) recommends national guidelines as well as the curriculum for all healthcare professionals to incorporate aspects of psychosocial support in the treatment of people living with HIV and AIDS. However, in this study, it was found that the participants felt that policies and guidelines were outdated, while some felt the documents were irrelevant. Similarly, Rujumba et al. (2010) found that health workers had limited information and reference guidelines. An indication that HIV and AIDS within social work is an area that needs attention in terms of guidelines and policies that would guide practise Moreover, the research found that a great majority of participants indicated that there are no guidelines and policies that guide practice. This finding raises the question: if social workers do not have policies to guide them, how are they able to measure their effectiveness or progress in service

delivery? Another finding in this area is that the lack of guidelines and policies poses a challenge for social workers in their work. In another study by Rufaro (2019), it was found that the MoHSS lacked policies that guide social worker practice.

4.3.3.2 Theme: Lack of Office Space, Furniture, and Equipment

It was found that office space within the ministry is a huge challenge for most social workers. Participants shared that they must share office space; in some cases, two to three social workers occupy one office, and sometimes other professionals, such as nurses. Furthermore, participants noted that this issue deeply saddens social workers; this was noticed as participants' tones of voice changed and the look on their faces changed when expressing their feelings. Participants noted that this creates an uncomfortable environment for the clients and delays for the social workers as they could have two in an office but are only able to assist one client at a time. Below, the participants share their challenges and how this has impacted them in their work:

Participant J: *"We are two people sharing an office, and it is challenging." We find ourselves sitting inside with two other people while many customers wait outside. "And we can only see one at a time."*

Participant M: "*As social workers, we do not have office space; we are sharing." Most of our sessions are supposed to be confidential. The social worker has to sit there while the other one is conducting a session. I was sharing my office with a nurse; she just moved. The other three are sharing one office, which is really a challenge, especially with this COVID-19 pandemic.*

Participant D: *"Like I said, social workers are stepchildren. I don't really mind; you know, because of my training, we were taught that you can even provide service under a tree. So, I do not mind. You keep on complaining, but nothing is really done. Sometimes we rotate offices, and* not all of us have computers; let's say three-fourths of us don't have them. You can even see the office setting, which is not even how it is supposed to be set. *But you just serve. People are complaining and wasting your time. "I honestly do not mind; even in a family session, I can give my chair for everyone to sit in, and I can stand, as long as I am able to offer the service at the end of the day."*

The findings above show that some of the institutional challenges faced by social workers were a lack of furniture, office space, and relevant equipment for practice. It was found that participants had to share office space, not only as social workers but also with other medical staff. This creates an environment that compromises client treatment. Furthermore, it was found that participants' office spaces were not sufficiently equipped or furnished for social work practice. Social work is a very sensitive profession, so clients that approach the office for help are very brave given the stigma around therapy. Therefore, creating a safe and conducive environment is important. Social workers also need to be updated with the latest treatment and practise developments. Having sufficient office space, furniture to accommodate clients, and the necessary equipment to practise are of importance. The absence or lack of the above does have a negative impact on social workers' work experiences. In a study by Kadarisman (2019), it was found that facilities and infrastructure in the workplace were an issue for social workers. The lack of office space and furniture contributed to poor working conditions for social workers in the sense that confidentiality for clients

was compromised and clients' participation in sessions would be affected. Marais and van der Merwe (2015, p. 153) note that "the physical setting of the counselling session contributes to a client's feeling of comfort," and when sharing an office, fewer clients would be seen during the day as two to three social workers could only attend to one case at a time.

4.3.3.3 Theme: Poor supervision

When participants were asked to share some of the challenges they face in their role as social workers working with HIV and AIDS-affected clients, most identified a lack of supervision as a major challenge. They shared how important supervision is, as it is supposed to help social workers deal with the stress that comes with the job, and that it lacks is an indication of a lack of leadership from their seniors. Participants noted that supervision should be structured and carried out at specific intervals. Below are quotes from participants G, F, and E:

Participant G: "*Supervision needs to improve, and supervisors should look at the work weekly or quarterly and assist with challenges." "Be more structured.*"

Participant F: *"There is no supervision or in-house job training." "There is no leadership, as they are the ones absconding; we have never had a meeting since January; there is no planning for the year."*

Participant E: *"Supervision is supposed to counteract the effects of absorbing the client's energy—the sad stories we hear daily." "If not checked, it can cause trauma to the staff member, although with supervision and support, this can be minimised."*

It was found that supervision was lacking for participants from almost all levels of practise within the hospital setting. Participants shared their expectation that supervision would be a sort of treatment for them to practise successfully. Furthermore, it was found that a lack of supervision can cause mental strain, resulting in poor service delivery. The findings are an indication of how a lack of supervision affects not only the worker but also the workload. For social workers to have a positive work experience and prosper within their workplace, Radey and Figley (2007) state that employees need to be supervised. Supervision can be a mechanism through which the workload can be managed. Furthermore, Rufaro (2019) also found that there is a lack of supervision for social workers as well as a lack of support from managers. Supervision is an essential component for every employee, more so for those in the helping professions. Supervision allows for self-reflection, learning, and the improvement of one's tasks. Poor supervision, or a lack thereof, can cause social workers not to be motivated to do their work to the best of their abilities. And it can also cause strain on social workers, as the profession is also one that may cause burnout and stress.

4.3.3.4 Theme: Lack of In-Service Training, Workshops, and Formal Training

The work setting is different from that in which formal education is acquired. And in health care, illness and treatment procedures are changing or advancing, so one needs to be updated in that regard. Participants in this study shared that, within their work setting, they have not received any induction training. Others shared that formal

training is generic and that medical practise needs specialised training, which was lacking. Below, participants A, D, and E identify the lack of in-service training, workshops, and formal training as a challenge they face in their workplaces:

Participant A: *"There's a need for in-service training on HIV for at least a week; it could be an added advantage." We are trained as generic social workers; we work everywhere. Knowledge is there, but it is not specific to HIV and AIDS. "We learned on the service that the university training is not specific to either HIV or mental health; it is basic."*

Participant D: *"Yoh, ever since I started working, I have never attended a course in HIV; the only course I remember is four or three years after I started working." I then received something to help adolescents with disclosure training. The training from UNAM is not enough; what we do at UNAM is theory, and here it's all practical. I wouldn't say it's enough. But it also comes with experience. "It's not enough." "It's not enough." "I'm trying to think of what we did at UNAM; I remember the aspect of how to get infected, but I'm not an ARV support person*."

