

AIDS and Social Work in Africa

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ABSTRACT

This paper describes the intensifying AIDS epidemic in SubSaharan Africa, and identifies a range of emergent needs in this connection. It examines existing social work involvement in AIDS and finds that social workers in Africa are currently considerably underutilised in this field. The paper explores potential social work roles and argues for the inclusion of AIDS issues in all social work training, and for closer coordination between medical and social aspects of care, to engage social workers and others in meeting growing needs more effectively. The author argues for the mobilisation of widespread community resources for the prevention of HIV, to provide support for people with HIV or AIDS and their families, and to recognise AIDS as a critical development issue demanding an urgent response.

Introduction

The 1980s have witnessed the rise of a global pandemic which, by the end of the decade, led to an estimated half a million people or more developing full AIDS, and over 6 million people acquiring HIV infection in approximately 150 countries. By the end of the century a Delphi projection by the World Health Organisation (WHO, 1990a) suggests a cumulative total of 10 million people with full AIDS, and at least 50 million with HIV. Three million or more of those dying of AIDS in the 1990s will be women and children, and over a million uninfected children are likely to be orphaned because of AIDS (Chin, 1990). These projections are likely to be revised upwards.

The WHO, coordinator of the Global Programme on AIDS, views HIV and AIDS as the most pressing health problem in the world today, because of its potential for rapid spread, and its impact on young to middle aged adults, previously population cohorts with the lowest mortality rates. In some major cities of SubSaharan Africa, the USA and Western Europe, AIDS is already reported to be the leading cause of death in women aged 20 - 40 (WHO, 1990b). Recent gains in infant and child mortality rates may be nullified or reversed with the impact of

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the AIDS epidemic. Whilst progress has undoubtedly been made towards production of a vaccine and effective treatment, experts in the field repeatedly warn against undue optimism. They suggest that it may still be several years before either is widely available at affordable prices. Thus prevention of infection through education for behaviour change and health safety measures (such as blood screening) is critical, as well as maximum support for infected people, most of whom are likely to die.

In SubSaharan Africa the epidemic is growing particularly fast through heterosexual spread and by transmission to babies. A quarter of all AIDS cases are babies. WHO (1990b) estimates that between 20% and 30% of sexually active adults in some cities are infected, whilst levels of HIV in rural areas are often lower. Key factors in the rapid heterosexual spread of HIV are multiple sex partners and the extent of other sexually transmitted diseases. Migrant labour, urbanisation, poverty, war, population displacement, extended family breakdown, rapid cultural change and inadequate services in health, education and welfare are some of the major underlying factors influencing sexual patterns, and therefore the risk of HIV. The inferior status of women is also significant.

Interventions for behaviour change are impeded by factors such as inhibitions about sex education for the young, and cultural and church related rejection of condoms, as well as the inevitable problems of economics, lack of infrastructure and trained staff, and so forth. In many countries in the region, as elsewhere, there has also been political reluctance to be very open about the epidemic, although this is now improving significantly.

The rapid spread of AIDS has been recognised, inevitably, first and foremost by medical practitioners. They are the people who diagnose HIV infection, take blood for testing, and treat patients developing HIV related disease and full AIDS itself. It is medical and allied staff who are doing research into vaccines and cures, while still improving palliative measures. In many countries in Central, Eastern and Southern Africa, as well as in the USA, parts of Europe and elsewhere, hospital beds are increasingly occupied by patients with HIV/AIDS, seriously exacerbating existing bed shortages. AIDS is now the leading cause of pediatric hospital deaths in Harare, Zimbabwe, and clinic time is increasingly devoted to outpatients with HIV related conditions.

Yet although AIDS first aroused medical concern, it is very much more than a medical problem. HIV infection and AIDS have psychological, social, ethical, legal, economic, material and political implications, as well as long term implications for socioeconomic development, planning, population growth, and population structure. It will change mortality patterns, and perhaps fertility, in many countries, and will undoubtedly lead to slower population growth, if not actual population decline in some areas (Over, 1988). There will also far reaching

implications for training and employment patterns, as large numbers of skilled employees die. AIDS is already beginning to be taken into account in life assurance and medical insurance policies. It will have an impact on social structures and family units, on male-female relationships, numbers of orphans, and on parenting by grandparents when the middle generation dies. A multiplicity of problems at the micro level are emerging.

