

**Subject area:** Cross cultural Social Work Student Practice  
– A Reflective Essay

**Title:** Lessons from South Africa: Reflections on International Social Work Practice

**Author:** Tracie Rogers

**Target Audience:** Social Workers, Social Work Students

**Key Transferable**

- Lessons:**
- (1) The social work student on international social work practicum is involved in practice learning as well as cross-cultural experiential learning
  - (2) Cross cultural learning can significantly impact the practicum experience



*Like the evils of Pandora's Box, HIV and AIDS has cast a shadow over Kwazulu Natal, the largest South African province, having infected nearly forty percent of its residents. In 1995, a small group of health care workers at Mc Cord Hospital reached for the only item remaining in Pandora's Box, Hope, and started climbing a mountain. Sinikithemba is an isiZulu word which translates in English to mean "We give hope". The Sinikithemba Clinic was started in 1995 as a McCord Hospital staff initiative to serve the specific needs of persons undergoing HIV/AIDS treatment. The succeeding are my personal reflections on the experience of social work practicum in Durban South Africa*

### Introduction

In *'Like the Flowing River'*, Paulo Coelho (2006) offers short stories, thoughts and reflections on life's twists and turns. Somewhere over the Atlantic Ocean, some 6 hours from Trinidad on my return journey from my field placement in South Africa, *'Like the Flowing River'* finds me and holds me in a short vignette entitled, *'How to climb Mountains'*. As I leaf through the three pages of the vignette, I smile, frown, pout, smile again, then snifle a thoroughly inappropriate laugh for my current altitude. *I have climbed mountains*. I feel the lessons, the growth, the frustrations, the seeds sown, moments of social work brilliance and moments that were far-from-brilliant - all running across three months which have taught me more about social work and myself than I thought I could possibly squeeze into 13 weeks.

As I reflect critically on the thirteen (13) weeks of my field work practicum, then add the six (6) weeks of funding and logistics warfare which preceded it, this paper can only be about the mountain climbers I have learned from as I journeyed from Trinidad to South

Africa and back again. I forward this reflective essay on the personal journey I made during my social work practicum.

### **How to Climb Mountains**

On 06, July, 2006, Professor Vishanthie Sewpaul, my Field Supervisor introduced me to Ms. Maud Mthembu, my Practice Teacher for the succeeding three months and the Sinikithemba HIV/AIDS Care Centre. Sinikithemba is now eleven years old and as the conversation quickly picks up between Maud and Vishanthie, it is clear that much has changed since its inception. The organization of the agency and its service provision has changed drastically since the previous student placement Vishanthie supervised. Vishanthie sends questions, Maud quickly responds and then adds more information. The pace is furious; both of these women impress me as experts and as questions morph into answers and trigger more questions and as well-structured, smooth, proficient answers circle the room I feel a knot around my lungs. There is utter dissonance brewing in me; *'I am not a newbie, I can have conversations with educated people, I know about HIV and AIDS, surely I am sufficiently competent to be here!! What is this? Anxiety? Surely this brain and these lungs do not belong to me?'* My tiny panic attack was interrupted by silence. They were both looking at me as I struggled to remember the question asked and string together an answer that would camouflage the convulsions rocking my body. It was a simple question – 'Are antiretroviral drugs available in Trinidad?' *And yes, I traveled thousands of miles to pursue an HIV/AIDS focused social work practicum and I am a blubbing fool to answer the simplest question.*