Participant E: *"I feel like we are very short-staffed, and we lack expertise in the form of training." Doctors are sent for training to specialize, and there is a need for social workers to be sent for specialisation in social work to handle, for instance, HIV and AIDS, cancer, etc. The world is changing, and there is a need for more training to*

specialise in specific issues. No, there's always room for improvement, and some of us graduated a long time ago. The world is changing, and due to new techniques, there is always a need to send people for specialisation and further education. "There is a need for training or specialisation in specific areas, such as HIV."

The above narratives show that social workers feel that there is a lack of in-service training within public health settings to better prepare them for the workplace. A study by Olivier and Dykeman (2003) found that nurses and social workers felt their formal training was insufficient in providing them with skills that are positively responsive to the psychosocial needs of clients infected by HIV and AIDS. In training during university, all social workers initially receive the same training; the distinction comes from the setting they are placed in. Social work does not have a specific approach that suits all its clients; the university degree programmes are generic to lay the foundation of how to get to the bottom of each client's circumstance and then how to build on helping the client. Therefore, when social workers graduate and start work, they need to be inducted, followed by workshops and training based on the nature of their work, to keep up with the new developments and to provide an effective as well as sufficient service to their clients. If there is a lack thereof, clients and social workers could both be negatively affected. A lack of in-service training, workshops, and formal training was found to be a result of social workers being short-staffed and a lack of opportunity for social workers to specialise in medical social work. This means that regardless of their work setting, the depth of knowledge each social worker possesses outside of their work induction is dependent on them. This thus means that most social workers do not have specialised training in medical social work, more so in HIV and AIDS management.

4.3.3.5 Theme: Lack of Resources for Case Management and Community Activities

Social workers within health settings deal with clients that come from poor socioeconomic backgrounds, and most of their needs are material or food based. Participants shared that food is a resource needed for case management but is lacking within their work setting and community. Participants further noted that the hospitals do not make provision for most of their community-based interventions, and this hinders their work. They also noted that a lack of transport to deliver their services made their relationships with clients questionable. Below, participants A, B, and M share their experiences and predicaments:

Participant A: *"Lack of resources to solve clients' problems." A client explains to you that "I know the importance of taking my medication, but you know that I cannot take my medication on an empty stomach." So, "If I take this medication and I do not eat, something is going to happen to me." Now, in that case, what do you do as a social worker? Because the ministry does not provide us with any incentives that we need to give to our clients who are like that. You just realise that there is nothing that I can do here. Because you try to refer to the Ministry of Gender, but they say, "No, we don't give grants to HIV-positive clients, and they don't meet other grant criteria." "Lack of resources is the number one problem that we face."*

Participant B: *"There are transportation issues at times for you to do a home visit. Cars are few, and home visits must be postponed. You must call the family again and inform them that I won't be able to come on this date because of transportation. We*

communicate with them, but you know how it is when you expect people to arrive, and they change? Others will believe you have a problem, but others may believe you simply do not want to come.

Participant M: "*Most of our funds for our activities have been cut, for instance, for commemoration days or those that have to do with any outside activities unless we look for sponsorship." So, it is also becoming a challenge for social workers, as there are no funds for other extramural activities.*

The findings indicate the lack of these resources makes social workers feel paralyzed, which negatively impacts their ability to effectively deliver services. Similar findings were found by Mthimkulu (2017), who noted that a lack of resources can negatively impact professionals' ability to deliver services and that it is disempowering. In addition to this, it was found that participants felt disheartened not to have a budget as a department. Having a budget that is readily available for their office activities would enable social workers to feel empowered and supported by top management.

4.3.3.6 Sub-theme: Social workers suffer human resources management injustices

4.3.3.6.a Social workers are understaffed.

Medical social work requires participants to be flexible. They must use all types of social work methods and work with large groups of people because the hospital serves

not only the local community but also many people. Participants in this study noted that they are understaffed, and this creates an overwhelming workload for them. Below are some responses from participants B, E, and J:

Participant B: "*Unfortunately, UNAM is the only institution that trains social workers. We are currently understaffed. If another institution could train, it could be an advantage. "Social workers are very few, and it is a well-known fact countrywide."*

Participant E: *"Not enough social workers; we are supposed to have three social workers for HIV alone." The paediatric side, the adult side, and a community education social worker would have been nice. But we do not have enough social workers overall in the staff establishment. "We have eight staff in the staff establishment; three were added in 2019."*

Participant J*: "We are understaffed, and we have to serve the hospital wards, court cases, schools, the district, and children at times." "Yet, we are only three social workers."*

It is clear from the findings above that social work departments within hospital settings employed fewer staff than needed. It was found that the issue of participants being understaffed burdens them with high workloads. This later results in poor service delivery as the work demands cannot be met. Participants noted the requirement for social work services in the different wards within the hospital as well as in the community, such as in the courts and schools. High workload is known to cause

burnout and stress, which have a negative bearing on counsellors as their mental health needs to be sound to assist their clients. A study conducted by Chiwara and Lombard (2017) posited that although social workers were focal providers of social welfare services, they were understaffed across the board, subsequently causing them to be overworked. Marais and van der Merwe (2015) extend this further by stating that overworked social workers are overwhelmed due to the human capital shortage in the country. This, in the long run, contributes to social workers being overwhelmed, burned out, and/or drowning in work-induced stressors.

