Social work in health care: A social development approach

A thesis submitted to the

Department of Social Work

School of Human and Community Development

Faculty of Humanities

University of Witwatersrand

In fulfilment for the degree of Doctor of Philosophy

By

Laetitia Petersen

May 2021

DECLARATION

I, Laetitia Petersen, student number 1580201, declare hereby that this study is a true reflection of my own research, and that this work or part thereof, has not been submitted for any degree in any other institution of higher education. Secondary material used was acknowledged and referenced in accordance with the requirements of the university. I understand what plagiarism is and the implications thereof in terms of the university policy.

I, Laetitia Petersen, grant the University of the Witwatersrand the right to reproduce this research report in whole or in part, in any manner or format, which the University of the Witwatersrand may deem fit, for any person or institution requiring it for study and research, providing that the University of the Witwatersrand shall waive this right if the whole research report has been or is being published in a manner satisfactory to the University.

_____ 31 May 2021

Signature Date

DEDICATION

All Honour, Glory and Power to GOD Almighty.

'...we also rejoice in our sufferings, because we know that our suffering produces perseverance; perseverance, character; and character hope. And hope does not disappoint us, because God has poured His love into our hearts by the Holy Spirit, whom He has given us.'

ROMANS 5:3-5

'All the days ordained for me were written in your book before one of them came to be.'

PSALM 139:16

'I can do everything through Him who gives me strength.'

PHILIPPIANS 4:13

ACKNOWLEDGEMENTS

My gratitude is expressed to:

All the participants, the social workers within Gauteng Department of Health, who so graciously sacrificed their time and of themselves to participate in this study. Your wealth of information, the open and honest sharing is much appreciated.

Prof Edmarie Pretorius, my supervisor for her guidance throughout the process.

Radisha Sukhlal for her unending support.

The ethics district chairpersons who have granted permission.

Colleagues who have supported and sustained me with your prayers and well wishes.

Social workers in Gauteng Department of Health for the challenging and instrumental work you fulfil.

My mother, Maria Petersen, who has endured the journey with me and made it bearable with all your sacrifices.

ABSTRACT

The promulgation of the Constitution in 1996 led to the inception and implementation of the White Paper on Social Welfare in 1997 and the social development approach to all social welfare sectors including social work. This implementation led to major changes that were met with resistance, challenges and confusing implementation practices. This also impacted on the role of social workers in health care. The study's purpose was to explore, describe and explain the implementation of the social development approach to social work in the Gauteng Department of Health. Utilising the social constructivist and pragmatic paradigms in conjunction with Habermas' theory on the two spheres of social reproduction i.e., the life world and the system, and ecological perspective, the study highlighted the state of, and the challenges experienced by social workers in health care regarding the implementation of the social developmental approach. The explanatory sequential mixed methodology research design was best suited in achieving the objectives of the study. The study was divided into four phases with regard to data collection and analysis. **Phase one** incorporated a quantitative approach in the form of a survey research design. Utilising saturation sampling, the cross-sectional survey was distributed to the entire social work population employed in the Gauteng Department of Health. Forty-five (45) surveys were completed. The data was analysed according to descriptive and inferential statistics with the aid of the Statistical Package for Social Science. Content analysis was utilised to code and analyse the open-ended questions of the survey. **Phase two to phase four** contained the qualitative approach of this research study which followed the cross-sectional survey sequentially. Interpretative phenomenology was the research design for these qualitative strategies. The samples for each of these phases employed non-probability purposive sampling. **Phase two** focused on collecting data via semi-structured interviews, with the use of an interview guide, from ten (10) social workers in health care. **Phase three** encompassed data collection from two focus groups using a focus group guide. Four and three participants respectively took part in these focus groups. **Phase four** focused on interviewing two key informants as highlighted from the survey, interviews and focus groups.

Interpretative phenomenological analysis was utilised to analyse the data from the different qualitative strategies. The study's findings offer clear understanding of the implementation of the social development approach to social work in health care. The social development approach is dominantly applied via its principles, awareness programmes, referrals to resources and liaison with stakeholders. The lack of consultation with social workers in the Gauteng Department of Health regarding policy implementation was raised. The absence of social investment strategies and community development are evident. Participants indicated social work in health care is a unique profession and has a pivotal role in a multidisciplinary team to enable the social development approach. Conversely, they reported that social work in health care is undervalued and seen as support staff to the rest of the multidisciplinary team. To be acknowledged as a specialist profession was implored by the participants. A framework of implementing the social development approach suitable for social work in health care should include a bottom-up approach that acknowledges the value of social work input. The need for a cultural competence model and practical examples of how to implement the social development approach in diverse health care settings were identified. It was evidenced that the implementation of the social development approach in the welfare sector impacted the roles and designated powers of social workers in health care. By virtue of this exploration social work, social development, social determinants of health and the sustainable development goals are inextricably linked through the mutual agenda of social justice, advocacy and empowerment. This study not only contributes to the field of social work in health care, the social determinants of health where social workers should be recognised as an instrumental role player, but also contributes to the implementation of the social development approach in health care settings in South Africa.

Key words: Gauteng Department of Health, Interpretative phenomenology, Pragmatism, Social constructivism, Social development approach, Social determinants of health, Social work in health care, Transformation.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF GRAPHS

LIST OF FIGURES

LIST OF ACRONYMS

AASW	Australian Association of Social Workers
CSDH	Commission of Social Determinants of Health
DSD	Department of Social Development
ECD	Early Childhood Development
FG	Focus Group
GBV	Gender Based Violence
GDH	Gauteng Department of Health
HiAP	Health in All Policies
HIV/ AIDS	Human Immune Deficiency Virus/ Acquired Immunodeficiency Syndrome
IASSW	International Association of Schools of Social work
IFSW	International Federation of Social Workers
IPA	Interpretative Phenomenological Analysis
ISDM	Integrated Service Delivery Model
MDG	Millennium Development Goals
NASW	National Association of Social Workers
NFLASW	New Foundland and Labrador Association for Social Workers
NGO	Non-governmental Organisation
NHI	National Health Insurance
OSD	Occupational Specific Dispensation
PIS	Participant Information Sheet
PMDS	Performance Management and Development System
PWD	Persons with Disability
SA	South Africa
SACSSP	South African Council of Social Service Professionals
SADC	Southern African Development Community
SAPS	South African Police Services
SASSA	South African Social Security Agency
SDA	Social Development Approach
SDG	Sustainable Development Goals
SDH	Social Determinants of Health
SONA	State of the Nation Address
SOP	Standard Operation Procedures
SOPA	State of the Province Address

SPSS	Statistical Package for Social Science
TOP	Termination of Pregnancy
UK	United Kingdom
UN	United Nations
USA	United States of America
VEC	Victim Empowerment Centres
WHO	World Health Organization

CHAPTER 1
INTRODUCTION

1.1 Introduction

The social work profession has experienced a great deal of transformation in South Africa. The transformation of social work in health care, in line with the implementation of the social development approach in the welfare sector has received minimal focus. It is based on the above assumption that this research study, a sequential mixed methodological study, explored the application and the implementation of the social development approach in social work in health care. The nexus of these two varied areas, i.e., social work in health care and social development linked to the transformation agenda, posed not only to be challenging and dynamic, but also as an area of research that needs in depth exploration. The outcomes of this study are envisaged to make major contributions to the fields of social work in health care and social development, the social determinants of health, and policy implementation.

1.2 Problem statement and rationale for the study

The promulgation of the Constitution in 1996 initiated the transformation of all sectors of South Africa (Gray & Lombard 2008; Midgley, 2001; Midgley & Conley, 2010; Patel, 2010). The consequent transformation of the South African welfare sector was guided by the inception of the White Paper on Social Welfare (Department of Welfare ,1997). This paper led to major changes within the entire welfare sector including social work (Gray & Lombard, 2008; Midgley, 2001).

One of the key transformational areas was the implementation of the social development approach (SDA) to the entire welfare sector affecting all social service professions and occupations (Gray & Lombard 2008, Midgley, 2001; Patel 2010). Patel (2010) and Midgley (2010) indicated that the field of social development is continually evolving and changing. Midgley (2010) categorised

social development as "…first it connotes an interdisciplinary academic field, and second, a set of practical and policy interventions designed to improve people's well-being." (p. 9). Midgley (2012) furthermore stated that defining social development is difficult as it incorporates such "diverse conceptual ideas and practical approaches." (p. 97). From most definitions it would seem that the fundamental core of social development is the improvement of the wellbeing of people (Lombard, 2008; Midgley, 2010, 2012).

The White Paper on Social Welfare (Department of Welfare,1997) ushered in major changes in transforming the South African welfare sector which previously encompassed institutionalised and remedial service delivery to the implementation of the SDA where now the major foci i.e. the principles of social development are on equality, human rights, welfare pluralism, participation, democracy, economic development strategies, partnerships and collaborations (Gray & Lombard 2008; Midgley, 2001; Patel 2010). Apart from the above, the Social Service Professions and Occupations Bill (Department of Social Development (DSD), 2008) was a direct response to encompass welfare pluralism and acknowledging all welfare stakeholders, professions and occupations. This, however, had implications for the roles, expectations and service delivery of all welfare professions and occupations. Confusion about the delineation of these professional and occupational categories remains evident (Dlangamandla, 2010; Gray & Lombard, 2008; Hölscher, 2008).

Gray and Lombard (2008) indicated that the transformation of the welfare sector left social workers feeling marginalised. This was due to limited consultation between the DSD and academic institutions regarding the process of implementation. Hölscher (2008) also highlighted that the implementation of the SDA in South Africa had been met with some resistance by social workers as they were unclear about how the approach incorporated economic strategies to address poverty. Despite the resistance, Government has continued with the transformation process, neglecting to

reflect on the lack of perceived efficacy or the resistance (Hölscher 2008). Dlangamandla (2010) reported that social workers in the employ of the DSD expressed their confusion regarding the SDA and its implementation. In fact, these social workers who were part of a research focus group indicated the need for on-going training. From these authors it seemed that the process of implementation of the SDA was met with difficulty and that inappropriate implementation was evident.

The transformation was also geared towards social workers in health care. Generally, literature regarding the implementation of the SDA to social work in health care is scanty. Literature on social work in health care in South Africa focuses mostly on the role of social work in certain or rather specialised areas within the health care (Beytell, 1994; Carbonatto & Du Preez 2001; Ross & Deverell, 2010). These writers do not address the complexities of the social work role and the role in relation to the SDA. Beytell (2002) in her doctoral thesis formulated a community development perspective with regards to primary health care and seems to touch on the transformation of social work in health care. Beytell (2002) was of the opinion that social work in health care is ineffective and in line with the SDA, proposed a community-based model for social work intervention in **primary health care** only. Beytell did not however focus on the social workers in secondary and tertiary health care settings. Bywaters and Ungar (2013) provided a comprehensive overview of the focus of research in health. They indicated that social work research in health care has been about enabling clients to share their experiences, meanings of health and proposed that the future of social work research in health may focus on the health service user, resiliency, the indigenisation and globalisation of social work in health care (Bywaters & Ungar, 2013).

Currently policies regarding the implementation of the SDA to social work in health care in South Africa are not readily accessible. The Annual Performance Plan 2019/ 2020 (Gauteng Provincial

Legislature, 2020) and the Annual Report 2018/2019 (Gauteng Provincial Government, 2019) do not contain information specifically related to social workers. Social workers are grouped with allied support staff or allied professionals. Further, the Annual Report 2019 of the DSD (Department of Social Development (DSD), 2019a) and the Annual Report 2019 of Department of Health (2019) does not specify the number of social workers employed in the DSD, Gauteng nor Gauteng Department of Health (GDH). Therefore, uncertainty regarding the state of the implementation of the SDA in health care exists. It is also not clear what processes have been followed and what strategies have been implemented. At the time of conceptualising of this research study; research was not yet done in this area and the study was deemed important.

The potential value of this study is manifold.

1. The study offers extensive descriptions of the experiences of social workers in health care settings regarding the implementation of the SDA and addressing the social determinants of health (SDH).
2. The information influences the possible formulation of a guideline for the application of the social development practices for social work in health care. This guideline will offer strategies on how the SDA may be implemented in social work in health care. This guideline may enable the development of a framework for social work in health care.
3. The study offers detailed information about the current social work health trends and challenges.
4. Challenges brought on by policy changes and the impact on the social work role are highlighted.
5. Contribution to theory is made regarding the implementation of the SDA and the social determinants of health (SDH) in social work in health care. Currently, social work has had minor applications to the social determinants of health. Therefore, additions to the knowledge base for the social determinants of health (SDH) for social work are made.

1.3 Definition of concepts

De Vos and Strydom (2011) viewed conceptualisation as the process of communicating meaning. This process may involve the identification of concepts or constructs and the meaning connected with it. Babbie and Mouton (2001) highlighted it as the identification of concepts. Mouton (2009) indicated that conceptualisation encompasses more than just identifying concepts but also incorporates the literature review and ultimately the understanding of the phenomenon to be studied. Engel and Schutt (2014) referred to conceptualisation as to be clear about the meaning of concepts as applicable to the study. From the above discussion this process may be described as concept identification, concept definition and allotting meaning to it. Terms that are conceptualised in this study are: *Health care, Social development approach, Social work and Social work in health care.*

1.3.1 Health care

The term health care may refer to hospital settings, medical care and hospital care. The Farlex Partner Medical Dictionary (2012), Mosby's Medical Dictionary (2009) and the American Heritage Dictionary of the English Language (2020) offer comprehensive views on health care that may be condensed as medical treatment offered by medical doctors and at times by other allied professionals in disease prevention, treatment and management of disease, and also the restoration of health. These services may be offered in clinics and hospitals. The Oxford Concise Medical Dictionary (2010) referred to health care as those medical services offered in a variety of settings that may be classified in primary, secondary and tertiary health care settings.

Primary health care services, according to the Mosby's Dictionary of Medicine, Nursing and Health Professions (2006), the Alma – Ata (WHO, 1988 in Dennill et al., 2007) and the Oxford Concise Dictionary (2010), may refer to entry level medical services that may entail preventative health care, promotion of health and wellbeing, the first steps in diagnosis and basic medical care.

In South Africa this is usually clinics in communities. Secondary health care services in turn incorporate those intermediary services that make use of specialised equipment in the confirmation of diagnoses and offering of medical treatment (Mosby's Dictionary of Medicine, Nursing and Health Professions, 2006; The Oxford Concise Dictionary, 2010). This may be community or district health care settings. Both Mosby's Dictionary of Medicine, Nursing and Health Professions (2006) and the Oxford Concise Dictionary (2010) identify tertiary health care service as those specialised and advanced services offered at only specific specialised settings. The above three levels of health care offer different medical services based on the complexities presented. In this research study these levels are also referred to as the various sectors in health care.

1.3.2 Social Development Approach

Payne (2005, 2014) indicated that defining social development may be controversial and difficult. According to Payne (2005) social development focuses on improving individual capacity. Most notable of all definitions was that of Midgley's (1995, p. 250) who defined social development as a "…process of planned change designed to promote the wellbeing of the population as a whole in conjunction with a dynamic process of economic development." This definition was updated in 2014 to "… a process of planned social change designed to promote the wellbeing of the population as a whole within the context of a dynamic multifaceted development process" (Midgley, 2014, p.13). Patel (2015) indicated that the SDA requires both state and non-state stakeholders' (such as any community or faith-based organisations') involvement. In addition, Patel also acknowledges that social investment strategies are integral to this approach.

Homfeldt and Reutlinger (2008) discussed social development by focusing on Midgley's concept of social development. They acknowledged that the World Summit for Social Development in 1995 acknowledged the basic rights of individuals and its strengths are micro, meso and macro levels of intervention. Elliot (2012) succinctly summarised that social development is a

progressive model of social work that encourages social justice and focuses on empowering the oppressed. The fundamental tenets of social development are summarised as equality, human rights, welfare pluralism, democracy, economic strategies, partnership and collaboration (Gray & Lombard, 2008, Midgley, 2001; Patel, 2010). Equality and human rights are the proponents of a rights-based approach for all people to ensure social justice and equal access to resources (Patel, 2010). The principle of democracy encompasses the ability of individuals to participate and to make decisions in society and enforce social justice (Patel, 2010). The principle of partnerships and collaborations links well with the principle of welfare pluralism which stresses a collective responsibility in addressing the needs of society (Gray & Lombard, 2008; Midgley, 2001; Midgley, 2012; Midgley & Conley, 2010; Patel, 2010). The principle of economic and social investments focuses on the economic wellbeing of individuals and communities (Gray & Lombard, 2008; Midgley, 2001; Patel, 2010). These economic strategies according to Midgley (2012), are people orientated in that it promotes the wellbeing of people. Midgley (2001, 2010, 2012) wrote extensively on social capital strategies to be utilised in the promotion of the wellbeing of individuals. Lombard (2008) highlighted that a key aspect of the implementation of the SDA was that social workers now had the opportunity to directly ensure social justice of the South African population.

Therefore, the SDA may be viewed as the umbrella concept that combines both social welfare interventions and economic empowerment strategies. This approach has therefore transformed social welfare in South Africa.

1.3.3 Social work

The New Dictionary of Social Work (n.d., p. 60) defined social work as "Professional services offered by a social worker aimed at the promotion of the social functioning of people." The Oxford Concise Dictionary's (2010, p. 679) description of social work includes the acknowledgement of

basic training of an approved degree in social work. Farlex (2020,12:56) defined a social worker as **"…**a professional trained in the treatment of psychosocial problems of patients and their families." In summation social workers are seen as trained professionals that offer a variety of services.

A global social work definition was formulated by the International Federation of Social Workers (IFSW) and was adopted by the International Association of Schools of Social Work (IASSW) General Assembly in July 2014. This definition is now the accepted norm and identifies "Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing." (International Federation of Social Workers, 2020, para 2).

In summary, Social Work may therefore be constructed as a specific profession underpinned by values, specific theories and specific interventions to benefit those in need. This may be offered in diverse settings, to diverse client populations by utilising diverse approaches.

1.3.4 Social work in health care

It is important as part of this research study that the concepts social work and health care be combined and discussed together to facilitate the understanding of social work in health care. Social work in health care was previously referred to as hospital social work or medical social work. With the discussion of the areas of specialisation of social work in South Africa the term was renamed as social work in health care (South African Council for Social Service Professionals (SACSSP), 2008). In conceptualising social work in health care, the alternative concepts of hospital social work and medical social work will also be considered. Most sources found it easier

to define the term hospital or medical social worker than just social work in health care. Both the Concise Oxford Dictionary (1997) and the Oxford Concise Medical Dictionary (2010) refer to a hospital social worker as being employed in a hospital setting and deals with social problems of clients. Dhooper (2012), The Collins Dictionary (2015) and Segen's Medical Dictionary (2012) in turn acknowledge the specialist skills of social workers in a hospital setting to offer a myriad of services that include counselling, support, assessment, interdisciplinary collaboration, discharge planning, post discharge follow-up, amongst others. The Australian Association of Social Workers (AASW) (2016a, 2016b) highlighted that social work in health care plays a critical role in helping the patient and family to address the impact of illness and treatment in order to maximise their wellbeing.

The National Association of Social Workers (NASW) Center for workforce studies and social work practice (2011) highlights social work in health care settings as spanning the continuum of health care services with major variations in specialisation areas, screening, counselling and the co-ordination of discharge planning.

The above definitions clearly defined social work in health care as the social work services offered in a hospital, medical or health care setting to patients and their families.

1.4 Research questions, goal, objectives and hypothesis

1.4.1 Research questions

This study sought to answer the following questions:

1. How was the social development approach implemented in health care settings in the Gauteng Department of Health?
2. What were the experiences of social workers and social work managers with regard to the implementation of the social development approach?

3. Was sufficient training and guidance provided to social workers and social work managers with regard to the implementation of the social development approach?
4. To what extent did social workers and managers participate in policy implementation?
5. How are the social determinants of health applicable with the application of the social development approach to social work in health care?

1.4.2 Goal

The goal of the study was to explain the implementation of the social development approach to social work in health care in the Gauteng Department of Health.

1.4.3 Research objectives

The objectives of this study are:

1. To explore, describe and explain, as based on the understandings and perceptions of social workers, social work managers and key informants, the application of the social development approach to social work in health care in the Gauteng Department of Health.
2. To highlight the governmental implementation strategies of the social development approach as pertaining to social workers in health care in the Gauteng Department of Health.
3. To explore the relevance of the social determinants of health in relation to the application of the social development approach to social work in health care in the Gauteng Department of Health.
4. To explain the role of social workers in health care in the Gauteng Department of Health with regard to policy implementation.

5. To solicit contributions from social workers for the establishment of a future integrated guideline for the social development approach to social work in health care in the Gauteng Department of Health.

1.4.4 Hypothesis

This study had one non-directional hypothesis:

The social development approach is applied by social work in health care.

1.5. Theoretical framework

In line with the fluidity of this explanatory mixed methods study two paradigms and two theories were utilised to position the research study and to interrogate the findings. Both the pragmatic and social constructivist paradigms were utilised. The social constructivist paradigm was instrumental in the exploration of the phenomena as according to the participants' construction of their worlds, referring to their experiences regarding the implementation of the SDA Realistic and existential pragmatism resonated well with constructivism as the focus of the study was on the exploration of the intersubjective lived experienced of participants. The pragmatic paradigm as the methodological paradigm enabled the fluidity between the use of the quantitative and qualitative approaches. This furthermore extended itself to the exploration of the phenomena allowing different data collection methods and enabled triangulation. In addition, a critical humanistic theory that of Habermas' social reproduction and the ecological perspective enabled further exploration and application of the findings of the research study.

1.6. Methodology

In achieving the aim and objectives of this study a mixed methodological strategy was selected. In line with mixed methodology the best suited paradigm is that of pragmatism. Pragmatism is not committed to specific paradigms and designs (Mackenzie & Knipe, 2006). The design was

explanatory sequential mixed methodology with greater emphasis on the qualitative strategies due to its intensity. In utilising an explanatory sequential design, the quantitative approach (cross-sectional survey) was followed by a qualitative approach (semi-structured interviews and focus group discussions). The study was divided into four phases. Phase one was the quantitative strategy which encompassed the survey research design. Phases two to four were the qualitative strategies which encompassed interpretative phenomenological research design. Phase two comprised out of interviews with participants, phase three focus group discussions and phase four interviews with key informants. The survey research design used saturation sampling as the questionnaire was distributed to the entire social work population in the Gauteng Department of Health (GDH). Purposive non - probability sampling was utilised in phases two to four. Forty- five (45) surveys were completed, and ten (10) participants and two (2) key informants were interviewed. Two focus groups were facilitated with four and three participants, respectively. Data from phase one was analysed via Statistical Package for Social Science (SPSS) and content analysis of open-ended data and presented via descriptive and inferential statistics. Data analysis in phase two to four were analysed via interpretative phenomenological analysis and presented via categories, themes and subthemes.

1.7. Limitations and delimitations of the study

The following limitations were evident for this study.

1.7.1 Issues relating to transferability and generalisability

The study was conducted with social workers in the GDH only. Therefore, this will not necessarily have the same transferability to social workers in health care in other provinces and to social workers in the welfare sector. The thick descriptions offered may be applicable to social work in health care.

1.7.2 Issues of social desirability

Neuman (2014) indicated that providing socially desirable answers are common. This particularly happens where certain norms are evident. For this study this may have been evident where participants may not have shared negative experiences against management or the employer. It was hoped that the anonymity assured would negate socially desirable answers. Appropriate ethical research practices may have been compromised if supervisors and or managers attempted to influence participants' answers. During interviews and focus groups the aspects of confidentiality and anonymity were particularly stressed. Social workers were found to be honest in their communication and therefore issues of social desirability seemed to have been minimised. The researcher established rapport with participants which also seemed to have minimised the offering of desirable answers. The observer in the focus group also reported honest, open and dynamic communication during focus groups and that social desirability was minimised.

1.7.3 Ethics processes and permissions

Gaining ethics approval from the GDH was cumbersome and frustrating. The application was also made on the National Health Research Data base on the 19 January 2019, but official communication with the Research Unit at the Gauteng Department of Health was established in June 2018. Communication was not received from this unit until June 2019 after communication was escalated to the MEC's office. Despite this, a lack of communication prevailed. In the end due to administrative issues two districts offered their permission verbally but not in writing.

A further concern is also expressed with regard to the confidentiality amongst the focus group members. Even though confidentiality was contracted and outlined in the participant information sheet (PIS) and consents, there are no guarantees that the participants in the focus groups will keep each other's identity or contributions undisclosed. However, as the participants were social

workers it is believed that the principle of confidentiality was upheld as in line with the social work profession.

1.7.4 Gatekeeping

Even though the researcher acquired the relevant permissions for conducting the study, gatekeeping was experienced. The researcher did not confront the conduct and complied with applying for ethics permission at individual hospitals and clinics as well. The issue with this was that it was time consuming, causing greater delay and in the end only two hospitals granted permission. It is therefore unclear if this gatekeeping with regard to ethics permission from the clinics and hospitals itself was an attempt by managers and supervisors to prevent participation of social workers. It also raised the question of the self-determination and rights of social workers to participate.

1.7.5 Non-responsiveness of social workers

The lack of response from social workers in the GDH was very concerning. Even though the researcher attempted to minimise coverage and sampling errors by continual communication with social workers in the GDH; the response remained poor. Where telephonic follow up occurred, promises of completion of the survey and participation was made. The extension of submitting surveys was granted several times. This did not remedy the poor response. Sixteen social workers indicated their willingness to participate in the interviews and focus groups, but when this was followed up, a change of heart occurred, or appointments were rescheduled. Telephonic interviews were also agreed upon largely as a result of the availability of participants. These extensions also continued for three months.

The lack of participation was explored at meetings, with managers and key informants. It was speculated (social workers, managers and key informants) that the lack of participation could be

due the apathy of social workers, lack of interest, being challenged by the type of questions and the possibility of professional jealousy. The aspect of gatekeeping experienced seemed to also reinforce the blocking of the researcher's progress and access. The researcher also feels that perhaps social workers refrained from participating as it was not part of their job description and they did not perceive their participation as necessary. This and the fact that reward and remuneration were not offered may have left social workers also disinterested.

1.7.6 Key informants

Four key informants were identified and only two indicated their interest to take part in the study. The non-responsiveness of the other two key informants may be because they felt compelled to participate. They may have also felt that their anonymity may not have been guaranteed. Their right to not participate was paramount and respected.

1.7.7 Researcher bias

Researcher bias may also be a factor that may distort the data. The researcher was previously employed in the GDH. As a result, the researcher had to carefully guard against biasness and refrain from influencing participants. The researcher would spend time preparing for the interviews and focus groups; and during interviews was listening and responding to that which was shared rather than to confront opinions and experiences. There was a continual reminder that the study focused on recording the experiences of social workers and not the researcher's experiences. In addition, a reflexivity journal was kept to record feelings, opinions and possible biases. The above enabled the researcher to fully appreciate the participants' work, value and contribution in the GDH.

1.7.8 Research practices and procedures

The researcher sent the participants all the relevant documents (including the interview and topic guides) before the data collection. This may not be practiced by other researchers, however, the researcher felt that this aided transparency and trustworthiness with the participants and for the study. This strategy worked well and was perhaps the reason for the wealth of information received from participants. Social workers could prepare for the contact and did not feel pressurised. This transparency may also have been the reason why some participants refrained from participating. Another aspect could be that participants felt interviews and focus group discussion were similar to the questionnaire and therefore declined participation.

The length of the focus groups may also be considered as an issue. The focus groups delivered valuable information and participants were eager to continue the discussion. The dynamics of cohesion and interaction displayed in both focus groups, contributed to the in-depth exploration of the study goal and objectives.

1.7.9 Issues regarding paradigms

The researcher's use of the two world views i.e., pragmatism and social constructivism may seem confusing. These two paradigms however worked in unison. The pragmatic paradigm was helpful with regard to the two different theoretical frameworks used and the use of mixed research methodologies. The social constructivist paradigm aided the in-depth exploration of the participants' understanding which was also enabled by using interpretive phenomenology as the research design for the qualitative aspects.

1.7.10 Issues regarding mixed methodology

There is still huge debate of the mixing of two different approaches. For this study, the exploration of the entire population via survey research design worked well as this gave an indication of the

population's understanding and experiences. It must be noted that literature did not reflect the experiences of social workers in health care with regard to the SDA, the SDH and policy implementation. So, this may be one of the few studies that considered this aspect. The qualitative strategies utilised an interpretive phenomenological design and attempted to explore and augment the findings of the survey as well as contributed to clarity of a possible guideline. The two approaches worked in unison in exploring the phenomena in totality and enabled valuable triangulation.

1.7.11 Issues regarding the quantitative strategy

The researcher's inexperience in conducting quantitative strategies may have impacted on the findings of the study. The researcher made use of SPSS to minimise the researcher errors.

This study did not set out to prove a relationship between the dependent and independent variables but rather to explore, describe and explain it. As a result, relationships cannot be confirmed but associations could be made.

1.8. Chapter Outline

Chapter 1: **Introduction**

The study is introduced, background and rationale, the major contributions and significance of the study, the research questions, goal, objectives and hypothesis are highlighted. A brief overview of the theoretical framework and methodology of the study are stated. Several limitations and the corresponding delimitations are discussed.

Chapter 2: Theoretical frameworks

This chapter highlights the pragmatic and social constructivist and paradigms as well as Habermas' theory of social reproduction and the ecological perspective. A synergy of the theories and the paradigms are offered.

Chapter 3: Social work in health care

The importance, roles and functions of social work in health care are discussed. Social work in health care in South Africa receives specific attention.

Chapter 4: The social development approach

This chapter highlights the social development approach and its implementation globally and in South Africa. The challenges of implementing the SDA are also pointed out.

Chapter 5: The social determinants of health

This chapter discusses the social determinants of health, globally and within the South African context. The application and relevance of the social determinants of health to social work in health care are presented.

Chapter 6: Research methodology

This chapter highlights the mixed methodological nature of the study. The design, sampling, methods of data collection and analysis and research instruments as according to the different phases are discussed. The ethics relevant for this study is also deliberated.

Chapter 7: Quantitative approach - Data presentation: Survey research design

Data obtained in phase one via the questionnaire and using survey research design will be presented in this chapter. Findings of the study will be presented according to the categories highlighted in the questionnaires. Associations and inferences are emphasised.

Chapter 8: Qualitative approach - Data presentation: Semi-structured interviews

This chapter presents the data obtained via semi-structured interviews during phases two and four with participants and key informants. The data is presented according to categories, themes and subthemes that emerged.

Chapter 9: Qualitative approach - Data presentation: Focus group discussions

This chapter presents the data obtained in phase four with the two focus group discussions. The data is presented according to categories, themes and subthemes that emerged.

Chapter 10: Discussion of the findings

This chapter offers summaries of the findings from the four phases and links it with the relevant literature. In addition, the triangulation of the methods, data, theories and paradigms are highlighted. A suggested guideline for the implementation of the social development approach and social determinants of health is tabled. Definite assertions as based on the study are made.

Chapter 11 Summary, Conclusions and Recommendations

A summary of the study and findings are provided. Key findings and conclusions are be tabulated. Recommendations geared at the GHD and government, academia, the South African Council for Social Service Professionals, social work in health care and future studies are offered.

1.9 Summary

This introductory chapter provided the background information for the intended sequential explanatory mixed methodology study. The rationale highlighted the necessity for the study's exploration followed by the definition of concepts relevant for this study, research questions, goal, objectives and hypothesis. The theoretical framework highlighted both the social constructivist and pragmatic paradigms as well as the theory of social reproduction and the ecological perspective. Mixed methods were introduced as the research design. Several limitations experienced as well as the delimitations were presented. Chapter two gives attention to the paradigms and theories considered applicable for this study. The application of each as well as the synergies amongst the paradigms and theories are highlighted.

CHAPTER 2
THEORETICAL FRAMEWORK

'***There is nothing so practical as a good theory'***

(Kurt Lewin in Robbins, Chatterjee & Canda, 2012, p.v)

2.1 Introduction

Theory influences the way we perceive, manage, interpret and understand the world, our professions, interventions, practices and experiences. All research should be guided by a theoretical framework to understand and interact with the phenomena to be explored. Tammivaara and Shepard (1990), and Payne (2005, 2014) acknowledged the importance of theory in practice.

In exploring the experiences and perceptions of social workers employed in the GDH about the application of the SDA and utilising mixed methodology, it was decided that the most suitable paradigms to be employed was that of pragmatism and social constructivist. This chapter addresses the fundamental decision in selecting these paradigms and highlights its suitability for the intended study. Both paradigms are discussed by highlighting the epistemology and the ontology. Thereafter, the specific theories appropriate for this study i.e., Habermas' social reproduction and the ecological perspective are discussed. The relevance thereof is applied to the study. Synergies amongst the paradigms and theories are offered.

2.2 Paradigms

Paradigms may be viewed as constructed philosophical frameworks that incorporate views of natural phenomena (Payne, 2005, 2014; Robbins et al., 2012). De Vos and Strydom (2011) concurred with this view and stated that paradigms revolve around philosophy. A paradigm may also be defined as a cluster of beliefs that guide how the research should be approached and studied

(Barnes, 2012; Creswell, 2009). Barnes (2012) like Creswell (2018) acknowledged the term of worldview in relation to paradigm. Bryman et al. (2014) described a paradigm as a cluster of beliefs. Bryman et al. (2014), De Vos and Strydom (2011) and Mouton (1996) indicated that Kuhn's scientific revolution in the 1970's led to the acknowledgement of other paradigms besides positivism. Bryman et al. (2014), highlighted that each paradigm has assumptions which draws on either an objectivist or subjectivist point of view. Here the epistemology and the ontology are of the utmost importance.

Barnes (2012), Guba and Lincoln (1994), Lincoln et al. (2018) and Ornellas et al. (2016) acknowledged that research, or more specifically the worldview or paradigm asks questions about the epistemology, ontology and methodology. According to these authors, the epistemology refers to the knowledge, ontology to the nature of the social reality and methodology to the methods of research in exploring the phenomena (Barnes, 2012; Guba & Lincoln, 1994; Lincoln et al., 2018; Ornellas et al., 2016). This therefore implies that the paradigm, worldview or orientation will largely dictate how the research will be approached, managed and conducted. Many authors, like Creswell (2018), De Vos and Strydom (2011); Payne (2005, 2014), Mouton (1996), Neuman (2014) and Ornellas, et al. (2016) indicated different worldviews and that consensus does not exist on the number of worldviews and what they are. One aspect is clear; historically the positivist framework was dominant and thereafter Kuhn's science revolution enabled a greater diversification of paradigms (Bryman et al., 2014; De Vos & Strydom, 2011; Mouton, 1996).

Barnes (2012) encouraged fluidity between paradigms and methods of research in exploring phenomena. Robbins et al. (2012) was also of the opinion that paradigms and models may be used interchangeably. This assumption therefore links with Barnes' indication of the fluidity. Ornellas et al. (2016) and Payne (2005), authors familiar in the social work field, suggested their formulations of these worldviews. Payne (2005) suggested three major discourses in social work

namely (1) **reflexive - therapeutic** (which in essence is the combination of interpretivism and constructionism), (2) **socialist - collectivist** (which is critical and transformative) and (3) **individualist - reformist**. Payne updated this typology in 2014 by highlighting the three discourses as (**1) empowerment, (2) social change and (3) problem-solving** (Payne 2014). Empowerment discourses of the 2014 typology resonates with reflexive - therapeutic social work of the typology postulated in 2005 in that both address helping clients and offering therapeutic interventions (Payne, 2005, 2014). Social change refers to socialist – collectivist social work strategies that focus on assistance to the vulnerable and oppressed individuals in society (Payne, 2005, 2014). Problem-solving and individualist - reformist are similar as both focus on attending to individual needs (Payne, 2005, 2014). Ornellas et al. (2016) considered various frameworks and developed frameworks for the social work profession. The four worldviews they suggested were (1) interpretivist - therapeutic, (2) individualist – reformist, (3) social - collectivist and (4) neoliberal - managerialist frameworks. Despite the different representation of the social work nature and worldviews, Ornellas et al (2016) and Payne (2005, 2014) share the same world views.

The researcher aligns herself with the stance from Barnes (2012) on the fluidity of views, assumptions and methods to data collections and analysis. As this was a mixed method study that aimed to explore, describe and explain the experiences of social workers in the GDH and the implementation of the SDA; two worldviews were of importance. Due to the nature of exploring and describing the intersubjective worlds of social workers in the GDH the social constructivist paradigm was most suitable. This, according to the framework offered by Ornellas et al. (2016) and Payne (2005) includes interpretivism as well. In aligning with mixed methodology, different theories and data collection methods were used. This therefore embraced the pragmatic paradigm.

2.2.1 Pragmatic paradigm

Barnes (2012) stated that pragmatism is a challenge to define. Mouton (1996) submitted that pragmatism may refer to the practical nature that is worthwhile. Hornsby (2015) addressed the practical problem-solving nature of pragmatism that advocates for the solutions to be rather sensible and practical than according to fixed ideas and theories. Creswell (2018), in conceptualising the pragmatic worldview postulated that this worldview is in direct opposition to a positivist frame of reference in that the foci is on the phenomenon to be researched and understood. Pluralistic approaches, methods and theories are then utilised in describing the phenomenon (Creswell, 2018). Barnes (2012) acknowledged dualism but also stressed the development of knowledge. Pragmatism considers both empirical and practical knowledge. James (2002) referred to it as a mediating system where theories become the instruments and not the answers. This resonates with the researcher's decision of the selection of the paradigms and theories.

Bryant and Charmaz (2010) added that pragmatism does not attempt to separate truth from values hence the utilisation of creative problem solving. There seems to be a focus of the exploration of the meaning people attribute to issues (Bryant & Charmaz, 2010). Margolis (2007) also indicated that pragmatism is not preoccupied with defining or exploring issues narrowly. The purpose of pragmatism at its core is functional efficiency in addressing objectives (Rescher, 2012). Realistic pragmatism is involved with the validation of human experiences, to answer human needs, to resolve doubts and to guide further actions (Rescher, 2012). Pragmatism is not committed to specific paradigms and designs (Mackenzie & Knipe, 2006). Therefore, in attempting to explore or address a phenomenon the researcher selects the most appropriate approaches. Acknowledging these ideals of pragmatism, the researcher used this approach because it enabled the best possible combinations of approaches to explore the identified research aim.

Both Barnes (2012) and Creswell (2018) confirmed that pragmatism is fluid with regard to the epistemology, ontology and methodology that best seeks to explore, describe, analyse and understand the phenomenon to be researched rather than to prescribe. Creswell (2018) stressed the individual researcher's choice in the matter of the duality in combining both quantitative and qualitative approaches. Barnes (2012) agreed to the connection between mixed methods and pragmatism but adds that it offers the aspects of inter-subjectivity and abduction (acknowledging both inductive and deductive reasoning) that may be useful for researchers. Rescher (2012) clarified when employing pragmatism, it should aid functional efficacy. Types of pragmatism may be realistic (understanding of human practices and experiences), existential (which is radical and restricts theory) and cognitive (evidenced based) (Rescher, 2012).

Realistic and existential pragmatism resonated best with the social constructivism and this research study. The study's foci were on the experiences and understanding of social workers in health care about the implementation of the SDA. Therefore, different theories and methods were utilised to explore and describe the social workers' knowledge (epistemology), how they see their world and the influence of government (ontology) and explaining it via several data collection methods (methodology). Pragmatism therefore provided the fluidity necessary to investigate this very complex phenomena. The researcher's study was very practical, solution orientated and mediated different theories, as suggested by Barnes (2012), Creswell (2018), James (2002) and Rescher (2012). The applicability of the pragmatic world view will be further addressed in the methodology of this research study.

2.2.2 Social constructivist paradigm

The social constructivist paradigm was suitable for meeting the aim and objectives of this study. Burr (2015) indicated that social constructivist or the constructionist view is a fairly new world view that incorporates various characteristics that complicates a single definition. Burr (2015)

summarised the key assumptions of the paradigm as a critical stance to 'taken-for-granted knowledge', historical and cultural specificity. Knowledge is sustained by social process where knowledge and social action interlink. In essence, these key assumptions refer to exploring the understanding of others in specific scenarios. Gubrium and Holstein (2008) summarised that social constructivism may refer to "… the dynamic contours of social reality and the processes by which social reality is put together and assigned meaning." (p. 3). The main aim of interpretivist or constructionist research approaches is to understand the world of the human experience, according to Mackenzie and Knipe (2006). The assumption is that this world or the reality is formed, and it is this constructed view of the participants that is being studied (Creswell, 2003, 2018; Mackenzie & Knipe, 2006). Mackenzie and Knipe (2006) highlighted that interpretivism is a social construction. Creswell (2008, 2018) further highlighted that this is considered as phenomenological research which focus on the understanding of mutually shared experiences and understandings of the world. Babbie and Mouton (2001) referred to this as the phenomenological or the interpretivist tradition as the main emphasis is on the human understanding. Babbie and Mouton (2001) further stated that all humans are actively involved in making sense of their worlds or reality. De Vos and Strydom (2011) and Neuman (2003, 2014) highlighted that the approaches are, based on hermeneutics and the detailed empathic understanding of the life experiences of others. Hesse-Biber and Leavy (2011) also emphasised that interpretivists or social constructivism think of the social meaning and understanding of lived experiences. Shah and Al-Bragi (2013) indicated that interpretivism is better known as constructivism and is concerned with subjective meanings of events and social reality. Creswell (2008) reiterated that social constructivism seeks understanding of the world. Mouton (2009) suggests that social constructivism represents diverse depictions of social worlds.