Coelho (2006) instructs that while climbing mountains one must have respect for the body and respect for the soul. Of the former he urges that you will only manage to climb the mountain if you give your body the rest it deserves. On the matter of the soul, he urges that you must not disrespect the soul by repeating *'I know I'm going to do it'* or lamenting *'This is harder than I thought'*. Coelho forwards that you must trust that the soul will succeed and take time to relax and enjoy the walk. The evening following my first day at Sinkithemba, found me lying on a small bed in my home for the coming

months, admitting for the first time how truly tiresome my journey to South Africa had been on my soul. I felt like a boxer who spent all her energies chasing endorsements, doing press conferences, ‘psyching up’ herself and the audience, dancing from the locker room to the ring and when the bell tolled, a light jab knocked me out in the first ten seconds of the first round. The journey to South Africa was a 1000meter hurdle event; a few of the highlights were funding challenges, visa technicalities which kept me in London limbo for two weeks, and negotiations with South African Airways ground staff to revalidate my ticket due to the visa delay two hours before my departure. I arrived in South Africa on a Tuesday and was at my practicum site on Wednesday – I was exhausted! When the tears flowed that night I knew that they were not about that day or the week before; these were tears of frustration, joy, excitement, sadness, anxiety and they were breath-giving. After a good cry I sat up from bed, and exhaled deep and long – *No one climbs a mountain on their back!*

#### The Context: HIV/AIDS in South Africa

It is common knowledge that sub-Saharan Africa has the highest HIV/AIDS infection rate in the world with estimations of 6.75 million HIV positive individuals (South African Department of Health 2005). Volumes of books have been written under this heading and there remain volumes undocumented and unexamined about HIV/AIDS in Sub-Saharan Africa. To set a backdrop for the context of my field placement in Durban, South Africa I will offer the broadest of overviews, stating a few of the social, economic, medical, psychological and political antecedents and consequences of the HIV/AIDS epidemic.

More than a quarter of the pregnant women in six of nine provinces in South Africa are HIV positive and in the province of KwaZulu Natal the highest rate of infection was recorded in women attending antenatal clinics – 40.7 % versus the national rate of 29.5% (South African Department of Health, 2005). Women are over-represented in the epidemic and bear the brunt of the socioeconomic impact. UNAIDS (2004) forwards that HIV/AIDS infections have increased the number of female-headed households and the economic strain experienced by these households as well as corroborates significant

survey data which indicates that between half and three-quarters of households in South Africa are female-headed. The HIV/AIDS population of most concern is young people between the ages of 15 -24. The impact of HIV/AIDS has manifested in every facet of individual, household and community functioning across the country. Although I am yet to source significant supportive statistical data, I forward as a noteworthy observation that many children and adolescents orphaned by HIV/AIDS are being raised by grand mothers and this occurrence has created additional psychosocial dynamics for the life span development of this group of young people. There is a missing generation in South Africa and grandmothers have re-donned their parenting gear. WHO's estimate of the number of children who lost their mother or father or both parents to AIDS and who were alive and under the age of 17 at the end of 2005 was 1,200 000 (WHO, 2006).

On the political antecedents and consequences of HIV/AIDS in South Africa, a topic on which I have little expertise, I forward this comment – it was my personal experience and the experience of many practitioners on the multidisciplinary team at Sinikithemba that whenever statements were made in the political domain about HIV/AIDS treatment and epidemiology, these sentiments were echoed by patients in their decision making concerning treatment. For example, while I was in South Africa it was asserted in the public domain that HIV is not the cause AIDS and furthermore the sitting Minister of Health forwarded that the inclusion of lemons, garlic and African potatoes as alternative treatment for HIV infection. On these occasions I witnessed clients questioning their treatment decisions citing these comments as the reason for their reassessments.

In 2005 at Mc Cord Hospital (Mc Cord 2005) 50 % of patients in Medical wards were treated for HIV-related illnesses. The epidemic has weighed in on every facet of society, demanding responses from the individual and community levels on its physical, psychological, social and economic consequences.

#### Background to the Sinikithemba Clinic

In 1995, there were increasing numbers of patients who presented themselves at the Hospital for treatment, unaware of their HIV status and seeking treatment for

opportunistic infections. At the time of the Clinic's inception, Antiretroviral Therapy (ART) was not available in South Africa and the country was also transitioning from an Apartheid State to the Democratic State which currently stands. These factors painted a bleak picture for the treatment of persons infected with HIV/AIDS. The Sinikithemba Clinic was established at 35 McCord Road with a complement of committed part time staff members; this team consisted of a nurse, two social workers, a pastoral counselor and one part time medical doctor.