4.3.3.6.b. Social Workers Are Exploited

Social workers, like other hospital professionals such as nurses, are educated for four years. However, participants shared that social workers are not allowed to claim overtime payments and that if their work extends after their working hours, it would be voluntary. Participants note that they find this practise unfair as their services are just as important and sometimes even more demanding compared to those of other professionals. Below are the responses from participants that support the above statement:

Participant A: *"Just like doctors and nurses, social workers should be treated the same in terms of overtime." "Just as the two professionals have fixed themselves over time, it should be the same for social workers as well." "Clients call during weekends and nights, but we are limited; you cannot come and assist the clients."*

Participant B: "*Before most patients are discharged from the hospital, they have to be discharged via the social worker." These are cases of neglect, those that need family intervention, parasuicide, TB, and so forth. Because we are not allowed to work overtime, on Monday you will find the queue full because all the weekend cases were kept. If a patient is admitted and it's an overnight suicide case on a Friday evening, instead of discharging on Saturday, they will keep this person until Monday. And the ones that get discharged and are told to come back on Monday never return. However, all this can be avoided by allowing social workers to work overtime and be on call.*

Participant C: *"Our services are crucial; however, the salaries of social workers are demotivating." As we speak, we do not claim overtime, although nurses and doctors do. This limits our time for service delivery, as we have to end work at five.*

Participant L*: "When it comes to overtime, social workers are not allowed to claim for overtime." So, at times, you find yourself dealing with a client after hours, so you are just sacrificing because there is no overtime. It can also be demotivating at times because you are doing something but receiving no compensation. Or sometimes you find a client is referred after hours, and as a social worker, I do not want to work after hours with no overtime. So, you end up telling the client to return the following: "And you discover that they do not return, possibly because they do not have transportation money."*

It is important to note that all professionals are experts in their field of service and that all professionals play a vital role in the hospital setting. The work environment should be fair and conducive for all employees, which will foster motivated and hardworking social workers. However, it was found that social workers are not entitled to overtime remuneration within the hospital setting, a benefit that other professionals (i.e., doctors and nurses) enjoy. This is found to be a demotivating factor for participants, as they feel that the impact and importance of their work are not recognized. This also limits their time for service delivery, which forces them to leave their work for the next day, which may negatively impact clients by forcing them to return to the hospital the following day again. Other researchers found that social workers are stressed at work because they are overworked, underpaid, have bad relationships with their co-workers and managers in the helping profession, and work in bad conditions (Wooten et al., 2011).

4.3.3.6.c. Social Workers Are Underpaid

Participants felt that they were underpaid within the ministry. Furthermore, participants felt that social workers who obtained their master's degree qualifications are neither recognised nor rewarded, although other professionals with similar qualifications receive higher salaries compared to them. Participants felt they were not fairly paid considering their qualifications, workload, and the importance of their profession. When compared with their counterparts' salaries in the entire health sector, social workers felt that they were underpaid. Below, participants are quoted to support the claims:

Participant B: "*We are underpaid; social workers were supposed to start with grade 7 because of the nature of our work. It's different for the nurses and doctors; if someone complains of a headache or something, you give them a specific medication. But imagine that a person has a marital problem—the husband is cheating or whatever is happening in that marriage. You need to involve both parties; yes, you have that session with the person who presented the problem, but you also need the people involved. With the time we spend with our clients, you cannot say you will be done in 20 minutes, because you do not know how the session will go or how long that will take. We are more concerned about the person's emotional well-being. It isn't just giving the medication and letting the person go. Perhaps after giving the medication, this person has no food at home, and that will cause the client not to take the medication. "Whereas others will take their medication on an empty stomach, and the medication will not be effective*."

Participant C: "*We do a lot of work, which cannot be compared to the salaries we receive; it really is not worth it*."

Participant E: "*I feel we are neglected." In terms of salary, the gap is too wide. In terms of opportunities for training for specialization, they are fixed over time, and we all work crazy hours. Yes, there is a huge gap, an extremely huge gap, between the professionals.*

Participant L: "*My salary is too low; I am a specialist." "Compared to clinical psychologists, they are paid based on their master's degree, just as specialist doctors*

are paid based on their specialised qualifications, but I am just paid on the same grade 8 entry-level social work salary."

In Namibia, to be a practising social worker, one needs to have formal training, and most ministerial work requirements to be employed are a bachelor's degree. All jobs within the ministry are graded, and currently, entry-level social workers are paid on a grade 8 scale. A grade 8's annual salary ranges from N$ 220 828 to N$ 263911 (Office of the Prime Minister, 2022). It was found that participants feel underpaid on this scale and would prefer a higher pay grade, as they feel that their workload and the nature of their work are not fairly compensated for. The issue of not being compensated for their efforts and time spent is highly dissatisfying to participants. Wooten et al. (2011) state that occupational stressors for social workers are caused as a result of being underpaid and working in poor working conditions. All this contributes to poor service delivery.

4.3.3.6.d Sub-Theme: Role Confusion

Participants noted that role confusion was the cause of their exclusion from some cases that other health professionals dealt with. They further noted that other staff members, such as the health assistant workers, are not clear on their roles versus those of the social workers, thus going overboard with services provided to clients. Another aspect of role confusion was that social workers were identified as providing food to the needy. Participants noted that this confusion created expectations for clients that they could not meet. This poses a challenge for them. Furthermore, participants noted that because of role confusion among both the participants and other staff, there is an

overlap of efforts from different professionals. Below are views from participants G, L, and M:

Participant G: *"In most cases, social work is not involved because they do not know our roles." You aren't included if your expectations are different from what we do. "Clients are referred to get food, whereas we do not provide it, and this creates an expectation from the clients, which poses a challenge for us."*

Participant L: "*Health assistants are not clear on their role; instead of only doing adherence counselling and referring, they try to go into in-depth counselling and stumble, and when they are challenged, they refer." On the other hand, social workers feel they cannot do adherence counselling because they feel that it is the health assistants who need to do that.*

Participant M: "*There's a bit of confusion between healthcare workers and social workers because people believe we are all just doing counselling."*

The findings above show that other professionals in health care settings are not well acquainted with the role of the social worker. And this, in turn, causes role confusion. A multidisciplinary team in a hospital setting consists of various professionals who, at times, may share one or two similar roles in the treatment of clients. Though everyone

on the team plays a distinct role in the treatment of the client, it is thus important to have clarity about the roles that every team member plays to ensure that clients receive the required help. It was further found that new graduates and other staff members often experience role confusion when the roles are unclear. It also portrays social workers as only providing counselling, which is only one of many roles that social workers play. This sometimes creates expectations from clients that cannot be met by social workers, such as wanting the social worker to provide them with food. Research notes that role confusion also results in a high workload for social workers and hinders their work performance (Ntshwarang & Malinga-Musamba, 2012).

4.3.4 Objective 4: To explore the coping mechanisms employed by social workers working with HIV and AIDS patients in selected state hospitals.