In view of the opinion of Burr (2015), there are numerous ways of understanding and applying social constructivism. It is acknowledged that daily interactions lead to the construction of the

world. Therefore, culture, language use, power relations, and so forth, influence our constructions of the social world. Multiple versions of the social world may exist (Burr, 2015). This then, links with the concepts or relativism and realism. Realism refers to the independent existence of the world independently. Relativism by contrast refers to various representations of the social worlds (Burr, 2015). Creswell (2018) acknowledged this relativistic character of social constructivism by stating that individuals have varied and subjective meanings of their experiences and social world. Within research, the goal is therefore to rely on the participants perspectives or viewpoints rather than that of theory. The main assumptions of social constructivism are therefore (1) the construction of subjective meanings and understandings, (2) engagement with the world to make sense thereof, and (3) meanings are always generated by social interaction (Creswell, 2018). The aspects of relativism here connect with the ontology of realist and existential pragmatism.

As the aim of the study was to explore the experiences and understandings of the social workers regarding the implementation of the SDA; social constructivism enabled the in-depth exploration and understanding of their experiences. It allowed for in-depth accounts of the social workers understanding and experiences. The study also explored this by using different approaches and research methods. The orientation of researcher was therefore to understand the experiences (relativism) even if there were discrepancies (realism).

In addition to the pragmatic and social constructivist paradigms, two other theories that will enable the comprehensive assessment of social work in health care are Habermas' theory of social reproduction and the ecological perspective.

2.3 Theories applicable for this study

Theories in contrast to paradigms are developed through systematic processes to offer guidelines, answer questions, explain the world, behaviour and understanding. (Bryman et al., 2016; Harris &

White, 2013; Payne, 2005, 2014; Robbins et al., 2012). Therefore, theories form a reference or lens through which to view phenomena. For this study Habermas' theory of social reproduction and the ecological perspective were most suitable in understanding the experiences of social workers in the GDH.

2.3.1 Habermas' theory of social reproduction

Habermas' theory of social reproduction is classified as either a radical humanistic or a contemporary critical theory. Contemporary critical theory particularly lends itself well to the exploration of individuals' experiences which is referred to as the inter-subjective objectivity, as well as to highlight inequalities and power relations (Beauregard, 2012; Bronner, 2011; Dant, 2003). By utilising this frame of reference, the study extensively recorded the experiences, opinions and understandings of the indicated population. It must be noted that Habermas' theory formed an essential part of the philosophical foundations of the social constructivist view of the critical stance of the subjective experiences of others (Gubrium & Holstein, 2008).

Houston (2013) highlighted that Habermas identified two spheres of social reproduction: life world and the system. The ***life world*** refers to communication and interaction, whereas the ***system*** acknowledges areas that are governed by the state which may involve political and economic subsystems (Houston, 2013). These spheres linked well with the aims of the study. Houston (2013) also connected socialisation with the life world and emphasised that it is important to protect the life world sphere from the system sphere. Habermas also indicted that there should be a balance between the two spheres. He linked the increase in bureaucracy and its processes (such as policies) that negates care as increasing the discontentment in the life world (Houston, 2013).

2.3.1.1 Application to the study

The life world sphere for the study entailed the exploration of the participants' experiences and their communication of these aspects which provided in-depth inter-subjective accounts of the social workers, social work supervisors and managers in the GDH. In addition, the study pointed out the power relations as well the inequalities that were evident in the implementation of the SDA to social work in health care and therefore satisfied the second sphere of systems. The explorations offered a clear understanding or the communications and implementations that occurred in the GDH. A difference in the consultation processes were noted. It was only certain policies that were viewed by some participants for input, whereas others indicated that limited consultation occurred. Policies seemed to be still implemented according to a political priority or agenda which was then unilaterally enforced. One particular case was the tragedy of Life Esidimeni. After this incident policies were implemented as to actively deinstitutionalise patients and at times to the detriment of the patient, family and community. There were other policies indicated in the survey and interviews that had a major impact on the role of social workers in the GDH. It was also evident that designated powers of social workers in health care was removed without any consultation.

A number of participants indicated that policies are created, and social workers are compelled to follow through irrespective of availability of resources and services. Here, it was clearly noted that social workers felt disenfranchised and power relations are evident. From the study, their experiences clearly detailed the influence of Government. With regard to the guideline for the implementation of the SDA and the consideration of the SDH of patients; social workers identified that limited guidance was offered by Government. The expectation exists that social workers should employ the SDA, but clear directives and resources are not evident. Due to the constraints of working in secondary and tertiary health care settings, the participants indicated that they do apply the SDA in facilitating social justice, human rights and participation. In this life world sphere the approach was well applied and numerous examples were offered. Social investment strategies

and community work were less successfully implemented. Social workers also exhibited creativity in dealing with the system sphere by seeking out specific community-based projects to answer this aspect from Government. A contradiction of policies as it pertains to the multidisciplinary team was also highlighted. This then prevented the patient from receiving holistic service delivery. In acknowledging the system sphere, social workers also shared that acknowledgment for their work and services are not received. In contrast their life world system specified that they value social work and based on the profession's skills and expertise, they hope it will be an important profession in addressing the biopsychosocial needs of the clients. Most social workers identified the value of heads of departments or supervisors that bridge the gap between the power dynamics from the system sphere and enabling the life world of social workers. The competence and approachability of managers were also identified as important in providing the necessary appreciation and protection from the health system. This is related to what Houston (2013)) stated about the protection of the autonomy of the life world system. Managers or supervisors were mostly seen as the protection against the onslaughts of the system sphere. Conversely managers were also seen as the implementers of the policies from the system sphere. This therefore indicates the dichotomous nature and position of the manager in the health setting. Habermas' social reproduction theory highlighted the contradictory stances that social workers in the GDH encounter.

From the focus groups, as based on the life world sphere, the social workers indicated components of a framework that may be used in implementing the SDA. This is in contrast with the system sphere where Government usually dictates the way forward.

2.3.2 Ecological perspective

Habermas' theory of social reproduction especially considering the theory's spheres links well with the ecological perspective. The ecological perspective highlights and acknowledges the

reciprocal and interdependent relationships between individuals and their environment (Jack, 2012; Kirst-Ashman & Hull 2010; Payne, 2005; Robbins, et al., 2012). Bronfenbrenner's Ecology acknowledges the dynamic and reciprocal nature of all processes and represents settings into various concentric structures such as micro-, meso-, exo- and macro systems (Jack, 2012). According to Bronfenbrenner's view the micro system refers to the person in a specific setting where he or she is involved in set activities or roles (Jack, 2012). The meso system makes reference to the interrelationship between two or more micro systems that a person may be involved with. Accordingly, all individuals are active participants in the micro and meso systems. The exo system refers to the system that has impact on the individual, but where the individual is not an active participant, whereas the macro system contains the aspects relating to culture, subcultures, beliefs and ideologies (Jack, 2012). The ecological perspective therefore highlights that the person cannot be understood appropriately without acknowledging the impact of the environment. The person and the environment have an interdependent and reciprocal relationship (Jack, 2012; Kirst-Ashman & Hull, 2010; Payne, 2005; Robbins et al., 2012). It is this interdependent relationship between the individual (social workers in the GDH) and their environment (the different health care settings in the GDH), where the SDA is being implemented, that was the focus of the exploration of this study. This links well to what Hugman (2009) indicated about the person in environment is part of radical social work especially when exploring the structural causes of social and personal needs.

2.3.2.1 Application to the study

The micro system for this study refers to the health care settings where the social workers in the study were employed. Most participants in this study were employed in secondary and tertiary health care settings. Policy implementation had a direct effect on the success of interventions in relation to the setting. Participants employed in tertiary health care settings indicated that these settings do not lend itself well for community work. Most indicated that community projects

focused on awareness creation as according to a health calendar, empowerment with knowledge or according to the needs of the manager. As highlighted under the spheres of reproduction, certain policies that were politically motivated which were conceived in the macro system, had direct implication for the micro system on how social workers may enact their roles. Contradictory policies with other health team members also prevented social workers to perform their roles. One participant highlighted that home visiting policies were contradictory. On a macro level the policy was developed so that social workers, accompanied by a nurse, should conduct home visits upon a patient's discharge. The policy for nurses is clear that they are not permitted to do home visits. The result is that the patient therefore remains in the hospital. Therefore, on a micro level the enactment of roles to completion was not always possible. This therefore added to the discontent, which Habermas indicated that we should guard against. Most participants also acknowledged their role as part of the multidisciplinary teams. Where their roles were grounded, their position was well respected and considered of value. Some participants have however indicated that their role was under threat with Governmental policy changes and lack of consultation of social workers in national strategic health care frameworks. Some participants also indicated that other professionals feel that they can enact the roles of social workers especially with regard to discharge planning. This then begs the question; what is the role of social work? Is it just attending to social matters? Has the SDA created unavoidable obstacles for social workers in health care? From the participants it was clear that their role was more focused on discharge planning and resolving social problems. Their therapy role is neglected, and they have difficulty in achieving the social development mandate. The exo system for this study was not identified. The influence of the macro system was more evident with regard to policy formulations and implementation.

2.4 Synergies amongst the paradigms and theories

The pragmatic paradigm enabled the practical exploration of the phenomena and the social constructivist paradigm enabled the understanding of how the participants framed their world.

Both these paradigms were helpful in data collection and analysis. Apart from this, both these paradigms linked well with the theories. Social constructivism and Habermas' theory both facilitated an understanding of the participants' experiences. What was clearly evident was how they dealt with challenges in their life world and how they constructed meaning from it to deal with the challenges. The impact of Government's policies from the system sphere (Habermas' theory) or macro system (ecological perspective) on the life world (Habermas' theory) or micro system (ecological perspective) of social workers in health care were clearly noted. Social constructivism also linked well with the ecological perspective in understanding the participants experiences at different levels. In turn, the researcher highlighted how well Habermas' theory and the ecological perspective linked. This linking enabled a clearer understanding of the participants and how they responded to governmental strategies and policies. This fluidity of the theories, with paradigms, facilitated the synergy of the pragmatic paradigm. In exploring the social construction of experiences of the participants; relativism and duality according to Rescher (2012) and Barnes (2012) were enabled.

It is therefore the opinion of the researcher that the selected paradigms and theories were appropriate to achieve the research the goal and objectives of the study. Further motivation of this will be offered in the methodology and data analysis chapters.

2.5 Summary

This chapter provided the position of the researcher as considering both pragmatic and social constructivist world views to enable the achievement of the research goal and objectives. An overview of the paradigms and theories that were utilised in the study was provided. The pragmatic paradigm was selected due to the fluidity of the theories and methods used for this study. This paradigm enabled the exploration of the phenomena from multiple viewpoints and facilitated a comprehensive overview. Social constructivism was selected as a paradigm for its ability to

explore the epistemology and ontology of the social worlds of the participants. Diverse views were considered and acknowledged. Realistic and existential pragmatism linked well with the social constructivist paradigm of exploring the inner world of participants. In addition, the theories of social reproduction and the ecological perspective also enabled a holistic view of the participants understanding, experiences as well as the impact of governmental health care strategies. The use of paradigms and theories enabled a holistic, critical and practical exploration of the study. Social work in health care is outlined in the following chapter.

CHAPTER 3
SOCIAL WORK IN HEALTH CARE

3.1 Introduction

This chapter's focus is on providing the historical overview of social work in health care globally and locally. In chapter one, the social work definition as tabled by the IFSW and adopted by the IASSW (2014), was highlighted. For the social work profession to internationally concur on such a unique and all-encompassing definition, a long history to this development is evident. This confirms the depth of knowledge with regard to the historical roots and transformations of social work as a profession. Globally, there is also a wealth of knowledge with regard to the development of social work in health care. The history of social work in South Africa, has been well documented as well as outlined and linked with the trends of colonialism, apartheid, democracy and transformation. The ever-changing nature of social work to respond to political, social and environmental demands is noted. Information on the development of social work in health care in South Africa is however minimal and not well recorded. The reactiveness of the social work profession to external demands will be highlighted as a stumbling block in developing and maintaining the unique identity of the social work profession. The characteristics of the profession will be clearly highlighted as well as the unique service delivery demands for social work in health care. Policy changes and political influences are highlighted as major factors that led to development of social work in health care.

3.2 History of social work

Social work, both internationally and in South Africa, has had a colourful albeit political history. A brief historical overview is of the utmost importance as it indicates not only the process of the development of social work, but also how social work as a profession was mostly shaped by other

disciplines, demands, policies, environmental and political influences. This discussion will also highlight the unique characteristics of the profession that was developed.

3.2.1 Global history of social work

The historical accounts for the development of social work internationally are well recorded especially in developed countries. It is known that social work started in the United Kingdom (UK), Europe and the United States of America (USA) with alms workers, charity and religious organisations, and the settlement housing movement (Dhooper, 2012; Kurevakwesu, 2017; Toseland & Rivas, 2017). Predominantly the profession had its start in charitable work. Kurevakwesu (2017) however indicated that the term social work was created in the twentieth century but that a variant of social work was evident from as early as the fourteenth to seventeenth centuries, in the form of work by charities. Nicholas (2010) indicated that social work's history had its origins from the Carnegie Commission in 1932 where the need for qualified social workers was made. Lombard (2000) stated that social work developed through the centuries from a non-professional to a semi-skilled profession and ultimately to the fully-fledged profession we now have. Lombard (2000) also highlighted that in 1915, already, Flexner concluded that social work is indeed a profession. This conclusion was reached before the ground-breaking Carnegie Commission of 1932.

The social work profession evolved from case work to group to community work and into a myriad of different settings and permutations. This part of the discussion will solely focus on the development of social work in four countries of the Southern African Development Community (SADC) i.e., Botswana, Lesotho, Namibia and Zimbabwe. The selection of these countries is motivated by their proximity to South Africa as well as the availability of literature. The evolution of social work in these countries respectively, are closely linked with their colonial histories and

social ills (Chitereka, 2010; Jongman, 2014; Kaseke, 1987; 1991; Kurevakwesu, 2017; Okoye, 2013).

3.2.2 History of social work on the African Continent

3.2.2.1 Social work in the four SADC countries - Botswana, Lesotho, Namibia and Zimbabwe

The welfare development of the countries discussed here (including South Africa), have the historical commonality of the origins from their colonial pasts. Nhapi and Dhemba (2020) connect the colonial pasts of these countries and highlighted their focus for social work to encompass poverty alleviation, dealing with the impact of unemployment, HIV and AIDS, aging populations, an increase in youths, the empowerment of communities, climate change and the provision of livelihoods.

Botswana

Similar to most SADC countries, social work in Botswana seems to be in an early stage of development. Jongman (2014) and Jongman and Tshupeng (2020) recorded that social work in Botswana, came into existence in 1946, as a response to care for returning soldiers from the Second World War. The Welfare unit was established and housed in the Ministry of Education and the foci of service delivery, were services to war veterans, the needy and youths. In offering these services, youth clubs needed to be established. In the 1960's more welfare officers were appointed to work in slums to address the unhygienic conditions (Jongman, 2014; Jongman & Tshupeng, 2020). The Botswana College of Agriculture offered the first social work training in community development from 1972 – 1984. In 1985, the University of Botswana began with training of social workers offering either a two-year certificate, diploma and a four-year degree (Jongman, 2014; Jongman & Tshupeng, 2020; Maundeni, 2009). After this, the social work profession seemed to diversify and multiply to various sectors such as child welfare services, hospitals, prisons and youths. Jacques (1993) indicated and Jongman (2014) confirmed that social work is still not

recognised as a profession which results in challenges to enforce ethical standards. This lack of structure, Jacques (1993) asserted, opens the field up to misconduct and misuse of power. According to Jongman (2014) and Maundeni (2009) combining social work with community development resulted in the loss of social work's identity.

Lesotho

Social work practice in Lesotho seems to have been recognised with the establishment of the Department of Social Welfare in 1976 (Nhapi & Dhemba, 2020; Tanga, 2013). The creation of the Department of Social Welfare was in response to the increased levels of poverty and social problems. According to Manyeli (2007**)** the social welfare delivery from 1994 to 2004 was focused on children and disability. The social work degree was only instituted in 2002, which seemed to have provided recognition to the profession (Dhemba & Marumo, 2016). Manyeli (2007) and Tanga (2013) also alluded that the Department of Social Welfare has been moved from department to department. This mobility resulted in the lack of stability and co-ordinated focus of the department. The welfare approach has been remedial but a concerted effort has been made to implement the SDA (Dhemba & Marumo, 2016; Manyeli, 2007, Nhapi & Dhemba, 2020). Furthermore, Dhemba and Marumo (2016) highlighted that the transformation of the Lesotho social welfare has been slow and reactive. The Department of Social Welfare was officially renamed to the Ministry of Social Development in 2013 (Nhapi & Dhemba, 2020). The aim of social workers in the employ of this ministry is to fulfil the SDA mandate by mainly focusing on poverty alleviation, addressing gender-based violence, HIV and AIDS, protection of children and risk management (Nhapi & Dhemba, 2020; Manyeli, 2007). However, due to resource restrictions case work is still the dominant social work method of intervention (Dhemba & Marumo, 2016; Manyeli, 2007; Nhapi & Dhemba, 2020; Tanga, 2013).

Namibia

Chipare et al. (2020) highlighted that welfare was introduced to Namibia by the Dutch Reformed Church to work with its white congregants. Namibia's attempt to remedy the legacy of apartheid was to align its social welfare services with that of its Constitution and democracy (e.hospice.com 2018; Freeman; 2017). From 1980 to 1992, social workers have been trained firstly by the Academy of Tertiary Education in South Africa. From 1992 to now social work training is offered solely by the University of Namibia (Chipare et al., 2020). Social work is still considered a young profession marred by a great deal of challenges including but not restricted to limited resources, shortages of social workers and non-specialisations (Chipare, et al., 2020). All social welfare services were distributed to different sectors of the Namibian society (Ministry of Health and Social Services, 2010). Amukwelele (2017) and Freeman (2017) summarised the roles of social workers in Namibia as fostering the populations wellbeing by ensuring human rights, addressing the needs of the population and especially the protection of children. In 2011, The Ministry of Health and Social Services (2011) highlighted that the scope of practice for social work includes 25 core areas which includes counselling, risk management, report writing, policy writing, advanced social work practice, amongst others.

Zimbabwe

Chitereka (2010), Kaseke (1987, 1991) and Kurevakwesu (2017) indicated that social work in Zimbabwe developed in response to social ills like, delinquency, prostitution and destitution. Social work during the colonial times was curative in nature and not preventive (Kaseke, 1987, 1991). According to Kaseke (1991), the Department of Social Welfare later became the Department of Social Services, and by the year 1990 had a remedial stance to service delivery. Social work practice gradually expanded in Zimbabwe which led to the social work service delivery in the areas of child welfare, juvenile delinquency, counselling, care of people with disabilities and the elderly, refugees, health, community and co-operative development (Chitereka,

2010; Kaseke, 1991). Masuka (2015) indicated that the focus of care in Zimbabwe is now developmental social work. This developmental approach tends to integrate casework with group and community work. Therefore, the approach spans the three domains of social care, social control and social change in Zimbabwe (Masuka, 2015). Despite the political and economic challenges that plague the country; it seems that social work practice in Zimbabwe has been progressive.

3.2.2.2 Social work in South Africa

Nicholas (2010) recorded that social work in South Africa had its existence as a social services profession from the 1920's in the form of charity work and beyond 1994 attempted to fulfil a critical role. Drower (2002) also indicated that this charity work from the 1920's, was dominantly focused on offering social welfare relief to South Africa's poor white population. The Dutch Reformed Church provided the services to the needy population (Drower, 2002; Engelbrecht, 1999; Smith, 2013, 2014). Brown and Neku (2005) located the welfare work of the Dutch Reformed Church when attempts were made to offer relief to poor white farmers as from 1657. This is also confirmed by Smith (2014), in the historiography of social work, and by Nicholas et al. (2010). The Carnegie Corporation of New York in 1932 recommended the establishment of the Department of Public Welfare and that the training of social workers be initiated (Engelbrecht, 1999; Nicholas., 2010; SACSSP, 2008). President HF Verwoerd was responsible for confirming that social work should be recognised as a profession and in 1936 initiated the three-year degree for social work (Nicholas et al., 2010).

The Department of Public Welfare was officially established in 1937 and official training for social workers was incepted in 1964 (Engelbrecht, 1999). As in line with the apartheid regime dominant then, training for social work was also segregated and offered according to race (Engelbrecht, 1999; Nicholas., 2010; Smith, 2013, 2014). Social work was transformed throughout the years

from the fragmentation of service delivery to residual welfare and institutionalisation to the implementation of developmental social work, which include the varied principles of social justice, equity, democracy, participation and humanity (ubuntu) (Gray, 2010; Nicholas, 2010). Smith (2013) in her PHD dissertation recorded in detail the historiography of social work during colonialisation and through the various political developments and transformation in South Africa. She clearly highlighted the metamorphosis of social work through the ages due to political influences.

Social work in South Africa is recognised as a profession and is offered in diverse settings, with diverse clients and communities (SACSSP, 2008). Apart from this the SACSSP and stakeholders are in the process of defining numerous specialisations within the field of social work. Social work in health care is under consideration of being a specialisation (SACSSP, 2008). As in line with the SDA as described in the White Paper on Social Welfare (Department of Welfare, 1997), developmental social work has been the method of policy implementation (Gray, 2010; Nicholas, 2014). Developmental social work at its core focuses on prevention, primary care and community development.

3.3 History of social work in health care

The development of social work in health care has a colourful history. Previously social work in health care was referred to as medical social work or health social work. This section offers a brief global, regional and South African history of the development of social work in health care.

3.3.1 Global context

Social work in health care's global history has been well recorded. Auslander (2001), Dhooper (2012), Ruth and Marshall (2017) and Skidmore et al. (1994) recounted the establishment of social work in health care at the Massachusetts General Hospital by Dr Richard Cabot in 1905. Auslander

(2001) and Gehlert (2006) said the establishment of social work in Britain happened much earlier. Indeed, the first almoner, Mary Stewart, was employed at the London's Royal Free Hospital in 1895. Her role was to consider the social aspects related to the health of patients. Auslander (2001) reiterated that the start of social work in health care in various countries was through charity work. In Hong Kong almoners were also employed from 1939. In Australia, the first almoners were appointed in Melbourne in 1929. So, the global history for social work in health care started with almoners or charity workers.

Social work services in hospital settings seems to have been shaped by the needs of the health care system and the multidisciplinary team (Auslander, 2001; Dhooper, 2012; Gehlert, 2006; Ruth & Marshall, 2017; Skidmore et al., 1994). Health care reform in the 1960's in America facilitated the diversification of social welfare services and social work services in health (Segal et al., 2018). Internationally, each country's development of social work in health care stemmed from charity work. Auslander (2001) surmised that social work services in health care continually develops based on the demands from others. Currently, social work in health care may be viewed as comprehensive, holistic and practical services, that may include, but is not limited to, biopsychosocial assessment, therapeutic interventions, discharge planning and care, education, brokering and mediations (Auslander, 2001; AASW, 2016a, 2016b; Bentley, 2002; Browne, 2006; Davis et al., 2005; Dhooper, 2012; Gehlert, 2006; Ruth & Marshall, 2017; Segal et al., 2018). Auslander (2001) also indicated the further diversification of the profession with the use of modern technologies to facilitate counselling or other services.

3.3.2 Social Work in health care in the African context

3.3.2.1 Social work in health care in the four SADC countries - Botswana, Lesotho, Namibia and Zimbabwe

Retrieving literature that highlights the development of social work in health is challenging for the African and South African contexts. The four identified countries i.e., Botswana, Lesotho, Namibia and Zimbabwe, all have social work or social services associated with health, and although it is evident that social work in health care is offered, the extent of the health care services is unclear. Literature specific to Namibia and Zimbabwe could be retrieved.

In 1991, Kaseke indicated that social work in hospital settings was struggling to form an identity in Zimbabwe. Chitereka (2010) indicated that in Zimbabwe there are more social workers in hospitals settings and that they form part of the Ministry of Health and Child Welfare. Furthermore, social workers in hospital settings are managed by medical superintendents and forms part of the different units such as surgery, medical, psychiatry, amongst other units (Chitereka, 2010). This management of social workers by non-social workers, is less than ideal as this compromises the profession greatly, especially with regard to its identity and enforcing of ethical standards. The current roles of social workers in hospital settings in Zimbabwe include counselling, discharge planning, supplying physical social needs i.e., clothing, food, travel warrants and immediate social needs. (Chiteraka, 2010; Kaseke, 1991). Namibia's National Health Framework: 2010 – 2020 (Ministry of Health and Social Services (2010) highlights the imperative role of social welfare in reaching its health outcomes. Chipare et al., (2020) highlighted that almost every hospital setting has a social work department. Social workers are required to implement programmes, offer support to individuals and families, and meet the social welfare needs of the country (Chipare, et al., 2020). Indistinct clinical roles were highlighted by Chipare et al. (2020), whereas Freeman (2017), highlighted seven roles that social workers should proactively pursue when working in palliative settings in Namibia, namely advocate, assessor, broker, counsellor, educator, facilitator, patient

liaison, discharge planner and manager. In addition, Chipare et al. (2020) highlighted that in hospital settings social workers offer counselling and crisis management. Resources, role clarification and understaffing are key challenges for social workers in hospital settings (Chipare et al., 2020; Freeman 2017).

3.3.2.2 History and development of social work in health care in South Africa

The historical development of social work in health care in South Africa also stems from charity work during its colonial period. Meyerovitz (1988) in her master's dissertation indicated that the development of social work in health in South Africa was directly influenced by the developments of social work in America and Britain. The start of social work services in hospitals were also initiated with alms workers. The first almoner was employed at the Somerset Hospital in Cape Town in the 1930's (Carbonatto, 2019; Meyerovitz, 1988). The Somerset Hospital was closed in 1938 and all the staff including the almoner was redeployed to Groote Schuur Hospital. During this time, the Nursing Association requested the Department of Welfare to establish trained almoners as part of hospital service delivery. In 1941, Dr Hugo, the superintendent at the Pretoria General Hospital, initiated a research study to explore the value of social work in hospital settings (Carbonatto, 2019; Meyerovitz, 1988). Based on the findings of this research, the first social worker was employed at the Johannesburg General Hospital on 1 July 1941. Five years later, in 1946, the first social worker was employed at the Pretoria General Hospital, where the research study was conducted (Carbonatto, 2019; Le Roux, 1964; Meyerovitz, 1988). The first social worker employed at the Tara H Moross Centre in Johannesburg was on the 7 January 1952. Le Roux (1964) indicated that from 1941 – 1964, 21 hospitals in South Africa employed social workers. An important aspect to be noted is that medical care services were also segregated according to the major population groups. It was only in the 1990's with the end of apartheid that segregation of services was ceased. The dominant social work services delivery compromised therefore of social welfare relief, preventative and treatment focused services. Carbonatto (2019)

highlighted that the current role of social work in health is diverse and social workers can practice in a range of private and public health settings. Carbonatto (2019) also expressed her hope for the recognition of social work in health care as a specialisation.

3.4 Relevance and role of social work in health care

3.4.1 Global context

Social work services in all sectors of health care are instrumental. Dhooper (2012) indicated that social workers in health care make unique contributions. Browne (2006) and Segal et al. (2018) indicated that social work is essential to the delivery and design of optimal health care services. Barker (1991) also highlighted that social work in health not only aids good health but is imperative in the resolution of social and psychological problems. Winnett et al. (2019) stressed the relevance and importance of social work in health care especially considering its transformative nature and adaptability to respond to challenges.

Riaz and Sarfaraz (2015) highlighted that social work is about the professional application of social work values based on a knowledge base that acknowledges human relations, human development, behaviour, social, economic and cultural factors. In addition, social work in health care is about the application of the abovementioned values and knowledge by social workers in health care settings and should focus on the impact of disease and hospitalisation on the psychological, social and emotional wellbeing of the individual and family (Riaz & Sarfaraz, 2015). The above is the current description of social work in Pakistan. Previously social work in Pakistan especially in hospital settings was seen as charity work or religious duty (Riaz & Sarfaraz, 2015).

The AASW (2016a, 2016b) has been proactive in the development of effective and appropriate social work services in health care in dealing with unique challenges. The scope of practice should be about maximising the wellbeing of individuals, families, groups, community and society

(AASW, 2016b). This view facilitates the bigger perception that social work in health care should have a scope that goes beyond the medical centre. The scope of practice for social workers in health care, according to the AASW (2016b) mentions the traumatic impact that arises from a diagnosis and hospitalisation which may have an effect on the individual's and families' personal control, financial constraints, decreased functionality and a wide range of emotional contagion. The social worker's role is considered instrumental for appropriate assessment and interventions to aid maximum rehabilitation and quality of life in such circumstances. In addition, the AASW (2016a) acknowledged that social work in health care provides a myriad of counselling strategies to individuals, families, groups and communities, education, resource referrals, advocacy and that the service delivery may include psychosocial assessment, counselling, resource counselling, discharge planning, and supportive care. In addition, social work in the Australian health care system also has to be proactively engaging in developing culturally competent intervention plans (AASW, 2016b).

Cleak and Turczynski (2014) highlighted the study by Judd and Sheffield (2010) which in turn focused on the roles of social work in hospital settings in the USA. It was recorded that 60% of social work time in hospitals was spent on discharge planning, securing and co-ordinating care of long-term patients (Cleak & Turczynski, 2014). Discharge planning should be considered as a key activity based on the effective psychosocial assessment performed by social workers. The role of social work in health care is also about empowering clients (Cleak & Turczynski, 2014). Apart from this, Cleak and Turczynski (2014) identified that the role of social work has become more complex, multidimensional and demanding of providing services that range over a wide domain from the individual to broader society. This they feared impacts the social worker's role of advocacy and counselling negatively (Cleak & Turczynski, 2014).

Giles (2009) indicated that social workers should continuously challenge the medicalisation of social ills and question the structural causes of the problems. Ashcroft (2014), and Ashcroft and Van Katwyk (2016) have similar thoughts in acknowledging that social work in health care should satisfy Payne's (2005) typology of social work practice as having a therapeutic, social order and transformational typology. As a result, social work in health care cannot just offer therapeutic services but a vast array of services that focus on different aspects. This clearly reflects that the role of social work is not just that of problem solving or counselling but also taking up social action.

Segal et al. (2018) and Skidmore et al. (1994) acknowledged the fact that social work in hospital settings forms part of multidisciplinary teams and requires collaborative work. The role and relevance of social work in health care differs from hospital setting and multidisciplinary teams (Skidmore et al., 1994). Dennill et al. (2007), Petersen (2015) and Skidmore et al. (1994) indicated the different settings to be arranged according to primary, secondary and tertiary health care services with their respective service delivery foci. Despite these differences Steketee et al. (2017) based on their systematic review, reinforced the value of social work in health care in ensuring the population's wellbeing.

Bywaters and Ungar (2013) provided a comprehensive overview of the focus of research in health. They indicated that social work research in health has been about enabling clients to share their experiences and meanings of health (Bywaters & Ungar 2013). Bywaters and Ungar (2013) proposed that the future of social work research in health may focus on the health service user, resiliency and both the indigenisation and globalisation of social work in health care.

The current dominant roles and services offered by social work in health care ranges from biopsychosocial assessment, counselling of patients and families, assisting the patient and family

socially, interdisciplinary sharing of knowledge, acting as a broker and or mediator, discharge planning, participation in policy making and engagement in research (Auslander, 2001; AASW, 2016a; 2016b; Bentley, 2002; Davis et al., 2005; Dhooper, 2012; Browne, 2006; Petersen, 2015; Segal et al., 2018). Skidmore et al. (1994) disclosed hope for a future for social work in health care but predicted, in 1994, that community work will be given prominence. This is exactly the circumstance with the implementation of the SDA in South Africa.

From the above discussions it was highlighted that there are numerous perspectives on the role of social work in health care settings. The importance of these roles was highlighted. The roles not only relate to the individual but should be focused on the family and community.

3.4.2 South African context

Literature of social work in health care in South Africa has traditionally focused on the role of social workers in relation to specialised areas of intervention. Carbonatto and Du Preez (2001) highlighted the important role of social workers in health care in assessing and preparing couples for artificial fertilisation. Modisane and Carbonatto (2001) also addressed the challenges for medical social work in working with black patients diagnosed with systemic lupus erythematous (SLE). The article generally describes the role of social work and the medical conditions thereof. The biggest challenges for social workers in dealing with these patients are linking them to resources, linking with the medical team and promotion of awareness about the disease (Modisane & Carbonatto, 2001). Steyn and Green (2010) explored the views of patients who had laryngectomies about the social work role. The patients indicated that the role of social work is important especially for post-operative care which incorporated providing support, information giving and meeting of needs. Saloner (2002) identified the critical role of social workers in the HIV/AIDS pandemic. Spies (2007) in her PHD thesis addressed poverty on the impact of HIV/AIDS and adherence. Petersen (2015) identified seven roles of social work in primary health

care as based on the transformation of the South African context but mentioned that a proactive strategy is required. These seven roles are advocacy, enabler, broker, mediation, social protector, educator and counsellor (Petersen, 2015).

As can be denoted, much is written about the social work role in health care settings in relation to biological pathologies and its impact, but very little is written on policy changes and transformation within the South African health context in relation to social work and the SDA. Beytell's (2002) doctoral research attempted to contribute to this facet as her research aimed at developing a community practice model to social work in primary health care. The thesis did not focus on the social workers in secondary and tertiary health settings. However, Beytell (2002) stressed the ineffectiveness of social workers in health care as they are not utilising a community practice model in social work. This may be seen as harsh critique, but perhaps in terms of the political and economic context of South Africa and the foundations of the SDA, it is instrumental to acknowledge this. It must be remembered that inequalities and poverty play a huge role in accessing resources, adherence to treatment regimens, follow up and nutrition. So, in these instances, social workers in health care perhaps need to have a greater focus on all the models of community work, but especially community development, and not just on case and group work. This view is echoed by Kaseke (2015) when he indicated that social workers need to reposition themselves by having a preventative and developmental focus and utilise community work as the main method of intervention.

A community practice model as suggested by Beytell (2002) may have difficulty in addressing the specialist counselling services that is required from social work in health care. The researcher proposes an integrated approach that focuses on the individual (micro), groups (meso) and communities (macro) as an instrumental part of the SDA for crossing the micro-macro divides. This is in line with the typology that is offered by Payne (2005, 2014) and is further represented

in the application of findings and recommendations of this research study. By only proposing a community approach the attention of individual and group interventions seem of lesser importance. But to make social work in health care more responsive does it only mean community practice or are there other aspects that should be addressed and incorporated such as developing culturally competent models? Few social workers in health care sources address cultural acknowledgement from a social work point of view. Ross and Deverell (2010) attempted to do so by addressing death and dying by acknowledging different cultural and religious views. Brown et al. (2018) addressed cultural determinants of the Zulu culture but from a medical point of view and not from a social work in health care perspective. Models of competence with regard to social work in health care in the South African context seem to be absent.

3.5 South African health care reform and the impact on social work in health care

The social work profession has been no stranger to transformation. Gregorian (2008) warned that the impact of restructuring or the transformation of the social work profession in health care, may have negative consequences as uncertainties may affect the impact of service delivery and the social workers' wellbeing. In particular Gregorian acknowledged the lack of understanding regarding the role of social workers in health by other colleagues and management. From Borst (2010), Gregorian (2008) and the WHO Technical Brief (2008), it is noted that any restructuring or transformation should be clearly communicated, and that consultation and effective training are of the utmost importance. Hill and Hupe (2014) compiled various positions on policy which included that policy must be purposive and a means to an end. Therefore, policy should have a specific goal or a need that should be addressed. Conversely, if policy is created devoid of a context that requires it or where it is unclear, challenges and confusion may be experienced as it is implemented. The above is of relevance if we consider the history regarding transformation of the South African context.

3.5.1 South African health reform

Transformation has been influenced by the political transition in South Africa. Benatar (2016), Dennill et al. (2007) and Venturino (2013) indicated that strategic changes in the South African health care system were based on the political transition. The aim of restructuring of the health care system has been equity in the accessibility of health care for all the people of South Africa and the formulation of various policies and legislation to impact the health care system (Dennill et al., 2007). As with the development of the White Paper on Social Welfare (Department of Welfare, 1997), so the White Paper for the Transformation of the Health System (Department of Health, 1997) was implemented. The White Paper for the Transformation of the Health System (Department of Health, 1997), as a framework in the health system, identified areas and processes of transformation such as the re-organisation of the health sector, focus areas for essential health services (e.g., mother and child health), the role of medical doctors and other professionals who form part of the health care system. Olver et al. (2011) and Bradshaw (2008) confirmed that the national health transformation focused on government reforms, re-engineering primary health care, implementation of the National Health Insurance (NHI), performance management and quality assurance. Benatar (2016) and Venturino (2013) indicated that the South African health care reform is principally focused on the public health care sector and geared at a district primary health care level. Furthermore, Venturino (2013) claimed that the initial health care reform instituted in 1994 did not have the desired outcomes and hence the second reform of primary district health care was necessitated in 2012. Venturino (2013) further warned that the economic disparities of South Africa need to be addressed for any health care reform to be successful. Ruff et al. (2011) echoed the gross inequality and ineffective health system and advocated for the resolution of the gross socio-economic dipartites. Kautzky and Tollman (2008) confirmed that the health reform was necessitated to address inequalities. Rispel and Moorman (2010) acknowledged the inceptions of several acts and policies as well as the focus on the millennium development goals (MDG) (now sustainable development goals) (SDG) to address health challenges.

The National Development Plan: Vision for 2030 (National Planning Commission, 2011) emphasised reaching the ideals of the primary health care strategy. In addition, the goals to be reached by 2030, include decrease in mortality, decrease in the burden of diseases, a ". . .significant shift in the quality, equity, effectiveness of the health care services" (National Planning Commission, 2011 p. 297), instituting of the National Health Care Insurance (NHI) and addressing the SDH (National Planning Commission, 2011). In addition, the targets also include revitalising the health care sector, the establishment of primary health care service teams and fostering trained health teams throughout South Africa (National Planning Commission, 2011). Heywood (2014) also confirmed that a major requirement of the health strategy was to grow the health care work force, referred to as the medical personnel. It should be noted, that included in these primary health team members are only doctors and nurses and no other professionals are mentioned. Additionally, documentations on the primary health care strategy clearly identify the roles of community health workers but not social workers. Scott et al. (2017) agreed that the re-engineering of primary health care promoted addressing the SDH. The three streams of primary health care are community outreach (also known as ward-based outreach teams), school health care teams and district clinical specialist teams (Scott et al., 2017). Here it is denoted that social workers are not acknowledged.

In considering addressing the SDH one would have expected that social workers may have been highlighted. The NASW (2009) stressed specifically that social workers should be considered and included in plans about health care reform. This is an important matter that is absent in most of the policies and reforms in South Africa.

The focus of transformation in the health care sector therefore focused more on restructuring the health care system, medical and nursing practitioners and not on other professional allied practitioners under which social work in health care is usually classified. The lack of

acknowledgement of the transformation of social work in health care suggests the possibility of limited awareness, or limited understanding of the contributions social workers make in health care. In addition, it might reflect the lack of acknowledgement or limited value placed on the role and contributions of social work in health care. More importantly this perceived lack of acknowledgement of the inclusion and transformation of social work in health care raises the question whether the integration of health services has been managed appropriately. Therefore, it is clear that transformation in the health care system brought with it many challenging situations.

Currently, as a result of the reform strategies the South African health care system is decentralised and divided into five levels. Levels 4 and 5 embody community and primary health care respectively, level 3 and 2 regional and secondary health care and level 1 central health care or tertiary health care settings (Conmy, 2018; FindDX.org, 2020). The different levels also embody different types of health care services delivered, as mentioned in chapter 1 where health care was defined (Conmy, 2018; FindDX.org, 2020). The Bertha Centre for Social Innovation & Entrepreneurship (n.d.) collapse the five levels into three tiers namely primary, secondary and tertiary health care, as described in chapter 1. Specialist medical treatment is situated in the tertiary tier. Conmy (2018) indicates that the health care system of South Africa is fragmented and yet the African Institute for Health and Leadership Development (2015) indicated that the medical teams are well qualified. GDH comprises of the same levels and multidisciplinary teams offers services to patients and families.

3.5.2 Impact of the South African health reform on social work in health care

The above discussion identified that social work was not considered as an important stakeholder in the transformation process during health reform in South Africa. Therefore, it is crucial that the impact of these changes on the social work profession is considered. Keefe (2010) indicated that because of disparities that may exist in health care service delivery, the role of the social worker

is of the utmost importance in dealing with inequalities. The question therefore is why social workers are not consulted or acknowledged in these processes.

The NASW (2009) reminds that social workers provide a range of services that is particularly valuable when changes occur. More importantly, NASW (2009) advocates for professional social workers to be included on all national planning or policy developing bodies.

Darnell and Lawlor (2006), Fairfax and Feit (2015) and Shaw (2012) addressed the impact of policy or reform on social work in health care. Darnell and Lawlor (2006) indicated that social work in health care is particularly efficient in alleviating disparities. However, due to the needs of the MDT and policy reforms, the role of social work has been minimised to discharge planning. But even in discharge planning, social workers do exhibit immense skills in linking patients and families with community resources (Darnell & Lawlor, 2006). This alone makes a strong call for revitalising social work services in health care.

Fairfax and Feit (2015) highlighted the policy and practice discourse as of relevance for social work. They, indicated that social workers have been proactive in recognising the disparities in health, applying social justice and addressing equity. As policies or reforms are implemented, social workers need to familiarise themselves with critical approaches and strategies to address disparities that may also include engaging with stakeholders, ensuring participation and self-determination, fostering tolerance and anti-discriminatory practices (Fairfax & Feit, 2015; Glaister, 2008; Schild & Sable, 2006). Therefore, health reform brings with it an entire transformational approach or diversification that social work in health care should employ. The question is whether this transformational approach in health care concurs with the SDA?

It should also be noted that in line with the transformational agenda, the scope of the roles of social work in health care should be more than just clinical, and it should also consider the greater communal aspects. If this is of importance, we need to also ask if it is feasible. Perhaps, at primary and secondary levels of service delivery, the broader macro practice is more feasible than at a tertiary level where the expectation may be more on the efficiency of the clinical roles of social workers. In the light of this, social workers in health care settings should critically reflect on if, and how they will attempt to creatively respond to the macro needs.