Sinikithemba was one of the first Clinics, with the help of foreign aid, to begin administering ART to patients in South Africa at a time when the newly elected democratic government's official position was that HIV did not cause AIDS. On September 2, 2006 I was fortunate to be at Sinikithemba celebrating its accreditation as a national ARV roll-out site. On this day, about 50 staff members gathered in Sinikithemba's Resource Centre, to thank God in congregation for the many blessings bestowed over the preceding six years of climbing.

***Be Joyful when you reach the top***

*Cry, clap your hands, shout out loud that you made it; let the wind (because it is always windy up there) purify your mind, cool your hot, weary feet, open your eyes, blow the dust out of your heart. What was once only a dream, a distant vision, is now part of your life. You have made it and that is good. (Coelho, 2006, p13)*

On this day, I was awed yet again by how easily South Africans can transform a gathering of three or more into an angelic chorus. There was clapping, shouting, weary feet and open eyes acknowledging that a once distant dream was now reality and yes... it was good.

**Organizational Dynamics: Funding, Human Resources & Service Provision**

The care offered by Sinikithemba is implemented by a multidisciplinary team seeking to provide holistic care to patients and their families. For the past one hundred years, McCord Hospital has remained true to its missionary ethos as a health care provider.

Sinikithemba's multidisciplinary team, although consisting of and providing services for persons of multiple faiths, is committed to the Christian ethic of McCord's Hospital.

Sinikithemba functions through three (3) operational units; the Sinikithemba Clinic, Sinikithemba Training Programme and the Sinikithemba Development Programme. The Sinikithemba Clinic provides medical and psychosocial care through two sites offering the following services:

- Hope House: Voluntary Counselling and testing, CD4 testing, psychosocial assessments and spiritual support
- Ridge House: Comprehensive Medical care, including Antiretroviral treatment (ART) for adults and children

The Sinikithemba Training Programme offers outreach to churches, communities and industries. The training programme offers comprehensive seminars, workshops and certificate programmes focused on HIV/AIDS counseling, home-based care and adherence training among others. The Sinikithemba Development Programme has three components; the Income Generation Programme, the PLWHA Support groups and the internationally acclaimed Sinikithemba Choir.

The Social Work Department is housed at Hope House; however social workers function within each operational unit of Sinikithemba. It is noteworthy that both the Training and Development programmes are the offspring of projects initiated by the Social Work Department.

Sinikithemba functions through the efforts of a tightly woven interdependent system of services which ensures that holistic and comprehensive care is provided for patients. Patients make their first point of contact with the Clinic via referral by Mc Cord Hospital or by self referral. In the case of the former, usually a member of the medical staff would make a referral to the Social Work Department. The social worker will visit the patient while warded and perform a Social Work Intake; a prime objective of this intake is to commence the discharge planning process. The patient's financial circumstances as well

as the proximity of his/her home to the Hospital would determine if a referral is made to Sinikithemba for outpatient care.

The second common source of referral is the mode of access for the majority of the patients who are members of the Clinic. For adults who self refer to Sinikithemba the first point of contact is usually the Counseling Department. Counselors are trained to provide pre and post test counseling as well as administer HIV tests and report results. The Clinic primarily administers the rapid test which facilitates an individual being taken through pre-test counseling, test administration, results reporting and post-test counseling in a two to three hour period. If an individual receives a negative test result, the post-test session focuses on risk reduction. If a positive result is given by the counselor, the post test session focuses on helping the patient begin to cope with the diagnosis. By the end of this session the counselor would orient the patient to the services which are offered at the Clinic. The patient is registered with the Clinic and a CD-4 blood count is recommended. Counselors are also a primary source of referrals; they will make a primary assessment of the needs of the patient upon which a number of referrals can be made. Counselors primarily make referrals to the Social Work or Psychology Departments to attend to matters which require intervention beyond their initial assessment.