The fourth objective of this study was to explore the coping mechanisms social workers employed to cope with the demands of working with HIV and AIDS-infected clients in the Kavango East, Khomas, and Oshikoto regions. The following themes emerged from the study:

Theme: Case review and debriefing

Theme: Supportive Colleagues

Theme: positive self-talk

Theme: Taking time off from work

Theme: referring to colleagues

Theme: Spirituality

Theme: Receiving therapy

4.3.4.1 Theme: Case review and debriefing

To deal with the stressors that come with the work, participants identified case review and debriefing as coping mechanisms. Participants shared that these practises helped them address their clients' needs effectively and gave them a different perspective than their own. Participants further noted that debriefing is also a form of self-care. Participants B, C, D, and E noted that:

Participant B: "*Sharing also helps." I speak to my colleagues. We share normally during our debriefing sessions. "We share our thoughts, how a case went, and so on."*

Participant C: *"At our department, we have debriefings every Monday, where we discuss the cases, we attended the previous week and how we addressed them, or how we could have addressed them. It really helps as you get to discuss and get new information or discuss the case and a possible way forward. That way, you know that you have done the right thing or can do it.*

Participant D: *"I look at case review and debriefing as a coping mechanism." As colleagues, we consult each other, and we also do case reviews. where we discuss difficult cases that we are dealing with, share what you have done, and consult on what else you need to do to resolve these cases. "We share and learn from each other."*

Participant E: *"Debriefing is part of self-care—coming together and discussing challenges and how to support one another."*

Social work service delivery cannot happen in a vacuum; social workers need support from colleagues. According to the study, debriefing allows one to gain a new or different perspective. Debriefing also allows the social worker to learn from others and see the case from a different perspective when stuck with a case or dealing with a case. Participants use the processes of reviewing their cases with colleagues or debriefing as coping mechanisms. Debriefing was found to work best in instances where peers are naturally at ease with one another in each setting; this makes the process easy and productive for the participants (Burns, 2016). Debriefing was found to include five main components: a) it should take place following an event; b) it should occur between a pair or group of people; c) it involves people being together and conversing; d) it requires a leader, and people need to share the occurrence as well as take others through what they had experienced (Winchester-Seeto & Rowe, 2019).

4.3.4.2 Theme: Supportive Colleagues

Another coping mechanism for participants is the presence of supportive colleagues to share their experiences with, be it by spending some leisure time together or relaxing after a hard day at work. Participants share that it is vital to work as a team that supports one another. Participants acknowledge that their work could get very challenging and that they would not cope if not for their supportive colleagues. Furthermore, participants shared the importance of the vast knowledge base of their colleagues, which they can tap into for support. Below, participants G, J, and M noted that:

Participant C: *"I also enjoy spending time with friends and colleagues." Sometimes the easiest coping mechanism when you are stuck is to consult a colleague on a possible way forward. "Because you sometimes find that some of these cases are really challenging, one needs to consult to find a way forward*."

Participant G: *"I usually just consult my colleague after seeing a client." "Supportive colleagues are very helpful and have an opinion."*

Participant J: *"If you do not have a strong support system at work or home, it can cause burnout and affect your work if care is not taken."*

Participant M: *"One of the coping mechanisms is working in a multidisciplinary team." We do not work as individuals but as a department. We always consult with others if we have to conduct a home visit; for example, we consult with Intra-Health,* a global charitable health organisation that works within the MoHSS to improve the

functioning of HCW and enhance the MoHSS service delivery system, *and we go together. I would say they are now family, friends, and supportive colleagues. They have now become part of us. "When you are free, you have a good time with your family."*

It is clear from the above that participants value the support of colleagues as an aspect that contributes to coping better within their workplace. It was also found that participants valued the professional backgrounds of their colleagues, whose expertise they could benefit from when receiving support. Participants mainly focused on seeking support when confronted with a difficult case, which they found difficult to assist clients with. This finding is similar to that of Limon (2018), who in his study found that social workers used peer debriefing to avoid being burned out and to help deal with complex cases. Similarly, Wooten et al. (2011) mentioned that studies over the years have shown a strong indication of the value added by social workers having empathetic colleagues and managers when dealing with work pressure. The researcher has found that empathetic listening and understanding help the participants feel a lot less isolated in the workplace.

4.3.4.3 Theme: Positive Self-Talk

Participants noted that they used positive self-talk to keep them motivated. They also noted that they used the mirror to reaffirm themselves, which made them feel better. Participants mainly used positive phrases to prepare themselves for the day ahead. And in other cases, self-talk is used to let go of the stressors faced earlier in the day. Below, participants F, J, and B's quotes are shared:

Participant F: "*I tell myself that I am going to work; whatever I face, I will have to deal with it." "If I don't know, I have to look for people who I know."*

Participant J: *"Positive self-talk in the mirror: "Yesterday was tough, but I am tougher today."*

Participant B: "*What helps me is when I speak to myself, telling myself that it is life, that that was the office and I am home now, and I need to focus on other things now." So, I do more self-talk just to keep going with what needs to be done. But previously, it used to affect me too much, but now it is not so bad."*

Positive self-talk is another technique that participants employed to cope with work and work-related stressors. It was further found that participants use positive self-talk to remind themselves that nothing is permanent, to prepare themselves for possible challenges they might face at work, and to just say something good to be motivated. Reaffirming statements to oneself was also found to be beneficial to participants. And this contributed positively to their work performance and emotional wellbeing. Similarly, Wood, Perunovic, and Lee (2009), in their study on positive self-statements, found that positive self-talk was motivating to participants within the workplace. The researchers furthermore found in their study that participants with elevated self-esteem, as compared to those with low self-esteem, benefited more from positive self-talk.