3.6 Summary

This chapter provided an overview of the history of social work in general and specifically in health care. It was highlighted how the foundations of both social work and social work in health care stems from charity work globally, regionally and in the South African context. It was also pointed out that the history of social work is in general well recorded globally, regionally and for the South African context. Globally the history for social work in health care is well documented. However, challenges were pointed out in recounting the history of social work in health care in the African and South African contexts. The roles that social work play is varied and manifold. An important consideration is that throughout history it would seem that social work roles and the profession's value were influenced and determined by the needs of policies and medical teams. Why should this be a reality for social work and not for other medical team members? South Africa's current health reform has also received attention and the impact of this was explored. In essence social work in health care has a very important role to play but the profession seems devalued as it is not consulted or acknowledged in most policy documents.

The following chapter describes the SDA and explores the application and implementation of the SDA.

CHAPTER 4
THE SOCIAL DEVELOPMENT APPROACH

4.1 Introduction

In addressing the very complex nature of the social development approach (SDA), this chapter provides a brief historical overview of the SDA and its implementation. In this delineation emphasis on the clarification of the concept of SDA, the fundamental purposes, principles and developmental social work are offered. This discussion foregrounds the complexity of defining and understanding the SDA. The White Paper on Social Welfare of 1997 (Department of Welfare, 1997) is identified as the major policy implementation strategy for social development in South Africa. The discussion reveals the reasons for the challenges experienced by social workers in the implementation of the SDA. The nexus of transformation of South Africa, policy changes and the implementation of the SDA emphasises the necessity for the reframing of the position of social work in health care to enable successful implementation of the SDA.

4.2. History of the social development approach

The origins of social development may be linked to the developing world, as according to Nicholas (2014). In line with the above, Midgely (1995, 2001, 2010, 2014) indicated that in a response to redress the impact of colonialism, countries had to reconstruct and reform. The SDA is therefore a proactive response to address inequality, colonialism and poverty. The ultimate aims of implementing the SDA are therefore to decolonise, transform or reform society, eradicate poverty, build human capacity, enforce equality and equity of a country.

Noyoo (2015a) provided an extensive overview of the process of the inception of social development. According to Noyoo (2015a) the United Nations (UN) declared both the decades of 1960's (in January 1961) and 1970's (in October 1970), decades of development. Noyoo (2015a)

and Patel (2015) highlighted four major UN initiatives that supported the global implementation of the SDA. These are

1. The Summit of Ministers responsible for social welfare in 1968. The aim of this summit included to establish and assess the status of social welfare, gain understanding of potential of the potential thereof and consider a new strategy for social welfare.
2. The Brundtland Commission in 1987. This was also known as the World Commission on Environment and Development. The objective of this Commission was to highlight sustainable development strategies.
3. The Copenhagen World Summit for Social Development on 6 - 12 March 1995. This was a major milestone as this was the largest gathering of world leaders that reach a consensus in committing their countries to the implementation of social development. This Summit was reconvened in June 2000 to establish the extent of the implementation of the SDA.
4. Thereafter the MDG was established in 2005. This was later replaced by the SDG in 2016 (Noyoo, 2015a; Patel, 2015).

Most authors like Gray (2014), Homfeldt and Reutlinger (2008), Nicholas (2014), Patel (2010) cited the Copenhagen World Summit on Social Development as instrumental in creating a common vision for the implementation of the SDA. However, Noyoo (2015a) indicated that the discussions on the SDA occurred from the 1960's. Perhaps the fact that 160 nations agreed to implement the SDA in Copenhagen 1995, made this a landmark summit (Gray, 2014; Nicholas, 2014). By 1 January 2016, the sustainable development goals (SDG) replaced the MDG and were developed in line with this SDA and aimed to foster prosperity and equality (United Nations, 2019).

After the Copenhagen World Summit for Social Development in 1995, South Africa developed the White Paper on Social Welfare, 1997 (Nicholas et al., 2014; Noyoo, 2015b; Patel, 2015). This directed the future for social welfare services for South Africa. Midgley (2001), Nicholas et al. (2014) and Patel (2015) indicated that this policy required a paradigm shift, set out priorities for the country and identified the levels of social services interventions. Kaseke (2015) indicated that *this* White Paper enabled social workers to reposition themselves, to thrust the developmental agenda and community work to be the dominant method of intervention. The White Paper on Social Welfare (Department of Welfare, 1997) furthermore ushered in major changes in transforming the South African welfare sector which previously encompassed institutionalised and remedial service delivery to the focus on the SDA principles of equality, human rights, welfare pluralism, democracy, economic development strategies, partnerships and collaborations (Gray & Lombard 2008, Midgley, 2001; Patel 2010).

4.3 Delineating the social development approach and developmental social work

Kaseke (2015) indicated that all social workers need to be clear about the meaning and promotions of the SDA. Demarcating the SDA and developmental social work for this study is therefore important as it had direct influence on the purpose of this research exploration.

4.3.1 The social development approach

Lombard and Warire (2010) referenced Midgley in stating that the origins of social development is in Africa. Payne (2005, 2014) and Midgley (2014) both highlighted that social development is not only a difficult concept to define and understand, but also challenging to implement. Estes (1998) at the Conference for Developmental Social Work indicated that the SDA is a multidisciplinary field of practice and crosses geo-political borders. Midgley (2010) reiterated that the SDA is both an interdisciplinary academic field and policy interventions. Noyoo (2015a) echoed this sentiment and clarified that development was always seen as economic development.

This was largely based on the assumption that economic development will result in the subsequent decrease in poverty, unemployment and in the upliftment of people (McKendrick, 2001; Noyoo, 2015a). Estes (1998) highlighted eight levels of intervention for social development as individual and group empowerment, conflict resolution, institution building, community building, nation building, region building and world building. This provides a clear progression or rather a continuum of development of the SDA from individual to the world. Noyoo (2015a) suggested the acknowledgement of Sen's view of development which focuses on human capabilities as well as the five freedoms. These freedoms are freedom, economic facilities, social opportunities, transparency guarantees and protective security (Noyoo, 2015a). Furthermore Noyoo (2015a) suggested key concepts that embody social development namely: capabilities, assets, empowerment, strengths and social capital. In addition, Noyoo (2015a) stated that the core of the SDA is concerned with social change, its impact and transformation of societies.

Gray (2014) also indicated that development is not only controversial but also indeterminate, intangible and an open-ended area of practice. For South Africa, the motivation for development is remedying the inequality of apartheid. Development in the South African context is furthermore perceived as the improvement in the welfare of people, economic growth, being redistributive in addressing inequality and poverty, acknowledgment of state intervention and enabling participation of all citizens (Gray, 2014).

Midgley (2014) highlighted that social development embodies a comprehensive macro perspective that facilitates dynamic changes in integrating both social interventions and economic development. Patel (2015) indicated that the social development approach requires both state and non-state stakeholders' involvement, and that social investment strategies to be integral in this approach. McKendrick (2001) stated in essence that the main aim of social development is poverty alleviation. He highlighted that social welfare is an important role player in this regard. In view of

this, South Africa developed the White Paper on Social Welfare in 1997 which addresses social development. Homfeldt and Reutlinger (2008) stated that the goal of social development is contributing to the social and economic wellbeing of people and encourages self- determination.

Whereas the other authors all confirm the broad and multifaceted understanding of social development, Elliot (2012) offered a perception that social development is a progressive model of social work that encourages social justice and focus on empowering the oppressed. As may be denoted the views of the SDA is varied. The unifying factors of the SDA are the fundamental tenets of social development as highlighted in The White Paper on Social Welfare and are summarised as equality, human rights, welfare pluralism, democracy, economic strategies, partnership and collaboration (Gray & Lombard 2008, Jones and Truell, 2012; Midgley, 2001; Patel, 2010; Truell & Jones, 2012). The five tenets as highlighted by Patel (2010, 2015) are unpacked below.

(a) The rights-based approach: This approach encompasses the goals of "…achieving social justice, minimum standards of living, equitable access and equal opportunity to services and benefits, and commitment to meeting the needs of all South Africans with special emphasis on the needs of the most disadvantaged in society." (Patel, 2015, p. 58). Therefore, essentially, this principle is to uphold the basic human rights, wellbeing and active participation of all citizens as determined by the Constitution of South Africa (Patel, 2010, 2015).

(b) Economic and social development: According to Patel (2015) this refers to close interrelation of economic and social development. It acknowledges the redistribution through social investment. There should an emphasis on human capital investments, asset-based strategies and social capital formation (Patel, 2015).

(c) Democracy and Participation: This refers to the position of a democratic society where people have a say and the opportunity to participate accordingly (Patel, 2015). This stems from South Africa's previous history of political inequality.

(d) Social Development strategies: These highlight that welfare or achieving the wellbeing of others should always embody a partnership approach or a collective strategy to meeting the needs of others (Patel, 2015). Five partnership strategies are highlighted by Patel (2015), namely, welfare pluralism, voluntarism and enabling policies, a non-governmental and non-profit organisational (NPO) model, balancing government and NPO roles, and innovations. As can be denoted this is a comprehensive approach to partnerships.

(e) Macro and micro divide: This principle directly attempts to refocus the attempts of service delivery intervention. Social welfare's focus before the implementation of the SDA was mostly on micro intervention strategies (Patel, 2015). Macro strategies received limited attention. The SDA requires that service delivery should transcend this divide whereby one method of intervention is not more important than another (Patel, 2015). It should also be acknowledged that sustainable macro strategies are required to deal with poverty, and inequality (Patel, 2015).

Therefore, social development may be viewed as the umbrella concept that combines both social welfare interventions and economic empowerment strategies. The difficulty in implementing this strategy is due to the varied understandings of what social development is and the diverse implementation strategies that exist in different countries (Midgley, 2014; Patel, 2015; Payne, 2005, 2014).

4.3.2 Developmental social work

Gray (2014) viewed developmental social work as more comprehensive than community development, as it acknowledges the influence of political and economic factors. Gray (2014) acknowledging Lund (2007), stated that it is essential for social workers to comprehend the economics of welfare and the importance of social security grants to fulfil major roles of social development. Gray (2014) highlighted that the social security system is important for the 'inclusion and mobilisation of the poor'. Apart from this, the value of therapeutic intervention has been indicated as instrumental for the healing needed for the country especially considering the conditions in South Africa. This unique view therefore values social security and therapeutic intervention as important. In fact, Gray (2014) argues that the debate of the relevance of case work in the SDA is irrelevant, unnecessary and opposing social development. It is well known that policy makers view case work as remedial and focused on the individual; but this does not decrease the value for case work for individuals and families. Gray (2002, 2014) furthermore indicated that developmental social work in South Africa is the translation of policy, the White Paper on Social Welfare (Department of Welfare, 1997), into practical means, in order for social service professionals to implement it. Estes (1998) clarified developmental social work as the realisation of people's full potential and the enhancement of sustainable practices in meeting their basic needs.

Nicholas (2014) highlighted that developmental social work is directly involved with poverty eradication, prevention, community development and cultivating strengths through community activities. Masuka (2015) clarified developmental social work as a paradigm that focuses on people's change of social and economic circumstances. Masuka (2015) also referenced the work of Hall (1990) and Kaseke (2014) and stated that developmental social work is a paradigm of social work practice that is comprehensive, change-oriented and attempts to address the social problems faced on the African continent. This developmental social work approach inclines to assimilate casework with group and community work. Therefore, the approach spans the three

domains of social care, social control and social change (Masuka, 2015). Lombard and Wairire (2010) demarcated developmental social work as holistic and an integrated approach in that it draws on anti-discriminatory practices for social and economic wellbeing. Lombard and Wairire (2010) further accounted the progress of developmental social work in South Africa and Kenya. In South Africa one of the milestones for developmental social work was when social work was declared a scarce skill (Lombard & Wairire, 2010).

Hochfeld et al. (2009) and Kurevakwesu (2017) offered several reasons for the reluctance of social workers to embrace developmental social work. These are as follows:

1. Social workers see developmental social work as different to social work due to the focus on economic development issues.
2. There is a lack of clarity of what social development entails.
3. A lack of knowledge about the positives of adopting a social development view exists.
4. Due to the unpredictability and oppressive conditions, it is difficult for social service professionals to employ the dominant principles of self-determination, empowerment and participation.
5. The lack of resources has been used as an excuse to deter the promotion of the social development perspective.
6. There is limited or no awareness regarding developmental social work.

Developmental social work embraces the professional social work values and principles and the principles and values of the SDA. Therefore, it is focused on enforcing the rights of all, promotion of self-determination, democratic participation, social and economic wellbeing by the proactive commitment to poverty alleviation.

4.4 Nexus of transformation, policy and the social development approach implementation

It is imperative, especially in the South African context to explore the impact of transformation and the implementation of the SDA on social work and specifically to social work in health care, due to the expected mandate of the socio-economic upliftment of the people of South Africa. Are social workers in South Africa really reluctant to implement developmental social work as suggested by Kurevakwesu (2017), and are they informed and knowledgeable about the SDA? This discussion will attempt to answer this as based on current available literature.

The transformation of South Africa, as underpinned by the Constitution (1996) encompassed strategic changes for the entire country. Midgley (2001) stated that the DSD's focus with the implementation of the principles of the White Paper on Social Welfare (Department of Welfare, 1997) were to reform inherited programmes, to establish a new developmental social welfare focus and to innovate service delivery. Ensuring that the fundamental tenets i.e., equality, human rights, welfare pluralism, democracy, economic strategies, partnership and collaboration (Gray & Lombard, 2008; Midgley, 2001; Patel 2010) of the SDA were met, the DSD realised the need to both retain and recruit social workers in all sectors (DSD, 2006a). The success of this strategy is questioned in considering that Nicholas (2014) reported that recorded ratios for social workers to the population by 2014 was 1:5 000 in urban areas and in rural areas 1:3 000. In their study, Dlamini and Sewpaul (2015), highlighted that in a particular agency, only fifteen (15) out of 37 social workers had access to computers. Earle (2008) and Potgieter and Hoosain (2018) indicated that the poor working conditions, limited resources and high caseloads of social workers in South Africa impedes effective service delivery. The Health Systems Trust (2013) also confirmed that in 2011, only 21% of social workers were employed in primary health care facilities and only 11% had the required equipment. A major need for social workers and in particular in health care settings are evident. A lack of viable basic resources such as office space and equipment may be still a very contentious issue considering the profession's ethics, the delivery of effective services

and meeting desired outcomes. If there is a shortage of social workers this may have a direct impact on the service delivery required, especially if the social workers need to fulfil the mandate of the SDA. Furthermore, even if South Africa has the required number of social workers, the question is will there be basic resources available for them to deliver effective services in meeting the SDA mandate.

The DSD (2006a) in its Retention and Recruitment Strategy reaffirmed the value of the implementation of the SDA as well as formulated the Integrated Service Delivery Model (ISDM) (DSD, 2006b). It was believed that this approach and model provided adequate clarity and training for all social workers employed in any Government sector in South Africa. This ISDM encompasses the principles of the White Paper on Social Welfare and identifies the levels of care (DSD, 2006b; Nicholas, 2014). It provides very limited if any strategies to implement developmental programmes directed at poverty alleviation. The integrated service delivery model was developed for the social workers employed in South Africa. It is not known if this model is also applicable for and implemented by social workers employed by the Department of Health. Whether this integrated service delivery model is a practical attempt to implement the SDA via developmental social work as suggested by Gray (2014) is up for debate. Is this strategy practical enough especially if one considers the limited practical strategies offered by the model?

In retaining social workers, Government's strategy suggested job rotation and incentives (DSD, 2006a). The Retention and Recruitment Strategy is only positive about the implementation of the SDA and the ISDM, and yet there has been some discontent, resistance and a lack of training regarding the SDA as indicated by Hölscher (2008), Dlangamandla (2010), Gray and Lombard (2008) and Kurevakwesu (2017). Hölscher (2008) highlighted that even though social workers may not be content with the current state of affairs considering the implementation of the SDA, there is limited critical engagement on this matter largely due to general inequality that is the

disparity between employee and employer. Are these recorded resistances and discontent a true reflection of the current state of affairs, despondency due to working conditions or just generally workers who feel they have the right to complain?

Cullen (2013) indicated that a new paradigm to social work in health care should have transformational leadership at its core. In turn when there are changes in the health care system, Cleak and Turczynski (2014) suggested clarity in job descriptions and the new tasks of social work as imperative. Cleak and Turczynski (2014) stressed that due to the massive role changes that social workers in health care have to contend with, there may be a neglect of important roles like advocacy and social justice. This is of relevance in considering the mandate of South Africa for the implementation of the SDA. As literature does not provide details of the policy changes for social work in health care in South Africa this research study contributed to this niche.

Borst (2010) indicated that social work in health care offers services that benefit the client and stressed the importance of the clarity of roles. It is vital with policy changes in health that social workers understand the expectations of them, their role and responsibilities. According to Borst (2010), this may not always be the case where policy is implemented and not clear. The success of the implementation of transformation is therefore dependent on clear directives, appropriate consultation and appropriate training to be offered to the relevant parties. In the light of the above, it was uncertain prior to the conducting of this study, if clear directives had been provided to social workers in health care in the GDH. This definitely warranted exploration. The WHO Technical Brief (2008) on integrating health services highlighted the importance of co-ordinated services and change management. This will ensure efficacy of the health system. The integrated service delivery model provides clear principles and values that social workers should espouse to, but the gap in poverty alleviation strategies and improvement of social and economic wellbeing may leave social workers ill equipped. Regarding social work in health, will social workers refer clients to

community-based services or be dominantly involved in community education strategies? A bigger question is how equipped are social workers to produce poverty alleviation strategies or facilitate economic wellbeing?

Riaz and Sarfaraz (2015) indicated that in Karachi, Pakistan, medical social work is closely related to the broader concept of social development. It grew out of humanitarianism and democratic ideas thereby upholding the principles of social development (Riaz & Sarfaraz, 2015). This indicates that the values and strategies of social development and social work in health care are not far removed. Therefore, once again it can be surmised that the principles of an ISDM are achievable.

Pockett and Beddoe (2015) highlighted that globalisation impacts on the health and wellbeing of clients. Convergence of health and social inequities is also linked to power relationships in communities, local structures, national structures and globally (Pockett & Beddoe, 2015). Social workers therefore need to be aware of the cumulative impact of inequalities and inequities on the daily lives of individuals. Kaseke (2015) however indicated that globalisation is working against social development. Be that as it may, social workers in health care cannot ignore the social and economic wellbeing of clients and need to proactively seek measures of development. It is evident that where there is a convergence of the social and health circumstances that influence the wellbeing of people (referred to the social determinants of health), a proactive approach is needed, and therapeutic counselling may not be what is required under these circumstances. This seems to correlate well with Beytell's (2002) views regarding the ineffectiveness of counselling and that a community-based approach should be implemented by social workers in health care.

Giles (2009), Keefe et al. (2006), and Pecukonis et al. (2003) particularly addressed the need for the proactiveness of social workers in the transformation process and policy implementation. In particular Keefe et al. (2006) highlighted that policy may be influenced from the bottom up by

mobilising patients with social action. Pecukonis et al. (2003) in turn highlighted that policy changes should also affect the curriculum for developing social workers to practice in health care. Giles (2009) urged practitioners and educators to creatively imagine transformation and making a difference in the client population on an individual and community level. It is clear that a total reimagining may be required that involves the training of social workers, mobilising clients to address social ills and ensuring that a difference is made in clients' lives.

4.4 Summary

Transformation associated with the implementation of the SDA brought about numerous challenges. The discussion highlighted the complexity in understanding and implementing the SDA and developmental social work. At its core, the SDA has enforced social justice, remedying inequalities and uplifting people. The challenges faced by social workers in implementing the SDA especially with regard to the implementation of economic strategies were described. Transformation in South Africa and the SDA are inextricably linked. The lack of resources and poverty alleviation strategies complicates the full realisation of the SDA and inevitably the transformation of South Africa. Developmental social work aligns itself with the SDA. The exploration of the SDA within social work in health care noted a broad alliance with regard to the overt principles of the SDA. Notably the social inequalities impact the wellbeing and health of people. Social work in health care in applying the SDA principles are able to address the wellbeing of people and social inequality. This very nature of social work in health care, the nexus among poverty, inequality and wellbeing requires the exploration of the SDH. There is a perceived link between the SDH and the SDA. The next chapter will address the SDH and clearly point out the link with the SDA.

CHAPTER 5
THE SOCIAL DETERMINANTS OF HEALTH

5.1 Introduction

This study's intention was to explore and describe the implementation of the SDA to social work in health care in the South African context. As social work in health care interfaces with health and biopsychosocial influences, the exploration of the SDH has been deemed imperative in this study. One cannot explore aspects in health without addressing the SDH. Apart from this, the SDA has a noticeable link with the fundamentals of the SDH, as established by the World Health Organisation (WHO). This chapter will provide a historical overview of the development of the SDH and the motivation for its existence. It will be highlighted that the development of the SDH was necessitated by inequalities and unequal access to health care. The delineation of the SDH, an overview of its implementation globally and in the South African context are described. The discussion will elucidate the link between the SDA, the SDH and social work as well as emphasise the valuable input social work can make towards the realisation of equable and accessible health care. The similarities between SDH, SDA, SDG and social work are shown through the common links with social justice and the promotion of wellbeing.

5.2 History of the social determinants of health

In the quest for social justice for *'all peoples of the entire world'* the World Health Organisation (WHO) established the Commission for Social Determinants of Health (CSDH) in March 2005 (Bhattacharya, 2010; Bywaters & Davis, 2012; Rispel & Nieuwoudt, 2012/2013; WHO, 2010).

Bywaters and Davis (2012) furthermore specified that the historical development of the SDH started with the implementation of the Alma-Ata Declaration in 1978, which addressed the issues

surrounding access to primary health care. Friel and Marmot (2011), and Rispel and Nieuwoudt (2012/2013) also recognised the Alma-Ata Declaration as a precursor for the CSDH. They, as well as Scott et al. (2017) furthermore acknowledged the inception of the Millennium Development Goals (MDG), later replaced be the Sustainable Development Goals (SDG), as a precursor for the establishment of the CSDH. From 2005 to 2008, it was the Commission's purpose to enhance the promotion of health equity by encouraging a global movement (WHO, 2010). It was always the intent that the Commission would be in existence for a brief period and that the mandate was to be handed over to the different countries that were signatories to WHO and the United Nations (UN) (Bhattacharya, 2010; Perlman, 2010).

In 2008, the WHO Final report by the CSDH, three ways to remedy the health care dilemmas were identified. These were firstly, improve daily living conditions, secondly, tackle inequitable distribution of power, money and resources and thirdly, measure and understand the problem and assess the impact of action (Bhattacharya, 2010; Forde & Raine, 2008; Perlman, 2010; WHO 2008, 2010; WHO CSDH, 2007a, 2007b).

Even though the Commission offered its last report in 2008, further discussion has permeated the global context. Donkin et al. (2017) highlighted that after the final CSDH meeting the "Rio Political Declaration on Social Determinants of Health was adopted by 125 member states during the WHO World Conference on 21 October 2011." (p. 2). As with the original report from the CSDH (WHO 2008, 2011, 2012), this commitment also called upon the reduction of health inequalities. This declaration was then further cemented by the UN General Assembly's adoption of the political declaration on the Prevention and Control of Non-communicable Diseases (Donkin et al., 2017; UN General Assembly, 2011). In 2012, the Rio Declaration was endorsed by the 65th World Health Association which in turn was endorsed by the UN Resolution on Global Health and Foreign Policy in December 2012 (Donkin et al., 2017; UN General Assembly, 2013). This

resolution urged all member states of the UN to accelerate universal health coverage (Donkin et al., 2017; UN General Assembly, 2013). In 2015, the General Medical Assembly passed the Declaration of Oslo in Moscow (Donkin et al., 2017). It codified the importance of addressing the SDH and the actions that should be taken (Donkin et al., 2017). Therefore, to date all members states of the UN, are compelled to address the SDH as finalised by the CSDH as well as by the Rio Declaration and the UN Assemblies.

5.3 The delineation of the social determinants of health

Offering comprehensive health care to all may be very challenging. Heiman and Artiga (2015) stated that many factors may impact on the individual's health. These factors, whatever it may be, have a significant impact on the health of an individual and numerous complexities. These complexities should be addressed by the SDH. The SDH acknowledge the social and economic factors that may impact on the wellbeing or health of individuals, groups and communities (Newfoundland & Labrador Association of Social Workers (NFLASW), 2016), and any other factors, adverse conditions or inequalities (e.g., age, gender, employment status, political, cultural, economic factors amongst others) that may impact on an individual's health status (Craig et al., 2013; Moniz, 2010; Scott et al, 2017).

The SDH may be seen as the following factors that either promote or hinder health outcomes:

1. Economic Stability which may include employment, expenses, debt, medical costs or bills.
2. Neighbourhood and the physical environment which include housing, transportation, safety, parks, geography, water and sanitation.
3. Education which includes early childhood development, literacy, vocational training.
4. Food which acknowledges access to food, hunger, malnutrition and so forth.

5. Community and social contexts incorporate social integration or inclusion, support, discrimination, stress, community empowerment or development.
6. The health care system may include accessibility, health care coverage, quality and competency, health care settings, linguistic and cultural competence (Bhattacharya, 2010; Craig et al., 2013; Davidson, 2015; Forde & Raine, 2008; Gribbin & Sadana, 2010; Moniz, 2010; NFLASW, 2016; Perlman, 2010; Scott et al., 2017; WHO, 2008, 2010; WHO CSDH, 2007a, 2007b).

In addressing the above SDH, Bhattacharya (2010), NFLASW (2016), Perlman (2010); WHO (2008, 2010) and WHO CSDH (2007a, 2007b) all indicated that in considering the three main goals of the CSDH the following should be noted:

1. To improve daily living conditions by enabling access and equity. Stringent efforts should be made to the development of healthy communities. Fair and acceptable employment practices including job security should be evident. If needed there should be comprehensive social protection and universal health care throughout the life span.

2. To tackle the inequitable distribution of power, money, and resources by the evidence of health equity in all policies, systems and programmes. Inclusion of all as gender equity should be maintained. Fair, responsible market and good governance practices should be strived towards, and

3. To measure and understand the impact of implementing the SDH imply continuous monitoring, research and training should be undertaken.

5.4 The implementation of the social determinants of health

Even though the CSDH was short lived; the impact and effects of the CSDH is ongoing. This section will consider some of the major implementation strategies and progress that has occurred

globally and in South Africa. In considering the implementation, it is also necessary to consider the relationship between social work and SDH.

5.4.1 Global implementation of the social determinants of health

Success of addressing the SDH is dependent on intersectoral collaboration. CSDH (WHO, 2010) prescribed that these collaborative intersectoral partnerships should include not just medical practitioners but representatives of all spheres especially economic spheres. Effective resolution of the SDH in accessing health are usually due to some economic constraint. However, most of the health reform strategies worldwide, but especially in South Africa acknowledged only medical practitioners. Further non-negotiable directives of the CSDH (WHO, 2010) to all signatories to the WHO and the UN, are global monitoring and accountable financial practices linked to policy coherence. Compulsory monitoring and evaluation of performances are necessitated. Apart from this, there should be overwhelming evidence of the response to the mandate that also involves a clear dissemination of information of the SDH to all (WHO, 2010). Ministers of Health, in every country have been identified as the accounting officers for addressing the SDH by the CSDH (WHO, 2010).

Schrecker et al. (2008) also identified the gaps in the implementation and reiterate the call of the CSDH for a co-ordinated global action. Forde and Raine (2008) reiterated the importance of public health policies to place the individual at the centre of addressing the SDH. In their opinion, this aspect has been neglected considerably and calls for not only social actions but also equitable distribution of resources and collaboration with individuals in communities (Forde & Raine, 2008).

Johnson et al. (2008) reviewed the actions of Canada in response to the mandate of the SDH and indicated that even though professional development and educational opportunities have proven effective in addressing and improving community health, health disparities remained.

Furthermore, national strategies that defy political, judicial and geographic barriers are encouraged (Johnson et al., 2008).

Even though Forde and Raine (2008), Johnson et al. (2008) and Schrecker et al. (2008) raised the health inequalities by 2008 already; Donkin et al. (2017) reiterated the existence of health disparities on a global scale by 2017. The WHO (2015) reviewed the global response to the Rio Declaration. By 2013, findings were that there was a positive response to the Rio Declaration. In 2013, member states of Africa, the Americas, Europe, Eastern Mediterranean, South East Asia and Western Pacific regions either had a plan, or a framework in place to address the SDH. The regional countries that were members states of the UN adhered to the progress of the mandate (WHO, 2015).

Donkin et al. (2017) in their review and analysis of world trends in addressing the SDH, recorded the progress according to the regions, as identified by the WHO (2015), as Europe, North America and Canada, South America, North Africa and Middle East, Sub-Saharan Africa, Asia and Australia. Donkin et al. (2017) also indicated that implementation of policies addressing the SDH, as reported by WHO (2015), is met with mixed results. For the European Union they (Donkin et al., 2017), stated that 53 member states, signed an agreement to include Health in All Policies (HiAP) in 2015. Canada has been very progressive in promoting the research agenda for the SDH. Former USA's President Obama made several policy changes to enable access of health care for all. There, however, seems to be a huge discrepancy between the progress regarding assimilation of the mandate of the CSDH in the South American countries. These countries are however focused on achieving the mandate of the SDG (Donkin et al., 2017). Northern Africa and Middle eastern countries are engaging each other on the SDH. The process for the Sub-Saharan region is spear-headed by the President of Zambia who established a ministry for the sole purpose of achieving the CSDH mandate. Kenya, Nigeria, South Africa and Zimbabwe have expressed their

eagerness to collaborate on this matter (Donkin, et al., 2017). Australia's political changes in 2013 resulted in minimising the CSDH mandate. According to Donkin et al. (2017) the regions that seemed to have shown the greatest achievement with regard to satisfying the mandate of policies addressing the SDH is that of Asia and the Pacific region. This region's commitment to equitable health care is manifested in China's continual health innovation, Bangladesh's increase in life expectancy and Thailand's decrease in the child mortality, amongst others (Donkin et al., 2017).

It appears that globally the majority of countries, per regional reports, have made a concerted effort to pledge their commitment to the SDH agenda. The success of the addressing the SDH has varied results and is complex to report on.

5.4.2. South African implementation of the social determinants of health

The South African response to the addressing the SDH, has been non-descript. By 2011, the South African health system was still faced with a great deal of challenges and unequal health disparities (Eshetu & Woldesenbet, 2011; Omotoso & Koch, 2018; Ruff et al., 2011). Eshetu and Woldesenbet (2011), Omotoso and Koch (2018) and Rispel and Moorman (2010) indicated that in an attempt to address the health disparities and the then MDG, South Africa developed several acts and policies.

Rispel and Nieuwoudt (2012/2013), further identified that the role of the National Development Plan: Vision for 2030 (National Planning Commission, 2011) offered a health strategy to address the SDH. The National Development Plan addresses plans for the health system but has limited focus on the SDH (National Planning Commission, 2011). This plan just reiterated the three main goals offered by the CSDH in 2008 with no specific strategies in place to achieve the mandate. It must however be noted that this plan provides an overview of addressing all the sectors important to eradicate poverty and inequality, and the development of South Africa (National Planning

Commission, 2011). It appears that the assumption is that in addressing the various sectors in South Africa, the SDH will automatically be addressed.

The WHO (2015) recorded that by 2013 South Africa has agreed to the health promotion strategy developed by the WHO Regional Office for Africa. Ataguba et al. (2015) acknowledged that South Africa has tried to address the SDH but still requires increased fiscal government support in developing key sectors and infrastructure and an improved health system that will deliver comprehensive health care.

Scott et al. (2017) confirmed that the SDH has been tabled on the health agenda and suggest that the manner of implementing measures to address the SDH in the South African context is characterised by the focus on re-engineering primary health care. They also acknowledged the role of the National Development Plan to redress poverty and all inequality. As part of the re-engineering of primary health care, the plan entails the appointment of a multitude of community health care workers who will address various SDH (Omotoso & Koch, 2018; Scott et al., 2017). Apart from a National Development Plan, the local governments also need to play their parts with regard to the physical environment and infrastructure such as water and sanitation. For further promotion of the CSDH mandate, Scott et al. (2017) also encouraged that South Africa follows suit like Europe to include Health in All Policies (HiAP) and awareness creation of the SDH via media. Even though Omotoso and Koch (2018) acknowledged and reconfirmed all the policy interventions, the re-engineering of the primary health care sectors and South Africa's commitment to address the SDH, little changed and minimal progress has been made. It must however be mentioned that South Africa has made health care free for children below six years of age (National Department of Health, 2019) and the instituted social grants for alleviating poverty (Rossouw, 2017), trailblazing treatment strategies for the treatment of HIV/ AIDS like Odimune (Southern African HIV Clinicians Society, 2014), a decrease in HIV related infections (Avert.org,

2020) and a decrease in the infant and mother mortality (Bamford et al., 2018). This is perhaps not overtly linked to the SDH but seems to address the SDH agenda and fulfil the mandate.

As evidenced in this discussion, addressing the SDH in South Africa are attempted mainly by policy intervention and re-engineering the primary health care system. Additionally, limited concrete strategies are noted and perhaps a co-ordinated strategic effort and report needs to be produced. The fragmentation of departments and service delivery in South Africa may be the reason for the lack of a coherent picture of the SDH in South Africa.

5.4.3 The social determinants of health and social work

Backwith and Mantle (2009) reflected that the CSDH did not address the value that social workers may contribute to addressing the SDH. This is not just of relevance to the SDH but there are many instances as indicated in the strategies for South Africa, where the value of social work is not addressed. This lack of acknowledgement should be reviewed and addressed by social workers.

Bywaters and Ungar (2013) shared that social work research may have an instrumental impact on the globalisation of health especially with regard to facilitate the SDH i.e., addressing poverty, climate change, conflict and access to health care. Marmot (2005) indicated that the inequalities associated with the SDH and the focus should be on meeting the human needs by focusing on wider social policy. Moniz (2010) clarified that the SDH is a biopsychosocial perspective, and specifically focus on the role of social work in achieving health equity. Moniz (2010) and Backwith and Mantle (2009) highlighted that social work is committed to social justice and equality, and therefore instrumental in achieving the outputs when addressing the SDH. Rine (2016) stated that that responding to the SDH is an important challenge that social work in health care should respond to. Craig, et al. (2013) highlighted that the SDH fits well with social justice of social work values and the ecological model because it acknowledges a broad context of

individual functioning. This links with Hugman's (2009) view that the person in environment perspective in terms of radical social work, is about understanding of the structural causes of social and personal needs which therefore address the environment. This is the biopsychosocial model utilised in health care (Craig et al., 2013). In summary, the importance of social work in health care is emphasised by Craig et al. (2013) in enacting social justice, but also in meeting the mandate of the social determinants of health. The values of social justice and equality as previously highlighted are also core principles of the SDA. These aspects are also well represented in the SDG.

Bhattacharya (2010) highlighted that the CSDH indicated three specific strategies to achieve health equity namely improving daily living conditions, equal distribution of power and the development of new perspectives to address problems. Moniz (2010) also indicated that social work needs to contribute to producing literature in the field of the SDH. The last strategy was particularly appropriate for this study as it encourages the formulation of models to change current problematic situations in health and encourages assessment of effectiveness of actions.

Backwith and Mantle (2009) reflected on the community practices in Cuba and the proactive role social workers play. They issued a call for review of social activism of social work in health care especially in India, South Africa and Nicaragua (Backwith & Mantle, 2009). The need for this request indicated the limited transformative strategies employed by social workers. Doostgharin (2010) reflected on the empowerment role of social work in addressing inequalities in health care in Iran. Doostgharin (2010) further boldly elaborated that the SDH is preventable with social work and foregrounded that social workers in health care are vital in Iran. In fact, they are the first point in accessing health care. Ali and Rafi (2013) also acknowledged the value of social workers in health care in Pakistan in fulfilling the role of liaison, arranging medicines, assessment of circumstance and linking people with employment opportunities. Doostgharin (2010) stressed that

health care inequalities should be the concern of policy makers and social workers. In addition, Bywaters and Davis (2012) indicated that health should be the mandate for all social workers. Fairfax and Feit (2015) indicated that social workers have identified health disparities and the impact thereof. It is therefore of the essence that social workers fulfil an advocacy and empowerment role in addressing SDH.

It is evident that the training of social workers and the values of social justice unifies the SDH and social work, therefore they are interrelated. Social workers' roles in the addressing health disparities need to be reviewed. Social workers should be proactively addressing the SDH mandate.

5.5 Nexus between social determinants of health and the social development approach

From the above discussion points it is clear that there is a link between social work and the SDH. At the same time, both these two fields link with the SDA due to the unifying principle of social justice for all. It was noted that the CSDH (2008), first point of reference was to address social justice as recorded by Bhattacharya (2010), Bywaters and Davis (2012), and WHO (2008, 2010, 2015).

From the discussion of the SDA in chapter 4, it was identified that the White Paper on Social Welfare of 1997 sought to redress inequality via social justice. It could be noticed that various authors such as Gray (2014), Homfeldt and Reutlinger (2008), Noyoo (2015b) and Patel (2015) addressed the principles of the SDA as ensuring social justice. Gray and Lombard (2008), Jones and Truell (2012), Midgley (2001), Patel (2010) and Truell and Jones (2012), indicated that the rights-based principle of the SDA utilises social justice to ensure the rights of all people.

Backwith and Mantle (2009), Craig et al (2013), Doostgharin (2010), Auerbach et al. (2007), Fairfax and Feit (2015), Glaister (2008), Moniz (2010) and Schild and Sable (2006) all addressed the relevance of social work and the SDH as well as identified the embodiment of social justice as one of the core fundamentals of the social work profession. This is also enshrined in the codes of ethics of various social work councils', namely, AASW (2016a, 2016b), NASW (2009), and SACSSP (2014). Social work is one of the few professions that has this fundamental principle. It is therefore ironic that social work has not been identified to play a more influential role in addressing the SDH.

As there are clear linkages between social work, the SDA and the SDH, it would be gross neglect to remove one of these domains from the equations when considering disparities and inequalities in general, but even more so in health care.

A fourth aspect that should be acknowledged in this discussion is that of the SDG. The SDG is the blueprint for poverty alleviation and betterment of the world (Scott et al., 2017; UN, 2019). The SDG has a total of 17 goals. These goals address various strategies for development of the world. All goals are essential for health and wellbeing of a nation, but three specific goals i.e., goals 3, 6 and 10 are directly addressing health. Goal 3 refers to the achievement of good health and wellbeing. Goal 10 focuses on the reduction in inequalities and goal 16 considers peace justice and strong institutions (UN, 2019). Therefore, it seems that the SDH, the SDA and social work fulfill the SDG mandate. May it then be said that these four domains, the SDA, the SDH, social work and the SDG, should not be separated from each other. Holistic, integrated and co-ordinated collaboration amongst these four domains will in all estimates be effective in addressing the mandates of ensuring social justice, attempting to redress all inequalities and upliftment of all people.

5.6 Summary

This chapter outlined the importance of addressing the SDH in fostering equal access to health care globally but specifically in South Africa, the pivotal role of social work to address the SDH, to enact social justice and encourage wellbeing for all resonated well with the SDH. Despite the ideals and the commitment made by global regions, the evidence of addressing the SDH is not clear and especially the application in South Africa. Social work in health care is imperative to highlight and resolve the SDH. This role is currently underutilised. The discussion also highlighted not only the link between the SDH and social work, but also among the SDA, the SDH and the SDG.

Chapter 6 focusses on the presentation and application of the research methodology. The sequential explanatory mixed methodology will be clearly outlined as well as challenges encountered.

CHAPTER 6
RESEARCH METHODOLOGY

6.1 Introduction

This chapter outlines the explanatory sequential mixed methodology applied by this research study. Research methodology, as according to Fouché and Delport (2011), Neuman (2014) and Mouton (1996), involves the methods and techniques in answering a research question. This is considered as the research plan for the study. In outlining the methodology, the discussion is divided into five main sections namely: *Section A: Research questions, aims, objectives and hypothesis*. Here an overview of the focus and purpose of the study is provided. *Section B: Methodology, paradigm and research design*. This section clarifies the pragmatic paradigm and the mixed methods research design. The suitability of this method and paradigm are motivated and detailed. *Section C: Phase One - Quantitative approach.* For the quantitative arm of this study, survey research design as it was utilised in the study is highlighted. The population, sampling procedure, the reliability and validity, and data collection of the study are addressed. Data analysis encompassed the use of the SPSS, to enable descriptive and inferential statistics. *Section D: Phase Two – Four - Qualitative approach.* The qualitative arm for this study is divided into three phases as according to the qualitative data collection strategies. For each phase the population, sampling, data collection, data analysis, trustworthiness and rigour are addressed. *Section E: Ethical considerations.* The ethical procedures and the limitations encountered for the study are described and addressed.

SECTION A: RESEARCH QUESTIONS, GOAL, OBJECTIVES AND HYPOTHESIS

6.2 Research questions, goal, objectives and hypothesis

6.2.1 Research questions

This study sought to answer the following questions:

1. How was the social development approach implemented in health care settings in Gauteng Department of Health?
2. What were the experiences of social workers and social work managers with regard to the implementation of the social development approach?
3. Was sufficient training and guidance provided to social workers and social work managers with regard to the implementation of the social development approach?
4. To what extent did social workers and managers participate in policy implementation?
5. How are the social determinants of health applicable with the application of the social development approach to social work in health care?

6.2.2 Research goal

The goal of the study was to explain the implementation of the social development approach to social work in health care in Gauteng Department of Health.

6.2.3 Research objectives

The objectives of this study were:

1. To explore, describe and explain, as based on the understandings and perceptions of social workers, social work managers and key informants, the application of the social development approach to social work in health care in the Gauteng Department of Health.