Therefore, it is crucial that the community in general and professionals in many spheres outside the health service become centrally involved in both prevention measures and in realistic planning and support services in a variety of areas. It is considerably more difficult to think of areas of national, economic and social life that may not be touched by AIDS in the long run, than to identify those areas that are.

In this increasingly difficult situation, social workers may have a particularly useful role to play. This paper will examine the roles social workers currently play in Africa in relation to AIDS, and explore how their expertise could be more usefully employed. Social workers are generic practitioners drawing on a wide range of disciplines and theoretical perspectives, working at the individual level as well as with groups, communities, organisations and in research, administration, and policy development. They provide direct counselling and support services to those in need, link individuals and groups with resources, promote services and resources, and help existing services and organisations to cooperate effectively. Their specialism is one of generalised adaptability and genericism, rather than narrow specialisation. While this may have drawbacks and limitations, it is a particularly relevant attribute in the field of AIDS - for example in seeing the broader picture, adapting existing practice in new ways, and making vital new linkages.

Of special value is the fact that social workers have, unlike the medical tradition, a philosophy of promoting self help, and client empowerment. In the face of AIDS, which all too often leads both patients and their doctors to feel helpless and powerless, this approach becomes more crucial than ever. For there to be any chance of progress with HIV and AIDS, the infection must be seen as a challenge and not as the end of all hope. This applies to both prevention and support strategies. With cancers and other potentially terminal conditions, those who challenge their ill health, and fight back against it, are widely reported to do better than those who face it with despair or even stoic resignation (Leshan, 1989; Siegel, 1986). The same has been reported of groups of patients with AIDS. Measures that boost the immune system may delay the onset of symptoms of HIV related disease, and undoubtedly the quality of 'life with AIDS' can be improved. Patients can be assisted to adopt an active and holistic approach to their own care, taking as much responsibility as possible within a framework that is meaningful to them.

At a wider level, social workers may be well placed to promote community awareness and hence the prevention of HIV. Community development and community health, from a social perspective, are already part of social work training in some schools of social work (for example Zimbabwe and Tanzania), and AIDS education can readily be incorporated into these and other courses. In both prevention and support work, social workers could work very effectively alongside health workers to provide a comprehensive and cost effective service in which primary health, psychosocial and material needs are all addressed.

In March 1990 the International Federation of Social Workers (IFSW) in conjunction with the WHO organised a workshop to discuss possible collaboration in identifying and developing social work responses to AIDS in different regions. It was recognised that there are both similarities and wide differences between regions in the range of need and the type of services available (Kaplan, 1990). Six broad areas of social work practice were identified: direct service provision, education and training, community organisation and mobilisation, programme planning and development, advocacy, and research and evaluation. It was recognised that whilst these are globally relevant to AIDS work, in many regions social workers are not effectively fulfilling all or many of these roles in general, let alone in respect to AIDS. In many regions social workers in reality play a narrow remedial role, doing basic welfare and casework rather than taking on developmental functions. Where this is the case, work in AIDS is initially likely to fit into existing narrow patterns of activity. However, in time, the necessity for AIDS work to expand into the other areas identified could prove a stimulus to expanding social work roles across the board. This would be a highly desirable development.

The WHO is also in the process of developing a comprehensive training manual on counselling for HIV/AIDS, the first draft of which came out in 1988. It has been field tested in a number of developing countries, and several workshops held to evaluate it. One such workshop for Southern Africa took place in May 1990 at the School of Social Work, Zimbabwe. Consideration was also given at this Workshop to social work roles in the region. These are broadly reflected in the potential roles discussed in the next section.

Current social work practice and AIDS in Africa

In February 1990 a detailed questionnaire on AIDS education for trainee social workers and on the current and potential roles of social workers in relation to AIDS was sent to organisations in 27 countries in Africa. The organisations included social work training institutions, departments of social work, and national associations of social work, drawn from listings of the Association of Social Work Educators in Africa (ASWEA) and IFSW. In some cases more than one

organisation was identified in a country, in these cases all the relevant institutions were circulated. Where two or more replies were received from one country, data was cross checked. However, in most cases only one reply was received from a country.