In South Africa an individual with a CD-4 count below 200 may be considered disabled and may be eligible to apply for a disability grant. Application for this grant is made at the District Pensions Office in nearest proximity to the individual's residential address and must be recommended by a social worker. Hence, the Social Work Department routinely assesses individuals for disability grants. On any given day at least a dozen such cases are attended by social workers.

All children and adolescents, individuals under the age of 18, are assessed by a social worker upon initial contact with the Clinic. A psychosocial assessment is conducted by the social worker to examine the vulnerabilities and strengths of the child and his/her

environments which can contribute to his/her emotional and physical adjustment throughout the course of the illness.

### Scope of Services provided by Social Work Department

#### *The Social Work Department*

The Social Work Department is serviced by a senior social worker, and two supporting social workers. The Department takes a maximum of three students at any given time. During my field placement period, there were two additional undergraduate students; each student completed two days of practicum per week for one academic year. The Department implements a combination of case work, group work and community work.

#### *Patient Population, Psychosocial & Cultural Context*

Although located in Overport City, a small town within the city of Durban, Sinikithemba's catchment area covers the entire Metropolitan Municipality or district of eThekweni which has a population of approximately 6 million.

HIV/AIDS care and treatment, inclusive of ART, can be accessed at no cost at State-sponsored Hospitals, however, the average waiting period for access to ART at public sector Clinics and Hospital is upwards of twelve months. At Sinikithemba, the average waiting period for access to ART is three (3) to eight (8) weeks and international and local aid allows Sinikithemba to offer ART at a subsidized rate. Although this cost is by no means easily affordable for a significant cross-section of South Africans, many have demonstrated a willingness to make the economic sacrifice to meet this cost. As a result, persons travel from great distances to access treatment at Sinikithemba.

#### *ARV Rollout and Care & Treatment*

Sinikithemba has established itself as a specialist ART centre with a clear family centered focus rather than a general HIV Clinic. The batching system for administration of ART is facilitated by a three week process for enrolling patients. There are three consecutive weekly two hour training sessions for all adult patients and caregivers caring for paediatric patients. These three modules are facilitated by counselors and systematically

address a range of topics relevant to adapting to ARV treatment including but not limited to HIV/AIDS medical management, stigma and discrimination, home-based care and adherence management. During week one, blood tests and chest x-rays are performed, in the second week each patient has a medical consultation and if medically appropriate, patients commence ARV treatment after attending the third training module.

### *Paediatric Clinic*

A pre-requisite for all individuals placed on ART is psychosocial support. All adult patients must have disclosed their HIV/AIDS status to at least one person to be eligible for ART. Assessing psychosocial support becomes a more complex matter with patients who are under the age of 14. Social workers are responsible for making an assessment of the readiness of all Paediatric cases prior to the commencement of ART. Patients are routinely delayed for ART if social workers cannot confirm that their environments are conducive for treatment adherence. At Sinikithemba, medical doctors will not start a paediatric patient on an ART regimen without the psychosocial assessment of a social worker.

### *Community Work & Group Work*

Mc Cord Hospital has long standing relationships with a number of community organizations in Durban and is a primary service provider for many of the townships in Durban and on the outskirts of the City. The Social Work Department has relationships with many Non-Profit Organizations in these townships and provides capacity building services. During my three months at Sinikithemba, there were three such community programmes serviced by the Social Work Department - the Siyaphila Clinic (a step-down HIV/AIDS care facility), the Sakhithemba Support Group and Adams Clinic (a community health clinic in a rural area serviced by McCord's Hospital once weekly).