2. To highlight the governmental implementation strategies of the social development approach as pertaining to social workers in health care in the Gauteng Department of Health.
3. To explore the relevance of the social determinants of health in relation to the application of the social development approach to social work in health care in the Gauteng Department of Health.
4. To explain the role of social workers in health care in the Gauteng Department of Health with regard to policy implementation.
5. To solicit contributions from social workers for the establishment of a future integrated guideline for the social development approach to social work in health care in the Gauteng Department of Health.

6.2.4 Hypothesis

As part of conducting a quantitative research consideration of the hypothesis, independent and dependent variables are necessary. Independent variables represented as X as according to Babbie and Mouton (2001), Creswell (2018), Williams et al. (2005), Neuman (2014) and Rubin and Babbie (2014) cause the dependent variable. Babbie and Mouton (2001), Creswell (2018) and Neuman (2014) described the independent variable as the variable in the study which exert or determines the change in the dependent variable. The dependent or explanatory variable, represented as Y, is the variable that depends on the independent variable (Babbie & Mouton, 2001; Creswell, 2018, Mouton, 1996; Neuman, 2014; Rubin & Babbie, 2014). This implies therefore that the dependent variable is what is being measured or observed. The dependent variable may be seen as the variable that is observed or measured (Babbie & Mouton, 2001; Creswell, 2018, Mouton, 1996; Neuman, 2014; Rubin & Babbie, 2014).

The study explored the application of the SDA to social work in health care. The **independent variable (X)** was identified as the ***social development approach***. The **dependent variable (Y)** (i.e., explanatory variable which was measured) was ***social work in health care***.

Limited information prevalent to the research phenomenon in the South African health care system before the commencement of the study; limited inferences regarding the two variables could be made. In such cases where there is a lack of information to establish possible relationships or associations amongst variables; a two tailed (non – directional) hypothesis may be formulated (Creswell, 2018; Williams et al., 2005; Nardi, 2006; Rubin & Babbie, 2014). This is also referred to as the null hypothesis as relationships are not indicated or noted (Neuman, 2014). The two-tailed hypothesis for the quantitative approach for this study was:

The social development approach is applied by social work in health care.

The data confirmed that the SDA is applied by social work in health care. Furthermore, data collected via the survey research design led to the formulation of directional hypotheses for future research. Directional hypotheses indicate a predicted relationship (Williams et al., 2005, Neuman, 2014; Rubin & Babbie, 2014). These hypotheses are highlighted in Chapter 10 of this research report.

SECTION B: METHODOLOGY, PARADIGM AND RESEARCH DESIGN

6.3 The pragmatic paradigm

In achieving the goal, objectives and hypothesis of this study; an explanatory sequential mixed methodological strategy was selected. In line with mixed methodology the paradigm for the methodology, was that of pragmatism.

Pragmatism is not committed to specific methods and designs (Mackenzie & Knipe, 2006). Barnes (2012), Bryant and Charmaz (2010), Creswell (2018), James (2002) and Rescher (2012) all indicated the fluidity between methods, approaches and the philosophies that pragmatism enables. Pragmatism may therefore be seen as a world view that encourages practical and realistic solutions towards exploring a phenomenon (Creswell 2018; Mouton, 1996).

As it encourages the mixing of methods, theories and philosophies in answering the research objectives in a comprehensive, creative and relative manner that enhances inter-subjectivity (Bryant & Charmaz, 2010; Creswell, 2008; 2018; Margolis, 2007; Rescher, 2012), it was deemed as the most suitable paradigm for the review of the methodology of this mixed methods study. Shah and Al-Bargi (2013) reiterated that an approach to mixed methodologies encourages triangulation and encourages confidence in the research data. This triangulation was particularly pursued for this exploration. Creswell (2018) also held the view that pragmatism is a philosophical orientation that mixes the quantitative and qualitative approaches in research. Barnes (2012) indicated that pragmatism and mixed methodology usually link well.

Creswell (2018) highlighted two major questions that pragmatism addresses namely, ***what*** is being researched and ***how*** will it be researched. The ***what*** for this study referred to a comprehensive exploration, description and explanation of how the SDA is implemented in social work in health care. Limited research on the application of the SDA in social work in health care necessitated the use of different methods to maximise data collection and evidence. This then referred to the ***how*** question, where different methods of data collection were utilised. This is further addressed in the study's research design which unpacks mixed methodologies. The mixing of methods for this study also enabled the realisation of functional efficacy, as deemed important by Rescher (2012), in that the phenomenon was explored, described and explained through different methodologies both quantitative (questionnaire) and qualitative (interviews and focus group discussions),

paradigms (pragmatism and social constructivism) and theories, (Habermas' social reproduction theory and the ecological perspective), the researcher and observer (in the focus group).

Realistic and existential pragmatism were the two types of pragmatism employed for this study. Cognitive pragmatism could not be readily utilised as limited research on the implementation of the SDA in social work in health care in South Africa was evident. Realistic and existential pragmatism, according to Rescher (2012) refer to the understanding of the human experiences, actions, practices, and meanings, without the overwhelming influence of theory on the above. Therefore, this study aimed to explore, describe and explain the experiences of social workers in health care, in the GDH in implementing the SDA approach. The existential nature was furthermore incorporated with the use of interpretive phenomenology as the design for the qualitative strategies. This fluid and creative movement between the different ontologies and epistemologies enabled the practical and solution focused investigation of the phenomena. This is in line with the views of Barnes (2012), Creswell (2018), James (2002) and Rescher (2012) regarding the fluidity and bridging of the two main world views (qualitative and quantitative) that pragmatism offers. For this study this was particularly evident as the quantitative strategy enabled the surveying of the 'entire' population's opinion of the SDA followed by more detailed explorations, descriptions and explanations of the social workers experiences and understandings embodied by the qualitative strategies. The application of pragmatic paradigm is further addressed under the research design of the study.

6.4 Research nature and design

6.4.1 Research nature

In exploring, describing, explaining and analysing the implementation of the SDA to Social Work in health care, the nature of the study was exploratory, descriptive and explanatory. Engel and Schutt (2014) and Neuman (2003) indicated that exploration may refer to seeking the answers or

learning about the phenomenon. Babbie and Mouton (2001) also acknowledged that exploration refers to familiarity with the area that is being studied but also that this is relevant when the exploration is new. Coleman and Unrau (2005) indicated that exploratory research useful when the area is new that needs to be explored. The application of the SDA to social work in health care is fairly new and not researched. Initially, with conceptualisation, it was endeavoured to contribute extensively to the knowledge bases for social work, social development and social determinants of health, which this study has proven. Therefore, exploratory research was useful and very appropriate.

The descriptive nature of research refers to the provision about the specifics which may include facts, processes providing a sequence, providing numbers, etc. of a phenomenon. Babbie and Mouton (2001), Coleman and Unrau (2005), Neuman (2014) and Rubin and Babbie (2014) added that this may also include the observation of the researcher in describing the phenomenon. In relation to this study, the nature of research was particularly noted in describing how the SDA was implemented by social work in health care and also describe the social workers opinion about matters. The descriptive nature of the study enhanced a comprehensive understanding of the phenomenon.

Babbie and Mouton (2001) and Engel and Schutt (2014) indicated that explanation encompasses the causes and effects of the phenomenon. The study's explanation was drawn from all data collection methods. The data collected provided a clear explanation of the implementation of the SDA, the understanding of the social workers of the SDA, policies and transformation, the SDH and social workers' views regarding it.

6.4.2 Research design

Mixed methodology was identified as the most suitable approach to achieve the objectives of the study but also enabled effective triangulation of the data. Creswell (2018), Johnson (2004), Leech and Onwuegbuzie (2009), Morgan (2007) and Morse and Niehaus (2009) stated that mixed methodologies are generally utilised where both quantitative and qualitative approaches are utilised in one study to comprehensively explore the same phenomena. They furthermore indicated that mixed methodology enhances triangulation as one would review and analyse the phenomenon from multiple sources. Creswell (2003, 2009, 2018) also echoed the above ideals regarding mixed methodologies and added that it attempts to understand the research phenomena either simultaneously or sequentially. Grbich (2012) stated that qualitative and quantitative approaches are rooted in different worldviews but can be linked by the mixed methodology.

Several reasons are argued by Barnes (2012), Creswell (2018), Johnson (2004), and Leech and Onwuegbuzie (2009) for employing mixed methods and apart from triangulation, it allows for the identification of overlapping aspects, may be developmental as it may be used to identify the other method, the discover paradoxes and expansion of scope for further research. The reasons for selecting mixed methods for this study were:

- **Triangulation:** As this study was exploring a complex field of social work, the researcher wanted to maximise the opportunity for information gathering and hence mixed methods was selected. Not only were different methods, in terms of quantitative and qualitative strategies, but also different methods of data collection, paradigms and theories triangulated.
- **Complementarity:** By using mixed methods overlapping was noted between all data collection methods with different groups of participants. This strengthened the findings of this research study.

- **Development:** In applying the study sequentially the researcher was able to change and develop the research instruments as based on the data collection methods. This influenced and allowed for more focused and streamlined exploration.
- **Initiation:** Even though complementarity and development were evident in this study, some paradoxes were also observed by using different methods. This was especially noted with regard to participants' feelings about rotation, their perceptions of what a framework for health should entail, roles played in the consultation of policy implementation governmental strategies, general communications, recognition, understanding and appreciation of social work, further development, social work in health as a speciality, and understanding of the SDA and the SDH. This will be explored further in chapters seven (7) to ten (10).
- **Expansion:** This was also relevant as information obtained from the survey led to the development of further or more specific data collection strategies during phases two to four. Also, information obtained from interviews was followed up in the focus group discussions and interviews with key informants.

Barnes (2012), Creswell (2018), Johnson (2004), and Leech and Onwuegbuzie (2009) offered several mixed methods research designs. These designs are convergent parallel mixed methods, explanatory sequential mixed methods, exploratory sequential mixed methods, transformative mixed methods, embedded mixed methods and multiphase mixed methods. The design for this research study was explanatory sequential mixed methodology with greater emphasis on the qualitative strategies. In utilising sequential mixed methodology, the quantitative approach (*phase one*) was followed by a qualitative approach *(phases two to four).* Explanatory mixed methods, as according to Barnes (2012), Creswell (2018) and Leech and Onwuegbuzie (2009) occurs when the researcher first conducts the quantitative research, which is then followed on by the qualitative research. This refers to the sequential aspect of the research. Before the qualitative approach

occurs, the quantitative data should be analysed, reflected upon and further explored and explained during the qualitative strategy (Creswell, 2009, 2018). For this research study the motivation for the survey was to attain an overview of the SDA and social work in health care. Here the researcher embraced Barnes' (2012) and Creswell's (2018) view of the fluidity and the motivation of the researcher to gain the optimal results. This approach was not only appropriate for this research study but also manageable and highlighted several informative insights.

This sequential mixed methods study, considering the work of Creswell (2003, 2018) and Padget (2008) was represented as:

6.5 Research Plan

For the purposes to foster a clearer understanding but more importantly for the management of the research study; the study was divided into four phases. The discussion under population and sampling, data collection and data analysis will also be presented according to these four phases. The four phases were:

Phase One: Quantitative approach – Questionnaire (completed by social workers employed in the GDH)

Phase Two: Qualitative approach – Semi-Structured interviews with social workers in the GDH

Phase Three: Qualitative approach - Focus groups discussion with social workers employed in the GDH.

Phase Four: Qualitative approach – Semi-structured interviews with key informants employed in the GDH

The researcher also developed a research plan that was shared with the social workers in health care. This honest and open communication also aligned with the ethical principles of honesty and

do no harm but more importantly communicating with the social workers that they were considered valued, equal partners in this study and not just as subjects.

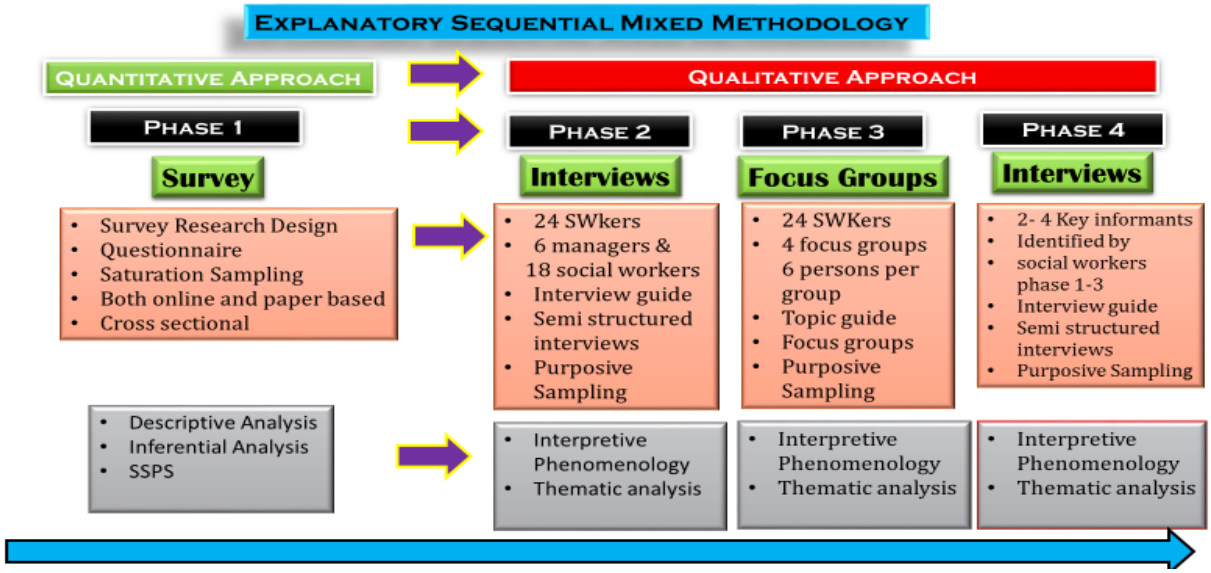


Figure 6.1: The intended research plan (proposal stage)

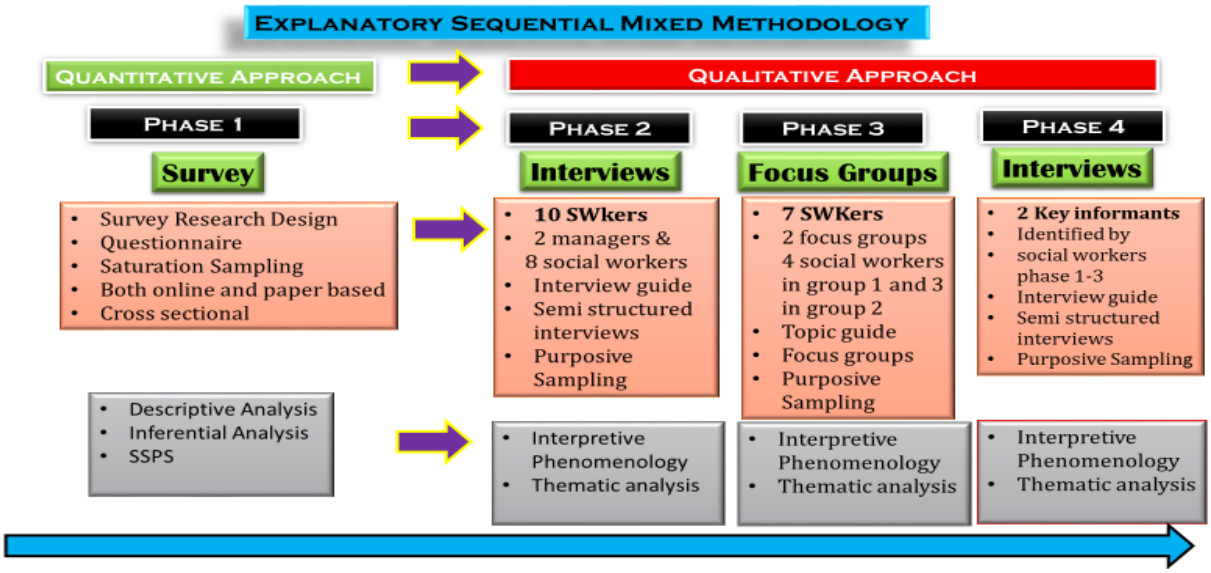


Figure 6.2: The actual research plan

Figure 6. 1 indicates the ideal plan that was set out during the proposal phase and Figure 6. 2 the actual plan as based on the responses from social workers. As may be noted, discrepancies are evident with regard to the number of participants in phases two to four. Fortunately, despite this major deviation, the study obtained important in-depth information that aided the understanding of the application of the SDA in social work in a health setting.

SECTION C: PHASE ONE - QUANTITATIVE APPROACH

6.6 Quantitative approach

The overall assumption is that quantitative research is deductive in nature and therefore driven by the quantification of results which are numerically presented (Babbie & Mouton, 2001; Bryman et al., 2014; Fouché et al., 2011). This quantification maximises the differences and similarities; thereby providing a set guide. Quantitative research employs measuring instruments that needs to conform to reliability and validity (Babbie & Mouton, 2001; Creswell, 2018; Fouché et al., 2011).

6.7 Survey research design

Survey research design is versatile in that it may enable the collection of primary original data from a large population via a standardised tool (Babbie & Mouton, 2001; Engel & Schutt, 2014; Nardi, 2006; Neuman, 2003, 2014; Sue & Ritter, 2012). Survey research design also offers accurate, reliable, valid and unique insights but also provides numeric or statistical descriptions of the population, trends, opinions, etc. (Creswell, 2008, 2018; Neuman, 2014). Neuman (2014) highlighted the usefulness of surveys but also stressed that without proper care it can provide misleading results. Surveys may be used for their exploratory, descriptive and explanatory nature (Neuman, 2014). Sue and Ritter (2012) indicated that all surveys have the same steps from developing the goals to the development of clear questions, dissemination, collecting and analysing. Surveys may use different formats from scales to intensity measures. Nardi (2006) and Sapsford (2007) also reiterated the value of survey research design in that it provides valuable base line information from the population.

Cross-sectional survey research design was the design that was selected for this study. As in line with the description from Creswell (2018), a cross sectional survey research design entailed the collection of data from the population at a specific time. According to Creswell (2018), Neuman

(2014) and Sue and Ritter (2012) this collection of data is representative of a certain period and reflects on the current views, attitudes and feelings. As according to the plan for this study this was the first step of the study which focused on exploring from the entire population about social work in health care and the application of the SDA.

Apart from the above, survey research design also has different types or modes in terms of the data collection methods. These may include paper-based (mail), electronic, telephone interviews, face to face and online (Creswell, 2018; Neuman, 2014; Nardi, 2006; Sue & Ritter, 2012). During the proposal development phase of this study the researcher consulted with the stakeholders in the GDH regarding the best method of conducting the survey. A paper-based survey was identified as the most suitable option due to limited or no access to resources social workers in the GDH experience. However, some social workers in the GDH who had access to computers opted for an electronic mode. Therefore, this cross-sectional survey research used mix modes of data collection namely paper-based and electronic. Engel and Schutt (2014) indicated that utilising mixed mode surveys maximize the participation rate. Ruel et al. (2016) affirmed that the type or mode of the survey that is selected should support the purpose of the research study. They indicated that one mode may not be the best option. Social workers therefore had a choice about the mode of completion of the survey. In the end nine (9) participants completed an electronic survey and 36 a paper-based survey.

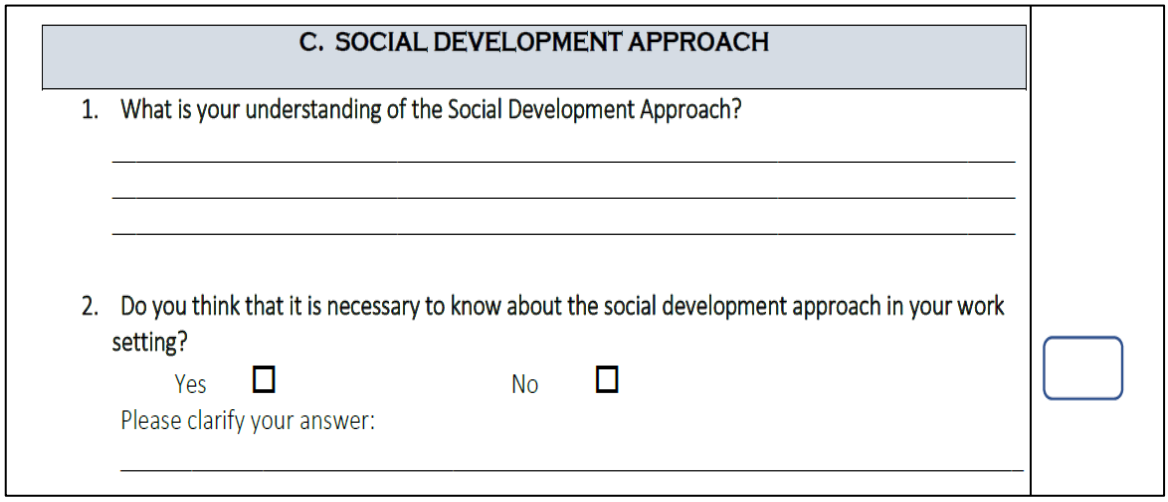
6.7.1 The questionnaire

The development of the questionnaire used in this survey research design was an important aspect. Creswell (2018), Engel and Schutt (2014), Nardi (2006), Neuman (2014) and Sue and Ritter (2012) all offered important guidance of the appropriateness, clarity, how the survey should be compiled and the presentation thereof. Bernard (2013) and Sue and Ritter (2012) suggested different questions as linked with the different levels of measurements. Creswell (2018), Engel and Schutt

(2014) and Neuman (2014) discussed the validity of open-ended, closed-ended questions, refraining from ambiguity and the length of the questionnaire. Neuman (2014) indicated that the type of questions should not only link with the purpose but be relevant. Open-ended questions are aimed at providing respondents with an opportunity to offer their opinion whereas close-ended questions offer a limitation on the choice of responses (Creswell, 2018; Neuman, 2014). The advantages of open-ended questions are in that individual responses are received may provide for interesting findings and valid contribution (Neuman, 2014). The disadvantages of open-ended questions are that the response may be varied not of relevance to the question, vague, unclear and incomplete. In addition, respondents may respond with different intensity levels that may complicate the data analysis (Neuman, 2014). Close-ended questions are advantages as it fosters uniform answers that will facilitate data analysis. Disadvantages are that these questions only seek to answer the question in a specific manner, and options are not provided for respondents which in turn may leave them frustrated as their views are not reflected (Neuman, 2014). Scaling questions offers usually a three or seven-point (depending on the type) rating scale, like the Likert scales, to record the views, attitudes or feelings of respondents (Bernard, 2013; McLeod, 2008; Neuman, 2014; Sue & Ritter, 2012). Intensities are offered on a continuum for instance: strongly agree, agree, neutral, disagree, strongly disagree (McLeod, 2008). McLeod (2008) added that the ranking offers the opportunity to show the extent of agreement or disagreement. This adds to the value of the measurements. The advantages that Likert scales bring are that of variability of answers, offers a choice in response (McLeod, 2008). Apart from the above the aspect of the length of the survey is also of importance. Neuman (2014) personally felt that lengthier questionnaires provide greater validity and clarity about the phenomenon to be explored. The layout, format and organisation should also contribute to the respondent to want to answer the questionnaire. As according to Neuman (2014) the logic, flow and visual design matters.

The researcher developed her own questionnaire as based on experience and literature, as a standardised questionnaire to explore the application of the SDA in social work in health care was not available. The questionnaire used in this survey requested identifying details (such as years employed, position, the type of health care setting). Training regarding the SDA attended, the social workers knowledge of the SDA was explored using a combination of open-ended and closed-ended questions as well as rating scale (Likert) questions. An opportunity for adding their own opinions was also included in the questionnaire.

This nine page questionnaire had nine sections namely: A. Demographics (age, gender and race), B. Employment background (experience of social workers, the type of setting, involvement in management and supervision, and general overview of the employment aspects), C. Social Development Approach (understanding and implementation of the SDA), D. Social Determinants of Health (understanding and implementation of the SDH), E. Policy Implementation (with regard to consultation, the SDA, the SDH), F. Associations (focused on measuring the social workers view of how SDA, SDH, social work and policy are linked), G. Components of the SDA framework (soliciting the opinion of the social workers), H. Key Informants (social workers identified key informants to approach), and I. Other (an opportunity for social workers to add any comments). *(See Appendix N).* The questionnaire seemed lengthy with nine pages, but this included spacing for open-ended questions as well as the scaling questions that were spread out throughout the document. The questionnaire was logically laid out and presentable. Several closed-ended questions were used in the document. Usually this was followed by open-ended questions. The open-ended questions contributed to the in-depth exploration of certain aspects especially where current procedures in health care were highlighted, the knowledge and contribution of the participants were sought. An example of an open- ended question in the questionnaire was:


C. SOCIAL DEVELOPMENT APPROACH

1. What is your understanding of the Social Development Approach?

_____

_____

_____

2. Do you think that it is necessary to know about the social development approach in your work setting?

Yes ☐ No ☐

Please clarify your answer:

_____

Rating questions were used throughout the document. These questions explored the extent of the social workers disagreement or agreement but also offered an option of being neutral. This enabled the collection of data at different points which contributed for effective statistical analysis. An example of a rating question was:

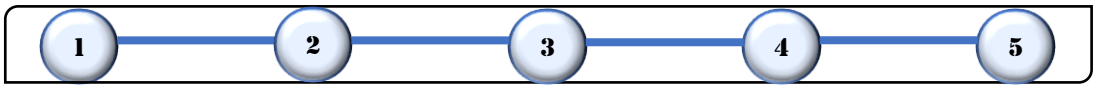
C: Social Development Approach

10. Training on the Social Development Approach:

Answer the following by making a mark (X)

① ***refers to strongly disagree,*** ② ***disagree,*** ③ ***neutral,*** ④ ***agree and*** ⑤ ***strongly agree***

10.(a) Training received on the Social Development approach has been helpful and enough



6.7.2 Pretesting of the questionnaire

The questionnaire was pretested with five social workers; one colleague who had experience in using surveys and four social workers who had experience in health settings. Creswell (2018), Neuman (2014) and Sue and Ritter (2012) stressed that pretesting of instruments is important for ensuring reliability and validity. All these participants made suggestions which were considered. Particular attention was given to the clarity of questions and validity of the questions in relation to

the goal and objectives. In addition, they indicated that the tool comprehensively measured the opinions, experiences, knowledge and understanding of the social workers in the GDH.

6.8 Population and sampling procedures

The population for this study, was all the social workers, social work supervisors, social work managers and key informants employed in the various sectors of the GDH. Sue and Ritter (2012) indicated that saturation sampling may be utilised when administering surveys. Saturation sampling is not generally indicated as a sampling method but an attempt to almost conduct a census of the entire population (Sue & Ritter, 2012). Saturation sampling is most appropriate for research conducted in governmental settings. Therefore, saturation sampling was most appropriate for this study as the survey was distributed electronically and via post to each clinic and hospital in Gauteng. A total of 320 paper-based surveys (more than the estimated population) were distributed as well as the electronic versions of this survey was sent to all hospitals and clinic managers as well as some social workers. Although coverage and sampling errors were minimised by the distribution of the paper-based survey to the entire population, the coverage via the electronic version may have been compromised as a result of social work managers who may not have distributed the survey to the social workers, social workers may not have had access to computers or internet access. Non-response error was evident as the bulk of the population did not complete the survey. The researcher followed the suggestion by Neuman (2014) and Sue and Ritter (2012) and attempted to encourage a better response by attending three meetings with social workers and managers in the GDH, telephonic contact and email communications to remind the population of the completion of the survey. The period for data collection of the survey (phase one) was also extended several times. In the end the sample for this phase of the study was 45 completed questionnaires. Some medical district managers were very upset about the poor response and from their position attempted to encourage staff to complete the survey. In the end the right of social workers not to participate was upheld.

6.9 Data collection

The survey in the form of a self-administered questionnaire was forwarded both electronically and in a paper based format to the entire population (i.e., all social workers in the employ of GDH) with the aid of the Deputy Director: Special Programmes and all the heads of Social Work Departments of the GDH. In an effort to market the study, encourage the completion and return of the surveys the researcher also attended several of the GDH's Social Work Executive Meetings as well as had consistent electronic communication with social workers in the GDH. The hard copies were distributed to the managers and social work representatives for distribution to the population. Clear instruction for the completion and return of surveys were provided. Engel and Schutt (2014) and Neuman (2014) addressed the facilitation of reminders for survey completion as instrumental for insuring the completion of the survey. In the end surveys were returned at meetings and emails. Nine (9) were electronic submissions and 36 from collection from meetings.

It was hoped that most social workers would complete the survey with a realistic return rate of 30%. This return rate has been widely described by Babbie and Mouton (2001) and Engel and Schutt (2014). Unfortunately, due to lack of response from social workers the return rate for this study was closer to 15%. The non-responsiveness of social workers remained a concern. This was particularly followed up in the interviews and focus group discussions. Needless to say, that those who have participated did not understand the lack of response. Others indicated a general apathy and laziness amongst social workers in health care, who was reluctant to do anything outside of their job description or comfort zones, and professional jealousy in contributing to the advancement of this study. Perhaps other aspects are that social workers were busy and overwhelmed with additional tasks that is not impacting on their job description or service delivery. Timing may have also been an issue. Another aspect that should be acknowledged is also the lack of reward for participating in the study. Some sort of incentive may have also contributed

to the completion of the survey. Further responses were not obtained even though the survey completion time has been extended for almost a year.

Once the completed questionnaires were received each were uploaded on the SPSS. All information was labelled according to codes and uploaded accordingly. A word document correlating with the indicated participant number was also populated with the open-ended contributions. To minimise human error the formulations of the variables and data tables as well as the correct uploading of all the data, were double checked by the researcher. Once this was done the researcher looked through the raw data and excluded data sets that was incomplete. The 45 respondents who completed the questionnaires also completed the rating scales and closed questions. Several respondents did not complete the open-ended questions. Those who completed the open-ended questions offered valuable information.

6.10 Data analysis and presentation

The usefulness of SPSS was identified by Creswell (2018) and Nardi (2006). SPSS is considered as an effective tool for social science research (Gavin, 2008). This study made use of the SPSS for data analysis which enabled the numerical representation of the data. The SPSS also enabled the development of inferences to be made about the variables and constructs. In addition to SPSS, the open-ended questions were analysed via thematic content analysis. A code document was established. According to Creswell (2018) and Neuman (2014) a codebook contains the codes and their descriptions and should be well organised. The code document contained the meanings of the codes for variable and data tables for the SPSS.

The quantitative data was presented via descriptive and inferential statistics. Descriptive statistics represent the numerical data in a manageable form that may have several facets of measurements that will encompass the distribution, central tendency and the dispersion (Babbie & Mouton, 2001;

Creswell, 2018; Gavin, 2008). Somekh, and Lewin (2011), Neuman (2014) and Williams et al. (2005) also highlighted that descriptive statistics involves the representation of data via measures of central tendency and variability. Engel and Schutt (2014) stated that inferential statistics refer to systematic analysis and making inferences. Creswell (2018) and Gavin (2008) indicated that inferential statistics are essential in testing the hypothesis. Williams et al. (2005) highlighted that inferential statistics eliminate the coincidental explanations of variables by making associations or difference highlighting differences. In addition, three out of the four levels of measurement were used i.e., nominal, ordinal and interval levels. Nominal refers to representation of the attributes of the population like gender, age and race. (Neuman, 2014; Sue & Ritter,2012; Williams et al., 2005). Ordinal levels of measurement refer to those question where ranking is indicated (Neuman, 2014; Sue & Ritter, 2012; Williams et al., 2005). This study used Likert scales to measure the opinion of the population. Interval scales refers to those values where clear distances are recorded (Creswell, 2018; Neuman, 2014; Sue & Ritter, 2012; Williams et al., 2005). For this study, the ages and years of experiences may be considered such scale. Measures of dispersion such as the range, variance, standard deviation and the Pearson correlation were used to present the spread of data and depict possible associations. The range were noted with the Linkert scale levels especially considering the minimum and maximum levels. The variance is the mean sum squared, whereas the standard deviation refers to square root of the variance (Bryman et al., 2014, Creswell, 2018, 2012 Neuman, 2014). The Pearson correlation ***(r)*** measures the relationships or correlation between variables (Bryman et al., 2014, Creswell, 2018, 2012; Neuman, 2014).

The open-ended questions in the survey were coded by utilising thematic content analysis. Babbie and Mouton (2001) described content analysis as a process of coding the information. The coding occurred as both manifest and latent content analysis. Manifested content may be described as the surface or visible content and latent content refers to the underlying meaning (Babbie & Mouton, 2001). This implies that the first steps of content analysis for the study will be using codes that depict the surface meanings as well as latent meaning. Each category was expounded upon.

6.11 Reliability and validity

Nardi (2006), Neumann (2014) and Sue and Ritter (2012) indicated that to receive a confidence level of 95% surveys need populations of about 9 000. As the population of social workers in health care was estimated as less than 300, such assumptions could not be made. Also, of relevance was the use of a research instrument. A pre-existing appropriate tool that was standardised was not available and therefore the tool had to be developed by the researcher. Any development of the questionnaire needs to satisfy the requirements of reliability and validity. Ruel et al. (2016) indicated that reliability and validity revolve around research errors or minimising it.

Reliability refers to testing the same phenomena every time (Creswell, 2018; Neuman, 2014; Strydom, 2011). Mindel (2005) suggested that reliability is the accuracy or precision of the results of the instrument. Corcoran and Secret (2013) referred to reliability consistency of the measuring instruments that produce the same results. Ruel et al. (2016) referred to reliability as dependable, applicable and consistent. For this study, reliability was ensured as the same questionnaire were provided to the entire population.

Validity refers to the instrument measuring what it is intended to measure (Neuman, 2014; Ruel et al., 2016; Strydom, 2011). There are numerous types of validity. For this study internal, external, face, construct and content validity were of reference. Internal validity refers to the degree that the instrument actually measures what it should and external the generalisability of findings (Ruel et al., 2016; Neuman, 2014; Williams et al., 2005). Ruel et al. (2016) further expanded that internal validity is when the relationship between the variables is measured. For this study how the SDA is and was implemented was explored. Also, the findings may be applied to the entire populations as different levels of hospital settings were present in the sample.

Face validity refers to measuring the desired results, construct validity refers to the instrument measuring what it is supposed to measure and content validity to the tool measuring the entire complexity of the phenomenon (Babbie & Mouton, 2001; Engel & Schutt, 2014; Nardi, 2006, Neuman, 2014; Rubin & Babbie, 2005, 2014; Ruel et al., 2016; Sapsford, 2007; Williams et al., 2005). With regard to face validity the questionnaire was structured, and the content was logically arranged. With reference to content validity the tool was extensive in that it surveyed all aspects of the study's objectives. With regard to construct validity the questionnaire did measure what it was supposed to measure. The pretesting process confirmed content and construct validity.

6. 12. Research errors

Research needs to be conducted in such a manner to minimise the presence of errors. In the development of the questionnaire as well as with data collection and analysis attempts were made by the researcher to minimise the errors.

Neuman (2014) described errors as where values do not reflect the true nature of the population. These errors may include errors in selecting the respondents, errors in responding to survey questions, survey administration errors and errors with the regards to the hypothesis. Errors for selecting respondents were minimal as the saturation sampling was utilised and the survey was distributed to all social workers in the employ of the GDH. The only possibility of coverage errors could have been if the electronic survey was not forwarded to all social workers. Therefore, the researcher ensured to minimise this category of errors. Errors in responding to the survey were present for this study. Even though the researcher ensured coverage of the entire population as well as provided ample time for survey completion; the study had a poor response. To minimise survey administration errors the researcher ensured and double checked all data entries.

Type I and type II errors with regard to making incorrect assumptions about the relationship between the variables. Type I error exists where indicated that a relationship exists when there is no relationship, and type II where there is no relationship, but it is said that it exists (Neuman, 2014). As this study had a null hypothesis, which did not indicate any relationship, reference to this could not be made. So therefore, neither error was present for this study.

SECTION D: PHASE TWO TO FOUR - QUALITATIVE APPROACH

6.13 Qualitative approach

The qualitative arm, comprising of phases two to four, of this mixed methodology study that sequentially followed the survey, involved semi - structured interviews with social workers, supervisors, managers, key informants as well as focused group discussions with social workers in the employ of the GDH. It was hoped that valuable descriptions of their opinions and experiences i.e., their subjective experiences will be collected. The qualitative approach may be viewed as the meaning that individuals provide for an observation or a phenomenon (Creswell, 2018).

6.14 Interpretive phenomenological research design

Interpretative phenomenology was the design for the qualitative approach. Hesse-Biber and Leavy (2011) indicated that interpretative phenomenology may be viewed as diverse approaches that focus on understanding, interpreting and recording the interaction between humans and their world. Eatough and Smith (2008) explained that it is the detailed exploration of the lived experiences of people. This, Creswell (2013, 2018) identified as the understanding of the essence of human lived experience. Pietkiewicz and Smith (2014) and Reiners (2014) indicated that phenomenology is a research tradition that considers how people make sense of their worlds. Smith, et al. (2009) and Noon (2018) indicated that phenomenology involves the systematic

investigation of major personal life experiences and focus on acknowledging the social and personal world of people. Neuman (2014) highlighted that any interpretative social science is focused on considering to social constructed meaning as pertaining to the individual. So, this may be very relative. Miller and Minto (2016) also acknowledged the diverse applications of interpretive phenomenology to qualitative research. This design also links perfectly with the identified paradigm and theoretical framework for this study.

Interpretative phenomenology is based on the fundamentals of phenomenology, hermeneutics and idiography (Lopez & Willis, 2004; Noon, 2018; Reiners, 2012; Smith, 2011; Smith et al., 2009). Phenomenology entails the philosophy of investigating the lived experiences of individuals (Lopez & Willis, 2004; Noon, 2018; Reiners, 2012; Sloan & Bowe, 2014; Smith, 2011; Smith et al., 2009). Hermeneutics in turn is concerned with the attempt to make sense of how the participants make sense of their lived worlds and experiences (Lopez and Willis, 2004; Neuman, 2014; Noon, 2018; Sloan & Bowe, 2014; Smith, 2011). Idiography, is the applied process of inspecting and analysing each case individually and acknowledging the subjective experiences of the participants in detail (Noon, 2018, Smith, 2011; Smith et al., 2009). These three fundamentals therefore give rise to the nature of interpretative phenomenology of reflection of the participants experiences of their worlds, their attempts to make sense of it and as characterised by detailed exploration. Interpretative phenomenological designs usually incorporate purposive sampling and homogeneity amongst participants (Noon, 2018; Smith, 2011; Smith et al., 2009). Appropriate data collection methods are usually in-depth interviews and or focus groups that requires an in-depth data analysis via a six-step data analysis process (Noon, 2018; Smith, 2011; Smith et al., 2009).

Interpretative phenomenology also acknowledges the use of bracketing. Alase (2017), Smith (2011) and Smith et al. (2009) all indicate the importance of bracketing as interpretive

phenomenology deals with idiograpy and the lived experiences of participants. This bracketing is where the researcher is aware of their own opinions and biasness, keep track of it in a journal to enhance trustworthiness (Alase, 2017; Smith, 2011; Smith et al., 2009). In fact, Larkin and Thompson (2012) indicated that the very inter-subjective nature of interpretative phenomenology mandates a reflexivity journal. The researcher could resonate with the participants and the reflexivity journal aided the separation of own experiences from that of the participants. The researcher also took an active stance to record the appreciation of the contribution that the participants made and the role they fulfilled.

The advantages of the approach are that the researcher makes extensive notes, thereby becoming fully immersed in the data, acknowledged the individual subjective experiences and is considered flexible (Noon, 2018, Smith, 2011; Smith et al., 2009). Due to the nature of this approach the researcher may also receive unexpected answers that contributes to the richness of the data (Noon, 2018). The application of this approach to this research study allowed for the gaining of valuable information and insights about the experiences of social work in health care, their challenges and value. Disadvantages of this approach are that the process can be taxing due to its intensity, there may be language barriers, the duality of idiography and limited transferability due to the acknowledgement of the subjective experiences (Noon, 2018, Smith, 2011; Smith et al., 2009). The application of the methods especially the transcribing of the interviews and focus groups were challenging. The researcher found that idiography was intensive, but this lent itself well to highlight categories and themes. Due to the wealth of information gained transferability in similar settings may be envisaged.

6.15 Population and sampling procedures

The population was the social workers, social work supervisors, managers and key informants employed in the various sectors of the GDH. The social workers, social work supervisors and

social work managers who participated in the study were employed in the GDH in one of the sectors such as primary (clinics), secondary (district hospitals), tertiary (academic hospitals), rehabilitative or specialist health care settings as well the GDH's main administrative offices. The two key informants that took part in the study were identified by social workers during phases one to three. The key informants were considered as experts in the field of health care. One key informant was employed in a regional hospital setting and the other in provincial administration.

6.15.1 Phase Two and Phase Three: Semi – structured interviews and focus groups discussion

Purposive sampling was utilised to select social workers, social work supervisors and managers employed in the GDH. Purposive sampling is a form of non – probability sampling that involves the selection of participants that is representative of the population (Engel & Schutt, 2014). Rubin and Babbie (2014) highlighted criteria for purposive sampling as the participants must be knowledgeable about of the phenomenon, willing to participate, representative, completeness and saturation.

For the individual semi-structured interviews, the sample size was ten participants. Criteria for selection of participants were:

- Social workers, supervisors and managers with an experience of minimum three years in the employ of GDH.

The sample size for the focus groups were planned as six per group. Due to the poor response only two focus groups were facilitated. The first focus group comprised of three supervisors and one manager and the second out of three social workers. The inclusion criteria were:

- Social workers, social work supervisors and managers with an experience of three years in health.

- Social workers, social work supervisors or managers needed to be willing to participate in a focus group discussion.

Three years of experience was an inclusion criterion for participants in both individual interviews and focus group discussions as it is assumed that participants will provide in-depth knowledge and experiences regarding the transformation that has occurred in health. Social workers with less than three years of experience may not have experienced the implementation of the SDA to social work in health care.