4.3.4.4 Theme: Taking time off from work

Participants reported that social workers within hospital settings are overworked, as they are understaffed in most cases. Heavy workloads can be mentally straining for social workers, and they use time off from work as a coping mechanism. They use their time off to go on vacation, have lunch with co-workers, debrief from a long day, or simply go home and sleep it off. Below are quotes from participants A, E, and F:

"I always see myself that when I go through stress or a hectic job or month, I would always want to take a break to go on vacation, and then just to go out and treat yourself for a while," says participant A. *Or during lunch, generally, you would buy lunch and take it home, or we would bring it to the office and eat there. But at times, you just need to treat yourself. You'd rather go to a certain place where you can buy yourself a decent meal. It helps as you offload; it is really needed.*

Participant E: *"I'm going on vacation and getting away from the workplace for a while." "After you knock off, you are just a normal human being."*

Participant F: *"At times my head of department, who is a doctor, will tell me to go home and sleep it off." She can tell something happened just by looking at me, and she will then tell me to go rest. "I have three lovely kids; my children are very sharp, as is my husband." "My children can tell if I am not well and make jokes that cheer me up immediately."*

The findings above show that taking time off from work by participants when they felt overwhelmed with work-related stressors was another coping mechanism that they employed. A service provider's poor mental health has a negative impact on the quality of service provided to a client. It is therefore imperative that social workers receive therapy as soon as the need arises to ensure that no harm is caused to their already vulnerable clients (Okafor, Onalu, Jecinta & Okaye, 2020). Taking a vacation and taking some time off from work gives one a new perspective and opens one's mind to new approaches to carrying out work activities.

4.3.4.5 Theme: Referring to Colleagues

Participants noted that some cases they dealt with became overwhelming for them, and the best approach to dealing with such cases was to refer them to their colleagues for intervention. Participants felt that at times they were unable to get through to their clients regardless of their different approaches and that a colleague would be better suited to carry out the task. Below, participants A, J, and M share their views:

Participant B: "*There are cases, especially one that involves a child, that I have not yet found a way to protect myself from. Usually, if I get a child's case and it is either of the two, I refer it to them, but if they aren't there, I will have to deal with it. "Even when I live in the office, my mind and everything are just on the case."*

Participant J: "Remind yourself that you cannot change everyone's situation and that you must encourage yourself to be able to help the next." *"And you refer to another social worker, nurse, or relative."*

"Sometimes I feel like letting me refer them to someone else; maybe they will make a difference," says participant M.

The findings above show that referring cases that are difficult to other colleagues for further intervention is one of the coping mechanisms used by participants. In some cases, a social worker would not have a positive outcome, and clients would show no improvement regardless of their efforts, which can cause them to be stressed. Referring these cases to another colleague brings relief on the part of the social worker who finds a case to be challenging. In a study by Marais and van der Merwe (2015), it was found that when dealing with a certain case that social workers felt was overwhelmingly difficult, participants would prefer to refer these cases. This would give participants some ease and could also be in the best interest of the clients. This would accord clients an opportunity to work with someone with a new or different outlook or perspective on their situation.

4.3.4.6 Theme: Spirituality

Participants in this study identified being spiritual and practising spirituality as a means of coping with their work-related stressors. Participants noted that going to church and praying relieved their stress. Praying made them feel better about the circumstances they faced at work. Participants B and M are quoted below:

Participant B: *"Being a Christian helps, but there are times when you are tired and everything at work is just too much." So, if you go to church, you pray. "At least that will lift your spirit, and you will be able to cope*."

Participant M: "*When it's church time, we attend; I also feel that's part of self-care."*

The above findings show that participants employ their religious practises as a coping mechanism. Religious practises include going to church, singing, and praying. This was found to bring relief and comfort to participants in distress. Spirituality allows one to rely on a higher power to handle their burdens and can be an important coping strategy even for clients. Mthimkhulu (2017) argues that religious activities play a vital role in dealing with the demands of social work. Similarly, Glicken (2011) found favourable outcomes for the integration of religion in health. Furthermore, it was found that going to church and having fellowship contributed to positive life outcomes for participants. The researcher acknowledges the benefits of spirituality and its association with better coping with various circumstances, which improves one's quality of life (Glicken, 2011). Pack (2014) found that religious beliefs were of high importance and that they positively helped people deal with overwhelming situations.

4.3.4.7 Theme: Receiving Therapy

Receiving therapy in a health and psychosocial setting is regarded as a cathartic exercise or an outlet for professionals to express themselves. Participants noted that taking care of their mental health is of utmost importance. The participants also noted

that a person cannot offer psychosocial services without dealing with their previously experienced trauma. Below are quotes from participants E and F:

Participant B*: "If you do not deal with your trauma and a client comes to you with the same problem, it triggers now." "So, if you handle yours, you'll be able to help the other."*

Participant E: *"It's just normal to take care of yourself physically, mentally, and in your personal life," not to make your work the only thing that is happening in your life. "To take care of your mental health, see a psychologist when you have your own issues*."

Participant F: *"Receive counselling from the head of department." I get along really well with the doctor. She can tell by my body posture that today "this one is not well." She will then summon me and talk to me about what is bothering me, effectively counselling me. "It really helps me."*

The above verbatims show that when participants notice that they are psychologically affected by their work, they seek therapy or counselling to deal with their issues. Participants acknowledged the importance of mental health care for professionals as well. Furthermore, participants valued the concept of receiving therapy. The findings

also indicate that participants are aware of the negative impact of not receiving therapy when faced with issues that require intervention. In their study, Radey and Figley (2007) argued that receiving therapy is a vital aspect of taking care of oneself.

4.4 Summary

In this chapter, all major findings are discussed under the four objectives of the study. The chapter first presented the participant's demographic details, which included the participant's age, sex, geographic location, and years of work experience. Also, the results were broken down into themes and sub-themes with direct quotes from the participants to give a true picture of the data that was collected and the conclusions that were drawn from it.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The previous chapter focused on the discussion of the research findings, which were divided into themes and sub-themes. This chapter gives a brief summary of the study's most important findings, conclusions, and recommendations.

5.2 Summary of Findings

5.2.1 Objective 1: To Investigate the Roles Undertaken by Social Workers as Part of Multi-Disciplinary Teams that Work with HIV and AIDS Patients in Selected State Hospitals

It was found that the main tasks that social workers who work within hospital settings undertake are those of an assessor, advocate, educator, facilitator, linker, psychosocial supporter or counsellor, and mediator. It was uncovered that social workers carried out these roles with both the clients and the medical professionals. These tasks are also undertaken with stakeholders to assist the clients. The main lesson drawn from all this was that all efforts made by the social workers are in the best interest of the client. These efforts are made to deal with the obstacles hindering client treatment and find ways to mitigate these factors. All social workers were able to identify their roles within the multi-disciplinary team and felt that their existence within the group was valued, regardless of some of the obstacles they faced.