### Student Role & Responsibilities: Finding my path

#### **Find out how to reach the Mountain**

Coelho (2006) forwards that once you have selected the mountain you wish to climb, the next task is finding out how to reach the mountain. Finding out how to reach the

mountain proved to be more technical and complicated than it initially seemed. My practice teacher, Maud, granted me absolute freedom to determine my social work contribution, however as the practicum progressed I realized that this task was as overwhelming as it was exciting. Formulating my learning objectives was an anxiety provoking and difficult task.

The breadth of services provided my Sinikithemba is extensive and attracts persons from many countries. Volunteers and interns stream in from the United States and Europe, all primed to help within the purview of the mandate of the funding agency responsible for their placement. As I began observing and probing I became aware of what I perceived as a quiet resentment beneath the surface of many interactions between local staff members and these (really us) international helpers. We, international helpers, often fly in with our agendas and preconceived notions of what 'Africa is like' and many other social notions we take for granted as shared. Many visiting students and professionals would attempt to tailor the Clinic to suit their research or practicum objectives. Unknowingly I fell into this category. Within the first week of my placement, I compiled a list of objectives and tasks I wished to complete. Much of my past experience was in clinical counseling and I was quite dissatisfied with a recent experience of how Voluntary Counselling and Testing (VCT) was practiced in Trinidad. Prior to my arrival in Durban, I had already given thought to a practicum focus on pre-test and post-test counseling. As I settled into Sinikithemba I quickly figured out that these tasks were not the primary responsibility to the Social Work Department nonetheless, Maud was willing to support work in this area. Although I heard Maud telling me that I could be helpful in other areas, I was very much married to what I wanted to do - to what I decided was the avenue in which I could be most helpful. I met with the Head of Counseling and quickly agreed to help him compile a Train the Trainer Manual on Counseling PLWHA. This was to be a mutually beneficial project, Mr. Monte Thomas would finally get the hodgepodge of information he used over the past five (5) years to train counselors in a manual form (a project his demanding schedule continued to deny him) and I would get exposure to all this wonderful information.

The other project I set my sights on was writing proposals for the PLWHA support group and offering assistance in their efforts to become established as a Non-Profit Organization. This was within the scope of the Social Work Department and Maud was extremely supportive of this venture. The third task I committed to was defining, researching and documenting 'The Role of the Social Worker in the Paediatric ARV Clinic.' In retrospect, I can appreciate Maud's patience as I stumbled through. She was most supportive of the latter project and I least enthusiastic about it. Maud encouraged me to question and explore my motivations and interests but did not instruct me to abandon any of the projects.

It was not until I was approaching my mid-point evaluation that I realized the extent to which I was sabotaging my social work practicum experience. I was sitting in the conference room which is located between the reception area and the social work offices where patients are seen. On this day I was preparing an agenda for my supervisory meeting with Maud to discuss my mid-point evaluation. The three social workers were out of the office and a female patient walked into the room and greeted me in isiZulu. I responded to the greeting and cringed as the woman continued to speak to me in isiZulu. I attempted to stop her on three occasions to tell her that I did not speak isiZulu, however, she continued speaking quickly, communicating urgency and a bit of panic. When I stood up and opened my palms in protest she looked shocked and deeply offended. 'How do you mean you do not speak Zulu?' Ten minutes after this incident, I began to consciously accept that I managed to remove myself as much as possible from interaction with patients opting to complete work that required the least amount of interaction with patients. I began to have a full appreciation of the extent to which I was sabotaging my social work learning by keeping myself in 'safe areas', engaging exclusively in work with which I felt comfortable, namely work which placed me squarely in the research arena.

As I gathered social work experience at Sinikithemba, I began to appreciate the practical, result oriented problem solver role of the social worker and that as a foreigner I was in a disadvantaged position to be a quick, result oriented problem solver. During my practicum I would test my theory that as a foreigner and non-isiZulu speaker attaining

crucial information from locals was likely to be thwarted. Let me offer this example, on one occasion I was furiously searching for a daughter of a patient who was ready to be discharged but without a family member to be discharged to. The only bit of information I had was that his daughter worked at a nearby KFC. I telephoned (after rehearsing the daughter's surname with another social worker, Nonhlanhla whose name I learned to make roll off my tongue by daily rehearsal, growing tired as I was of waiting for her to look my way to get her attention) and I received a mocking laugh before I was told that no such person worked there. Thirty seconds later Maud telephoned and was able to get information about the daughter's shift as well as a mobile contact. Maud and I would run these experiments a number of times with similar results.