6.15.2 Phase Four: Semi-structured interviews with key informants

Key informants are considered experts in a particular field. Key informants are usually identified from the population under investigation (Fouché & Schurink, 2011). The key informants were identified from phase one, two and three. One manager at a secondary, regional hospital setting and a deputy director were identified as the two key informants by ten participants. Two other key informants were identified but did not respond to the various requests to participate in the study as a key informant.

6.16 Data collection

6.16.1 Phase Two and Phase Four

Both phases employed two respective interview guides for the semi – structured interviews with social workers, social work managers and key informants.

Eatough and Smith (2008) indicated that interviews are the best tool for qualitative research. Interpretative Phenomenology both acknowledges that the semi-structured interview as the most effective tool (Noon, 2018, Smith, 2011; Smith et al., 2009). Semi-structured interviews are a balance between unstructured and structured interviews and uses a set of questions as a guide

(Eatough & Smith, 2008). This guide is the interview schedule or guide (Eatough & Smith, 2008). Greeff (2011) indicated that semi-structured interviews are interviews that gain a detailed view of a participants' beliefs or perceptions. Greeff (2011) described the interview schedule as a guide with predetermined questions that are asked to the participants.

6.16.1.1 Pretesting of the research instruments

The interview guides were pretested with a social worker and social work manager who had extensive experience in health care settings. The social worker made the recommendation of describing the term of the SDH to participants. This was not included as the nature of the study was to explore the social workers understanding and current knowledge base of the SDA and the SDH. A suggestion was made to include a question of the future vision of social work in health care. This was added to the guides. The participants commented that the guides were trustworthy and served its intended purpose.

6.16.2 Phase Three

A focus group topic guide was utilised with the two focus groups. A focus group guide may be viewed as a guide with questions that will direct the discussion to be followed (Liamputtong, 2012). This not only contains the key elements but also offers a guide to how to navigate the focus groups (Liamputtong, 2012). It is therefore essential that an effective focus group guide be developed. Focus groups incorporate a number of participants in a carefully planned discussion that will aim to illicit the perceptions of the participants (Greeff, 2011). Furthermore Greeff (2011) indicated that focus groups are self-contained and offers supplementary sources of data. The nature of focus groups promotes self-disclosure. Smith, et al. (2009) indicated that focus groups may offer a comfortable interaction and offer many points of view. Freeman (2006) stated that focus groups are an interview with a group of participants that share about a specific topic. Freeman (2006) furthermore warned that the focus group should be carefully constituted and led by a moderator

that will utilise a carefully constructed topic guide to enable detailed sharing. A focus group requires a topic guide for the group discussion (Engel & Schutt, 2014). Morgan (1998) and Litosseliti (2003) indicated that focus groups are small, structured groups that is purposive in exploring specific topics and views. Puchta and Potter (2004) indicated the diversity and usefulness of focus groups.

Focus groups should make use of a moderator and an observer. Krueger (1998), Litosseliti (2003), Stewart et al. (2007), and Stewart and Shamdasani (2015) highlighted the qualities of a moderator as being competent in group processes, should be dynamic, curious, friendly, show interest in people, good listening skills and be open to new ideas. The moderator should always keep the group on track. Krueger (1998) strongly motivated for an assistant moderator to be appointed as well. The assistant moderator should not only have interest in the study but also have some dissimilarities from the moderator. The role of the observer is to observe, take notes and assist in the recording of the session (Litosseliti, 2003; Stewart et al., 2007). The moderator will facilitate the actual interview and the assistant moderator will act as the observer, analyst or recorder (Krueger, 1998; Litosseliti, 2003; Stewart et al., 2007; Stewart & Shamdasani, 2015). Stewart et al. (2007) and Stewart and Shamdasani (2015) further highlighted that moderators should exhibit leadership, be skilful, diplomatic, persuasive, knowledgeable about the tasks, and organised. The researcher fulfilled the role of the moderator due to being a qualified social worker with experience in group work, was organised, diplomatic and skilful in the facilitation this group. A social work colleague was used as the observer. She kept notes of the discussion as well as summarised the session and offered debriefing at the end of the discussion.

The focus group topic guide was formulated and pretested with social workers regarding its suitability and applicability for a focus group discussion. Whereas the interview guides focused on collecting the general experiences of social workers in health the focus group topic guide

acknowledged the experiences offered some findings from phases one and two, as well requested the participants to creatively problem solve a framework appropriate for health.

Focus groups invitations were sent to all social workers in the GDH. Only seven participants, four supervisors and three experienced social workers, indicated their willingness to participate. The supervisors were grouped in focus group one (FG 1) and the social workers in group two (FG 2). This separation was deemed important as in line with Habermas' theory of social reproduction where we need to keep the workers free from intimidation from supervisors (i.e., those in power). This also enabled the exploration of the phenomena from distinct viewpoints i.e., those of supervisors (managers) and the workers. This separation also ensured that the groups were small and manageable. Every participant had the opportunity to voice their opinion without fear of intimidation or judgement. This has proven very successful in data collection.

All participants were provided with the topic guide, the PIS and consent forms *(see appendices E to M)* three days before the meeting. This ensured preparation but also transparency in the discussion. A reminder was sent to all participants a day before the meeting. The venue was prepared a day before the meeting. A welcome file containing the topic guide, participant information sheet and consents forms, pens and paper were prepared. The observer was orientated to the focus group procedures and requirements beforehand and on the day of the focus groups also received a file with the documentation and also an outline of responsibilities and tasks. During the session the researcher, in the role of the moderator, kept track of the conversation using flipcharts. Refreshments were served before, during and after the meeting. Each session taking into account the breaks and refreshments took three hours. This was over the time estimated of two hours that was suggested by Liamputtong (2012). Anonymity and confidentiality cannot be ensured within focus groups (Litosseliti, 2003; Morgan, 1998; Liamputtong, 2012), and this may be perceived as a major threat. With the start of each focus group the moderator highlighted the

importance of confidentiality and anonymity. Confidentiality is an important principle for social work and the participants agreed to the conditions. The dynamics in each group was conducive to information sharing to the extent that participants were able to unpack most of the stressors as well. The focus groups seemed to have been an outlet for frustrations with regard to how the SDA approach and policies were implemented in the government sector. This was permitted as interpretive phenomenology encourages this expression of the inner worlds. It also assisted with double hermeneutics for the researcher. At the end of the session each participant also received a certificate of participation which could be used for continual professional development.

The advantages of focus group discussions are numerous. It provides the opportunity for detailed exploration, it provides and offers insights, highlights differing views and collects useful information (Litosseliti, 2003; Morgan, 1998; Liamputtong, 2012; Stewart & Shamdasani, 2015). Litosseliti (2003) indicated that focus groups also help with generating of new ideas and exploring complex topics. This was of particular relevance for the study's focus as the participants deliberated on what a framework for health care needs to contain.

Disadvantages of focus groups are that it will not be useful if there is a mismatch with the participants and the topic, biasness and manipulation if the moderator misleads the participants (Litosseliti, 2003). The researcher attempted to minimise this by sticking to the guide as well as requested the observer to evaluate the facilitation of the group. Care needs to be taken with strong personalities that may influence others in the group, which in turn may lead to a group consensus that is false (Litosseliti, 2003; Liamputtong, 2012; Stewart & Shamdasani, 2015). Focus groups delivers volumes of data that may complicate data analysis and issues of transferability (Litosseliti, 2003; Morgan, 1998; Liamputtong, 2011; Stewart & Shamdasani, 2015). The small focus groups enabled that all participants' voices could be heard. As the participants were social workers, they were also very mindful of colleagues' opinions and invited participation from quiet members. The transcription of the focus groups was challenging. The summary of the entire discussion by the

researcher (moderator), the observer's concluding remarks, and debriefing enabled the appropriate resolution of the focus groups.

6.17 Data analysis and presentation

The data collected via the qualitative approaches i.e., the semi-structured interviews and focus groups are of reference here. Interpretative phenomenological analysis (IPA) was utilised.

IPA as according to Smith (2011) and Smith et al. (2009) is utilised to understand the participants' perceptions of their world and offers a detailed account. The six step IPA process as proposed by Smith (2011) and Smith et al. (2009) was used to analyse the data.

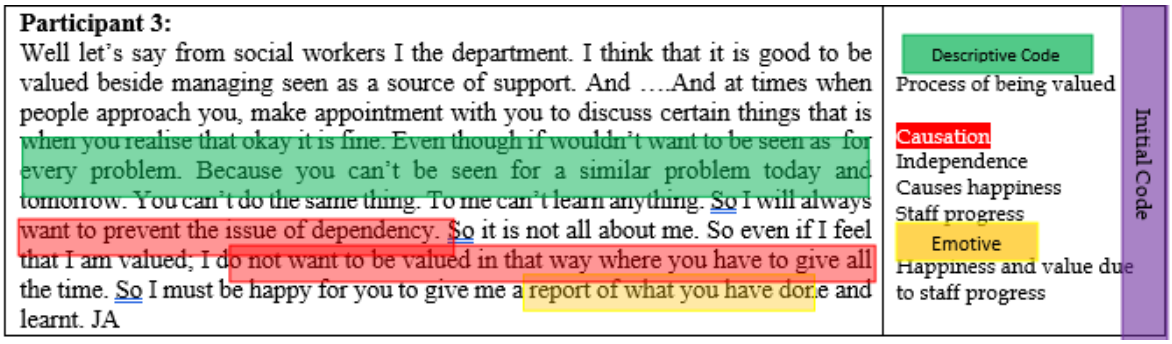
Step 1: Reading and re-reading

The data for both the interviews and focus groups were transcribed. The researcher listened to the audio recording carefully and double checked the correctness of the transcriptions. In essence this listening, reading and re-reading enabled the researcher to become very familiar with the findings. The essential aim of this step as according to Smith (2011) and Smith et al. (2009) is to have an understanding of the discussion.

Step 2: Initial noting

According to Onwuegbuzie et al. (2016), Smith (2011) and Smith et al. (2009) this may be a very intensive process as it would involve the researcher noting the language use, intonations, etc. This will then be followed by a descriptive phase which takes note of the participants' life world. Thereafter deconstruction should occur whereby the transcription is examined sentence by sentence. Lastly under this step is the overview of the initial notes (Onwuegbuzie et al., 2016; Smith, 2011; Smith et al., 2009). The researcher made use of coding during this stage and utilised descriptive, invivo, process, emotion, versus value and assumption codes as highlighted by Saldaña (2009) and Onwuegbuzie et al. (2016). A code may be viewed as a short description

that captures a part of the discussion (Onwuegbuzie et al., 2016; Saldaña, 2009). The variation in codes used resulted in a richer presentation of the data and highlighted latent meanings. The example below is an exert from the interview with Participant 3. Four codes are highlighted namely, initial, descriptive, causation and emotive codes. *(See Appendix S for the full example).*



Step 3: Developing emergent themes

This phase of managing the data was about highlighting themes. These themes should be ordered chronologically as based on their presentation in the discussions (Smith, 2011; Smith et al., 2009) This is instrumental for the understanding of the context of the discussion.

Step 4: Searching for connection through emergent themes

This refers to connecting themes that is similar. Smith (2011) and Smith et al. (2009) suggested several possible techniques to be utilised in connecting themes. Abstraction is one technique that refers to clustering of the themes (Onwuegbuzie et al., 2016; Smith et al., 2009). Abstraction, polarisation, contextualisation and numeration were all utilised by the researcher. This links well with Saldaña's (2009) approach to coding for patterns which recognises similarities, differences, frequency, sequence, correspondence and causation.

Step 5: Moving to next case

This refers to the next transcript of the next participant where the same process as from steps 1 – 4 will occur (Smith, 2011; Smith et al., 2009). The researcher applied the same process with each of the interviews and focus group discussions.

Step 6: Looking for patterns across cases

Once all cases were reviewed coded and themes identified this step is about looking for similarities and idiosyncrasies. Onwuegbuzie et al. (2016) and Smith et al. (2009) indicated that at this time the themes may be reconfigured or relabelled. The data from interviews and the focus group discussions were organised into categories, themes and subthemes. For the interviews and focus group discussions categories of the nature of current social work in health care, SDA, SDH, policies and the future vision of social work were highlighted. Recurrent themes noted were uniqueness of social work, challenges of social work, challenges with the SDA, diversity of settings, services and clients amongst others.

6.18 Trustworthiness and rigour

Of importance for the qualitative components will be rigour and trustworthiness. Padget (2008) considers rigour as the researcher's self-discipline and the vigilance of methods and trustworthiness as the accountability which encompasses that research should be carried out fairly and ethically. Aspects that were taken into consideration are credibility, transferability, dependability and confirmability (Babbie & Mouton, 2001; Schurink et al., 2011).

6.18.1 Credibility

Credibility is the degree of fit between participants' views and the researcher's description and interpretations (Babbie & Mouton, 2001; Padget, 2008). This can usually be assured by a number of aspects e.g., persistent observation, prolonged engagements, triangulation, member checks, peer

debriefing and referential adequacy, etc. (Babbie & Mouton, 2001; Padget, 2008). For this study all of the above was utilised.

Prolonged engagement occurred as most participants were interviewed for an hour. Some interviews were 40 minutes long and others an hour and thirty minutes. Irrespective of how long the interviews were, valuable information was obtained from all. This prolonged engagement was however very challenging with the focus group discussion where the engagements lasted for three hours. The participants were invested and passionate in the discussions. These prolonged engagements ensured in-depth exploration. Persistent observations occurred during interviews and focus group discussion to note comfortability, clarity of the communication, etc. In the focus groups the observer was involved in persistent observation and offering reflections and debriefing which added to credibility.

Johnson (2004) indicated that triangulation results in the explanation of the phenomenon in a rigorous and credible manner. Schurink et al. (2011) and Loh (2013) indicated that triangulation may be gained by using different measures (sources), methods, observations and the use of different theories. Triangulation in this study was ensured by utilising different measures in terms of a survey, semi-structured interviews and focus group discussions. This study also made use of mixed methods thereby utilising both quantitative and qualitative approaches in measuring the phenomena. This study was also employing the social constructivist paradigm, pragmatic paradigm, Habermas' theory of social reproduction and ecological perspective thereby enabling theoretical triangulation.

Member checking was utilised to verify the discussions that occurred by taking the information back to participants for verification of authenticity. This specifically referred to the individual interviews. The audio- recording also enabled this.

Peer debriefing, as according to Babbie and Mouton (2001) refers to the researcher consulting colleagues. This was utilised by the researcher in discussing pitfalls and challenges with colleagues but also having discussions about the progress with the supervisor.

Referential adequacy refers to how the findings was documented (Babbie & Mouton, 2001). All sessions were audio recorded and transcribed. This was especially of importance to verify the correctness of the data.

6.18.2 Transferability

Transferability was ensured by providing thick descriptions via IPA of the experiences of social workers, supervisors and managers regarding the implementation of the SDA. Transferability may also refer to generalisability or how the information may be applied to others (Babbie &Mouton, 2001; Schurink et al., 2011). With regard to this study this was ensured by offering thick descriptions of the phenomenon. The participants in this study represented the different levels of social work in health care but more dominantly tertiary health care settings. This will be generalisable to all social workers in health in the GDH.

6.18.3 Dependability

Dependability refers to measuring the same aspects in similar contexts in essence this refers to reliability (Babbie & Mouton, 2001; Schurink et al., 2011). For this study, the researcher pre-tested the interview and the focus group topic guides to estimate if it sets out to measure what it is intended for. Those who participated in the pretesting were asked for their guidance and evaluation if the guides should be augmented. Valuable suggestions were made by the two pretested participants regarding adding a question about the future of social work and this was added. These participant's findings were not included in the study. Dependability was ensured using the same interview guide with all the participants and the same topic guide with the two different focus groups.

6.18. 4 Confirmability

Confirmability refers to objective and correct reflection of data (Babbie & Mouton 2001; Schurink et al., 2011). This ensures that the data is a true reflection and not concocted by the researcher (Padget, 2008). The audiotapes and transcription were sent to the supervisor to verify the authenticity of the data. In addition, the raw data is and will be kept in a password protected computer for two years following publications and six years if no publications are eminent.

The researcher kept a reflexivity journal to minimise the threat of researcher biasness and asking leading questions. This journal was sent to the supervisor. In addition, the researcher consulted the supervisor. Peer debriefing was also utilised to deal with researcher bias.

6.19 Reflexivity Journal

To prevent researcher biasness, the necessity of keeping a reflectivity journal was evident. This was particularly necessary considering the researcher's previous employment in health but also to ensure the trustworthiness of the data. This also is of reference when using IPA that requires the bracketing of own feelings, views, perceptions or leading of participants. As in line with Larkin and Thompson's (2012) view of the epistemological nature of interpretative phenomenology of exploring the inter-subjective lived experiences of participants, the reflexivity journal served the purpose of ensuring bracketing and trustworthiness. As summarised by Alase (2017) bracketing enables the participants to share their experiences. The researcher therefore does not dominate the findings. This reflexive process also enables thick descriptions of data (Alase, 2017). The keeping of a reflexivity journal and bracketing feelings before and after interviews and focus groups aided the researcher to honestly reflect on the participants' experiences and opinions. It also allowed for the recording of totally diverse opinions and experiences that were contradictory with the experiences or assumptions of the researcher. These differences led to further explorations which aided the value of this research study. In addition to the reflexivity journal, the researcher and

observer had preparation meetings before hand highlighting the purpose and debriefing sessions afterwards to highlight issues of biasness. This was also recorded in the journal.

An example of a journal entry:

23 January 2020 Interview participant 1 48 minutes

Lessons learnt from the pre-test resulted in all documentation emailed to the participant. This resulted in a much more fruitful and focused discussion. The participant could then in their own grapple with consents. There was no need to actually go through the consents and PIs with the participant.

The interview lasted 48 minutes and 24 seconds. It was focused, concise and offered wealth of information.

The sharing of the interview guide was of great help as the participant could offer a wealth of information of the implementation of the social development approach. It also alleviated the anxiety of the participant.

SECTION E: ETHICAL CONSIDERATIONS

6.20 Ethics

It is of the utmost importance to facilitate sound ethical research. Hugman (2009) indicated that the importance of research ethics is to ensure accountability and integrity. Engel and Schutt (2014) summarised that the foundations of ethical principles are respect for persons (the focus is on anonymity), beneficence (to offer benefits and not to do harm) and justice (to minimise risks). Kar (2011) stated that all researchers need to adhere to ethical standards as this ensures good practice. Israel and Hay (2006) reminded that ethical behaviour is essential to protect others, curtailing harm, safeguarding trust and integrity. Neuman (2014) highlighted that the need to adhere to ethical codes are due to the power that researchers have, to minimise the abuse of it and to safeguard the participants. In ensuring ethical behaviour, Israel and Hay (2006) shared that various ethics codes, councils and boards were established to be protect participants. Research ethics now demands respect for others, beneficence and justice (Israel & Hay, 2006).

6. 20.1 Informed consent

All participants in this study were provided with a PIS and informed consents before data collection. Strydom (2011) stated that the informed consent should accurately contain all information necessary to decide on participating in the research study. The informed consent should include the purpose, procedures, advantage and disadvantages, and the credibility of the researcher (Strydom, 2011). Neuman (2014) furthermore indicated that privacy should not be compromised, and that participation is voluntary. The researcher took the utmost care in clearly stipulating the goal and objectives of the research study, highlighting voluntary participation and only requested information relating specifically to answering the goal and objectives of this study.

The social workers, social work supervisors and managers as well as the key informants participating in the semi-structured interview and the social workers in the focus groups all signed an informed consent. This informed consent they could withdraw at any stage. None of the participants withdrew their consents.

6.20.2 Voluntary participation

As indicated by Babbie and Mouton (2001) the informed consent should clarify that participation is voluntary and that all participants have the right to refuse or even withdraw the informed consent. Babbie and Mouton (2001) further indicated that this condition will further enable the participants to share of themselves. The informed consents included this condition that the participants have the right to refuse to participate, that participation is voluntary and that they may withdraw their consent at any time during the survey, the face-to-face interview and focus groups.

6.20.3 Confidentiality and anonymity

Engel and Schutt (2014) stated that the privacy of all participants should be maintained, and that confidentiality is important for the protection of the research participants. This involves ensuring

that information cannot be linked to a particular participant and securing records. Confidentiality may be seen as a promise by the researcher not to reveal the identity of the participants and thereby ensuring the protection of the participant's identity. Strydom (2011) argued that privacy, right to self-determination and confidentiality should all be seen as synonymous. Confidentiality should be seen as handling information in a confidential manner and self-determination as the participants' right and competence to evaluate information and their participation (Strydom, 2011). Israel and Hay (2006) stressed the importance of confidentiality due to having consequences for the participants and should limit access to the participants personal details.

Anonymity in turn refers to the inability to connect a particular participant with a given response (Strydom, 2011). In summary the researcher therefore should ensure that the information is given anonymously and thereby ensures privacy confidentiality.

Confidentiality and anonymity were not major aspects to consider for the surveys, as the any identifying details were not recorded on the survey. As surveys were received, they received a number e.g., S1 (for survey 1). The surveys that were received online were printed, added to the other surveys and also a received a number. In this manner confidentiality and anonymity were ensured.

The participants who were interviewed were assured of confidentiality and anonymity. The participant's identity and the hospital or clinic where they were employed was not revealed. In addition, all participants were referred to as Participant 1 or 2, and so forth.

The same principles as with the individual interviews was stressed with the focus groups. For the focus groups, confidentiality was contracted upon indicating that members may not breach confidentiality of co-members of the focus groups. The informed consent addressed voluntary

participation, anonymity and confidentiality of each participant (Hugman, 2009; Neuman, 2003, 2014; Reyn, 2005). Litosseliti (2003), Morgan (1998) and Liamputtong (2012) stated that privacy and boundary setting with participants needs to be stressed. The researcher did this, and all participants agreed to this principle and signed the consent. The participants were all social workers and confidentiality is an important principle of the profession. However, at the same time it could not be guaranteed that those in the focus group will keep the anonymity of the members. As with the interviews the participants were named focus group (FG) participant 1 i.e., FG Participant 1.

6.20.4 Avoidance of harm

Babbie and Mouton (2001) indicated that research should always attempt not to injure the people being studied. They stressed that subjects can be harmed psychologically as a result the researcher must take care in the subtle dangers that will illicit deviant behaviour and attitudes that may be unpopular. This may foster them to feel uncomfortable and contribute to their personal agony (Babbie & Mouton, 2001). Strydom (2011) on the other hand stated that it may be difficult to determine if harm will be experienced by the participants. In addition, if the participants do feel some discomfort, it may be less in comparison with the real situation (Strydom, 2011). Israel and Hay (2006) indicated that harm should be avoided by offering debriefing.

It was noted that the exploration of this study may cause some discomfort especially if the social workers have experienced frustration with regard to policy implementation. For those involved in the individual interviews and focus groups who may have required assistance in dealing with their discomfort; they could make use of debriefing services of a colleague in private practice. This colleague had no previous connections with the GDH. The costs of the debriefing sessions would be paid by the researcher. None of the participants requested debriefing or approached the social

worker listed in the PIS. The participants in the focus group discussions were debriefed by the observer immediately after each session.

6.20.5 Permissions

Engel and Schutt (2014) indicated that the application for ethical clearance from review boards should be gained. These ethical review boards ensure that ethical standards. Ethical clearance was applied from the Human Research Ethics Committee (Non - Medical) - University of Witwatersrand. An ethics certificate, protocol number **H 18/ 02/ 32**, was issued for this study, *(See Appendix A)*. In addition, ethical clearance also had to be applied for to the five districts of Gauteng. All five districts granted permission but only three districts offered written permission *(See Appendix B)*. The GDH's ethics review process is extremely flawed due to the delay of the research study for more than 18 months. As a result of the delay in response from the GDH the research also applied for ethical clearance from several hospitals and clinics in Gauteng. Only two responses were received.

6.20.6 Conflict of interest

The researcher was not employed at any health care institution therefore conflict of interest was not evident. However, due to the researcher's previous employment history, the researcher kept a reflexivity journal to prevent researcher bias.

6.20.7 Publications

Both Babbie and Mouton (2001) and Strydom (2011) addressed the ethical issues around publications. Publications should have appropriate ascription of authorship, make reference to the participants, should acknowledge rejection of any form of plagiarism and no simultaneous submission of the same manuscript (Babbie & Mouton, 2001). As in line with the above prescripts

the researcher will ensure the anonymity of the participants in future publications but also ensure good ethical practices in producing work for publications.

6.21 Summary

This comprehensive overview highlighted the sequential explanatory mixed methodology of this study. Five domains of discussion were the research questions, goal, objectives and hypothesis, methodology and the paradigm, the quantitative approach, qualitative approach and ethical considerations. The seamless pairing between the mixed methodology design, comprising of questionnaires, interviews, focus groups, and pragmatism enabled triangulation, complementarity and development for this study. Survey and interpretive phenomenological research design structured over four phases of data collection enabled the in-depth exploration of the phenomenon. The data obtained from 45 questionnaires, ten participants interviewed, two focus group discussions and two key informants offered a detailed account of the application of the SDA of social workers in health care in the GDH. The survey research design enabled the collection of information from various respondents, whereas interpretive phenomenology offered the opportunity for inter-subjective and in-depth exploration of the participants viewpoints and experiences. The method therefore lent itself well to contribute to the research area. Compliance with ethics at various points was instrumental and enabled the in-depth sharing of participants. The next three chapters represent the findings of this sequential mixed methodology study. Chapter 7, essentially phase one of the study, represents the findings of the survey research design and points out several associations that are of value in focusing of the application of the SDA, the SDH, policy implementation and job satisfaction of social workers in health care.

CHAPTER 7
DATA PRESENTATION
SURVEY RESEARCH DESIGN

7.1 Introduction

The focus of this chapter is the data presentation and analysis of the data collected via the survey research design. Descriptive and inferential statistics are used to present the results as according to the categories of demographics of the survey population, employment specifications, findings on the social development approach (SDA), the social determinants of health (SDH), policy implementation, the suggested SDA framework and general associations and potential correlations. The demographics will introduce the population by providing the sample's identifying details which include the age, gender and racial classification of the 45 respondents. The employment background of the survey population will a comprehensive overview the experiences of social workers, their grades, the types of hospital settings, supervision and or management responsibilities, core areas, job descriptions and satisfaction. The findings on the SDA will present the respondents' understandings, implementation, examples of the SDA, views on rotation, cultural competency and training on SDA. The findings on the SDH will present the respondents' understanding and addressing the SDH. The discussion on policy implementation highlights how policy was implemented and the perceptions of social workers regarding it. The discussion on associations and possible correlations between the SDA, the SDH, job satisfaction and policy implementation will present the respondents' perception thereof. The main argument throughout this data presentation is that the population is diverse, well equipped, creative and work under extreme difficulties.

7.2 Demographics of the study population

To avoid coverage errors the survey was distributed to entire population via post and email. Despite this, 45 surveys were returned. This represents a 15% return rate and not the expected 30%. The findings of these 45 surveys are presented here.

Table 7. 1: Age Distribution

Age Levels	1	2	3	4	5	6	7	8	Total
Ages in years	22-25 yrs.	26 -30 yrs.	31-35 yrs.	36 -40 yrs.	41-45 yrs.	46 -50 yrs.	51-55 yrs.	56 -60 yrs.	
Total	2	3	3	11	11	7	5	3	45
Percentage	4.4%	6.7%	6.7%	24.4%	24.4%	15.6%	11.1	6.7%	100%

Table 7. 1 provides an overview of the age distribution of the population. Eight (8) categories were formulated that contained four-year intervals per category except for the first category which makes provision for the initial entry into the profession of all social workers. An *Other* age category was also available if a participant were to be either younger than 22 years or older than 60 years. This option was not selected. Each age category was represented in this survey. This contributes to representativeness of the study population according to age. As can be noted, the bulk of the population, i.e., 11 individuals or 24.4% were in the age categories 36 – 40 years and 41 – 45 years, respectively.

Table 7. 2: Age distribution, Gender and Racial Classification

Age Levels	Gender		Racial Classification			
	F (female)	M (male)	B (Black)	C (Coloured)	I (Indian)	W (White)
① 22-25 yrs.	2		1			1
② 26 -30 yrs	1	2	3			
③ 31-35 yrs	3		3			
④ 36 -40 yrs	9	2	10		1	
⑤ 41-45 yrs	9	2	10	1		
⑥ 46 -50 yrs	7		7			
⑦ 51-55 yrs	5		2		3	
⑧ 56 -60 yrs	3		2		1	
Total	39	6	38	1	5	1
Percentage	86.7%	13.3%	84%	2.2%	11.1%	2.2%

Table 7.2 unpacks the study population in terms of gender and racial classification. Thirty-nine (39) respondents or 86.7% of the survey population were female and 6 or 13.3% were male. In addition, 84 % of the survey population were classified as Black. Thirty-two females i.e., 71%, were Black and were represented in all age categories. All racial categories were represented in the study. Of the population, 5 or 11.1% were Indian, and the second largest representation in the survey. It can be surmised that the bulk of the population i.e., aged between 36 – 40 years and 41 – 45 years were female and black. The six male respondents in this study were all classified as Black and were represented in the age categories of 26 – 30 years, 36 – 40 years and 41 – 45 years.

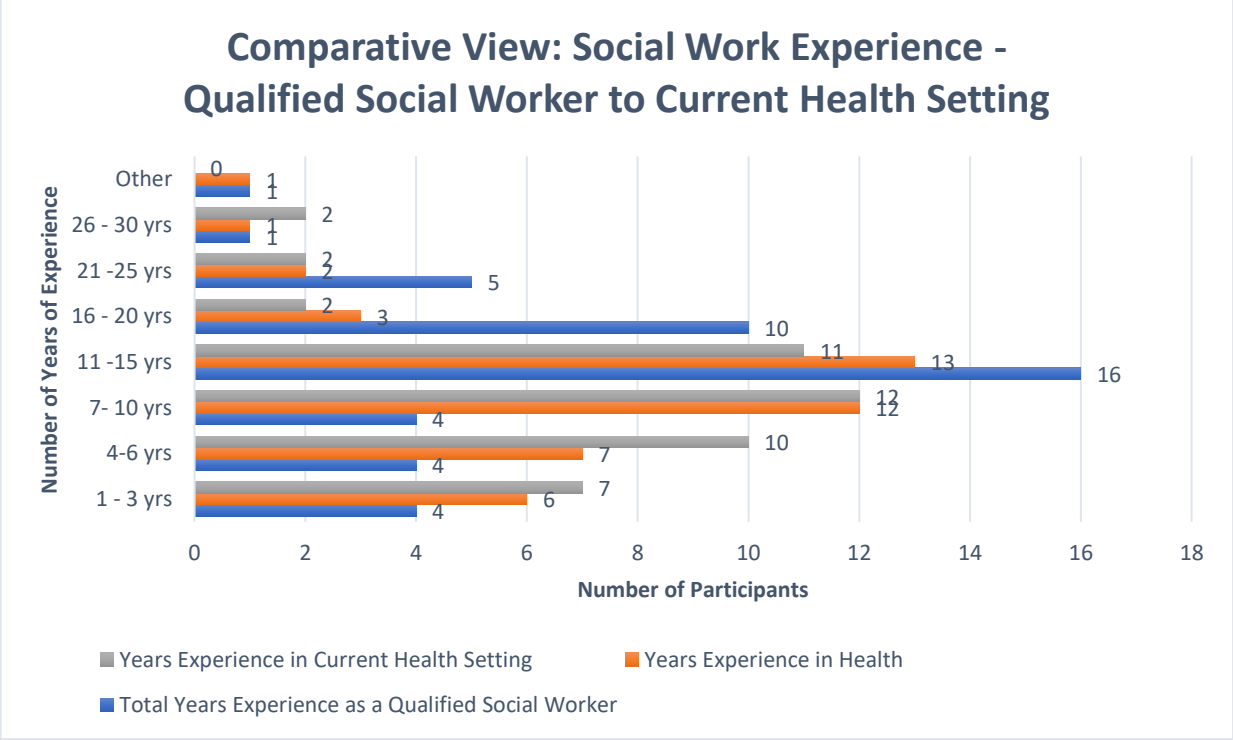
7.3 Employment specifications

Table 7.3: Overview of the demographics and employment specifications

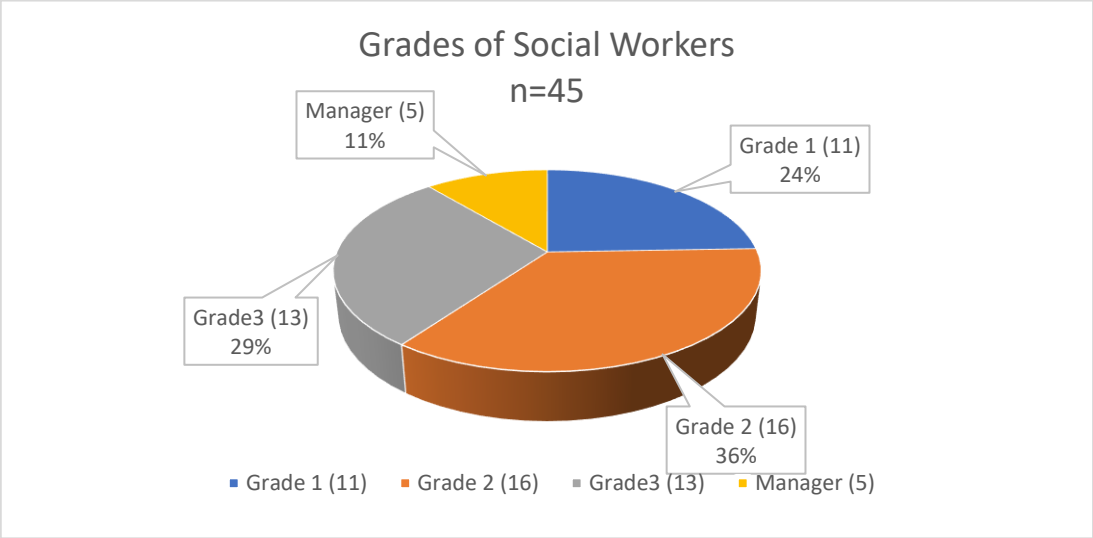
Age Levels		1	2	3	4	5	6	7	8	TOT	%
Gender	F	2	1	3	9	9	7	5	3	**39**	**86.7**
	M		2		2	2				**6**	**13.3**
Race	B	1	3	3	10	10	7	2	2	**38**	**84.4**
	C					1				**1**	**2.2**
	I				1			3	1	**5**	**11.1**
	W	1								**1**	**2.2**
Total Years of Experience as a Social Worker	1-3 yrs	2	1		1					**4**	**8.9**
	4-6 yrs		1		1	1	1			**4**	**8.9**
	7- 10 yrs		1	1	1	1				**4**	**8.9**
	11 -15 yrs			2	4	5	4		1	**16**	**35.6**
	16 - 20 yrs				4	4	1	1		**10**	**22.2**
	21 -25 yrs						1	4		**5**	**11.1**
	26 - 30 yrs								1	**1**	**2.2**
	Other								1	**1**	**2.2**
Years of Experience in Health	1-3 yrs	2	2		2					**6**	**13.3**
	4-6 yrs		1	2	1	2	1			**7**	**15.6**
	7- 10 yrs			1	3	5	1	2		**12**	**26.7**
	11 -15 yrs				4	3	5		1	**13**	**28.9**
	16 - 20 yrs				1	1		1		**3**	**6.7**
	21 -25 yrs							2		**2**	**4.4**
	26 - 30 yrs								1	**1**	**2.2**
	Other								1	**1**	**2.2**
Years of Experience in Current Health Setting	1-3 yrs	2	2	1	2					**7**	**15.6**
	4-6 yrs		1	2	3	3	1			**10**	**22.2**
	7- 10 yrs				2	6	1	3		**12**	**26.7**
	11 -15 yrs				4	2	5		1	**11**	**24.4**
	16 - 20 yrs							1	1	**2**	**4.4**
	21 -25 yrs							2		**2**	**4.4**
	26 - 30 yrs								1	**1**	**2.2**
	Other										

Age Levels		1	2	3	4	5	6	7	8	TOT	%
Rank or Grades	Grade 1	2	3	1	4		1			**11**	**24.4**
	Grade 2			2	3	6	3	2		**16**	**35.6**
	Grade 3				2	5	3	2	1	**13**	**28.9**
	Managers				2			1	2	**5**	**11.1**
Type of Hospital Setting	Tertiary	2	3	1	8	7	7	4	2	**34**	**75.6**
	Secondary				2	1		1	1	**5**	**11.1**
	Clinic			1	1	2				**4**	**8.9**
	Rehab					1				**1**	**2.2**
	Specialist			1						**1**	**2.2**
Involved in Supervision	Yes		1	2	8	6	3	4	3	**27**	**60**
	No	2	2	1	3	5	4	1		**18**	**40**

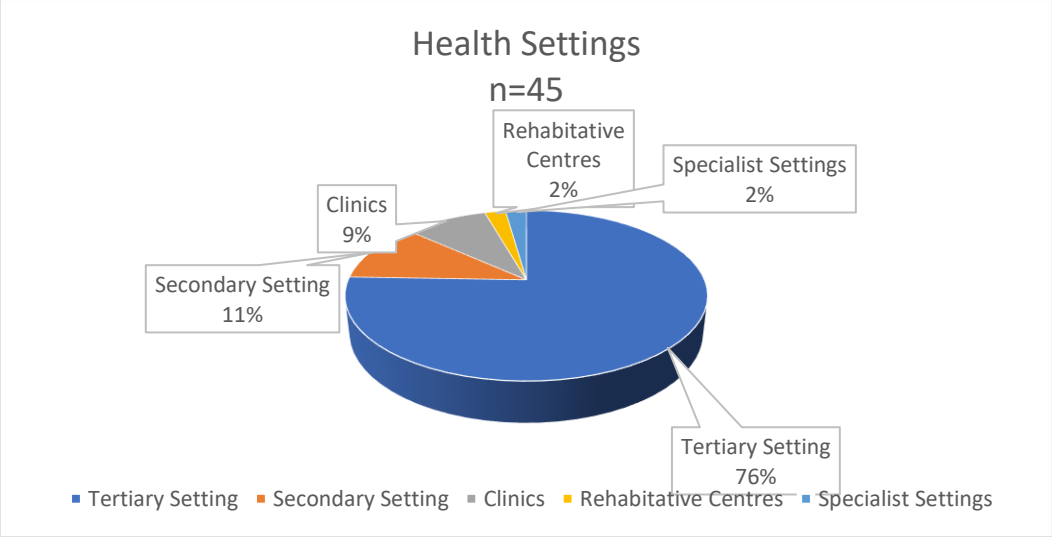
Table 7.3 provides a comprehensive overview of the age categories of the respondents in comparison with gender, race, total years of experience as a social worker, experience as a social worker in health, experience as a social worker in the current health setting, rank or grades, the type of hospital setting and involvement with supervision and or management. Sixteen (16) respondents had 11 – 15 years and ten (10) 16 – 20 years of experience as a social worker.



Graph 7.1: Comparative view: Social Work Experience (Survey)



Graph 7.2: Grades



Graph 7.3: Types of health care settings

Graph 7.1 unpacks the social work experience from general to the current health care setting. As can be noted from the survey population that 7 – 10 years of experience in a current health setting were the most selected with 12 respondents followed by 11 respondents with 11-15 years of experience. Four respondents (8.9%) of the population had three years or less experience as a social worker in general and 6 respondents (13.3%) had less than three years of experience in a health care setting. Therefore, in general 41 respondents i.e., 91.1% had more than four years of experience as a social worker. Thirty-nine respondents or 86.6% of the population had four years

or more experience in health care. In addition, 38 respondents or 84.4% of the population had four or more years of experience in the current health setting. It should also be noted that there was one participant that had more than 30 years of experience as a social worker within health. The experience as social workers and in health care are indicative of a population rich in experience. They were therefore ideally situated to offer the most comprehensive and accurate information on this study.

Five of the respondents indicated that they were managers with two managers being in the age group 56 - 60 years, two in the age group 36 - 40 years and employed in secondary or regional health care settings. Eleven (11) respondents or 24 % of the population may be categorised as entry level social workers that is grade 1, being in the younger age group with one participant between the age of 45 - 60 years, who presumably entered the profession late. Grade 2 social workers comprised out of 35.6%. *See also graph 7.2*. Most respondents i.e., 34 or 75.6%, who completed the survey indicated that they are employed in tertiary health care settings with secondary or regional health care settings making up 11.1 %, clinics 8.9% and rehabilitation settings and specialist hospital settings with 2.2% respectively. *See also graph 7.3*. All levels of services delivery within the health care setting were represented in the study. This therefore aids the comprehensiveness and diversity of the findings.

It should also be noted that 60% of the population, representative of all age and experience categories were involved in supervision may it be of student social workers, social auxiliary workers and social workers.

7.3.1 Job descriptions

The content analysis of the open-ended questions is indicative that there are varied perceptions regarding job descriptions. From the 33 different descriptions offered about the job description it

is clear that the respondents perhaps listed their roles they play within the health care setting rather than the overall job description categories which usually refers to patient care, administration, supervision and management, training and development or coaching and mentoring.

Job descriptions for patient care included child protection, macro-outreach to community, continual support, disability grant (DG) application, direct patient care, indirect patient care, adoption, awareness campaigns, home visits, community work, reunification services, family liaison, DG and identification (ID) application and discharge planning. Multidisciplinary team (MDT) meetings, case work, tracing families, linking with resources and the education of patients and families were indicated twice respectively. Group work and clinical work were indicated four times respectively, assessments were identified nine times and counselling 17 times.

Job descriptions for administration, supervision and management were also explored. Respondents did not identify administration as part of their job description. The implementation of operational targets, staff morale and performance management, attending meetings, quality assurance, monitoring and the general running of the department were all indicated once. Supervision and management were indicated four times, respectively.