5.2.2 Objective 2: To Investigate Social Workers' Perspectives of their Experiences when Working with HIV and AIDS Clients in Selected State Hospitals

The participants identified both positive and negative experiences they encountered working within the state health setting. The negative experiences are that working with HIV and AIDS patients is mentally demanding, traumatic, and exhausting, and that it causes social workers to question their capacity to carry out their work. The positive experiences are compassion, satisfaction, being able to learn from other professionals, and creating an environment that allows social workers to experience a broad scope of work in which they can have a variety of social work methods to practice. This indicates that though there are negative aspects to providing treatment, the positive aspects outweigh the negative ones. Most participants indicated that the negative aspects were there, but they were equipped to handle them, which made their work bearable.

5.2.3 Objective 3: To Explore the Institutional Challenges that Social Workers Encounter While Working with HIV And AIDS Patients In Selected State Hospitals

Participants identified seven main challenges that affect social workers in public health settings: a) the lack of relevant policies and guidelines on social workers working with HIV and AIDS affected clients; b) the lack of office space, furniture, and equipment; c) poor supervision; d) the lack of in-service training, workshops, and comprehensive formal training; e) the lack of resources for case management and community activities; f) the injustices experienced by social workers under their human resources in the public health sector; and lastly, g) the role confusion experienced by social

workers in multi-disciplinary teams The above-identified challenges are all major issues that weigh heavily on social workers.

5.2.4 Objective 4: To Explore the Coping Mechanisms Employed by Social Workers Working with HIV and AIDS Patients in Selected State Hospitals

The main coping mechanisms that were identified were case review and debriefing, positive self-talk, taking time off from work, referring challenging cases to colleagues, spirituality, and receiving therapy when the need arose. It was clear that as experience grew, so did the coping mechanisms and the need for them. All the participants knew when they needed to take care of themselves, so they used different ways to deal with stress.

5.3 Recommendations

The researcher makes the suggestions listed below in response to the study's findings and the learnings from the participant interviews across the three regions.

5.3.1 Policies and Trainings

- It was found in several studies, including this one, that the Directorate of Social Welfare Services (DSW) lacks in providing guiding policies for social workers. It was noted that the DSW developed a guideline on psychosocial support services for people with life-limiting illnesses in 2014. This document is closely related to this study. It is therefore recommended that the DSW revise the 2014 guideline on psychosocial support services for people with life-limiting illnesses.

- It is further advised that adequate and regular training on these guidelines and other relevant guidelines impacting social workers be provided for. The DSW needs to make guidelines for in-service training for its new social workers. This training should be required for all entry-level social workers.
- It is further recommended that UNAM, as the only social work training institution, consider implementing a programme for social workers (like that of the Bachelor of Psychology students) that would allow social work students to choose if they wish to specialise in one of two or three specialised fields, for example, medical social work, children-focused social work, or juvenile and criminal justice systems.

5.3.2 Office Space, Furniture, and Equipment

- It was also found that at some hospitals, staff members share offices. The participants noted that this poses a strain on both the staff and clients. As there would be two social workers in one office, they could only attend to one client at a time. Therefore, it is recommended for the Psychology and Social Work Council of Namibia to liaise with the MoHSS and inform them of the ideal conditions under which social workers can operate optimally. There are clear guidelines under which social services should be rendered, and the only way the MoHSS will recognise and provide social workers with these conditions is if the professional council intervenes.

5.3.3 Poor Supervision

- Poor supervision has been noted in a study conducted by Rufaro (2012), and similar findings were found in this study. It is therefore recommended that the DSW develop a guideline stipulating what supervision is, when it is required, and the frequency with which it should be carried out. Furthermore, a logbook needs to be developed that needs to be reported on every month. This would create a sense of accountability among senior staff members and serve as record-keeping for top ministerial management to draw from.

5.3.4 Resources for Case Management and Community Activities

- Another finding was the lack of resources to mitigate client food needs, which was one of the major issues that all participants experienced. Therefore, it is suggested that the MoHSS work with UNAIDS, the Ministry of Agriculture, and the Ministry of Rural and Urban Development to set up community gardens that produce food in a sustainable way for the benefit of the communities.

5.3.5 Human Resources Management Injustices

- Another finding was that social workers are not paid for working overtime, and the only special measures put in place were for COVID-19-related cases. All participants shared their frustration in this regard, and additionally, their salaries are rated lower than their qualifications and the nature of their work. The MoHSS is therefore recommended to re-evaluate the social worker's pay grade based on their qualifications. The ministry also needs to investigate the

issue of overtime and how important psychosocial support is in the healthcare setting.

5.3.6 Training, Induction and Workshops

- Participants indicated that they had not received any induction training. Some have not even received HIV/AIDS training, despite expressing a desire for it. In this regard, a recommendation is being made for the DSW to develop a policy on induction for all entry-level social workers. It is also suggested that the DSW conduct a training needs assessment among the staff and cater to their needs.

5.4 Conclusions

This study has met its objectives by unearthing the answers to its research questions. There is much groundwork to be done in terms of providing an ideal environment for social workers in the public health space.

From a human resources perspective, the staff's remuneration needs to be adjusted as per the qualifications obtained and the experience held by the individual. Additionally, there should be clear roles of responsibility in the multi-disciplinary team setting. Moreso, the work environment should be fit for social service purposes, the same way that provision is made for medical services in a public health setting. These are all shortcomings that should be addressed by discussions between the MoHSS and the Health Professionals Council of Namibia.

From a career development or human resource development perspective, the study indicated a need for the existing social work programme to be revised and for specialties to be introduced. This is to ensure that the quality of the graduate social worker is refined to a specific focus, which may better prepare them for the workplace. Moreso, this cannot be done in isolation but should rather be done in consultation with all stakeholders in the sector to ensure that the programmes remain fit for purpose and meet the actual market demand. Furthermore, the DSW needs to consider developing induction training material for entry-level social workers in the public health space to equip staff for the tasks they will do.

Additionally, the researcher has learned that social workers apply techniques that assist them in breaking away from the pressures of the job to ensure that they do not overexert themselves on a case. This they have managed to do in various ways, and these techniques have helped to keep them grounded and ensure that the clients receive the best treatment possible.