I accepted this excuse disguised as an explanation wholeheartedly until that day in the conference room. I did not fully grasp how intimidated I was by the language barrier until this incident. During the interaction I felt an internal panic about not being able to adequately provide for the needs of the patient. This is a panic which I would work through during the succeeding weeks. I cannot name the trigger that made it apparent that I made language a barrier, an excuse for not challenging myself to gut out that international social worker in me who would learn to adapt in any given situation by the merit of her social work skills if by nothing else.

***Be prepared to go the extra mile***

*'The distance to the top of the mountain is always greater than you think. There is bound to come a moment when what seemed close is still very far away. But since you are prepared to go still further, this should not be a problem.'* (Coelho, 2006)

Once I clarified this small point, doors of understanding swung open before me. While most of the patients spoke isiZulu as a first language, on average three (3) out of five (5) persons were fluent English speakers and nearly all of the children attending the Clinic were English speakers. Unlike adults, children and adolescents were enthusiastic about speaking English and did not hold historical and culturally based aversions (undoubtedly

justified) to speaking English. The move to focus on social work in the Paediatric Clinic was the activating agent for the work I found most meaningful and helpful to Sinikithemba and my development as a social worker and social work researcher.

By mid-August, some 6 weeks after the start of the field work, I managed to choose the mountain I wanted to climb, by pushing myself beyond my comfort zone and facing the challenges of the reality of my placement.

The following are tasks I successfully completed during my social work practicum:

- Formulated and produced an organizational profile for skills development and income generation programmes for the Sinikithemba Support group for PLWHA
- Conducted a study of disclosure of HIV status to children at the Sinikithemba Paediatric Clinic
- Produced a HIV status Disclosure Protocol for children and adolescents at the Sinikithemba Paediatric Clinic
- Produced a Disclosure Policy for Sinikithemba Paediatric Clinic
- Produced and presented Guidelines for staff: Working with Children & Caregivers on Disclosure at the Sinikithemba Paediatric Clinic
- Produced the working document, 'The Role of the Social Worker in the Paediatric ARV Clinic'
- Produced an updated Psychosocial Assessment Paediatric Intake form for the Sinikithemba Clinic
- Attended to casework with children and their families at the Sinikithemba Paediatric Clinic, interview patients seeking disability grant & attend to patients with social work needs presenting at Mc Cord Hospital Wards
- Completed Modules I, II & III at the Sinikithemba Training Department at Hope House for accredited Certificate in HIV/AIDS Counselling
- Completed the South Africa Department of Health ARV Training Program for Social Workers

I did not 'Assist the Head of Counselling in the formulation and production of the Training the Trainer Manual for HIV/AIDS Counselling' as stated in my learning contract.

### **Lessons on the Climb**

In the Introduction of this essay, I stated that this paper can only be about the mountain climbers that I have learned from during my journey. As I reflect on these two areas of work I am amazed by the body of knowledge possessed by the staff and patients at Sinikithemba and appreciative of the guidance I was given by Maud and Vishanthie. It is on this knowledge base that I was able to build a solid practicum experience, challenging my confidence while simultaneously fortifying it, embracing moments of tremendous disease as lovingly as the great moments of ease and accomplishment. My social work contribution attests to the brilliance of the mountain climbers who repeatedly explained concepts, demonstrated patience and supported me as I struggled, guided me through processing my personal and professional experiences and offered tons of inspiration.