Job descriptions for training and development was mentioned twice. Two respondents did not highlight any job descriptions. It is clear as with the diversity of the population, so diverse is the service delivery.

Most important services as based on the opinions of the social workers were sought. Clinical or therapeutic or counselling (including trauma counselling and crisis intervention) were indicated as the most important service to be offered with 23 or 51.1% of respondents. Assessment, training

and development, mediation, support, adherence, amongst others as well were highlighted once or twice as the most important services to be offered by social workers.

It was evident that macro strategies employed by social workers were not well described. Six (6) respondents indicated case work, three (3) group work and family preservation, four (4) indicated referrals to the DSD and other organisations, and involvement with the MDT as macro strategies. Four respondents indicated that macro strategies were not implemented or not applicable. It would seem that most respondents were involved in macro strategies such as community liaison with stakeholders identified as SAPS (South African Police Services), VEC (Victim empowerment centres) (n=2), awareness campaigns (n=10 or 22.2%), community work (n=3), outreach (n=1), projects according to the health calendar (n=2), health talks (n=6) and quarterly results (n=1). It is not clear if proper community actions are occurring.

Likert scales were utilised to explore the respondents' opinion of their contentment and frustrations in the role as social workers, in supervision, management or with policies. The Likert scales had five categories ranging from ***1***. *strongly disagree,* ***2***. *disagree,* ***3***. *neutral,* ***4.*** *agree and* ***5.*** *strongly disagree.*

Table 7.4: Contentment and frustration with role, supervision and policies

Categories	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
I am content with my Supervision responsibilities	45	2	3	5	3.60	.654	.427
I am content with my Managerial responsibilities	45	3	2	5	3.38	.684	.468
I feel appreciated in the Role I fulfil	45	4	1	5	3.36	.857	.734
I know I can implement Innovative Strategies in my roles	45	4	1	5	3.93	.863	.745
I am recognised for my Innovative Strategies	45	4	1	5	3.22	.902	.813
Contentment as a social worker	45	4	1	5	4.07	.889	.791
Frustration due to Rules and Policies	45	4	1	5	3.13	1.079	1.164
Frustration due to Policies from Gauteng Health	45	4	1	5	3.16	1.224	1.498
Innovative Strategies valued	45	4	1	5	3.20	1.198	1.436
Frustrations shared with Family or Friends	45	4	1	5	3.67	1.087	1.182

As can be noted in Table 7. 4 for most of these categories the majority of scoring ranged between intervals 3 to 4. This implies that the responses ranged from ***neutral to agree*** for most categories. The standard deviation and variance of the first six categories seems to indicate a significance in the findings as scoring was below ***1.00.*** The respondents were generally content with their role, supervision, management, being recognised and for their innovative strategies. The survey population seemed to be more neutral regarding frustrations with policies and indicating no significance. Frustrations were shared with family and friends as this mean averaged ***3.67.***

7.4 Findings on the social development approach

7.4.1 Delineation of the SDA

Apart from five respondents, 88.9% of the population had some concept of the SDA. The descriptions offered included the fostering of self-sufficiency, self-worth and self-reliance *(n=10)*, improvement, change and wellbeing of individuals *(n=9)*, progressive improvements of people's lives to ownership of own problems *(n=5)*, prevention and early intervention services *(n=5)*,

empowerment of clients and community *(n=5),* focus on the strengths of clients *(n=3),* sustainable development *(n=2),* partnerships *(n=1),* poverty eradication *(n=1*), protection of the vulnerable *(n=1),* investment in people *(n=1)* and an holistic approach to address social ills *(n=1).* One respondent defined the term '*approach as a set of steps'* only and did not provide further explanation of the SDA. The descriptions were diverse and comprehensive. This is suggestive of the diverse and complex understanding of the SDA as was also pointed out in chapter 4.

7.4.2 Strategies of the SDA

The respondents' understanding was further explored by requiring their description of the SDA strategies employed by themselves and Government. Here, diversity of responses was also noted. Five respondents indicated that government did not have any SDA strategy. Others listed grants *(n=6),* family preservation *(n=1),* programmes of sustainable livelihoods (*n=4*), provision of food *(n=1),* access to free health care *(n=2),* free education *(n=2),* poverty alleviation *(n=2),* partnerships and projects *(n=1).* Some of these aspects were not clarified and it is not entirely sure if the respondents understood its application. In identifying their own strategies of the SDA the respondents listed: empowerment of clients *(n=3*), poverty alleviation *(n=1),* advocacy *(n=2),* workshops and education (n=3), screening and referring for grants *(n=5),* placements *(n=*6), child protection *(n=1),* registering of births *(n=1),* encouraging people to look for opportunities *(n=1),* methods of social work *(n=1),* problem identification *(n=1),* crisis intervention and trauma counselling *(n=1),* focussing of strengths of *clients (n=1*) and fostering self-sufficiency *(n=1).* From the above, aspects that pertains to the role of social work or the general job descriptions was also included like child protection, applying of social work methods, problem identification, counselling, etc. It is therefore not clear if these are part of the SDA or social work or the fundamentals of developmental social work. Some aspects listed are also associated with general programmes of the country and not necessarily pertaining to the SDA. The findings may be either

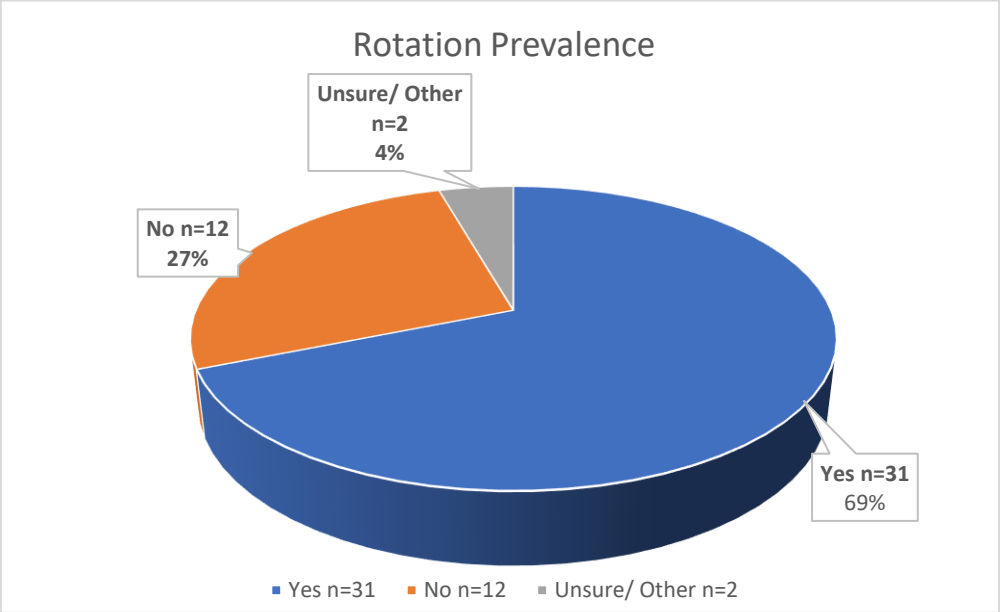
suggestive of difficulty in proving which roles or activities pertains to the SDA or that social work in health care is highly social development oriented.

7.4.3 Social justice

In exploring the role of social justice and advocacy as pertaining to the SDA, 16 (35.6%) respondents indicated that they advocate for their clients through the general role of social work. Could this advocacy through the embodiment of the social work role be more definitive of the SDA and embedded within the social work profession? Other indications of advocacy were linking clients with resources *(n=9),* tools to empower themselves *(n=3),* the application of non-judgemental attitudes *(n=2),* placements *(n=1),* using the acts *(n=1),* information giving *(n=1),* going to the South African Social Security Agency (SASSA) offices *(n=1),* disease prevention and adherence *(n=1)* and opening of court procedures *(n=1).* Three respondents listed only social justice as to explain strategies of social justice. It is therefore not clear what these respondents implied and if they understood the concept.

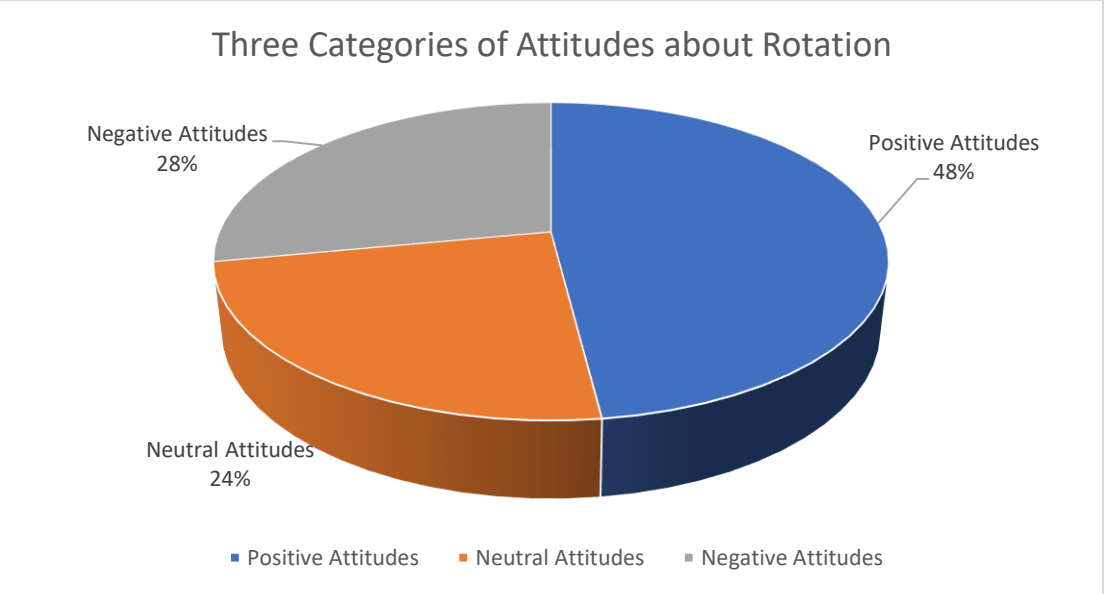
7.4.4 Rotation

Rotation as according to the DSD (2016a) was implemented as part of the SDA for the management, the care and remuneration of social workers to prevent high attrition rates. The prevalence and understanding of this in the health sector were explored.



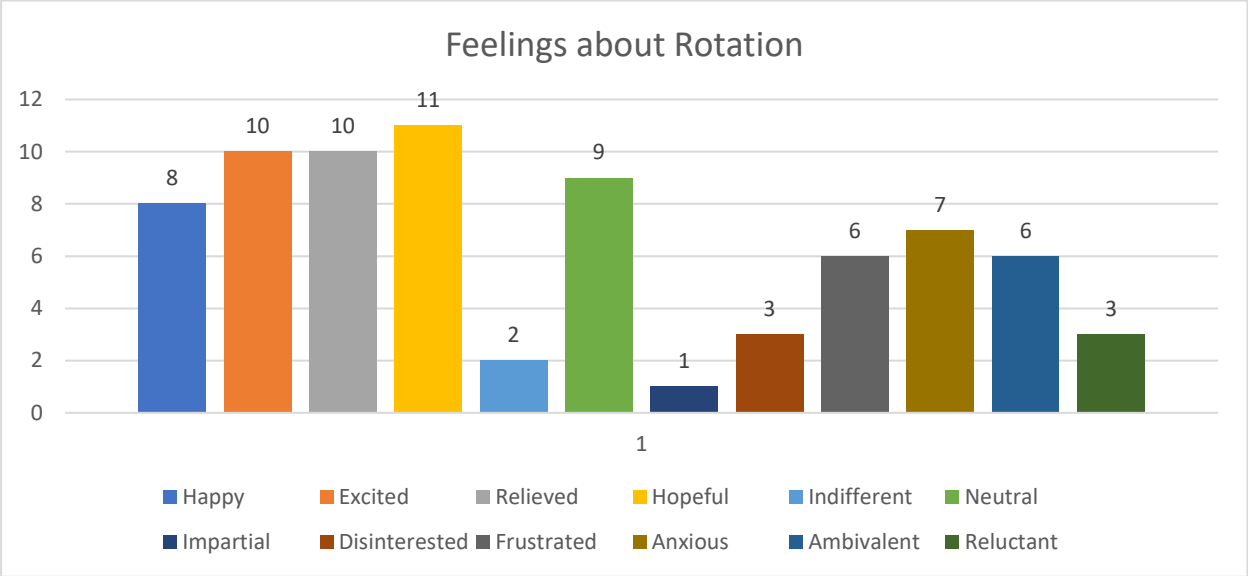
Graph 7.4: Rotation prevalence

Graph 7.4 indicates a 69 % application of rotation in health care settings, 27% where rotation is not applied and 4% where there is uncertainty if it is applied.



Graph 7.5: Three categories of attitudes about rotation

Graph 7.5 indicates that 48 % of the population is positively inclined towards rotation and 28 % is negatively inclined. Twenty-four (24%) percent of the population were however neutral about rotation.



Graph 7.6: Accumulative feelings about rotation

Graph 7.6 represents the various feelings associated with rotation. Respondents could indicate as many feelings as possible. As can be noted that feelings of happy, excitement, hopefulness and relieved were selected the most often, followed by feelings of neutrality with nine indications. Feelings of frustrations, anxiousness, ambivalence and reluctance were also selected but to a lesser degree.

Reasons for rotations included exposure of social workers to different units or wards in the hospital *(n=21 i.e. 46.7 %)*, gain experience *(n=5)*, update of skills and knowledge *(n=4)*, professional growth *(n=2)*, explore interests *(n=2)*, familiarise and to gain knowledge *(n=2)*, empowerment of workers *(n=1)*, prevention of burnout *(n=1)*, increasing efficiency *(n=1)*, staff members are on leave *(n=1)*, expose as not to specialise *(n=1)*, for educational purposes *(n=1)* and to balance the quality of services *(n=1)*. From this it was clearly noted that rotation is needed and to ensure non specialisation. The bulk of the respondents *(n=20 i.e., 44%)* indicated that rotation is enforced, decided by managers or just informed. These social workers apparently have no opportunity to discuss the changes. Fourteen respondents however indicated that there seems to be either discussions or interest that is considered. Seven respondents indicated that rotation does not occur

of which two respondents indicated that it will be implemented at a later stage. Different systems with regard to implementation was also indicated like a release system when people are on leave or when new posts are advertised.

7.4.5 Cultural competence

Twenty-eight or 62 % of the population confirmed that culturally competent models are not available in the GDH. All the respondents i.e., 100% indicated that they use their own skills, professionalism and social work values to navigate culture and diversity. The necessity of this model was indicated.

7.5 Findings of the social determinants of health

7.5.1 Delineation of the SDH

Whereas the respondents could clarify and qualify their perceptions and application of the SDA, the SDH proved more challenging. Most of the responses were generic and encompassed the social conditions that seems to prevent access to health care *(n=9)*, conditions where people are born in *(n=4)*, socio economic status and access to social support *(n=3)*, wellbeing *(n=2)*, advocate for fair equitable access to health *(n=2)*, the holistic approach *(n=1)*, believing in people *(n=1)*, people to make their own decisions *(n=1)* to utilising the biopsychosocial approach *(n=1)*, social inclusion *(n=1)*, social inequalities *(n=1)*, assessment of circumstances *(n=1)* and improve education *(n=1)*. Two respondents indicated that they were not sure as to its meaning. From the descriptions it can be noted that some aspects of the SDH are being addressed but not fully described by the bulk of the population. It is noted that there seems to be an unfamiliarity regarding delineating the SDH by social workers in the GDH.

7.5.2 Relevance of the SDH to social work in health care

Table 7.5: Relevance of the SDH to social work in health care

Category	Frequency	Percentage (%)
Strongly Disagree	2	4.4
Neutral	12	26.7
Agree	16	35.6
Strongly Agree	15	33.3
Total	45	100.0

Table 7.5 indicates the impressions of respondents about the relevance of the SDH for social work in health care. As denoted 33.3 % strongly agree that the SDH is applicable to social work in health care. The majority of the population i.e., 35.6% indicated that they agree with the relevance of the SDH. Those who were neutral about the relevance of the SDH to social work in health care was 26.7% and 4.4% indicated that the SDH are not of relevance to social work in health care.

7.5.3. Strategies of the SDH

The indications regarding strategies to the SDH as implemented by government and themselves also proved varied results. Some respondents refrained from offering any indication of strategies of the SDH employed by government. Provision of or access to health care was identified by 9 respondents. Other strategies suggested by the respondents, included access to basic resources *(n=3)*, development of health policies an application *(n=3)*, poverty alleviation *(n=2)*, education, preventative services, reducing health inequalities, GBV, shelters, well informed programmes and research were all indicated once.

In exploring the respondents' own strategies with regard to the SDH, 10 respondents indicated that the SDH is enforced by referring clients to resources. Other suggestions that were indicated once were understanding of the physical and economic environments, implementation of the standard operation procedures (SOP), food security, research, empowerment, awareness programmes, reporting of gender-based violence (GBV), adherence to treatment, behaviours that emanate from

social ills and motivate patients to start their own gardens. It was therefore clear that the respondents were less familiar with the SDH but also that there was a strong overlap between the elements raised by respondents for the SDA and the SDH. It would also seem that these two concepts are perhaps seen as similar by the respondents.

7.6 Findings on policy or SOP implementation

The exploration of policy implementation occurred via Likert scales and open-ended questions.

7.6.1. Policy or SOP changes on social work role

Most respondents did not list any policies or SOP that was implemented or on their role. Some policies or SOP that were implemented included policy changes due to the Life Esidimeni tragedy *(n=2)* and placement of undocumented immigrants, adoptions, termination of pregnancy (TOP), dealing with elderly, statutory cases, children's and performance management and development system (PMDS) were all listed once. Some of the implication on policy changes on the role were challenges relating to the children's act *(n=5),* the home visits policy *(n=2),* challenges with older persons *(n=2),* challenges with reporting teenage pregnancies to police *(n=2),* long hospitalisation of undocumented immigrants *(n=1),* forced involvement with TOP despite own beliefs *(n=1),* children giving consent for TOP *(n=1),* completion of various forms (form 22) *(n=1),* PMDS biases *(n=1),* and social security created dependency and placed pressure on social workers to perform miracles *(n=1).*

Table 7. 6: Policy matters

Categories	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
Policies implemented in a Consultative manner	45	3	1	4	2.84	1.065	1.134
Government values input to Policy	45	3	1	4	2.51	.991	.983
Policy Changes are appreciated	45	4	1	5	2.91	.973	.946
Policy Changes in line with Transformation	45	4	1	5	3.44	.967	.934
Policy Implementation has been clear	45	4	1	5	2.84	.928	.862
Managers/supervisors clarified policies	45	4	1	5	3.51	.944	.892
Relationship between Job Satisfaction and Policy Implementation	45	4	1	5	3.56	.990	.980
Relationship between Job Satisfaction and Transformation	45	4	1	5	3.51	.869	.756
Policies correctly understood	45	4	1	5	2.69	1.083	1.174
Manager/ supervisor advocacy	45	4	1	5	3.07	1.031	1.064
Manager/ supervisor questions policy	45	4	1	5	2.98	1.055	1.113
Social Action against Policy	45	4	1	5	3.18	1.134	1.286
Role unaffected by Policy Implementation	45	4	1	5	2.80	1.120	1.255
Policy Changes reiterated the Value of Social Work	45	4	1	5	3.13	1.057	1.118

P<0.05

Via Likert scales respondents were able to rate the impact of policy implementation. From the questions on policy implementation included seven categories where the results seem to move to significance considering the standard deviation and variance as recorded in table 7.6. These aspects included Government values input into policies which indicated a ***.991*** standard deviation for disagreeing to being neutral with this statement. It would seem that social workers in health care are generally not consulted with regard to policy implementation and changes. Policy changes are generally also not appreciated or clear with the responses leaning towards disagree even though there seems to agreement to strongly agree that all policy changes are in line with transformation. The respondents also indicated the importance of managers and or supervisors clarifying policies. Respondents also indicated a strong relationship between policy and job satisfaction and transformation. Some respondents indicated that policies that has impacted their role both positively or negative included policies that were developed after the Life Esidimeni tragedy, the

Children's Act, performance management, statutory cases, placements of undocumented migrants, adoption, TOP and SOP. The respondents only highlighted challenges with new policy implementation or SOP such as long delays in hospitals due to discharge policies, home visits policies, social workers forced to open cases with the police of all teenage pregnancies despite family involvement and reluctance of police to act. The contradiction amongst policies with regard to reporting teenage pregnancies but a twelve-year-old may consent to a TOP and the intensive administration involved with changes in acts and policies e.g., the Children's Act were noted. One respondent also mentioned that policies with regard to social security created dependency but enhanced the expectations from patients that social workers should be miracle workers. Another respondent pointed out the duality of the TOP act where social workers are not permitted to exercise their belief in being prolife whereas doctors may decline working with TOP based on their ethics.

7.7 Relationships between constructs

Via the use of Likert scales respondents could also indicate their perception of possible relationships between their role, job satisfaction and transformation, relationship between the SDA and the SDH, knowledge of the SDA and the SDH on competence, the successful implementation of the SDA on the role and the successful implementation of the SDH on role. Respondents were offered the opportunity to qualify their rating. All respondents did not make use of this option.

Table 7. 7: Associations

Categories	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
Relationship between Job Satisfaction and Transformation	45	4	1	5	3.51	.869	.756
Relationship between SDA and SDH	45	3	2	5	3.78	.823	.677
Knowledge of SDA and SDOH on competence	45	4	1	5	3.87	.894	.800
Policy Changes and Improvement of Role	45	3	2	5	3.56	.841	.707
Successful implementation of SDA on Role	45	3	2	5	3.62	.747	.559
Successful implementation of SDOH on Role	45	4	1	5	3.56	.893	.798
SDA and SDH on role of Social Worker	45	4	1	5	2.62	1.230	1.513

P<0.05

Table 7.7 reflects the opinion of the respondents on the relationship amongst constructs. As can be noted from table 7.7 that the first six categories suggest strong associations amongst the constructs. Respondents indicated an agreement that there could be a possible cause and effect relationship between job satisfaction and transformation considering the mean of ***3.51,*** a standard deviation of ***.869***.and a variance of ***.756.*** Respondents also indicated that there is a relationship between the SDA and the SDH with a mean ***3.78*** i.e., leaning towards agreement and a standard deviation of ***.823***. Respondents also indicated that knowledge of the SDA and the SDH improves their competence with a significant standard deviation of ***.894***. Even though the respondents did not indicate a great deal on the open-ended aspects of policies, here it was indicated that policy changes have had an improvement on the role of social workers with a mean of ***3.56*** and standard deviation of ***.841***. Respondents also indicted that they have successfully implemented the SDA and the SDH as part of their roles as social workers. The SDH standard deviation is significant as ***.893*** which seems to be contradiction with the limited understanding of the SDH that was offered by the respondents. Here it can be clearly noted that the qualification of aspects needs major work. Where the elements of the impact of the SDA and the SDH were combining the two aspects and stated with neutrality as *'SDA and SDH have not real bearing on my role as an effective social worker'* the social workers indicated a mean of ***2.62*** and a standard deviation of ***1.230*** vacillating between disagree and neutral, thereby indicating insignificance.

7.8 SDA framework

The respondents were also requested to indicate what the possible social development framework for social work in health should contain and their training needs regarding the SDA. Regarding their suggestions of what a social development framework should comprise; one participant indicated that due to her involvement in marking for a higher education institution she is familiar with the SDA framework and that this framework is inclusive and should not be altered. What this framework entails was not clarified. However, *44 or 97.8%* of respondents indicated that an SDA

framework is not available. They informed that an SDA framework for social work in health should include but not be limited to housing, social wellbeing, financial and physical resources, GBV, HIV/AIDS, empowerment of communities, persons with disability (PWD), early childhood development (ECD), substance abuse, labour market programmes, youth programmes, inclusion of all groups, rights base harmonising, prevention and early intervention services, focus on education, employment and socio-economic status. As can be noted that the above seems to indicate the need for practical resolution of societal issues and conditions of patients. Currently this is missing from the ISDM.

The respondents indicated a variety of training needs that may not be generally considered as the SDA framework. Training needs which included training on the SDA itself accounted for 20 respondents, with the other respondents indicating economics, dealing with refugees and foreign nationals, sign language, statutory and adoption services, family preservation, GBV and other developmental or psychosocial models. The aspects suggested may be inclusive of the respondents' general training needs and not necessarily associated with the SDA. The expression of what the framework should contain, and training needs is perhaps suggestive about the gap of knowledge regarding the SDA.

7.9 Inferential analysis of constructs

Tables 7.8 – 7.12 represent various inferential analyses, using the Pearson Correlation Coefficient and Sig. (2 tailed), of the dominant constructs measured for this study.

Table 7.8: Inferences 1

		Government values input to Policy	Policies implemented in a Consultative manner
I am content with my Supervision responsibilities	Pearson Correlation	-.203	.137
	Sig. (2-tailed)	.180	.369
	N	45	45
I am content with my Managerial responsibilities	Pearson Correlation	-.124	-.074
	Sig. (2-tailed)	.418	.631
	N	45	45
I feel appreciated in the Role I fulfil	Pearson Correlation	-.112	.012
	Sig. (2-tailed)	.465	.937
	N	45	45
I am recognised for my Innovative Strategies	Pearson Correlation	-.003	-.082
	Sig. (2-tailed)	.985	.595
	N	45	45
Frustration due to Rules and Policies	Pearson Correlation	-.023	-.199
	Sig. (2-tailed)	.882	.190
	N	45	45
Policy Changes and Improvement of Role	Pearson Correlation	.360*	.302*
	Sig. (2-tailed)	.015	.044
	N	45	45
Policy Implementation has been clear	Pearson Correlation	.113	.159
	Sig. (2-tailed)	.460	.297
	N	45	45
Role unaffected by Policy Implementation	Pearson Correlation	.381**	-.084
	Sig. (2-tailed)	.010	.584
	N	45	45
Frustration due to Policies from Gauteng Health	Pearson Correlation	-.030	-.086
	Sig. (2-tailed)	.847	.576
	N	45	45
Policy Changes in line with Transformation	Pearson Correlation	.256	.488**
	Sig. (2-tailed)	.090	.001
	N	45	45
Policy Changes reiterated the Value of Social Work	Pearson Correlation	.345*	.342*
	Sig. (2-tailed)	.020	.022
	N	45	45
Policy Changes are appreciated	Pearson Correlation	.425**	.469**
	Sig. (2-tailed)	.004	.001
	N	45	45
Frustrations shared with Family or Friends	Pearson Correlation	.035	-.262
	Sig. (2-tailed)	.819	.082
	N	45	45

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Utilising the Pearson Correlation, it would seem that negative associations among supervision responsibilities, managerial responsibility, appreciation of role, recognition of innovative strategies, frustration due to rules and policies, frustration due policies from the GDH with the construct of Government values my input to policy, as table 7.8 indicates. Negative associations are indicated with managerial responsibilities, recognition of innovative strategies, frustration due to rules and policies, role unaffected by policy implementation, frustration due to policies from

GDH and frustration shared with families and friend with the independent variable of Policies are implemented in a consultative manner. Therefore, frustrations increase, contentment decreases as the perceived lack of value of input into policies is seen. With the perception of respondents being valued or recognised it would seem that the perceived value diminishes. But despite this lack of perceived value, the respondents felt recognised. Frustration increased as there is a lack of value from Government. The contentment also decreases where policies were not implemented in a consultative manner. Positive associations were noted with regard to the Sig. (2 tailed), which is suggestive that if input to policies is valued and consultation occurs, so contentment, appreciation and lack of frustration are evident.

What should be noticed is that are six associations that shows significance. Policy changes and improvement on role with both Government values input in policy and policies are implemented in a consultative manner where $p<0.01$. Roles of social workers were also unaffected where social workers input was valued with a significance of ***.381*** where $p<0.05$. Where policy changes were in line with transformation significance of ***.488*** where $p<0.05$, where policies were implemented in a consultative manner. Policy changes showed a significance of ***.425*** where $p<0.05$, with Government values input and a significance of ***.469*** where $p<0.05$ with policies implemented in a consultative process.

Table 7.9: Inferences 2

		Manager/ supervisor advocacy	Manager/ supervisor questions policy
Managers/ supervisors clarified SDA	Pearson Correlation	.441**	.344*
	Sig. (2-tailed)	.002	.021
	N	45	45
Managers/supervisors clarified policies	Pearson Correlation	.501**	.331*
	Sig. (2-tailed)	.000	.026
	N	45	45

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Table 7. 9 points out that the significance where managers or supervisors either clarified the SDA and policies, with the supervisors or managers question policies and advocated for social workers. So, it would seem where managers advocated for social workers or questioned policies managers were also able to explain and clarify policies. It may be deduced that the effective role fulfilment of social workers was highly influenced by the commitment of managers to their staff when it came to advocacy and questioning of policies.

Table 7.10: Inferences 3

		Successful implementation of SDH on Role
SDH application to Social Work in Health Care	Pearson Correlation	.496**
	Sig. (2-tailed)	.001
	N	45
Relationship between Job Satisfaction and Transformation	Pearson Correlation	.299*
	Sig. (2-tailed)	.046
	N	45
Relationship between SDA and SDH	Pearson Correlation	.481**
	Sig. (2-tailed)	.001
	N	45**
Relationship between Job Satisfaction and Policy Implementation	Pearson Correlation	.388**
	Sig. (2-tailed)	.008
	N	45**

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Table 7. 10 indicates that the successful implementation of the SDH were significant if a positive relationship with job satisfaction and transformation, acknowledging the relationship between the SDA and the SDH and if job satisfaction with policy implementation is evident.

Table 7.11: Inferences 4

		Relationship between Job Satisfaction and Transformation	Relationship between Job Satisfaction and Policy Implementation	Relationship between SDA and SDH
Helpful and enough training on SDA	Pearson Correlation	.034	.130	.215
	Sig. (2-tailed)	.823	.394	.157
	N	45	45	45
Helpful Culturally Competent Training	Pearson Correlation	.192	.357*	.215
	Sig. (2-tailed)	.206	.016	.157
	N	45	45	45
Own Culturally Competent Skills	Pearson Correlation	-.161	-.004	-.051
	Sig. (2-tailed)	.291	.977	.740
	N	45	45	45

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Table 7. 11 explains the dynamics where limited associations could be made. There seems to be a significance indicated with being culturally competent or being trained, job satisfaction and policy implementation. In other words, as there is investment made into social workers by offering them culturally competent training so job satisfaction increases. Social workers making use of their own skills or experience to be culturally sound indicate a negative association with job satisfaction, policy implementation and the relationship between the SDA and the SDH.

Table 7.12: Inferences 5

		Relationship between SDA and SDH	Knowledge of SDA and SDH on competence
Policy Changes and Improvement of Role	Pearson Correlation	.445**	.433**
	Sig. (2-tailed)	.002	.003
	N	45	45
Successful implementation of SDA on Role	Pearson Correlation	.526**	.535**
	Sig. (2-tailed)	.000	.000
	N	45	45
Successful implementation of SDH on Role	Pearson Correlation	.481**	.550**
	Sig. (2-tailed)	.001	.000
	N	45	45

Table 7. 12 confirms that improvement and successfulness are significant when the relationship with the SDA and the SDH is evidenced, when social workers perceive themselves as competent with regard to their knowledge of the SDA and the SDH. Clear associations are therefore evident.

7.10 Summary

This chapter offered an overview of the findings from the survey research design. It presented the demographic information of the 45 respondents who completed the survey. The sample was well experienced and diverse in offering accounts of their current role of social work, the understanding and application of the SDA and the SDH, the impact of policies or SOP, factors that contributes to job satisfaction and associations that may exist. The respondents offered a wide range of indications regarding job descriptions which seem to resonate with their function and tasks. The diverse delineations of the SDA offered by the respondents, links with the general overview of literature. This diversity adds to complexity of the application of the SDA. The SDA application

seems to be dominantly implemented using the SDA principles. Even though the SDH was not clearly delineated by the respondents, they nevertheless indicated the relevance of the SDH. A strong positive association among being valued, consulted, appreciated and policy implementation was evident. Respondents also indicated a strong association between job satisfaction and transformation. Transformation as with rotation seem to be important for the wellbeing of social workers. It was also important for respondents to be knowledgeable about the SDA and the SDH as this has a positive effect on their roles and competence. Several other inferences were made of which the role of the supervisor or manager was identified as instrumental for the wellbeing, protection and advocacy of social workers. The needs for training on the SDA and the SDH was also strongly suggested by the findings. The findings therefore extensively contribute to the exploration but also triangulates well with the qualitative findings. The following chapter specifically represents data obtained from the semi-structured interviews with participants and key informants. The discussion will be presented according to categories, themes and subthemes.

CHAPTER 8
DATA PRESENTATION
SEMI-STRUCTURED INTERVIEWS

'We do what we need to do…' ***Participant 1.***

8.1 Introduction

This chapter's focus is specifically to present and discuss the findings as obtained from the semi-structured individual interviews from ten participants and two key informants. The first aspect is to provide the demographic information of the participants. Thereafter the categories, themes and subthemes are expanded on. The discussion is grouped according to five themes namely nature of the current social work practice in health, the SDA, the SDH, policies and vision for social work.

8.2 Demographics of the sample population

Table 8.1: Participants – Demographic profile

	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Age	51-55 yrs	22 -25 yrs	36 – 40 yrs	31 – 35 yrs	31 –35 yrs	46 – 50 yrs	36 -40 yrs	46 -50 yrs	41-45 yrs	46 -50 yrs
Gender	Female	Female	Male	Male	Female	Female	Female	Female	Female	Female
Race	Indian	White	Black	Black	Black	Black	Black	Black	Black	Black
Grade	Grade 3	Grade 1	Supervisor	Grade 1	Grade 2	Manager	Manager	Grade 3	Grade 2	Grade 3
Setting	Tertiary	Tertiary	Tertiary	Tertiary	Tertiary	Tertiary	Regional	Tertiary	Tertiary	Tertiary
Supervision	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes
Supervision offered to	Students	Students	Social Workers and Students	Students	NA	All Staff	All Staff	Students	NA	Students
Number of supervisees	1	1	7	1	NA	5	5	1	NA	1

P = Participants

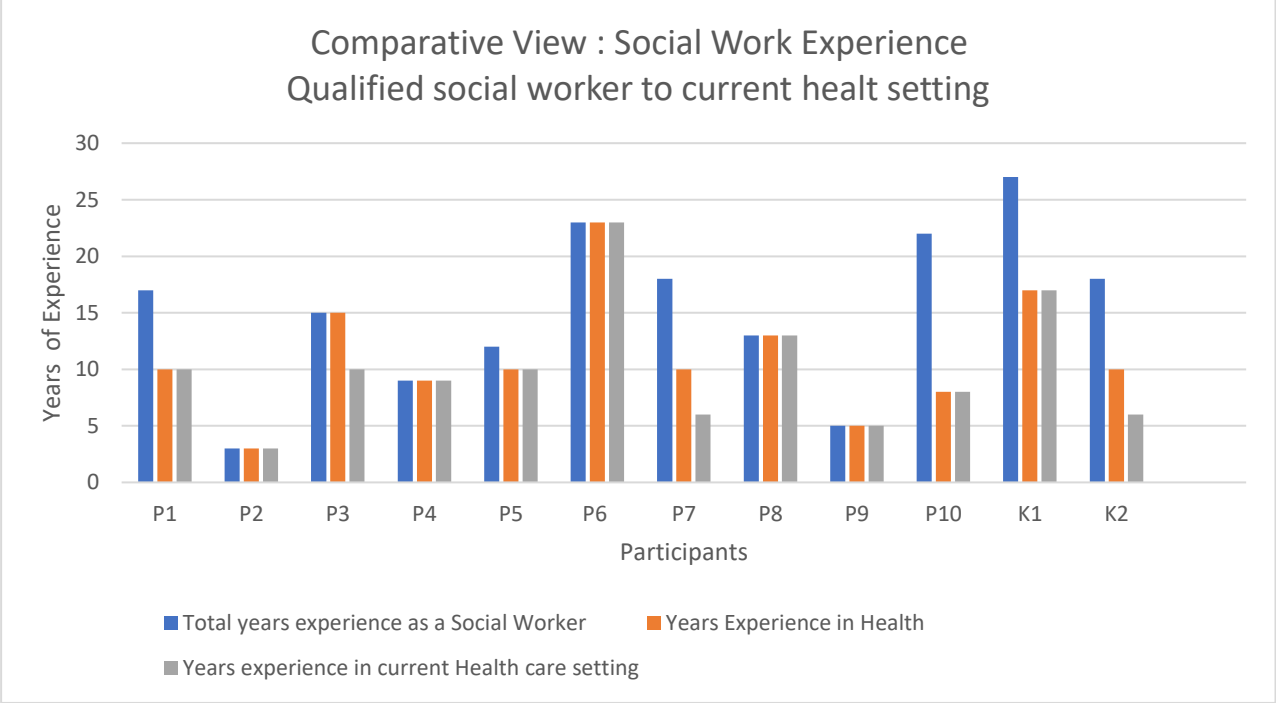
Table 8.1 provides the demographic profile of the ten participants interviewed.

Table 8.2: Key Informants – Demographic Profile

	K1	K2
Age	51-55 yrs	46 – 50 yrs
Gender	Female	Female
Race	Indian	Black
Grade	Deputy Director	Manager
Setting	Provincial	Regional
Supervision	Yes	Yes
Supervision offered to	All Staff	All Staff

K = Key Informant

Table 8.2 provides the demographic profile of the two key informants.



***P** = Participants and **K** = Key Informant*

Graph 8.1: Comparative view – Social Work Experience (Interviews)

Graph 8.1 highlights the years of experience for both participants and key informants from the time they entered the profession to their current years of experience within the current health care institution.

The social work participants were well represented with regard to age, years of experience, grades and involvement in supervision. The bulk of the population, eight participants were racially

classified as Black and one participant each was Indian and White. Females were dominant with eight participants and two male participants. Both key informants were female with one being Indian and the other Black. The calculated average age ranges are 38.6 – 42.5 years.

Two participants (Participants 6 and 10), both black females, had between 21 - 25 years of experience as a social worker. Participants 1 and 7 indicated to have 16 - 20 years of experience as a social worker. Three participants (Participants 3, 5 and 8) had between 11 - 15 years of experience as a social worker Five participants, 1, 3, 4, 5 and 9 all had between 7 - 10 years of experience in their current health care setting. From the participants, the range of total years of experience ranged between 11 – 15 years, the years of experience in health 8 – 11 years and experience in the current health care setting 6 – 11 years. Normatively the years decreased from total years of experience to the current health care setting. This seems to be the norm for most participants and both key informants apart from Participants 6 and 8 where they were employed at the same institution since the inception of their careers as social workers.

The number of years of experience in the current health care setting ranged from three years (participant 2) to between 21 -25 years (Participant 6). Therefore, the population were well experienced to offer comprehensive information regarding social work in health care and the implementation of the SDA. As may be noted both key informants were well experienced as social workers and social workers in health care.

Participants were also interviewed telephonically due to constraints with scheduling and social distancing norms. It must however be noted that the telephonic interviews did not impact on the quality of the interviews and a wealth of information was received. The average length of interviews were 50 minutes with Participants 3, 4 and 6 extending over an hour.

8.3 Categories, themes and subthemes

From the interviews the data could be organised into five categories and several themes and subthemes. The five categories, to which the themes and subthemes will be discussed are nature of current social work practice in health care, SDA, SDH, policy implementation and vision. Table 10 highlights the categories, themes and subthemes.

Table 8.3: Interviews – Categories, themes and subthemes

Category	Themes	Subthemes
1. Nature of current social work practice in health care	1. Services offered	1. Uniqueness of social work 2. Diversity of settings, services and patients 3. Involvement in the MDT 4. Challenges of social work
	2. Social work role	1. Relevance of the social work role 2. Central or pivotal role of social work in the MDT 3. Dilemmas of a profession occupying a secondary role in health care 4. Advocacy for patients
	3. Macro strategies	1. Nature of community work strategies in health care 2. Importance of access to resources as community work 3. Importance of stakeholder involvement for community work
2. SDA	2.1 Delineating the SDA	1. Acknowledging the worth and potential of others 2. Changes and improved quality of life 3. Empowerment 4. Acknowledgement of welfare 5. Challenges of the SDA 6. SDA requires broader strategies
	2.2 Rotation	1. Importance of rotation 2. Diversity in the application of rotation 3. Specialist versus generalist practice debate 4. Rotation associated with development, growth and protection 5. Challenges with rotation
	2.3 Cultural competence	1. Necessity for models and guidelines 2. Cultural competence is broader than language 3. The competence versus cultural competence debate 4. Diversity of the South African health care context 5. MDT as a resource to enable cultural competence 6. Drawing on own skills, experiences and undergraduate training 7. Impact of globalisation necessitates cultural competence
	2.4 Evidence of Application of the SDA	1. Application via the SDA principles, social justice and advocacy 2. Application via liaison with external stakeholders and referral

Category	Themes	Subthemes
3. SDH	3.1 Delineating the SDH	1. Uncertainty of meaning of the SDH 2. SDH as factors important in psychosocial assessment 3. SDH as environmental and living conditions 4. SDH as the acknowledgment of social ills of society 5. SDH as access to resources 6. SDH as equal access to health care 7. SDH as physical and mental wellbeing 8. SDH as instrumental 9. SDH links with the SDA
	3.2 Application of the SDH in social work	1. Difficulty in connecting the SDH with social work interventions 2. Relevance of the SDH for social work in health care
4. Policy Implementation	4.1 Governmental strategies for the SDA and the SDH	1. The challenge of associating Governmental strategies with the SDA and the SDH 2. DSD the custodian of the SDA 3. Grants and poverty alleviation: strategies for addressing needs 4. Lack of unity amongst all departments and sectors
	4.2 Policy and or SOP Implementation	1. Versality of SOP and Policies 2. SOP or Policy as a guide 3. Consequences of applying SOP or policies to context 4. Policy as a factor of frustration 5. SOP and policies may affect social workers emotional wellbeing. 6. Relevance and practicality of policies and SOP 7. Dichotomy of the consultation process 8. Contradiction amongst policies 9. Social work is not heard 10. Competing professions in health care 11. Political nature of policies
5. Vision	5.1 Future of social work in health care	1. Hopeful Social work future 2. Threats to the role of social work 3. Social work is unique and essential in health care

8.3.1 Category 1: Nature of the current social work practice in health care

This category required both the participants and key informant to indicate the services offered by social workers in health care settings. From the transcripts three themes were highlighted namely services offered, social work role and macro strategies.