Replies were received from only 11 countries: Ethiopia, Ghana, Malawi, Mauritius, Mozambique, Nigeria, Tanzania, Togo, Uganda, Zambia and Zimbabwe. The reply from Mozambique did not contain the information requested, leaving 10 replies that ranged from full details to partial discussion of the prevailing situation. The responses received probably over-represent AIDS education and social work involvement, rather than under-representing it, as it is probable that countries with greater social work involvement in AIDS are more likely to respond to the questionnaire. Personal communication with social workers and allied professionals in a number of countries in the region (Kenya, Mozambique, Namibia and Botswana) reinforces this view. A 1989 WHO listing of Non Government Organisations (NGOs) involved with AIDS in Africa listed only 31 organisations in 15 countries, not one of which is a mainstream social work organisation, and most of which are church related or hospital based. (This is undoubtedly very incomplete, but it is nevertheless an interesting indication of the lack of prominence of social work and community agencies in the field).

Findings from the questionnaire (see Table 1) indicate that by 1990 organisations in 5 out of 10 countries had begun to include AIDS education in their curricula. All schools indicated this to be an area of need, and all, with the exception of Togo, said that the extent of AIDS education needed to be increased. In Mauritius, Ethiopia and Nigeria a basic lack of factual material was cited as a barrier to education. In the other 7 countries information was seen as widely available through a variety of media.

All respondents felt that social workers need AIDS education, that they have a potentially major role to play in relation to AIDS, and that social workers are currently underutilised in this field. They indicated a primary need for social work involvement in preventive and supportive counselling, particularly to assist with emotional problems. Fear of infection, stigma, and family problems were also acknowledged by several respondents, and bereavement, job loss and other problems were cited. Material needs and general poverty were specifically noted, as was the need for community support. Social workers were seen as having a particular role in community education and mobilisation. All respondents said that close collaboration with health professionals was essential, but 8 cited this as a problematic area. This was expressed in two cases as "Each discipline tends to hoard its own territory" (Nigeria), and "There is some professional distance on the part of medical officers" (Ghana). In the majority of countries social workers were not actively involved in National AIDS Control Programmes. All 10 countries,

however, acknowledged insufficient training, knowledge, skill and information as barriers to social work involvement, while six also cited lack of agency concern and funding, and 3 pressure of work. It would appear that a combination of inadequate training and expertise regarding AIDS, and insufficient recognition and involvement of social workers by medically dominated National AIDS Control Programmes, and health services in general, primarily prevent social workers from being more involved in this area. Their employing agencies need to be more alert to the issues, and AIDS needs to be given more priority in work allocation.

In addition, the range of employing agencies for social workers needs to be expanded, particularly in the health sector itself, if they are to be more centrally involved in AIDS work. Social workers themselves need to take more responsibility to develop their skills and role in this field.

Potential social work roles

Particular roles that social workers may play include at least those noted below. In different countries and settings priorities will, of course, vary and services and organisations will be different. Social workers will need to liaise and be involved with a wide range of community organisations, and government and non government bodies to implement the roles suggested here.

1. Preventive counselling and education.

In the absence of an effective vaccine or cure for AIDS, prevention must be the cornerstone of any strategy to cope with the epidemic. Social workers may be involved in

- * individual counselling and education on HIV and AIDS
- * promoting small group focused discussions, for instance in workplaces, in women's clubs, at schools and in numerous other community venues
- * helping to mobilise people with HIV or AIDS (PWHIV/As) as educators
- * giving talks, disseminating leaflets and other educational materials
- * educating others while providing support for infected or ill people
- * running workshops on AIDS, including psychological and social aspects
- * training peer group counsellors in numerous settings
- * promoting awareness and supportive policies in their own workplace
- * being involved in existing educational and awareness initiatives
- * establishing new groups and organisations to promote AIDS awareness
- * putting AIDS on the agenda in a wide variety of fora.

2. *Supportive counselling*

In many ways this will be seen as the most central role of social workers regarding AIDS. Many publications (Miller and Bor, 1988; Jackson, 1988; Green and McCreaner, 1989) discuss this issue. AIDS counselling is a natural extension of existing counselling roles. The main areas of counselling need are:

- * for the 'worried well', to allay unfounded fears, and to explore realistic anxieties
- * pre and post test counselling. This is already being undertaken by non medical counsellors in many countries, and can greatly assist overworked medical staff in both hospital and clinic settings. Good counselling at this stage can help prepare people for a positive HIV result, so that they cope better with their emotions and are able to take more responsibility for protecting others
- * crisis intervention, for instance when an infected person loses their job, or first becomes symptomatic, or first faces life-threatening ill health
- * continued supportive counselling (for emotional needs, to promote health care, and so on)
- * terminal support
- * bereavement
- * counselling for relatives, including children, and close friends
- * counselling for work colleagues, employers, teachers and other relevant people
- * counselling for stressed health and other workers to enable them to continue to cope with the distress of AIDS, and avoid burn out.