#### ***Make a Promise***

*Now that you have discovered a strength you did not even know you had, tell yourself that you will use it for the rest of your days; promise yourself, too, to discover another mountain and set off on a new adventure. (Coelho, 2006)*

While in South Africa and since my return to Trinidad, when speaking about my practicum experience persons would eventually sigh, 'That must be so depressing!' I respond more confidently with each succeeding conversation I have, as I continue to reflect on my experience – 'Absolutely not!' The HIV infection rate in the province of KwaZulu Natal is estimated at 40% which is certainly a grim picture. However, Sinikithemba is not a place where people come to feel sorry about their illness or feel sorry about the illness of other persons. Instead, it is a place where people come everyday to work on **Living and nurturing hope**. There is sadness at Sinikithemba on many days, but there is no time for depression.

Armed with this experience, I believe that the greatest pitfall in the endeavours to treat with HIV/AIDS in Trinidad is our lack of appreciation that people are **Living** with HIV/AIDS. Our National approach to HIV/AIDS has been made deficient by its failure to invest resources in safe-guarding the emotional and economic wellbeing of PLWHA. We spend millions of dollars recruiting Soca Stars to promote prevention campaigns which subtly and not so subtly reinforce stigma and discrimination, promote at-risk behaviours and destroy any molecule of **hope** that may have floated by. We insult the intelligence of our young people by thinking they will not see the contradictions in Soca stars who urge 'come test my grind, I dare you' in February but in March pronounces that their bodies are temples. As a society we pay lip service to PLWHA and our Government allocations to PLWHA are farcical.

ARVs, condomizing, abstinence and monogamy are all necessary approaches to addressing the realities of HIV/AIDS in Trinidad, but our approach will not be holistic until we begin addressing **Living** with HIV/AIDS. This approach necessitates moving beyond addressing the physical manifestations of the illness to focusing on its social and emotional realities for **Living**.

### Conclusion

My only recommendation is that this practicum be offered to a post-graduate student who is able to complete an entire academic year at the University of KwaZulu Natal. I feel a pang of remorse about being unable to be part of the implementation of the policy documents I assembled. I spent half of my practicum time settling into the culture and learning about the placement. A part of me feels as though my social work practicum experience was only six weeks long.

After making a promise, the final instructions Coelho offers is *'Tell your story! Tell everyone that it is possible and then other people will find the courage to climb their own mountains.'*

I have taken his advice and promised myself that I will find another mountain and set off on a new adventure and I have begun telling my story. My story is not what I have written in this paper. My story is that I committed myself to making a journey, trusted that the universe would conspire to make it come to pass; I tried to be mindful of the toll the struggle took on my spirit and monitored my process a little more than the progress of the climb.

## References

Coelho, P., (2006) Like the Flowing River. Harper Collin Publishers, London

Department of Health (2005). Report. National HIV and syphilis antenatal seroprevalence survey in South Africa [On-line]. Available:[www.doh.gov.za/docs/2003hiv-f.html](http://www.doh.gov.za/docs/2003hiv-f.html).

UNAIDS (2005). Facing the future together: Report of the Secretary-General's Task Force on Women, Girls and HIV/AIDS in southern Africa [On-line]. Available: [www.unaids.org/NetTools/Misc/Docinfo.aspx?LANG=en&href=http://gva-doc-ow/WEBcontent/Documents/pub/Publications/External](http://www.unaids.org/NetTools/Misc/Docinfo.aspx?LANG=en&href=http://gva-doc-ow/WEBcontent/Documents/pub/Publications/External)

World Health Organization (2006) Epidemiological Fact Sheet: South Africa on HIV/AIDS and Sexually Transmitted Diseases [Online] Available: [http://www.who.int/GlobalAtlas/predefinedReports/EFS2006/EFS\\_PDFs/EFS2006\\_ZA.pdf](http://www.who.int/GlobalAtlas/predefinedReports/EFS2006/EFS_PDFs/EFS2006_ZA.pdf)

Zeichner, S., Read, J. (2005) Textbook of Pediatric HIV Care. Cambridge University Press