8.3.1.1 Theme 1 - Services Offered

This theme encompassed the perceptions and experiences of the participants and key informants regarding current social work services within the different health care settings. This theme

highlighted the uniqueness, importance and value of social work services. These themes also highlighted the involvement of social workers in the MDT and the challenges encountered. The MDT forms the backbone of effective and comprehensive service delivery in health care settings. The MDT's perception of social work and the hierarchy evident in the MDT may cause a great deal of challenges for social workers; yet social work plays an instrumental role in the MDT achieving it treatment management of patients.

8.3.1.1.1 Uniqueness of social work

All ten participants as well as both key informants highlighted the uniqueness of the social work role in health care. Participants 1, 2, 3, 4 and 7 all indicated that the uniqueness relates to a very specialist role to fulfil in health.

Participant 4: "Hmm, I think for me **[hospital X]** is unique because first of all it is a tertiary hospital; that on its own makes it unique. The services that we give here is of high quality profess… I mean specialist."

This uniqueness was further expanded in terms of the MDT, the social worker's role and the offering of therapeutic services. Five participants substantiated the role of the social worker in relation to the MDT. Six participants highlighted the therapeutic role of social work in health. The above was also substantiated by both key informants.

Participant 1 shared her passion about her job and the value of her role in the team by stating

> Uhmm…[smiling] and just personally I love what I do. I am very passionate about my work. I am happy to be here every single day of my life to here. I know it sounds weird, but I do not need any rewards or anyone to say that I am

doing a good job. Uhmm… however I think every now and then the team are glad to see me a…[little laugh] …and I think in that they do not know what to do with this aa uhm can you help? But often it is valuable information that is helpful for the team. So, I think that my team accept that my role is valuable.' And 'Huh, I'm not sure but I think realising in this setting that the MDT is really important. So, I see my role as part of the multidisciplinary team. I know that sometimes we have challenges around people understanding their specific role and sometimes we have people overlapping role, people that may not have clear enough boundaries, but I think for me knowing as a social worker I contribute in a certain way to the team and I think that is my role. (Participant 1)

Participant 3 indicated

The other thing is that you are working with the other members of the MDT in the hospital as compared to social worker who is working in social development, where it is them and them alone and the community. But here you are working with the other members of the MDT, you've got time frames, limitations in terms of beds, say for instance patients that is admitted. (Participant 3)

Participant 2 shared

And I think that's what makes this context quite unique. I think in terms of the care that we provide for patients. The context of specialised services here and in terms of social work services here, I think social work is much more therapeutic here in this health care context. The social work interventions are quite limited in terms of what is expected of social workers I think that there's a lot of therapeutic interventions in this context which allows you to use different methods. But I think being in specialist services has helped us get some recognition and our role

> sort of elevated within the multidisciplinary team and within health at large. (Participant 2)

Key informant 1 indicated that the uniqueness and therapeutic role of social work as well as the role to play in the MDT by stating

> Yes, and I think the social worker is more the advocate for the patient. The patient finds it easier to communicate with the social worker compared to other multidisciplinary team members, and I think because we look at the environment and all the social determinants of health. (Key informant 1)

Part of the uniqueness of the service delivery is the time frames that is associated with service delivery in health. This was acknowledged by Participant 2 whom highlighted the constraints of discharge and home visits, Participant 3 who acknowledged the time frames working within an MDT and Key informant 1 who indicated the short time frames for service delivery. Participant 3 articulated this well by stating

> But here you are working with the other members of the MDT, you've got time frames, limitations in terms of beds, say for instance patients that is admitted. Here you have patients that you've not even found where they were supposed to go when discharged and they are vulnerable to where they must go. When they block a bed; then you get pressures saying social work get this patient out of the ward. And where? You are obligated by your statute and regulations, norms and standards that this patient is vulnerable and can't just let them go. Then you got so many challenges with the key issues of who these persons are. So, it creates frustrations so that you would not want to have cases of a similar nature. But you know you are in this environment you have to deal with it. So, you you'll find yourself that you become so frustrated. But if you receive

support, mentorship, more training and maybe even more resources one can have the groundedness. Ja… (Participant 3)

Key informant 1 highlighted

> But also, I think it's a big adjustment that you have to make when you come into health care where you don't have the luxury of time with your patients, unless you doing it in a clinic environment or you're in a medium term stay environment. But you will have to maybe apply all your skills within one. (Key informant 1)

8.3.1.1.2 Diversity of settings, services and patients

Even though all the participants were employed in hospital settings there is clear diversity associated with the type of setting (and the context in which the hospital is situated), the services offered and type of patients. For instance, highly specialist tertiary health care settings for example the academic and quintenary settings offers specialist services and as such the social worker operates in specialist units that requires the acquisition of specialist knowledge.

This was clearly substantiated by Participant 3 who stated that

> One can say, health care social work can be the same but because of the environment, they are completely different the kind of work, the bulk of work in terms of intervening will be completely different from someone who is working in a smaller hospital somewhere whether it is Gauteng or somewhere further your Ekurhuleni's, your Westrand, your CBD is completely different. (Participant 3)

Participant 4 also acknowledged the specialist nature of the hospital setting. Participant 6 acknowledged her long history associated with being knowledgeable about the setting

and environments as a strength. Key informant 1 also acknowledged the differences of settings and the various services that are offered and stated: “Each level of care provides a different package of service to the patient, so they all have their place.”

Participants listed several roles and services they perform which speaks to the diversity of service delivery and clientele. These included workshops, patient education, liaison with various resources and stakeholders, family reunification services, assessment, placement and discharge planning, advocacy for basic rights, empowerment, mediation, tracing, enabling disability grant, community involvement, trauma counselling and different awareness creation as according to the setting. In addition, Key informant 1 highlighted that a social worker in health care may utilise all skills and approaches in one session. This not only speaks to the diversity of services but also competence of social workers in health care. In addition to the above, Participant 6 also acknowledged that the length of working aided the competency

> So, I can say rich experience and … and know what is expected of us and knowing the department and I must say also the commitments as well. You know people that are mature and the know what going on and I must say the level of commitment. (Participant 6)

8.3.1.1.3 Involvement in the MDT

Participants 1, 2, 3, 4 5, 8, and Key informant 1 all alluded to the social work role in the MDT. All acknowledged that all must function within the MDT. Participant 5 pointed out the unique situation of how professionals in a hospital setting will group together to establish a reminiscence of an MDT by stating that

> Uhh.. I can only speak for ***[hospital x]***. In psych what makes it unique is our ability to function in a dysfunctional MDT. I am not sure if you understand?… In psych we are not designated but we do 72-hour observation. So, you do not have a structured ward round and all that. Because we are not really designated. But we have formed our little community and making sure that we discuss our patients and those who need further assistance. With the dysfunction is the strength to create a way that we can function as an MDT. (Participant 5)

So, the MDT is part of effective service delivery and offering holistic services for patients.

8.3.1.1.4 Challenges of social work

In addition to the uniqueness and value of social work services in hospital settings so the participants highlighted the challenges that social work in health care are faced with. The very factors that contribute to the uniqueness of social work seem to be the challenges as well. This specifically refers to the MDT and time frames.

As Participant 3 and Key informant 1 alluded to social workers work under extreme time frames especially when the MDT wants to discharge a patient. Participants 3 pointed out that according to policies the social workers are obligated to refrain from discharging vulnerable patients. This then causes a great deal of frustration with the MDT. Participant 3 further stated

> So specifically working with MDT is challenging to …uhm.. to put up a specific judgement about feeling valued or not because you feel like other people… because you know we are a support system. We are a support team in the situation. And there are times when you feel that there are other members of

> the MDT that values your work as very important and as part of the team and there are those that feel that your job is so substandard. So, you will have different types of colleagues who will view you differently. So, at the end of the day as long as you know this is my role and I can play it to the best of my ability. I always encourage social workers as members of the MDT if you were asked to do your work for a particular client, you must play your part to the fullest. And you must be able to stand your ground to say this is my role; this is not my role. Because if you jump when you are instructed: you must do this, you must that; then it means that you do not know where you stand. So, it is something that is ongoing. (Participant 3)

This speaks to the pressures of dealing with the MDT but also the skill and expertise that social workers should have to confidently navigate the challenges posed by the MDT.

Regarding the MDT Participant 2 also pointed that the MDT has a clear hierarchy and social work may be least important and not be heard. Participant 2 shared

> I think unfortunately there is always a hierarchy there are times where I feel that your opinion is not necessarily valued but I don't know if that if that is towards social work or just anybody mostly makes do with all team members. (Participant 2)

Participant 5 and 6 both highlighted the secondary role of social workers in health care which impact on how social work is perceived. Participant 6 augmented this view by stating

> There are times when you may not feel valued in terms of allocation of resources. You know it is health and they will prioritise … the patient directly in terms of treatment for the patients, the medical care. That is where the frustration comes in. Other social work activities…they will attend to it, but it would not take much of priority. Take for instance the training budget. Take for instance if you motivated for discipline specific training…you know… there is something that… that is health related. You know that is when they will start listening and making provision for that. Sometimes you feel that you are just an extra in the department. Which is normal. (Participant 6)

The limitation that social workers in health care has as a result of not having designated powers may complicate service delivery. Participant 3 highlighted his in terms of statutory work and Participant 1 where referrals are enforced but a lack of service is received.

Participant 5 also indicated that there is still a huge need to clarify the roles of social worker in health by stating

> I think they could have programmes that educate people about the core functions of social work. Uhmm and also to eradicate the misconceptions that people have about social work. For example, things like you give people food parcels. You know almost like an administrative function; we remove children from families. We are perceived as these monsters as we remove children. You are also perceived as if you don't have money, you don't have this. Ooh no just go to the social worker. I think government needs to educate people more on our role from the social development approach especially. Because my

> understanding is that there has been a move from social welfare. But I think it is only on paper it is not a reality. (Participant 5)

8.3.1.2 Theme 2 - Social work role

This theme encompassed the role of social work in health care, its impact, dilemmas and advocacy. This theme encapsulates the importance of social work and the important role it fulfils in the MDT but also the dilemmas the profession face. Five subthemes were highlighted here namely relevance of the role, central or pivotal role of social work in MDT, dilemmas of a profession occupying a secondary role in health care and advocacy for clients.

8.3.1.2.1 Relevance of the social work role

All participants and both the key informants identified that social work in health care is important and relevant. As indicated earlier a number of times the role is determinant or influenced by the setting or the ward or unit the social worker is placed in. So even the role is very relevant it would seem that it is dictated by the setting. Key informant 1 alluded to the holistic services that social workers offer which strengthens the relevance in hospital settings.

Participant 1 shared " . . . I think because I am so passionate about health it has a role. I think social workers are so well equipped to do different things."

Participant 4 stated

> I think social work in health care are valued a lot because when I check the multidisciplinary team approach, M-D-T. There is no MDT that can function

without a social worker. Not at All. So social work is playing a central role in the … in the… wellbeing of the patient. . . . Social work has a pivotal role. Social work is needed. (Participant 4)

8.3.1.2.2 Central or pivotal role of social work in MDT

All participants and key informants highlighted the important role of social work. It is a pivotal role and yet it has a secondary role in health care settings.

Participant 1indicated

> Hhm, I'm not sure but I think realising in this setting that the MDT is really important. So, I see my role as part of the multidisciplinary team. I know that sometimes we have challenges around people understanding their specific role and sometimes we have people overlapping role, people that may not have clear enough boundaries, but I think for me knowing as a social worker I contribute in a certain way to the team and I think that is my role. (Participant 1)

Participant 3 highlighted the competence necessary to function within the MDT

> So specifically working with MDT is challenging to …uhm… to put up a specific judgement about feeling valued or not because you feel like other people… because you know we are a support system. We are a support team in the situation. And there are times when you feel that there are other members of the MDT that values your work as very important and as part of the team and there are those that feel that your job is so substandard. So, you will have different types of colleagues who will view you differently. So, at the end of the day as long as you know this is my role and I can play it to the best of my ability. I always encourage social workers as members of the MDT if you were asked to do your work for a particular client, you must play your part to the fullest. And you must be able to

> stand your ground to say this is my role; this is not my role. Because if you jump when you are instructed; you must do this, you must that; then it means that you do not know where you stand. So, it is something that is ongoing. (Participant 3)

Participant 4 eloquently and passionately clarified his position

> I think social work in health care are valued a lot because when I check the multidisciplinary team approach, M-D-T. There is no MDT that can function without a social worker. Not at All. So social work is playing a central role in the … in the… wellbeing of the patient. . . . Social work has a pivotal role. Social work is needed. (Participant 4)

8.3.1.2.3 Dilemmas of a profession occupying a secondary role in health care

This aspect related specifically to the rise in challenges where the role is pivotal and yet considered secondary. This dichotomy was pointed out by all participants and Key informant 1.

Participant 6 presented this dichotomy very tactfully.

> There are times when you may not feel valued in terms of allocation of resources. You know it is health and they will prioritise the patient directly in terms of treatment for the patients, the medical care. That is where the frustration comes in. Other social work activities…they will attend to it, but it would not take much of priority. (Participant 6)

Participant 5 also recognised the secondary role but steadfastly acknowledged the importance of the role with regard to patient wellbeing by stating that "Because in a health setting, we are more a secondary service. But that secondary service actually impacts on that patients' health."

Key informant 1 reiterated that this secondary role is historical. “Historically we haven't had a voice within health. There is just too many competing professionals.”

Both Participant 2 and 5 accentuated the prevailing hierarchies evident in hospital settings and the role of social work. Participant 2 attempted to see the potential of the role whereas Participant 5 expressed that the lack of appreciation for social work in health care is not only as a result of this secondary role but also where supervisors and or managers of the social work fraternity in health also do not listen to the colleagues that they need to support and advocate for. She highlighted how this affected her negatively.

> I think the feeling is that we are the people that do the groundwork. We are the ones that deals with; so, if my opinion won’t be heard then what is the point? It is okay if I just do case work and if I just continue. Like I said you learn to choose your battles; But sometimes it really does affect you. (Participant 5)

So even if social work does not offer primary medical services, the role of social work is imperative for the holistic wellbeing of patients. The secondary role should not be viewed as less important.

8.3.1.2.4 Advocacy for patients

Participants highlighted the importance of ensuring social justice via advocacy. They may present patients’ needs and rights with families, team members and organisations. Five participants explained they voice the opinions of the patients about their treatment with the medical team. One participant indicated that his actions also involve the protection of the economic rights and injustice of patients. Participant 1 and 8 indicated that their advocacy also extended to correcting the perceptions of stakeholders about the

patients' wellbeing and coping. Participant 7 and Key informant 2 particularly highlighted the advocacy role with being present within communities and ensuring that service delivery occurs. Participant 5 specifically referenced her knowledge of the various acts and the use of it to promote the rights and participation of her clients as ensuring that social justice occurs. All participants and key informants acknowledged that referral to external resources is essential to ensure that clients are not only aided but also that social justice occurs. Therefore, the role of advocacy in ensuring social justice was perceived as not only as an instrumental role of social work in health care but also necessary in fulfilling the principles of the SDA. It could also be noted from the participants and key informants that effective and appropriate advocacy was dominantly influenced by experience, competence and knowledge.

Participant 4 alluded to the complexities and importance of social justice and advocacy by stating

> I think the concept of social justice is broad nê and we can address it in various forms like the one I just gave you. But the core of social justice has to address the social injustices that the patient or client are faced with. Socially so or economically so. There are social injustices that they are facing. So, when they come to me as a social worker there are issues. Someone somewhere did this patient wrong. How do I address it? … Social workers who are dealing with social justice, they must not look at it in minus view saying we are only dealing with this problem. It is broad there are so many cases or examples that one can give that address it. Psychosocially they are suffering if they can't get this small grant from SASSA. But someone in the SASSA receives the patient with all the medical reports and all the social work reports to say he does not qualify for the grant. You are denying

him the right for social justice. With the grant some of the social problems will be addressed he will have money to come for follow up, take a taxi. (Participant 4)

With the above Participant 4 also indicated the competence and discernment the social worker should have. The quote also reflects the passion the social worker should have and the mandate to act.

Conversely, Participant 2 indicated how her advocacy may be perceived differently especially where instead of enabling patients' rights to self-determination she advocates for admittance of patients for their protection. This is a contradiction to the principle of self-determination of the SDA. Participant 2 reflected

> Yeah, I think the episodes of deinstitutionalization comes with very little information. It's a pressure of all the resources and on top of that the deinstitutionalization also as we are dealing with people that are very unwell. . . . Considering the context, the mental health context, in which I work and if we think of things like self-determination and clients' rights and patients and discrimination there are issues; there are issues because they may not be able to make decisions for themselves and we force them into participate in programmes for their own wellbeing. So, it's quite tricky. I think most will try to do that. I always make sure that families are very aware of the process. I try and use a lot of psychoeducation with families, to empower them to better manage the patient. I think we try our hardest to involve the patient in our decision-making where it is not always sometimes possible. We do try to do that particularly when they are well again, we want to try for patients to be involved in their own decision making even if they're well and ready for discharge. (Participant 2)

Advocacy is an essential and core role of social work but also very tricky to enact in complex health settings and policies.

8.3.1.3 Theme 3 - Macro strategies

Community work as a form of macro strategies is a core fundamental practice method in social work. There are different conceptions of community work. Participants 1, 3 and 4 and Key informant 1 alluded to the precarious position of implementing community work in health care settings. Based on the responses it is also wondered if some of the participants understood the differentiation between micro, meso and macro work. Participant 3 succinctly provided the context for community work and the DSD in relation to social work in health care as

> Ja so... Remember social work in the health sector; we get all our policies from Social Development. So, we have to interact with Social Development because most of our patients are going back to the community where Social Development is the biggest player there. So, it is not possible to say that I cannot utilise the social development approach because the patient does not belong to the institution. They belong to the community. So, they have to go back to the community. (Participant 3)

Here it can be noted that social work in health care should have a continuous relationship with communities.

8.3.1.3.1 Nature of community work strategies in health care

> Along with the diversity of settings and their contexts, so the focus and implementation or involvement in community work differs. It would seem that tertiary settings versus secondary and primary health care settings will have very different focus areas of community work. Community work in the general sense of the word especially with regard

to community development will be less likely to be implemented by social workers in hospital settings. All participants apart from one participant and one key informant indicated their involvement in either health talks, awareness creation or workshops. A number of participants also indicated that they would utilise the health calendar and create awareness programmes according to it. Participants 1 and 3 identified that they will utilise statistics of the patients aided, or problems identified to develop their awareness or psycho education programmes or workshops.

Participant 1 further described the challenge of community work by stating "So because we are a hospital community work is quite hard."

Participant 8 indicated that both case and group are community work and Participants 1 and 9 indicated that family reunification services also form part of community work. Participant 7 and Key informant 2 indicated that their involvement is with the actual community. This may be the result of being a regional hospital within specific communities. The emphasis is always to establish sustainable projects. Key informant 1 also highlighted community gardens as a sustainable community work strategy.

From the exploration it is clear that the social workers in health care settings are actively involved in community work but specifically and predominantly only with awareness programmes or community education. All participants, apart from Participant 4, and the key informants indicated that these macro strategies are effective. Participant 4 acknowledged the value of awareness programmes but questioned if it addresses the need of the community.

> I think nê when I look at our community work services here because they are done on calendar basis like this month, they are on cancer awareness, So, every

> month or every day there are various awareness or campaigns that is done. But when I check if it is the need of the community; for me ever since I've been here, I don't think they meet the needs of the community. They don't. They are just done so that the department of social work maybe we will say for our PMDS. You know when you go for evaluation you have done these kinds of projects; you have done this. But when you go and evaluate the impact it has on the community; it has zero or I don't think that there is a value in those strategies that are being implemented in terms of the macro strategies that we use here. So, most of the things that you do here on the macro level, they don't meet the needs of the patients. (Participant 4)

In addition, Participant 1 and 3 indicated challenges of social work in health care is that need to await responses from social workers from DSD. In highlighting the above Participant 1 stated that "I think my team tends to feel quite despondent about social workers in statutory organisations. We feel we send things out there and it gets lost in the system so nothing happens."

Participant 3 stated "Ja frustrations! I think it is still a big issue I think it is under review. There is delay in terms of it being completed. So, it is a big issue coupled in terms of the issue of resources."

Empowering the communities with information is essential but as indicated by Participant 4 there is a need for different strategies. Perhaps a greater focus should be on the social investment strategies identified by the SDA but also community development as an alternative community work approach to community awareness.

8.3.1.3.2 Importance of access to resources as community work

The participants and both key informants indicated that the efficacy of aiding patients and services that is seen as community work is referral to resources within the community. Key informant 1 indicated

> Macro strategies I think can be community work, . . . It's actually critical because we do not work in isolation and we do rely on so many interdepartmental and intersectoral partners. In order to facilitate process is for patients and also community work has its place for prevention and promotion because as a Department we are striving for preventative services rather than curative. (Key informant 1)

Access to resources was considered important by all participants and key informants. This is largely due to resources being available in communities than in health care settings. Therefore, for this access to resources to be successfully utilised by social workers for their patients, social workers need to be knowledgeable about available resources. The competencies of social workers are also reflected on the knowledge of available resources. It may therefore be concluded that effectives of offering holistic services to clients rest upon liaison with communities and the resources.

8.3.1.3.3 Importance of stakeholder involvement for community work

Associated with the above all participants highlighted the importance of stakeholder involvement in appropriate service delivery. Access to resources cannot be envisaged without the liaison with stakeholders. This also rest upon effective relationship building. Key informant 1 indicated that collaborations are instrumental for the benefit of clients.

> It's actually critical because we don't work in isolation and we do rely on so many interdepartmental and intersectoral partners in order to facilitate processes and services for patients. Also, community work has its place for prevention and promotion because as a Department we are striving towards preventative rather than curative services. (Key informant 1)

Participants also highlighted their liaison with stakeholders like SASSA, DSD, SAPS and Department of Education to ensure service delivery.

8.3.2 Category 2: SDA

SDA as a category refers to the general view of the SDA but also how this approach is implemented within the health care setting. This category is an instrumental aspect as the aim and objective 1 of this research study is contingent upon it. This category was divided into four themes namely: delineating SDA, rotation, cultural competence and evidence of application of the SDA.

8.3.2.1 Theme 1 - Delineating the SDA

As line with the discussion of chapter 4, Participant 2 pointed out the complexity of delineating the SDA

> So, it is a confusing term because the term social development comes up everywhere like the Department of Social Development. Now we always the hear these terms we use these keywords we use these buzzwords like self-determination but what it means is not always clear. We have these buzzwords, but we have incorporated them it becomes a little bit more tricky. (Participant 2)

This theme highlights the complexities of the SDA. The responses received from participants sustained the view offered in chapter four of this research report. In highlighting the delineation of the SDA several subthemes are described below.

8.3.2.1.1 Acknowledging the worth and potential of others

All participants indicated that the SDA acknowledges the worth of others. It reflected on the individual's strength and unique contributions to be made. The importance of individuals to be self-sufficient and unearth their own potential were emphasised by five participants. This, as can be noted is in line with the principles of self-determination and rights based.

8.3.2.1.2 Changes and improved quality of life

Even though the participants offered generic impressions of the SDA there was consensus that the SDA should bring about changes and an improved quality of life. These changes and improved quality of life were represented in a variety of ways by the participants. Participant 6, 7 and 9 as well as Key informant 2 highlighted that poverty alleviation, social security and social investment strategies should be instrumental in conveying changes in people's lives. Six participants indicated that a change in the quality of life also incorporates and improved wellbeing. Participant 8 indicated that changes should be brought about with offering effective social work services. These services were referred to as the services introduced by government and not themselves.

Participant 1 in support of the above stated

> Ja, so I, I look at the word social development I assume it is about bringing about change in terms of people's social environments. So, I am thinking about environments around education and housing and living conditions and

poverty, so economics. So, I think it is about bringing about change in the way that people experience their worlds. That will be how I will summarise it. (Participant 1)

Participant 2 stated

> I was a little bit unsure because a lot that I heard is about the developmental approach and about the intervention strategies but then but then I realise it's a lot of what underpins social work practice and so it's empowerment and having to facilitate by doing about self-determination about quality of life a process of transformation it's a macro issues that actually transformation is positive about their lives. (Participant 2)

8.3.2.1.3 Empowerment

This theme is linked to advocacy that social workers are involved with to ensure social justice. All participants identified that they are actively involved in ensuring social justice by offering advocacy. Participant 1 highlighted this empowerment by clarifying her role facilitating the understanding and treating of mental health as:

> I think that speaks to social development by empowering people to understand different factors as it contributes to mental illness, understanding ADHD for example, so that it remains ADHD and does not become a conduct disorder, because of a parent treating it incorrectly and in parenting ways that are unhelpful, So, Ja. I think that will be it. (Participant 1)

Participant 4 shared his view of empowerment as "I think from my understanding of this term of social development it is all about empowering the communities or individuals in the communities. it is all about giving power to the people, you know."

Participant 1 further indicated that where a distinct right or wrong was evident social justice has been ensured for her patients. A number of participants indicated that their advocacy also incorporated the protections of the rights and safety of others. Participants 1, 3, 8, 9 and 10 identified this may also include the rights and safety of children and Participant 2 indicated that this includes involving patients in decision-making when they are mentally unwell. Participant 2 shared

> I think we try our hardest to involve the patient in our decision-making where it is not always sometimes possible, we do try to do that particularly when they are well again, we want to try for patients to be involved in their own decision making even if they're well and ready for discharge yeah I think mostly in terms of psychoeducation and empowerment in most cases where we do try and engage with patients. (Participant 2)

Advocacy was also seen in terms of offering information to patients that was deemed as empowering them to with knowledge to secure services. This was highlighted by Participants 1, 4, 5 and 6. Participant 4 was very passionate about the aspects of social justice and indicated the complexity, the various policies and implications of it. He indicated that all social workers need to take this aspect of the profession very seriously and consider not only the social aspects of it but also the economic implications that clients may face.

Empowerment is seen as core for the SDA and social work. Empowerment is therefore another unifying aspect between social work and the SDA.

8.3.2.1.4 Acknowledgement of welfare

Participants indicated that social work's roots are in welfare. Participant 5 highlighted that this welfare connotation of the social work profession is preventing the acknowledgement that it should have. Participant 5 shared

> So, I guess my understanding when I studied; Prof Patel… you know social work was more of social welfare, you know - *you give*. And patients or clients were not really empowered to be able to stand on their own. That is why your get the revolving door clients unable to cope because the only way they cope is because they sort of get a handout. (Participant 5)

Key informant 1 however offered a broader view of that connection to welfare. She indicated that all social workers need to align themselves with this approach and its principles. This was linked to the advocacy strategies to enforce the rights and self-determination of patients in hospital settings.

8.3.2.1.5 Challenges of the SDA

Challenges of the SDA were also highlighted. Participant 2 particularly referred to the concept of social development itself. This participant indicated that this concept is confusing in terms of developmental theories which may refer to Erikson's and other psychosocial theories but also to the Department of Social Development (DSD). In addition Participant 2 highlighted that the SDA is what underpins social work in general. This honest reflection and struggle of defining the SDA links well with what was highlighted in chapter 4 of this dissertation about delineating the SDA.

Participant 2 furthermore highlighted the challenges of implementation of the SDA in terms of the rights of patients especially regarding the right to self-determination. She

highlighted that her role is to protect the vulnerable patients by not discharging them. This seems to be an overt contrast to the SDA approach. Participant 2 clarified the position by stating

> Considering the context, the mental health context, in which I work and if we think of things like self-determination and clients' rights and patients and discrimination; there are issues. There are issues because they may not be able to make decisions for themselves and we force them into participate in programmes for their own wellbeing. So, it's quite tricky. I always make sure that families are very aware of the process. I try and use a lot of psychoeducation with families, to empower them to better manage the patient. I think we try our hardest to involve the patient in our decision-making. Where it is not always sometimes possible, we do try to do that particularly when they are well again. We want to try for patients to be involved in their own decision making even if they're well and ready for discharge yeah. I think mostly in terms of psychoeducation and empowerment in most cases where we do try and engage with patients. (Participant 2)

In line with this view, Participant 4 also indicated that the SDA stresses the de - institutionalisation of patients. This focus creates enormous problems where clients are not well and not ready for discharge.

Participant 3 highlighted that at times social workers in health care settings have limitations due to designated powers awarded to social workers in the DSD. Due to this, social workers in health care settings are dependent on their colleagues in the DSD that may respond late. Participants indicated that some cases would remain unaddressed by the DSD for months. This in turn creates huge dilemmas with patients and with the MDT. In the end the reputation of the social worker in the hospital setting is affected. To safeguard the social

workers, some departments have enforced a highly administrative processes of documenting all referrals and all specifications. Even though this is cumbersome it is important for the prevention of medicolegal issues.

Participant 4 and 7 indicated the dealing with foreign nationals are challenging. Even though the SDA acknowledges and embraces the rights of all irrespective of nationality, the practicality of it in terms of the services that foreign nationals or immigrants may receive are limited. Participant 4 highlighted that perhaps the implementation of the NHI may resolve such matters. But is this part of the SDA or the SDH or the transformation of the health care system? These difficult and confusing areas are evident with not just the SDA but the general South African context considering the limitations but also the acts. The disparities seem to make it very difficult for social workers in hospital settings.

8.3.2.1.6 SDA requires broader strategies

All participants were able to indicate the application of the SDA through advocacy by ensuring rights, self -determination of patients and empower with information. Most also indicated the need for referral to community resources and non-governmental organisations (NGO) or other governmental departments for services.

Participant 8 highlighted her knowledge about the principles of the SDA and stressed that the micro - macro divide needs to be bridged but only mentioned referral and no other strategies to bridge the divide. It would seem that the participants did not entirely see their involvement in macro strategies or community work or outreach as the SDA requires. Participant 7 indicated that community outreach needed to be sustainable and saw a clear link with the SDA. Overt community development strategies employed by social workers

in the hospital settings are not evident. It would seem that the type of setting dictates the services to be delivered.

Key informant 1 highlighted this diversity of service delivery by stating “You see because we work with a range of programmes. Each level of care provides a different package of service to the patient, so they all have their place. I wouldn't put one as more important than another.”

The participants were able to highlight poverty alleviation strategies like Zero Hunger and social security programmes as governmental strategies to ensure the implementation of SDA. Key informants 1 and 2 agreed with these sentiments and stressed the value of social investment and sustainable programmes as implemented by Government.

8.3.2.2 Theme 2 - Rotation

As part of the implementation of the SDA in South Africa, rotation has been identified as an important aspect for the retention of social workers. The opinion about rotation was sought. Generally, most participants were highly enthusiastic about rotation and its value. There was however also a diversity of opinions recorded. Five subthemes were highlighted. This seems to be in contradiction to most participants perceptions of the purpose and impact of rotation in health care settings. Key informant 1 indicated “It should be for purposes of growth and development exposure.”

8.3.2.2.1 Importance of rotation

Nine participants and Key informant 2 expressed the importance for rotation. These participants indicated that development, professional growth and protection of the social workers are associated with rotation. All participants apart from Participant 1 and 6

indicated that the purpose of rotation is to expose social workers to the entire hospital setting, develop the social workers in terms of knowledge and experiences, and to empower them to address various aspects. Participant 3 also indicated that rotation is essential to prevent burnout and medico legal issues. Burnout was explained to relieve social workers from very demanding wards or units and the prevention of medicolegal issues of a person that cannot cope in a certain setting or who neglects their role. Participant 5 shared the importance of rotation as

> So, I think the relevance in term of the social development approach re rotation is that you as a social worker will also get empowered to understand how different departments function. So, I get that social development is empowering, I get empowerment so if I for example knows what goes on for example in the internal medicine ward. The social worker gets sick and one has to stand in in you will definitely feel disempowered and inadequate to help. Because you are thrown in the deep end for a lack of a better word. (Participant 5)

Six participants indicated that all should rotate. Participant 1, 2, 6 and 9 indicated that rotation should be for certain people. This specifically referred to social workers new to a health care setting who need to know the hospital. Participants 2, 3 and 4 all acknowledged the flexibility and adaptability of social workers that are enhanced by rotation.

8.3.2.2.2 Diversity in the application of rotation

Due to diversity of the health care settings, service delivery but also the view of specialist versus generalist practice, difference of the application of rotation is also noted. Key informant 1 alluded to this complexity and suggested that there should be multiple models of rotation depending on the setting and needs.

> OK, I think a rotation needs to be an area of work that is very carefully managed. It should be for purposes of growth and development and exposure. Looking at coverage, ensuring you know you're not left with a situation, where should somebody not be at work that day to patients. So apart from growth, development, exposure for the professional, it's access to social work by patients, but rotation should be done in a reasonable way, you know. I think there you can look at the services of the hospital. You know you would do rotation differently from a district hospital as opposed to specialist kind of hospital. (Key informant 1)

Participant 1 and 2 indicated the difficulty with rotation is with regard to specialist areas. Here specifically it was mentioned that it takes time to navigate certain areas. Participant 1 indicated that rotation is counterproductive as it will remove an experienced social worker from one area to another, thereby leaving gaps in service delivery. In addition, in specialist units the social worker and patients get to know each other well which aids improve management of the patient. As indicated by Key informant 1 there is no set rotation policy but 6 participants, i.e., Participants 3, 4, 7, 8, 9 and 10, indicated that it occurs in their settings every two to three years. One participant indicated that rotation occurs on a relief basis or stand in system. Participant 2, 3 and 4 also indicated that a disservice to social workers and patients occur if rotation does not happen.

8.3.2.2.3 Specialist versus generalist practice debate

It would seem that the SDA encourage generalist practice and therefore the opinion of seven participants that generalist practice and not to specialise is what is needed. This is in contradiction with the views of Participant 1, 2, 6 and Key informant 1 who were of the opinion that specialist areas or centres of excellence is required. It would seem that SDA is in direct contrast with specialisation.

Participant 1 clearly highlighted the influence of rotation on generic practice:

> So, I see the benefit of this [rotation] as one would have generic skills. But what I do think is that I have the ability to offer specialised services. . . . So, I think specialised knowledge is important in a tertiary setting. (Participant 1)

8.3.2.2.4 Rotation associated with development, growth and protection

Nine Participants and Key informant 2 highlighted that rotation enables growth and development.

> In terms of professional development, it is good for the social worker. And I think for the community it is also good because an informed and exposed social worker will render a better quality of service compared to a social worker who is not exposed. (Key informant 2)

Participant 3 particularly highlighted the need for this development when one becomes a social worker. This exposure to different units enables the effectiveness of supervision. In addition, the rotation also ensures protection in terms of medico legal matters where a social worker is not effectively functioning in a particular unit. Participant 3 shared

> But I rotate because I understood the benefit of the work in that area. For me to be where I am today was because I have accepted to be rotated to different departments even if I had my own preferences. (Participant 3)

8.3.2.2.5 Challenges with rotation

Even though most participants identified the positives of rotation, it would seem that some challenges exist. The first matter is the non-availability of a policy. So currently there are different models operational. As indicated by Participant 6 and Key informant 1 different

models should be applied according to the health care setting. Key informant 1 also highlighted the need for centres of excellence. Participant 6 shared her view.

> Ja. It works for the department and as a team and to be more comfortable. And me personally, as a supervisor … you know… I always ask them rather to be allocated in a department that you fit. Because I know some of my colleagues, they are not comfortable working in psychiatry and we would not want to put them into a position … you know the fact of the matter is someone … I believe someone excel better where they are in terms of their passion and interest. (Participant 6)

Participant 2 also warned against rigidity of rotation and encouraged the flexibility

> I also think that if it's too rigid that that will prevent growth or services to be offered. I think in my context specifically it is not a problem that we don't rotate but I do think in another context people be more flexible and develop skills.

The difficulty is how to manage centres of excellence and other models. Participant 3 also highlighted a scenario where social workers were employed for a specific area. These social workers will not be rotated due to the appointment specifications. Where different models operate in one setting may be problematic. (Participant 2)

8.3.2.3 Theme 3 - Cultural competence

Diversity and cultural competence are important aspects both in South Africa and globally. This theme highlighted the diversity of the clientele that the social workers in health care aid. The needs for awareness and being informed of diversity seemed to be of importance in working in health care settings.

Participant 7 highlighted

> We cannot shy away from the fact that there is a lot of globalisation; people move and whatever. . . . So, I think once we become aware of that we can be more competent to understand how and where other people are coming from. (Participant 7)

Participant 5 stated that "For me it is very important to be culturally competent, because now you are working with people from diverse cultures."

8.3.2.3.1 The necessity for models and guidelines

The participants indicated that despite the diversity of the South African context there is a clear absence of cultural or diversity models that they can draw from or apply with clients. They have indicated that it is important to establish models as social workers in general deal with a diverse clientele. Participants indicated the settings of where the hospital is situated for instance in CBD's will attract different people. More specifically, as highlighted by Participant 2, 4 and 5, the acknowledgement of traditional and religious viewpoints within the medical setting especially with regard to psychiatric patients should be clearly highlighted. They indicated that the lack of models or guidelines makes it difficult to honour the rights and self-determination of patients especially if it is contrary to the MDT or to navigate problematic situations. Participant 4 highlighted how traditional beliefs conflicts with medical treatment. The MDT may consider the patient not ready for discharge, but the traditional views may indicate a different point of view.

Participants 5 stated

> Firstly, it is my own skills and competence. . . . To be honest there is no guideline. I have never seen a guideline in Gauteng or anything that says that if you are not culturally competent, these are the rules. (Participant 5)

8.3.2.3.2 Cultural competence is broader than language

Even though four participants, i.e., Participant 3, 4, 8 and 10, indicated the fluency in an indigenous language is beneficial most felt that cultural competence does not solely rest on it. They indicated that speaking the same language enable the patients to express themselves better. Participant 4 highlighted the complexities and ethics of involving a translator that may detract from the process. In fact, several participants indicated that ***competence*** should be focused on and not so much ***cultural*** competence. Here also the globalisation was highlighted by acknowledging the numerous foreigners that are accessing (or attempt to access) public health care in South Africa. It will therefore be impossible to speak the language of the patients. Therefore, having some sense of their culture, traditions or beliefs are imperative for effective service delivery. Participants also highlighted that speaking the same language does not mean that one is culturally competent neither competent. Participant 1 made this much clearer with examples where her competence aided patients than a person's ability to speak the language.

> Because as long as you are competent you will be able to do the job. Uhmm I have sent people to their community and then they do not get help from a person with the same cultural background and they come back to me and I'm from a different cultural background. (Participant 1)

Key informant 1also stated the following about cultural competence **"**It's broader than language. It's, I think if you're a skilled social worker, you'd be able to identify issues with your client."

Participant 2 and 4 also indicated that aspects of traditions and religious views form part of being culturally competent therefore it is much broader than language. Therefore, from

the participants cultural competence may incorporate more than just culture or a similar language.

8.3.2.3.3 The competence versus cultural competence debate

Even though all participants acknowledged the value of culture and diversity. There was a clear indication that competence of social workers should be the focus and cultural competence as a sub focus area. Participant 1 indicated previously patients did not secure any assistance from professionals speaking their own language. Even though she was from a different culture and did not speak the patient's first language she was able to successfully aid the patient. Not speaking the language is perhaps a stumbling block but not an unsurmountable task to climb when the focus is to help patients. Her view "I know that cultural difference and I'm quite sure that that is a barrier to how we engage, but I still want to believe that if I'm competent that, that will be the priority."

All participants agreed with the concept of competence rather than culturally competent. It would seem that being culturally competent is part and parcel of the social work profession and being competent.

8.3.2.3.4 Diversity of the SA health care context

Participant 1 indicated that the MDT is diverse and aids with the cultural understanding of patients. This she indicated previously patients where patients were referred to those from the same culture and did not receive the help required. She was able to rely on her MDT for culture specific information which aided in assisting clients. The diversity of the MDT helps with intervening with patients. Participant 3 also indicated that with hospital settings in the CBD one will encounter a diversity of patients that may be very different to the social worker.

> One can say, health care social work can be the same but because of the environment they are completely different, the kind of work, the bulk of work in terms of intervening will be completely different from someone who is working in a smaller hospital somewhere whether it is Gauteng or somewhere further your Erkhuleni's, your Westrand, your CBD is completely different. (Participant 3)

8.3.2.3.5 MDT as a resource diversity to enable cultural competence

The diversity of the hospital settings and those which compromise the MDT may enable the understanding of diverse cultures and traditions. Five participants acknowledged the importance of the MDT in health care settings. Participant 1 indicated that the MDT may be perceived as a resource to understand cultural differences and implications. The MDT may be used in the intervention. Her example was of a patient that shared similarities with an MDT member; knowledge and understanding may be gained from them. This is also useful for the continuance of effective service delivery as the MDT member is familiar with the team's procedures and processes. The MDT may therefore be considered a valuable resource that should not be neglected. Participant 1's view

> So, I think we are quite culturally sensitive but I don't think that there is a model that we follow in any way. I think what helps is a multiple diverse team, so we are aware. There is a lot of time when we will be saying somebody said this oh yes this is where it comes from. So, we have a good sense. (Participant 1)

8.3.2.3.6 Drawing on own skills, experiences and undergraduate training

All participants indicated that they view the understanding of culture important but in the absence of culturally competent models they use their own skills, understanding and training, from the undergraduate degree, to deal with patients. Non-judgemental attitudes are used to avoid stereotypes. Participants 6 and 8 specifically denoted the adaptability and

flexibility of social workers to adjust to different clients. Professionals to manage interaction with diverse clients drawing from own experience and the social work undergraduate training are suggestive of a highly competent work force.