Social workers in many settings can expect to see increasing numbers of clients with AIDS, and their families. The most obvious setting is that of health care. In many countries in Africa few social work posts exist in hospitals or clinics. In Harare, Zimbabwe, the two major teaching hospitals have a complement of four social work posts between them, if psychiatric departments are excluded. AIDS highlights the psychosocial and material needs of patients and their relatives both in the hospital and on return home. The need for community back up is increasingly being recognised, and one or two attempts are being made to address this need (such as the Salvation Army home care mobile team based at Chikankata Hospital in Zambia, which stresses pastoral care, Williams, 1990). Many AIDS patients have to, and indeed may prefer to, die at home where they are spiritually at peace (and where they are not blocking the scarce resource of a hospital bed). They and their families need support to enable them to cope with the medical, psychosocial, spiritual, material and practical needs that arise in this situation.

Social workers in the armed services and in prisons, as in other settings, are likely to see many clients with HIV or AIDS. In both settings the level of HIV infection and, consequently, the incidence of AIDS, are likely to be high. In refugee camps AIDS is also likely to be a growing problem, adding to the difficulties and costs of supporting large numbers of displaced persons, particularly in Southern Africa.

One important aspect of supportive counselling may be helping to put people with AIDS/HIV in touch with each other for mutual selfhelp, and facilitating selfhelp groups where these have not developed through other channels, or on their own. Such peer support is well developed amongst the gay community in many countries. In Uganda a support organisation called TASO has been developed by people with HIV/AIDS and their relatives, but this is unusual. In Zimbabwe, by the end of 1990, only one person had publicly acknowledged having AIDS. He is trying to establish a selfhelp organisation, but it includes those without HIV infection so there is ambiguity over who is infected.

3. *Practical and material support*

As people with HIV progress to AIDS they are likely to experience financial, material and practical hardships. Income from employment may be lost just when medical costs are rising and a nutritious diet is most essential, and when added stress is most damaging. Pension and other benefits may be curtailed. Medical aid may have limits put on it to safeguard the fund against the rising cost of AIDS treatment. On top of these financial hardships, friends, and even family members, may draw away, yet this is a time when people most need practical help with household chores, transport and so on. Extended family members may be unwilling or unable to take on orphaned children, who then need other sources of care. In part of Uganda, two children in every five, totalling thousands upon thousands of children, are reported to be orphans because of AIDS (Kaleeba, 1990). This problem will increase throughout the region. Social workers may assist in this and other problems by:

- * providing state assistance through welfare departments
- * promoting assistance through NGOs such as Save the Children Fund, Red Cross Societies and others
- * supporting selfhelp initiatives and income generating projects amongst affected individuals and families
- * developing new resource organisations and networks
- * promoting supportive attitudes in the community in general, and in specific agencies and organisations, to mobilise them to address the growing needs. Residential homes for orphans may need to be expanded or developed, and more imaginative community care strategies at lower cost will become increasingly relevant.

As already noted, priorities will vary in different regions. Social workers need to monitor new areas of need and anticipate growing problems.

4. *Promote positive policy development*

Few countries in Africa have any specific legislation on AIDS - and the legislation that is being introduced in many developing and developed countries around the world often contains negative discriminatory measures at the expense of safeguarding individual rights. Public health is frequently polarised against individual rights and needs, and national safety is put above international solidarity. At least 34 countries now have some entry restriction on AIDS (Panos, 1988), including the USA which provoked the widespread international NGO boycott of the International Conference on AIDS held in San Francisco in June 1990. Some countries have implemented compulsory screening for visitors, or for those deemed to be in 'high risk groups', or even for national populations, as in the case of Cuba. In some countries pre-employment screening for HIV is permitted, sometimes clandestinely, and two states in the USA have reportedly experimented with, and rejected, a policy of premarital screening. Nevertheless, many countries in Africa and elsewhere have ratified various supportive WHO declarations on AIDS, indicating a general willingness to avoid discrimination in principle.