This study did come with its limitations and challenges, and the researcher took note thereof in the scope and the time required to conduct this exercise to meet the requirements for the Master of Arts in Social Work programme at the University of Namibia. The study was also limited by the availability of the participants, in that they were in public health settings across the country. The researcher would want to propose a comparative study focused on public and private health sector social workers employed in multidisciplinary settings to see if the experiences are similar or not. Another point of inquiry would be to investigate the awareness of the injustices unearthed in this study and to test the extent to which the MoHSS and the HPCNA engage about these shortcomings. Lastly, another point of inquiry would be to develop

a multidisciplinary study of the shortcomings expressed from a human resource or career development perspective and investigate ways to overcome these shortcomings.

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Appendices

Appendix One: Ethical clearance certificate from UNAM

UNAM
UNIVERSITY OF NAMIBIA

ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: UNAM-DEC-HSS/03/03/2021 **Date:** 10/03/2021

This Ethical Clearance Certificate is issued by the University of Namibia Decentralised Research Ethics Committee (DEC) in accordance with the University of Namibia's Research Ethics Policy and Guidelines. Ethical approval is given in respect of undertakings contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the DECs at the Faculty/Centre/Campus/Unit.

Title of Project: AN EXPLORATORY STUDY OF SOCIAL WORKERS' EXPERIENCES OF WORKING WITH HIV INFECTED CLIENTS IN THE KHOMAS, KAVANGO EAST AND THE OSHIKOTO REGIONS

Nature/Level of Project: MASTERS (NON HEALTH)

Researcher: MELISSA VERONICA PETRONELLA KATUPAO

Student Number: 200845217

Supervisor: PROF. VICTOR CHIKADZI

Faculty: HUMANITIES AND SOCIAL SCIENCES

Take note of the following:

(a) Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the DEC. An application to make amendments may be necessary.
(b) Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the DEC and the CRP.
(c) The Principal Researcher must report issues of ethical compliance to the DEC (through the Chairperson of the Faculty/Centre/Campus/Unit Research Ethics Committee) at the end of the Project or as may be requested by DEC and the CRP.
(d) Approval is valid for a period of one year from the date of issue.
(e) A mid-year report to be submitted to DEC (where applicable), thereafter to the CRP
(f) The DEC retains the right to:
  (i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,
  (ii) Request for an ethical compliance report at any point during the course of the research.
  (iii) *Cognizance and the observation of Namibian's Research Science and Technology Act of 2004 which makes it compulsory for Non-Namibian Based researchers to obtain the compulsory Research Permit from the National Commission on Research Science and Technology (NCRST) FIRST, BEFORE the research can commence.*

The DEC wishes you the best in your research.

Prof. T. Kalusopa, DEC Chairperson - FHSS

Appendix Two: Research permission letter

REPUBLIC OF NAMIBIA

MINISTRY OF HEALTH AND SOCIAL SERVICES

Ministerial Building
Harvey Street
Private Bag 13198, Windhoek

OFFICE OF THE EXECUTIVE DIRECTOR

Tel: No: 061 -203 2507
Fax No: 061-222 558
Andreas.Shipanga@mhss.gov.na

Ref: 17/3/3/MK
Enquiries: Mr. A. Shipanga

Date: 14 April 2021

Ms. Melisa Katupao
PO Box 1571
Tsumeb
Namibia

Dear Ms. Katupao

Re: An Exploratory Study of Social Workers' Experiences of Working with HIV and AIDS infected clients in the Khomas, Kavango East and the Oshikoto regions.

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
   - 3.1 The data to be collected must only be used for academic purpose;
   - 3.2 No other data should be collected other than the data stated in the proposal;
   - 3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;
   - 3.4 A quarterly report to be submitted to the Ministry's Research Unit;
   - 3.5 Preliminary findings to be submitted upon completion of the study;
   - 3.6 Final report to be submitted upon completion of the study;
   - 3.7 Separate permission should be sought from the Ministry for the publication of the findings.
4. All the cost implications that will result from this study will be the responsibility of the applicant and **not** of the MoHSS.

Yours sincerely,

EXECUTIVE DIRECTOR
MINISTRY OF HEALTH AND SOCIAL SERVICES

BEN NANGOMBE
EXECUTIVE DIRECTOR

All official correspondence must be addressed to the Executive Director.

Appendix Three: Interview Schedule

Interview Schedule

Interviewee letter (A, B, C):

Date of interview:

Starting time:

Ending time:

Age:

Sex:

Region:

Length of work in health:

What services does your office provide?

1. What are the roles of a social worker in the treatment of a client affected by HIV or AIDS, that works in a multi-disciplinary team?
2. What is your role in the multidisciplinary team?
3. Tell me about how other professional view and value your role in the treatment process?
4. Please tell me about your experiences in your role and responsibilities of providing treatment for patients leaving with HIV or AIDS?

5. Please tell me about some of the challenges you face in your role as a social worker working with HIV and AIDS affected clients.

6. Do you face any institutional challenges in providing treatment for your clients?

7. What are the advantages of providing treatment within the hospital setting?

8. Would you say that social workers receive adequate training when perusing their qualifications to provide adequate service to clients affected by HIV and AIDS

9. Given the above stated challenges, what are some of the coping mechanisms that you employ in your work as part of both self-care and service delivery.

10. What recommendations would you give, that can help the ministry of health and social services to improve the working environment for social works?

11. What do you commend the ministry of health and social service on, that they are doing well for social workers to strive in their work?

12. Is there anything else that you would like to share regarding social worker's experiences working with HIV and AIDS clients in state hospitals?

Appendix Four: Informed consent

INFORMED CONSENT FORM

Informed Consent for Informed Assent for Social Workers for the research titled "An exploratory study of Social Workers' experiences of Working with HIV Infected Clients in the Khomas, Kavango East, and the Oshikoto Regions"

Name of Principal Investigator:	Melissa Katupao
Name of Sponsor:	Prof. V. Chikadzi

This Informed Consent Form has two parts:

- **Information Sheet (this section, to share information about the study with you)**
- **Certificate of Consent (for signatures if you choose to participate)**

You will be given a copy of the full Informed Consent Form.