It is essential for social workers concerned about AIDS to become very well informed on the issue and to campaign for the fundamental human rights issues that it raises. They need to help promote positive policy development at national, local, enterprise, organisational and community level. Individual rights to confidentiality, to information on their own health, to work, to enjoyment of all societal amenities and services, to occupational, health and pension provisions, to travel, and to other basic human rights, need to be safeguarded. Where discrimination is unavoidable it should be minimal to safeguard the needs of all concerned. For example, some occupational pension funds will go bankrupt if no account is taken of changing mortality rates through AIDS. Yet there are all too many advocates of repressive measures in different countries (including compulsory screening, quarantining infected persons in camps, tattooing, castration and other injustices) which reflect a fearful plague mentality. These must be constructively challenged early on before they become enshrined in law.

Social workers need first to be convinced themselves that supportive policies are the most appropriate ones. There are many persuasive arguments for this from fundamental ethical concerns to the practical realities of controlling the epidemic. Essentially any measures that increase public paranoia about AIDS, by discriminating against infected or at risk people, will serve to drive HIV infection further underground. This will impede educational efforts to reduce risk behaviour, and make attempts to assist those already infected, or ill, less effective. Yet

prevention depends on those at risk, or already with the virus, voluntarily changing their sexual behaviour (and risky injecting behaviour). Far from being polarised with respect to HIV/AIDS, public health and individual needs coincide in many ways. The open integration of PWAs in their communities, workplaces and so on potentially provides the most effective measure to promote awareness and safe behaviour in others, as well as providing the best potential support for infected persons themselves. The WHO has consistently advocated supportive, not discriminatory, strategies.

Social workers may become involved in policy issues by:

- * becoming well informed about existing policy, and of the ethical, moral and legal arguments involved, knowing policy precedents elsewhere, and actively promoting positive policy development at the national level, through whatever channels are most appropriate, and at local and agency level
- * advocating for individual rights when PWHIV/As are discriminated against, taking up or referring people for legal aid or to pursue test cases to establish legal precedent (for instance regarding dismissal from work, or exclusion from public amenities, for having HIV/AIDS)
- * promoting positive policy development, support services and educational campaigns at their own workplaces.

5. *Research, monitoring and evaluation*

Need identification, the evaluation of intervention strategies, and other forms of research on AIDS are urgently required. In many countries KAP (knowledge, attitude and practice) studies have been carried out, which form an important basis for assessing community and group awareness, concerns and risks regarding AIDS. Often, however, they do not go far enough, and merely reinforce the researcher's anticipated results. More in depth analysis is required. For example, to provide effective prevention strategies against the sexual spread of HIV it is helpful to know exactly what risk behaviours people have, what sustains these behaviours and what might modify them, what people understand and believe about their personal risks, what they feel about condom use and about monogamy or having multiple partners, what is the basis for these views, and what economic, social, cultural and other factors reinforce them? How do people talk about sex with same sex groups, with spouses, and with casual sexual partners? Other questions include: Is sex education in schools practicable? What are the barriers to this, and how might they be overcome if sex education is assessed as highly important? At what age do most young people engage in full sexual activity, and what type of education would be appropriate to make this less hazardous in regard to HIV and other sexually transmitted diseases, and pregnancy? Are educational messages about fidelity in marriage, and chastity before it, realistic and appropriate,

especially where migrant labour, family disruption, and poverty and other factors prevail? Is promoting safer sex through condom use more effective, although controversial? How can different educational strategies be evaluated?

As with other community needs, social workers are often in the front line in the battle against AIDS. The medical profession was the first to confront the central health problem, but the many psychosocial, economic and material consequences fall squarely at the door of the social workers and allied professionals. Research is needed to identify the most pressing problems now, what is happening within families and what are going to be the needs of tomorrow. Two obvious problems include large numbers of orphans and destitute families whose breadwinner has AIDS. Problems of stigmatisation and discrimination are likely to increase in many countries, and may need counselling and other intervention. There are also a number of other related concerns. Issues like the impact of AIDS on women, and on male-female relations. Fertility rates also need to be analysed. At the demographic level, will they increase as women conceive again quickly after the death of a baby from AIDS, or decline as many women die during their reproductive years? How will AIDS affect population structure and dependency ratios? What role do traditional healers, the extended family and other traditional sources of help in the community, play regarding AIDS? What are the barriers to their greater involvement? How can they be more effectively engaged? What are their needs in the face of the epidemic? These and numerous other questions must be asked and thoroughly researched. Interventions for prevention or support services should be well researched before implementation, and be constantly evaluated and modified.