PART I: INFORMATION SHEET

Introduction

My name is Melissa Katupao, and I am pursuing a Master of Arts in Social Work degree at the University of Namibia. I am conducting research on the experiences of social workers working with HIV-infected clients. I would therefore like to invite you to participate in this, given that you are part of the social work workforce working in hospital settings. Your participation is entirely voluntary, and refusal to participate will not be held against you. If you have questions regarding the research, I will answer them to the best of my ability.

Purpose of the Research

The purpose of this study is to explore social workers' experiences in working with HIV-infected clients in the Khomas, Kavango-East, and Oshikoto regions. The study specifically seeks to interview social workers who work in health settings and have worked with HIV and AIDS patients. The research explores the roles that social workers within hospital settings play as part of multi-disciplinary teams. The research also seeks to investigate the specific roles that social workers play in hospital settings when intervening with HIV and AIDS clients. Lastly, the research will look at the problems social workers face in these situations and the ways they deal with them.

Type of Research Intervention

This research will involve your participation in an in-depth interview, which will be guided by a semi-structured interview guide. It is expected that the interview will last for approximately 45 minutes.

Participant Selection

I have selected you to participate in this research because, firstly, you are a social worker, and my focus is on social workers, and secondly, because you are working with people living with HIV and AIDS as part of your work in the hospital and would be able to provide me with in-depth knowledge based on your experiences.

Voluntary Participation

Please be informed that your participation in this research is entirely voluntary. It is your choice whether to participate or not. You may withdraw from the study at any time, and this will not be held against you.

Procedures

If you accept to participate in this study, you will be asked to take part in an interview that is guided by a semi-structured interview guide and is expected to last for about 45 minutes. You will also be at liberty to choose where and when the interview will take place. The interview guide will be focused on four objectives: (1) to investigate the roles undertaken by social workers as part of multi-disciplinary teams that work with HIV and AIDS patients in selected state hospitals; (2) to investigate social workers' perspectives on how they experience working with HIV and AIDS clients in selected

state hospitals; (3) to explore the institutional challenges that social workers working with HIV and AIDS patients in selected state hospitals face; (4) to explore the coping mechanisms employed by social workers working with HIV and AIDS patients in selected state hospitals.

Duration

The study will take place over two months. During that time, I will only visit you once for an interview that will last approximately 45 minutes.

Risks

No potential harm to participants is anticipated in this research. However, in case of any distress or need for debriefing, provision will be made for referral to counselling services.

Benefits

There will be no direct benefit to you, but your participation is likely to help us find out more about how the ministry of health and social services can improve the working environment for social workers in your line of work by identifying the gaps that exist.

Reimbursements

You will not be provided with any incentive to take part in the research. But in instances where you must travel for the interview, a reimbursement of the full transport costs will be made, and you will be provided with refreshments.

Confidentiality

The researcher will protect all data gathered within the scope of the project from being divulged or made available to any other person. All data will be stored on a password-protected computer and destroyed five years after the findings are published. All information will be treated with confidentiality, and no one other than the student will have access to the data. No identifying details of all participants will be included in the final research report, given that pseudonyms will be used.

Sharing the Results

Nothing that you tell the researcher today will be shared with anybody outside the research team, and nothing will be attributed to you by name. The knowledge that we get from this research will be shared with you and the Ministry of Health and Social Services before it is made available for wider circulation in the broader community.

Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to, and choosing not to participate will not affect your job or job-related evaluations in any way. You are free to withdraw from the interview at any time without affecting your job. I will give you an opportunity at the end of the interview to review your remarks, and you can ask to modify or remove portions of those if you do not agree with my notes or if I did not understand you correctly.

Who to Contact?

If you have any questions, you can ask them now or later. You may contact the research Melissa Katupao on 0813397446 or via email on melissaktp@yahoo.com

This research has been reviewed and approved by the relevant Ethics Review Committee at the University of Namibia, which is a committee whose task it is to make sure that research participants are protected from harm. The committee reports to the University's Centre for Research Services. If you wish to contact this Centre, please call +264 61 206 4673 or send an e-mail to research@unam.na.

You can ask me any questions about any part of the research study if you wish to. Do you have any questions?

PART II: CERTIFICATE OF CONSENT

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked, have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

…….

……

Name of Participant (print) Signature of Participant

……

Date (day/month/year)

Statement by the Researcher/Person taking Consent.

I have accurately read out the information sheet to the potential participant and, to the best of my ability, made sure that the participant understands that the following will be done:

- An interview will be conducted, which will last approximately 45 minutes.
- The participant will agree on a time and location that are convenient for them.
- The research is voluntary, and the participant can withdraw from participating at any time during the research.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent and that the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.

……. ……

Name of Researcher/Person taking Consent (print) Signature

……

Date (day/month/year)

Appendix Five: Language, Copyediting, Proofreading Certificate

NAURU CONSULTANT AND RESEARCH INSTITUTE

11 February 2023

LANGUAGE & COPY-EDITING CERTIFICATE

RE: LANGUAGE, COPYEDITING, AND PROOFREADING OF MELISSA VERONICA PETRONELLA KATUPAO'S (STUDENT NUMBER: 200845217) THESIS FOR THE MASTER OF SOCIAL WORK OF THE UNIVERSITY OF NAMIBIA

This certificate is to inform you and/or your organisation that our company, NAURU Consultant and Research Institute, has indeed copyedited and proofread Ms. Melissa Veronica Petronella Katupao's (student number: 200845217) thesis for the Master of Social Work entitled: **An Exploratory Study of Social Workers' Experiences of Working with HIV and AIDS Infected Clients in the Khomas, Kavango East, and Oshikoto Regions**.

NAURU declares that we professionally copyedited and proofread the thesis and removed mistakes and errors in spelling, grammar, and punctuation. In some cases, we improved sentence construction without changing the content provided by the student. We also fixed some typos in the thesis and made sure it was formatted according to the rules for research at the University of Namibia.

NAURU has trained language and copy editors and has edited many postgraduate diplomas, master's theses, dissertations, and doctoral dissertations for students studying at universities in Namibia, Zimbabwe, South Africa, and the UK. We have also copyedited company documents for companies in the region and abroad.

In light of the above, please accept the assurance of our services.

With Much Appreciation,
Fares Shipaxu (Research Associate, NAURU Consultant and Research Institute)

https://nauruconsultant.com/

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