Facilitating social work involvement

For an effective role in the AIDS struggle, social workers must be adequately trained and informed. At the very least this means they must:

- * be well informed about the epidemic itself, including its scale and spread, have basic up to date medical facts about HIV infection and AIDS, and sound information on transmission and non transmission of the virus
- * be able to handle and discuss sexual issues openly, as well as terminal illness and death
- * be personally well adjusted with regard to personal risks and fears
- * be self aware and control their prejudices, and moralising and judgmental attitudes
- * be well informed about the psychosocial stress of HIV and AIDS, and material, practical and other problems
- * know what relevant resources exist in the community.

These are additional to the need for well developed social work skills and praxis. AIDS involves some of the most stressful situations that social workers are likely to encounter: prolonged ill health and death of young adults and babies, family and community disintegration, stigma and prejudice, a linking of sexuality and death, blame and guilt, destitution and all that it implies in this context. In addition, the problems of clients with AIDS are not their problems alone, but problems likely to affect the social workers' own extended families and friends, and a number of social workers themselves.

Many practising social workers trained long before AIDS was on the agenda. They need in service training to update themselves. Students currently on social work courses must be exposed to AIDS issues as an integral part of their curriculum, within individual casework and groupwork programmes, community work and community health, within socioeconomic development and administration courses, and other areas. Some schools may prefer to devote entire courses to AIDS, for those who wish to specialise in the field. However, in many schools existing demands on the curriculum preclude this, and it may, in any case, be felt that AIDS should be an integrated rather than a specialist subject. All students need this education, and they must see it as relevant to all sorts of client groups and in a wide range of practice settings. For example, in Southern Africa AIDS is of particular relevance to at least the following groups, or in the following settings:

- * in hospitals and other health settings
- * in refugee camps
- * in the armed forces
- * in prisons
- * in family work
- * with women (and some men) sex workers and their clients
- * as an integrated part of any health education work
- * in personnel and welfare departments in all types of workplaces
- * in welfare departments, rural and urban planning, community development, and other ministries and departments of government.

In all these areas of work the problem of AIDS will become of steadily greater importance. Many more social workers could be employed in all these situations, or with these groups, to help meet the counselling, support and educational challenge. This could mean many agencies employing social workers for the first time. In particular, social workers should be widely deployed in the health services to help meet the growing psychosocial and material needs of AIDS patients and their families.

Discussion

Social workers have the potential to play a major role in both the prevention of HIV and the provision of support services. In much of Africa, and possibly many other

regions of the world, they are to date an underutilised resource. In order for social workers to begin to be effectively utilised in this field, certain prerequisites must be met. These are:

- * the incorporation of AIDS as an integral part of social work education for all trainees
- * development of in service training on AIDS for all (or as many as possible) trained social workers in the field
- * the creation of new or expanded posts for social workers in critical areas (including health care settings, prisons, armed services, schools and colleges, refugee camps, company personnel and welfare departments, AIDS support organisations, relevant non government developmental and remedial organisations, and government departments and ministries)
- * increased linkage between medical and social aspects of care, and the breaking down of barriers between the medical and social work professions.

If these basic prerequisites can be met, then social workers may begin to apply their generic training much more effectively to AIDS work. Apart from direct benefit to the community, this would facilitate medical inputs themselves, by making them more cost-effective, more appropriate and more sensitive to the psychosocial needs of both the patients and their families. A team approach to illness, death and bereavement with a holistic orientation may achieve far more for those affected, and also promote education for prevention in the community.

Where there is resistance in sectors of the health profession to 'non medical interference' in patient care, this must be broken down, not by aggressive challenge or competition but by demonstrating the advantages to the health profession itself, as well as to the public, of an integrated approach to AIDS. It is easy for medical personnel to feel a deep sense of failure when patient after young patients dies. Treatments are gradually improving, but the numbers of those dying will nevertheless continue to rise in the foreseeable future. Maximising the quality of life, engaging to the full the patient and family's coping capacity, and promoting prevention of infection, all remain central concerns. The achievement of these goals relies at least as much on time spent in one to one or group counselling as it does on medication. Yet how many doctors or nurses can afford to spend more than a few minutes per consultation on a ward round, or in an outpatient clinic, or can make any home visits at all? Clearly it is not cost effective for the counselling role to fall squarely on medical staff alone. Nor do many nurses and doctors have the training, skill and desire to spend considerable time counselling patients and their families about issues possibly only indirectly related to their health. For example, in two minutes one can advise a patient that an HIV test is needed, and elicit one or two questions on and how it will be conducted and what the test result means. But does this address what patients most fear regarding a positive result, how they will handle the sexual behaviour changes that may be required, or how they can best

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