Participant 6 stated "I ja… do think that we need to some extent be able to be flexible and versatile and be able to understand. You know you start where the client is including their culture. I think you will understand better."

8.3.2.3.7 Impact of globalisation necessitates cultural competence

Participant 4, 7 and both key informants acknowledged the effects of globalisation which may result in foreigners accessing public health care. Participant 7 indicated that we need to be accommodating.

> Although I am not aware if there is a model that is important. Because we cannot shy away from the fact that there is a lot of globalisation people move and whatever. We've got people from other countries coming in. (Participant 7)

Participant 4 indicated the need for assistance in placement and assisting foreigners. With globalisation there is a huge demand for knowledge and training on diverse cultures and beliefs. This was indicated by all participants and both key informants.

8.3.2.4 Theme 4 - Evidence of the application of the SDA

The participants indicated a wealth of strategies that they follow with patients, that may embody developmental social work as indicated by the SDA. The SDA's process of intervention that was stressed by participants, was that of a generalist approach which enables rotation and enhances service delivery in diverse hospital settings, units or teams and with patients. This particularly indicated their involvement with the exposure of social workers to all units within the hospital,

ensuring continual service delivery and the diversion of medico legal issues. More dominantly the SDA approach could be acknowledged in the interventions that reinforce the rights of patients, self-determination and crossing the micro macro divide by referrals. The current community work strategies employed are in terms of awareness, outreach, psychoeducation and projects as based on the health calendar. Sustainable socio-economic interventions are not evidenced and this, as according to the participants, are largely due to the lack of resources, the focus of the service interventions and the setting. Most participants indicated that settings within a community may implement macro strategies more easily. Participants 7 particularly clarified that with the SDA in mind the social work team make themselves visible in the community via their projects.

> The more in terms of the service that we render, the more were available, the more that we are visible, the more that we are implementing programmes the more that we are involved in management, you know the Exco, the Manco, the more that we take part in the activities within health; I think gradually other disciplines of departments will see that it is something that is happening even though it is slow. (Participant 7)

Therefore, the SDA is applied but this manifested in the three dominant principles of the SDA namely being rights based, self – determination, and crossing the micro macro divide by referring. The themes manifested were application via the SDA principles, application via liaison with external stakeholders and referral, application through social justice and advocacy, absence of community development strategies and gaps in service delivery.

8.3.2.4.1 Application via the SDA principles, social justice and advocacy

All participants could identify their service delivery clearly resonating with the principles of the SDA. The principles that were most highlighted were that of rights based, self-determination and participation in their own health care. Participant 8 could identify the

principle of crossing the micro-macro divide. The participants also linked these principles for the enactment of social justice and advocacy. It was previously highlighted how most participants could identify the use of empowerment strategies to be in line with advocacy, social justice but also to fulfil the SDA mandate. All participants felt extremely impassioned about the application and fulfilment of these aspects.

8.3.2.4.2 Application via liaison with external stakeholders and referral

Key informant 1 and Participant 3 both highlighted the necessity to work collaboratively in resolving patients' problems. This they indicated is part of the collaborative nature of the SDA. Participant 5 highlighted that social workers cannot address the issues of patients and families if there is a lack of community involvement.

> So, for me at that macro level you work closely with a social worker and one of doctors who worked at ***[hospital X]*** also works fulltime at ***[hospital X]***. So, we make use of them at a macro perspective. To the community to reach out to patients when they get discharged. (Participant 5)

Participant 3, 4, 8 and 9 indicated that the nature of health care settings and the focus area of service delivery necessitate referrals to offer comprehensive services. Apart from this it would also seem that there are constant meetings with stakeholders to ensure collaboration and aid to patients and families.

8.3.3 Category 3: SDH

This category specifically centred around unpacking the application of the SDH by social workers in health care. This category was divided in two themes namely delineating SDH and application of SDH to social work in health care. Each were then divided into subthemes.

8.3.3.1 Theme 1 - Delineating the SDH

This theme refers to how social workers in health care view and understand the SDH. Apart from the three participants and the two key informants some explanation of what the SDH means were required. It would seem that the participants have heard of the terms but does not use the specific terms in their daily work. They however seem to be consistently involved in addressing the patient's SDH especially when assessing and resolving patients' challenges.

8.3.3.1.1 Uncertainty of the meaning of the SDH

Most participants offered a very generalised view of the SDH. In most interviews i.e., 7 out the ten participants some clarification needed to be offered. In comparison with the survey, participants seemed to have difficulty in delineating the SDH. In preventing awkwardness or feelings of inadequacy the researcher most often would clarify the terms.

Key informant 1 indicated that there has been communication about the SDH to social workers but that either managers do not inform social workers of it or that social workers do not recognise their involvement in addressing of the SDH. Key informant 1 clarified the reasons for this possible difficulty or uncertainty of the explanation of the SDH.

> You know, uhm, well, maybe it doesn't cascade down because I can talk to managers. It's in our strategic plan. You know the social determinants of health being your external factors. And you know your poverty and economy and employment, then everything around us and how it impacts us. Specifically, I think the social workers don't realise that qualities and they were not able to make the link, but the issues around the social determinants of health impacts us in a major way. (Key informant 1)

8.3.3.1.2 SDH as the factors important in psychosocial assessment

In most cases the relevance of the SDH was related to the biopsychosocial factors that social workers identify during assessment. Even though social workers are aware of the concepts it is not always clearly explained. The participants could extensively expand on psychosocial factors but were not clear as to which would constitute the SDH. From the discussion of seven participants, it would seem that the SDH and psychosocial factors could be used interchangeably during assessments with patients.

If one considers the aspects of the SDH i.e., the factors that influence access to health care like the community, support, geography, employment, education and literacy; it is clear these aspects resonate with the assessment of social workers who consider education, geographical distance from setting for treatment compliance, family and support, etc. It is indicated that social work in health care, perhaps has to update the terminology.

Participant 4 shared his understanding

> Those are very key and that is what we ask on a daily basis in the psychosocial assessment of our patients. Because that is what we have to do before any intervention. So that we know who these persons are, where are they coming, from their education and support system. So, this is very key for us to understand it. It helps not only us but also our MDT, our doctors, pharmacist if they are dealing with this type of a patient coming from this environment. (Participant 4)

8.3.3.1.3 SDH as environmental and living conditions

Six participants indicated some sense of what the SDH could entail and mostly made reference to the circumstance or environments affecting people. The connection with access to health care was not highlighted. This theme indicated that the participants are

aware of the importance of the physical and environmental factors and living conditions on the wellbeing of patients. Participant 2 highlighted

> I think my understanding of that is like the circumstances conditions under which people live, the economic situation, education, policies, etc. And all of that is relevant because that is what affects everything e.g., genetics if we are predisposed to mental illness uhm therefore we need to keep that in mind if we treat families or patients when we look at the environment that people come from. (Participant 2)

8.3.3.1.4 SDH as the acknowledgement of social ills of society

Participant 6 and 7, in addition indicated that the SDH also incorporates the social ills that people are confronted with. The attendance of the social ills will result in the wellbeing of individuals and society. Participant 6's view is reflected as:

> I explained earlier that we are coming from communities where there is lot of poverty and unemployment. You know now lately there is substance abuse in our communities. It is very prevalent when you dig deeper there are stressors that come from social ills like unemployment or… family stressors… you know social ills. (Participant 6)

Participant 7 referred to the SDH as

> Ok…Ok it is relevant because if we think of health it is not only about physical wellbeing. It is physical, mental it is whatever. So definitely it is important. We need to and also as social workers we are not the main people in health we cannot shy away from the fact that almost all patients that come to hospital, there are social problems or whatever which influence them as well. So, it is definitely important. (Participant 7)

8.3.3.1.5 SDH as access to resources

Access to resources such as education and clinics were indicated by four participants. One participant also stressed the importance of social inclusion and access to resources by foreigners or immigrants.

8.3.3.1.6 SDH as equal access to health care

Participant 2 and 10 indicated that the SDH are not fairly distributed and Participant 8 indicated that social workers need to advocate for the equal access to health care. These three participants and Key informant 1 seemed to have grasped the understanding that the SDH is centralise around access to health care. Participant 4 also indicated this access to health are by the inclusion of foreigners or immigrants to health care and resources. Key informant 1 described the SDH and the processes as follows

> You know, uhm, well, maybe it doesn't cascade down because I can talk to managers. It's in our strategic plan. You know the social determinants of health being your external factors. And you know your poverty and economy and employment, then everything around us and how it impacts us. Specifically, I think the social workers don't realise that qualities and they were not able to make the link, but the issues around the social determinants of health impacts us in a major way. And you know, and I think our Department is trying to work a little bit better in terms of the social class stuff, because the social class that tends to look a little bit more integrated. So, looking at your social development, looking at education. (Key informant 1)

8.3.3.1.7 SDH as physical and mental wellbeing

> Ok it [SDH] is relevant because if we think of it, health is not only about physical wellbeing. It is physical, mental, it is whatever. So definitely it is important. We

need to and also as social workers we are not the main people in health we cannot shy away from the fact that almost all patients that come to hospital, there are social problems or whatever which influence them as well. So, it is definitely important. . . . I will make an example of the parasuicides. . . . Because when they are discharged, they go home to wherever they came from. And if that social ill that contributed to that person wanting to kill themself is still there, we have lost. That person may come back again, or they may try and do the same thing again. (Participant 7)

Two participants and one key informant stressed the significance of physical and mental wellbeing as part of the SDH. Participant 7, as indicated above, in particular indicated that the wellbeing may be associated with the resolution of social ills in society.

8.3.3.1.8 SDH as instrumental

Both the key informants specified that the SDH are instrumental for social workers in health care. All ten participants acknowledged the importance of the SDH for social workers in health. All participants indicated that it is essential for social work to be knowledgeable about SDH. It is therefore interesting to note that all identified the relevance of the SDH but that the majority of the participants were not entirely knowledgeable about it.

8.3.3.1.9 SDH links with the SDA

As based upon the descriptions of the participants and key informants of access to resources, equality, wellbeing and inclusion; there seems to be a strong link between the SDA and the SDH. In fact, most participants indicated the relationship between the two but highlighted that the SDA is much more relevant due to the link with the social workers in health care's connection with the DSD. Also, from the descriptions offered for the SDA

and the SDH another unifying aspects was that of social justice and empowerment of patients.

8.3.3.2 Theme 2 - Application of the SDH to social work

This theme encompasses the exploration of how the SDH were applied by social workers in health care. It was evident that the very nature of social work in health care addresses the SDH. In fact, this highlights the pivotal role social workers in health plays in enabling patients to comply with treatment.

8.3.3.2.1 Difficulty in connecting the SDH with social work interventions

As indicated by Participant 2 *'buzz words'* or key words are used without any understanding of their appropriate use or meaning. In addition, from the responses it would seem that the SDH is a neglected area as it is not terminology that is used directly with the intervention with patients. The SDH is not used in the daily communication as compared to advocacy and self-determination identified in the SDA. Unlike the SDA, the SDH does not have a White Paper that makes it enforceable within the health care settings. Hence the perception that the SDA is of more importance. Tangible evidence of the application of the SDH apart from the consideration of factors in terms of biopsychosocial factors, could not be provided by most participants. Participants were however able to provide evidence of policies like free health under the policy discussion but not as a specific SDH strategy.

8.3.3.2.2 Relevance of the SDH to social work in health care

The relevance of the SDH to social work in health care were clearly highlighted by all participants and key informants. In particular the access to knowledge regarding the SDH were stressed. It is therefore interesting to note that all identified the relevance of the SDH but that the majority of the participants were not entirely knowledgeable about it. Perhaps

these aspects indicate the need for information to be provided but also that it may be assumed that within the South African health context the SDH is a neglected area. This resonates with the information provided in chapter 5 about the SDH and that minimal evidence of its enforcement in South Africa exist.

8.3.4 Category 4: Policy implementation

This category focused on the strategies that the South African Government has employed with regard to the SDA, the SDH and other policies. This also captured the social workers awareness of these strategies and if they perceived strategies or policies as pertaining to the SDA or the SDH.

8.3.4.1 Theme 1 - Governmental strategies for the SDA and the SDH

This theme highlighted that participants were generally very knowledgeable about strategies enforced by Government. The challenge was however if these strategies could be identified as SDA or SDH.

8.3.4.1.1 The challenge of associating Governmental strategies with the SDA and the SDH

All participants were knowledgeable about strategies that has been implemented due to political reasons, policy implementation and or tragedies. If these were linked to an overt commitment by Government to the SDA or the SDH was not always clear.

Participant 3 stated *"*Remember social work in the health sector; we get all our policies from Social Development."

Participant 4 also stated "I am not aware on such nê except that there are policies that we get from our managers and supervisors to say to us, but we call them SOP, standard operational procedures."

Participant 5 “In terms of social development strategies I have not really known of them or have not been given any or rather escalated from management.”

Participant 6 ‘s answer to the question was brief “No there is nothing.”

Eight participants including the two key informants indicated that there are no strategies evident. Participant 1 and 3 indicated that general strategic plans of Department of Health contain this information. What most participants indicated was the SOP that are developed or changed due to Governmental strategies or policies. These SOP are informed also by political decisions, which social workers should adhere to. Eight participants indicated the use of SOP only. Participant 2 specifically referenced the Life Esidimeni tragedy that occurred and how policies were affected with regard to de-institutionalisation. This she was able to link with self-determination as contained in the principles of the SDA but not a Governmental strategy of the SDA. Linked to this Participant 1 also added that the medical doctors do not consider these aspects i.e., the SDA or the SDH, and in a sense it is not relevant. This could explain the perceived lack of such strategies. Key informant 1 indicated that strategies will usually be implemented when it entails statutory regulations to be considered or changed. Key informant 2 highlighted that some policies are not for social work. Perhaps what should be noted is that it would seem that the SDA is only for social work. The position of the SDH is unclear.

8.3.4.1.2 DSD the custodian of the SDA

Participants 1 and 3 acknowledged that the DSD is the custodian of the SDA.

Participant 3 stated “Social Development is the custodian of the legislation…”

As such the Governmental strategies will not be evidenced in health care policies. This explanation could be considered very feasible for health care settings; but one would question the validity of such rationale to the SDH?

8.3.4.1.3 Grants and poverty alleviation for addressing needs

Participants 1, 5, 6, 7, 8, 10 and Key informant 2 indicated that that there are several social security and poverty alleviation strategies, such as Zero Hunger and social relief strategies employed by the SASSA, that may be considered as broad strategies employed by Government. According to these participants, these strategies are largely informed by the SDA. In addressing the poverty, hunger, social ills, as according to Participant 6 the link with the SDH is established.

Participant 6 highlighted "Okay there is social security. Okay it is the doctor that motivates for the grants. . . . Well, there I know there is one in particular poverty alleviation programme and then the Zero Hunger that comes from social security."

Participant 5 shared "Well I know there was an initiative from SASSA. They called it the Zero Hunger programme when it comes to food security and income level*"*

8.3.4.1.4 Lack of unity amongst all departments and sectors

Key informant 1 highlighted clearly that there are a number of competing professionals in health. "Historically we haven't had a voice within health. There are too many competing professionals."

This results in social work being marginalised. In the end the more important professions will 'win'. This was also particularly stressed by Participants 5 and 6. Both these participants addressed the secondary role of social work in health care.

Participant 5 stated " …because in a health setting, we are more a secondary service." Participant 7 and Key informant 2 also added that as a result with regard to major policies social workers are not consulted. Participants 5 stated that the Department of Health has forgotten about its social workers.

A major obstacle of working in silos was also identified by Key informant 1. This lack of cohesiveness creates also great difficulty in delivering effective services to patients. Participant 6 highlighted where hospital administrators have the mandate to collect payment from patients, yet access to health care is prioritise in the White Paper for transformation of the health sector. Participant 2 indicated that with the de-institutionalisation of patients, the requirements that upon discharge the patient should be accompanied by the social worker and a nurse. This is an obstacle as nurses are not permitted to accompany patients when discharged. This is a good example of the effects of working in silos and the lack of consultation.

8.3.4.2 Theme 2 - Policy and SOP implementation

This theme specifically considered the manner of either policy and or SOP implementation. Eleven themes are discussed namely versality of SOP and policies, SOP or policy seen as a guide, consequences of applying SOP or policies to context, policy as a factor of frustration, SOP and policies may affect social workers wellbeing, relevance and practicality of SOP and policies, dichotomy of the consultation process, contradiction amongst policies, social work is not heard, competing professions in health care and political nature of health care.

8.3.4.2.1 Versality of SOP and policies

All participants indicated the myriad of SOP they must comply with. They acknowledged some policies are applied to social work but indicated that they predominantly work with SOP. They indicated that the SOP are versatile in that it covers a wide range of areas and offers guidance of which steps social workers should follow in offering a diversity of services. These SOP enable the social worker in health care to be prepared to deal with a situation as well as offer clear guidance in the form of steps to follow. This also enhances

the competence of social workers regarding service delivery. Participant 1 was clear about the value of policies and SOP.

> All of those things are now in writing and the guides are working. We can say to our colleagues look this is how we operate. So, I think that it is helpful in that way. We are mostly doing things that is best practice in any way. (Participant 1)

8.3.4.2.2 SOP or policy as a guide

All participants as well as the key informants acknowledged the usefulness of SOP in being a guide for social workers in health care. SOP generally offers steps or procedures that needs to be followed with diverse cases, for example removal of children, discharge planning, issues regarding consents and treatment, etc. Most participants indicated that it takes the guess work out of sometimes complicated cases. In addition, as the SOP is seen as a guide; each hospital setting may also apply it to its context. Key informant 1 indicated that any policy or SOP should be contextualised.

Participant 3 stated that "Sometimes a policy guides you, but it does not limit you."

Participant 4 stated

> Policies give direction of how you must approach certain issues. That is the role that policy gives me., apply my skills in my social work roles with every patient. So, it directs me on how I must deal with a matter. (Participant 4)

8.3.4.2.3 Consequences of applying SOP or policies to context

Even though contextualisation of policies or SOP to the different hospital settings are encouraged, the consequences may however be unpleasant. Participant 4 particularly indicated that at times social workers are encouraged to think out of the box. This thinking out of the box may result in the social worker being adversely affected and will be solely disciplined. In a sense the supervisor will not assume accountability. His account

> Because policy can upset your being. If you do not follow policy, you are in violation of that policy and no one want to be in that kind of situation. Only when there is a problem that was supposed to be addressed by that policy, then they sit down and say you have done wrong here, the policy has changed. You find yourself in the middle of trouble. (Participant 4)

Participant 1 also reiterated that not following SOP may lead to reprimanding. So therefore, creative problem solving is encouraged but the consequences are only levied at the social worker.

8.3.4.2.4 Policy as a factor of frustration

Three participants i.e., 1, 2 and 4 indicated that generally there are good policies which is not always enforceable or achievable. In this regard participant 1 mentioned the lack of follow through by especially the DSD. Participants 2 also shared that at times these revised SOP or policies create expectations which cannot be met due to a lack of resources. Four participants acknowledged the continual frustration with policies and SOP. These frustrations particularly referred to the lack of follow through, resources and consultation. Participants 4 and 5 indicated that at times social workers are not consulted or their input is rejected. Participant 4 shared that supervisors may neglect sharing information about SOP or policy changes only after an event or a case that required the application of a specific policy. This was deemed as frustrating. Participant 5 shared of an example when the new statistics procedures needed to be discussed. Discussion occurred on a departmental level and when their supervisor needed to provide the input to the social work executive it was not accepted. According to Participant 5 the SOP for new statistics procedures were implemented without proper consultation and agreement. Participants shared that there are numerous policies that are implemented without

consultation. Participant 3 also indicated that they are reminded that they will be able to input on current SOP at a later stage. This in the end results in a great deal of frustration. Participant 4 shared his view

> But the problem that I think comes with these policy changes nê … when policies change year after year. The same policy changes. This year you knew how to deal with it. Next year the policy comes again. No this is how you must do it now. So that brings a lot of confusion for examples stats. Changes impact on daily activities. So, I think policies can impact on how efficient one can be in his role. Policy can make you very effective and at same time very ineffective in your work of how you must address issues. I think policy changes have a very serious impact on the daily function of social workers. Policies can also have an emotional impact on my emotional wellbeing. Because policy can upset your being. If you do not follow policy, you are in violation of that policy and no one want to be in that kind of situation. (Participant 4)

8.3.4.2.5 SOP and policies may affect social workers' emotional wellbeing

Participant 4 stressed that frustrations caused by SOP or policies changes especially where the input of social workers were not required or not acknowledged also cause a great deal of emotional distress.

Participant 4's view "Because policy can upset your being. If you do not follow policy, you are in violation of that policy and no one want to be in that kind of situation."

The distress may be due to the fear of the consequences i.e., not following the policy or SOP or do not know it. Another aspect that Participant 4 highlighted was the institution of certain policies like the OSD (Occupational Specific Dispensation) and PMDS (Performance Management and Development System). These policies seem to degrade

social workers and attempt to minimise the role or value of social work. As a result, it causes a great deal of emotional distress. Social workers do not receive any aid for resolving their emotional distress or their discomfort are not acknowledged.

8.3.4.2.6 Relevance and practicality of policies and SOP

All participants indicated that the SOP and policies are of benefit and relevant. However, it was indicated that not all policies are always practical to implement or relevant to social work. Participants 5, 6 and 7 indicated that the major policies in health (not SOP) acknowledged social work as fulfilling a secondary role. Social workers are not involved in direct patient care admission, treatment, sanitising the hospital, etc., and therefore seen as less important.

8.3.4.2.7 Dichotomy of the consultation process

The participants that fulfilled a supervisor or managerial role and key informants indicated that consultation regarding the SOP and policies do occur. In fact, Key informant 1 shared that during the consultation process staff are required to sign off on viewing the SOP or policy. This was also confirmed by Participant 1, 2 and 3. Participant 2 confirmed this by stating

> Because if you think of policy, it is quite broad, that it is sort of rigid, but I do find if new policies are made, they do consult with us first of all the heads of departments and then to us asking for comments. And we do usually give comments. (Participant 2)

The other participants indicated that there is a consultation process which is not usually followed. Participant 4 and 5 indicated that supervisors will neglect providing information timeously. The participants indicated that signing off of the SOP indicates that the social

worker assumes full accountability and will be held responsible if not followed. Therefore, the consultation process is challenging.

Participant 5 shared how she has experienced consultation “To be honest with you I see no consultation or rather not a thorough one. For example, with the SOP. In terms of a proper and thorough consultation I don’t think it was done properly.”

8.3.4.2.8 Contradiction amongst policies

Excellent policies which is well written is evident, but the practical implementation thereof is concerning. Participant 2 highlighted that there are different policies regarding discharge. The example provided was that of the discharge policy that requires the social worker and a nurse to accompany a patient home where needed. Unfortunately, the nurses do not have a policy that permits them to accompany social workers and patients.

Participant 2 clarified by stating

> For instance, we have a home visit policy, and our policy says if we want to take a patient home, basically anywhere we go we have to be with a nurse. The nurses’ policy states that they were they don't transport patients. This then impacts on me because I cannot do a home visit. (Participant 2)

Participant 6 also highlighted that patients should get essential treatment irrespective if they can pay for it. (This opinion aligns well with the fundamentals of the SDH). There are however policies regarding the collection of revenue from patients. If patients are unable to pay, they are not registered at the hospital for services and as a result cannot access treatment or health care professionals. Participants 1 and 8 also drew attention to policies and SOP that requires statutory compliance in particular regarding reporting and

completion of forms. It would seem that even though this requirement is there, the DSD does not enact on it and thereby delaying cases.

8.3.4.2.9 Social work is not heard

Attesting to the type of policies and procedures followed, a number of participants informed that social work is not being heard in the GDH.

Participant 5 said succinctly that “Health has forgotten about us.”

Key informant 1 added that usually for any social work input Government approaches the DSD and not the directorate for specialised programmes with the GDH, where the social work profession is housed with. She also indicated that impact is being made by the awareness creation of the presence of social workers in the GDH. Key informant 2, Participant 2 and 7 alluded that social workers need to be proactive with regard to their role and presence in health care settings.

8.3.4.2.10 Competing professions in health care

Linked to the hierarchy and secondary role of social work the theme of competing professions was also clearly indicated. As social work is not definitively involved in medical or physical patient care the needs of social work in health care settings are not met. Key informant 1 indicated this competing nature in health. Participant 6 also indicated that at times when funding or assistance are sought for social work, due to the secondary nature of the role; social work will not be considered.

8.3.4.2.11 Political nature of policies

Participant 2, 3, 6 and Key informant 1 indicated that at times political agendas are set out in terms of de-institutionalisation, statutory provisions, key health priorities and response to suicides. Participant 6 summarised the political impact.

> Because right now there is the SOPA commitments that our principal [X] was telling us about. And when you look at those activities that they expect from us…they are more from the politician's point of view. You know there is this thing from the premier that we must deal with parasuicide. This person does not even understand this whole multifaceted thing to deal with it. (Participant 6)

Based on these aspects social work needs to respond and fulfil a service perhaps not in the ambit of social work, without being consulted. These political demands usually occur after the State of the Nation or State of Provincial Addresses (SONA and SOPA). Participant 6 and Key informant 1 however indicated the role of the deputy director specialist programmes is to enlighten those in provincial government of the role of social work in health care. Key informant 1 shared some recognition and successes that occurred including where social workers in health care were considered. Despite this these political agendas impact social workers negatively.

8.3.5 Category 5: Vision

The last category encompassed the views of the participants regarding the future of social work in health care.

8.3.5.1 Theme 1 - Future of social work in health care

This theme attempted to gauge the views of participants about social work in health care. Generally, all participants were very optimistic about social work and the role it fulfils in health

care. In describing this theme three subthemes were highlighted namely hopeful social work future, threats to the role of social work, and social work is unique and essential in health care.

8.3.5.1.1 Hopeful social work future

All participants expressed their hopefulness of the future and value of social work. The participants indicated that social work has a pivotal and central role which the MDT cannot operate without. The services are needed and will remain needed in health care settings.

Participant 1 qualified her opinion

> So again, I think because I am so passionate about health; it has a role. I think social workers are so well equipped to do different things. …We have been well trained to do a lot of work in a health setting. (Participant 1)

Participant 2 echoed "I definitely think there is a future. . . . I don't think we are as proactive and involved as we are supposed to be, but I do think we have a future in health."

Participant 3 shared: "We will still need health care social workers, but I think they must be seriously trained."

Participant 5 explained "I envision seeing social work in health care be treated as a speciality."

Key informant 1 elaborated her view about the future of social work in health care as follows

> I really think that we need to continuously try to elevate the social worker within health. Uhhm. And I think once we get some acknowledgement from National Health, it might be a little better. But I think the fact that the Council is looking

> at health care social work as a specialisation, that might sort of elevate the social work profession. (Key informant 1)

Participant 5 also qualified her hopefulness, by indicating the future for social work if structural changes will occur.

8.3.5.1.2 Threats to the role of social work

Even though most participants were in unison about the value of social work, Participant 4 also accentuated threats for the social work role. He carefully provided examples of how other staff members are taking up the role that is assigned to social work.

> So, some social issue that are picked up by some doctors … you will find that some doctors they are able to admit them without involving social workers. Some doctors you may find have enough time and can trace the families. Which is supposed to be social work. Even the nursing staff are able to carry out social work stuff. And that is a threat to social work. . . . Exactly they take my job. For me I just feel like the way things are going. How I see the future is a little bit bleak, because we as social workers are not assuming advances. The broader aspects are not well encouraged. The clinical part is not encouraged. (Participant 4)

Furthermore Participant 4 indicated that the structuring of the PMDS occurred in such a manner that social workers are marginalised, and chances of promotions is limited. He indicated that it seems that the role of social work is diminishing because of these constraints.

> New PMDs format which tells social work this is your functioning. This new format is cutting a lot of social work roles. Someone looked at it and said for us not to give PMDS to social work, we must not allow them to do one, two three. They cut our functioning. Minimising the role of social work. So, I am not sure how social workers will be needed in the future. There is also the skills audit. That is one thing that will also kill social workers. Your skills should go to correctional service for example, to the DSD. I think social work in the health setting is not much appreciated. Social workers are under threat because of the current changes. (Participant 4)

8.3.5.1.3 Social work is unique and essential in health care

Social work is unique and essential in health care, according to all the participants and the key informants. Key informant 1 stressed that without social work in health there will be a huge gap especially in addressing the SDH. Key informant 1, Participants 5, 6, 9, and 10 stated that the medical teams do not always take cognisance of social and economic aspects. As Participant 5 indicated that social workers may have a secondary role, but it is an essential role in the holistic treatment of patients.

Key informant 1 summarised the hopeful future of social work.

> So, I think the province is slowly becoming aware because of my daily sort of reminder … But I think being in specialist services has helped
> us get some recognition and our role sort of elevated within the multidisciplinary team and within health at large and the value of social work. (Key informant 1)

8.4 Summary

This chapter offered the position of ten participants and two key informants of the current social work practice in health care. The findings represented a well experienced population that is knowledgeable about the SDA. It is clear that the SDA is applied in terms of the principles, referral and stakeholder involvement. The SDA is a necessity to ensure social justice but confirmed that the catalyst for enabling the SDA in health settings are social workers. Even though the participants and key informants were knowledgeable, challenges with the implementation of the SDA are noted. Confusion of how the approach should be applied, lack of information and resources seems evident. This is further complicated by role changes that is levied at the SDA. Participants realised that the SDH are being addressed but informed that the terminology is not used. It would seem that various SOP are versatile, guides social workers but also impact on their mental wellbeing. The absence of culturally competent models, rotation models and governmental strategies for the implementation of the SDA and the SDH is very concerning. The numerous challenges and 'de-valuing' of the social work profession does not deter the participants about the pivotal role of social work and its hopeful future. Chapter 9 presents the findings of the two focus groups.

CHAPTER 9
DATA PRESENTATION
FOCUS GROUP DISCUSSION

'As social workers we've been trained to say go down to the level of the client. So… (all laughing) so we went down to the level of the client and even went down with…. '(all laughing) ***FG1 Participant 1***

(Overlapping) 'So we forgot to go back.' (all laughing) ***FG1 Participant 3***

9.1 Introduction

This chapter offers an overview of the findings of the two focus group discussions. The demographics section will unpack the compilation of the two focus groups. The dynamics evidenced within the focus groups are highlighted. Thereafter the findings will be highlighted according to six categories, ten themes and several subthemes. The six categories that will be discussed are the nature of the current social work practice in health care, SDA, SDH, policy implementation, vision and framework for social work in health care.

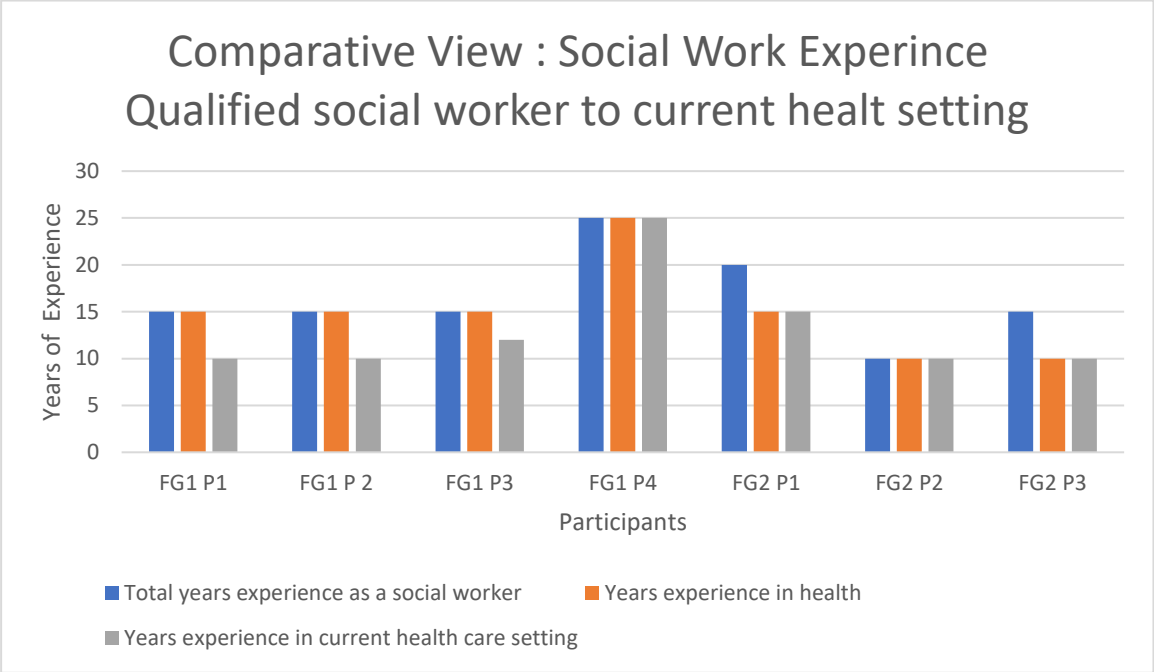
9.2 Demographics

Table 9.1: Focus Groups - demographic profile

	FG1 P1	FG1 P2	FG1 P3	FG1 P4			FG2 P1	FG2 P2	FG2 P3
AGE	36 – 40 yrs	36 – 40 yrs	36 – 40 yrs	46 – 50 yrs			56 – 60 yrs	31 – 35 yrs	31 – 35 yrs
Gender	Female	Male	Male	Female			Female	Male	Female
Race	Black	Black	Black	Black			Black	Black	Black
Grade	Supervisor	Supervisor	Supervisor	Manager			Grade 2	Grade 1	Grade 2
Setting	Tertiary	Tertiary	District	Tertiary			District	Tertiary	Tertiary
Supervision	Yes	Yes	Yes	Yes			No	Yes	No
Supervision offered to	Social Workers	Social Workers and Students	Social Workers	All staff			NA	Students	NA
Number of supervisees	5	7	8	5			NA	1	NA

FG1 P= Focus Group 1 (one) Participant FG2 P - Focus Group 2 (two) Participant

Two focus group were facilitated. Table 9.1 represents the demographic profile of these two focus groups.



FG1 P= Focus Group 1 (one) Participant **FG2 P** - Focus Group 2 (two) Participant

Graph 9.1: Comparative view – Social work experience (Focus Groups)

Graph 9.1 represents a comparative view of the social work experience of participants from being a qualified social worker to the current health care setting.

Focus group 1 (FG1) comprised out of four participants, two males and two females. Three participants were supervisors and one was a manager. Participants 1, 2 and 3 were all in the same age category i.e., 36 – 40 years of age and the Participant 4, the manager, was in the age category 46 – 50 years. As may be denoted from graph 9.1 all participants in FG1 had 15 years or more total experience as a social worker. All participants had a minimum of ten years of experience in their current health care setting, apart from Participant 4 who had between 21 – 25 years of experience as a social worker and in the current health setting. All these participants were involved with supervision and apart from Participant 3 were all employed in tertiary health care settings.

Focus group Two (FG2) comprised out of three social workers: two female and one male participant. Participants 2 and 3 were in the age category of 31 – 35 years and Participant 1 was in

the age category 56 – 60 years. Participant 1 was employed in a district health care setting and Participant 2 and 3 in a tertiary health care setting. It would seem that Participant 1 entered the health care settings in the last 15 years. Participant 2 had 10 years of experience in social work and the same health care setting. Participant 3 had 15 years of experience as a social worker of which 10 years were in the current health setting. Participant 2 was the only participant who were involved in supervision.

Both groups comprised out of individuals who were well experienced in the field of social work in health care. As evidenced valuable information was attained irrespective of the uniformity of the population groups.

9.3 Group dynamics and interaction

Focus groups demand reciprocal interaction and cohesion for sharing. FG1 was very dynamic and could draw from experiences and evaluate what was important as well as what was required for the future. This group of supervisors could provide in-depth understanding of the lived experiences of other social workers that they supervise, but also considering varied settings. This reiterated the principles of interpretive phenomenology especially idiography. This group was cohesive and shared lots of laughter in discussing at times very important issues and the realities that the social work profession face. The quote at the start of this chapter's introduction attests to the cohesiveness and use of humour of this group. The similarity in ages could perhaps have aided this as well. Focus group two was cohesive but more serious and critical about what was needed for the profession.

Both groups started off being very apprehensive and tentative about providing opinions. In considering group processes and dynamics this is very appropriate. Krueger (1998), Litosseliti (2003), Stewart et al. (2007), and Stewart and Shamdasani (2015) indicated that the role of the moderator is important in facilitating meaningful expression and cohesiveness. This is what the

researcher enacted, and the initial apprehension dissipated resulting in open and honest sharing. The overlapping and open sharing that occurred are indicative of the cohesion experienced. In FG2 the moderator needed to solicit more responses. Participants 2 and 3 were more vocal in this group. In considering cultural norms, perhaps because Participant 1 was older, the other two participants expected her to respond first. Participant 1 seemed more reserved. Drawing from their social work knowledge Participant 2 and 3, (but especially Participant 2) would draw Participant 1 in by directly soliciting her opinion. Silences occurred appropriately as it was not uncomfortable but due to thinking. During the thinking process a number of probes and encouragement was used to facilitate the thinking process and to normalise the silence.

The focus group discussions took longer than expected for both groups. The moderator (researcher) found that the focus group discussion was also used to ventilate and deal with issues that the participants were currently experiencing. It offered debriefing regarding challenges. Both groups were committed in exploring solutions to current challenges. In focus group discussion mindfulness about prefacing the individual versus group responses are important. The experience of participants in groupwork allowed for the participants to resolve and acknowledge individual opinions to the group's opinion. Where differences occurred, the participants were respectful and acknowledged this. Both groups were different, but the content and interaction were valuable.

The observer concurred with the moderator's observation of cohesiveness and the wealth of experience of both groups. The observer was also appreciative of the diversity and experience of the groups. The observer offered debriefing to the groups, summarised salient points and points of appreciation of each participant. This led to the participants staying longer and socialising with one another.

9.4 Categories, themes and subthemes

The categories identified were focus areas of the discussions. Each category has themes and subthemes. The six categories are the nature of current social work practice in health care, the SDA, the SDH, policies, vision and framework for social work in health care themes were highlighted. In discussing the findings, the categories, themes and subthemes will be highlighted. See table 17 for the overview of categories, themes and subthemes.

Table 9.2: Focus group – Categories, themes and subthemes

Category	Themes	Subthemes
1. Nature of the current social work practice in health care	1.1 Social work in health care	1. Embodiment of social work role 2. Neglected counselling role. 3. Competence of the social work profession 4. Challenges of social work in health care settings 5. Feelings of unappreciation and lack of recognition 6. Impact of the welfare roots of social work
	1.2 Macro strategies	1. Community practice in health care settings 2. The value of community awareness strategies 3. Community work's empowerment agenda in line with the SDA
2. SDA	2.1Delineating the current SDA	1. Indication of the SDA in Social work in health care 2. DSD owner of the SDA 3. Social work as catalyst of the SDA in health care settings 4. Importance of multisectoral collaboration 5. Challenges with the SDA
	2.2 Rotation	1. Necessity of rotation 2. Dilemmas with rotation 3. Need for different models of rotation
	2.3 Competence	1. Acknowledging the competence of social work 2. Pitfalls of comparisons with psychologist 3. Need to enhance language use 4. Need for cultural understanding and models 5. Challenges with unifying cultural perspectives with health care settings
3. SDH	3.1 SDH indicated in Social work in health care	**1.** Delineating the SDH **2.** SDH in relation to psychosocial factors 3. Hospitalisation accentuates the SDH 4. Link between the SDA, the SDH and social work.
	3.2 NHI and determinants	
4. Policy Implementation	4.1 Policies and SOP implementation	1. Reactive policies 2. Role changes due to policies or SOP 3. Lack of social work consultation 4. Absence of an SDA and a SDH framework
5. Vision	5.1Future of social work in health care	1. Necessity of social work 2. Reframing the position of social work 3. Resource constraints 4. Social work under threat 5. Social work in health care as a speciality
6. Framework for social work in health care	6.1 Framework of the SDA for social work in health care	1. Essentials of the framework 2. Role of academia 3. Challenges that the framework should address

9.4.1 Category 1: Nature of the current social work practice in health care

This aspect explored the perceptions of social work in health care but also the current application thereof and challenges experienced. Two main themes i.e., social work in health care and macro strategies were identified.

9.4.1.1 Theme 1 - Social work in health care

This theme presents the impressions of the participants about the current enactment of social work in health care. Apart from delineating the role the participants also expressed what should be included or emphasised for the role as well as the possible framework.

9.4.1.1.1 Embodiment of social work role

In both focus groups the participants highlighted the core and important role of social work in health care. FG1 participants outlined the core of social work in health care as counselling, empowerment and support, whereas FG2 participants highlighted educating staff and patients about the role of the role of social work, treatment supervision, psychoeducation and support.

FG1 Participant 2 stated that counselling is ". . . planned and structured."

FG1 further expanded on the nature of counselling as a structured and planned process of intervening as well as the use appropriate approaches during intervention. Empowerment was unpacked as providing information and education. This also linked with referral of patients to external resources. FG2 explained there is a continual need of clarifying the role of social work with the medical team as well as with patients. Treatment supervision were unpacked by FG2 as the interventions offered by social workers to ensure that there is treatment compliance once discharged. This group also highlighted the education or

offering of information to patients. Both groups highlighted the function of support as a core function of social work. This was highlighted in terms of the support given to patients, families and staff.

9.4.1.1.2 Neglected counselling role

Even though the counselling role was identified as a core function; both groups identified that it was very difficult to enact. FG1 was very particular in what constitutes counselling. These four participants expressed concern if counselling can just happen haphazardly.

FG1 Participant 2 stated "It is easy to say, but in reality, what is counselling? That is why most of the practitioners due to pressures of work in the institution will say that I have provided counselling."

FG1 Participant 1 overlapped with FG1 Participant 2 by agreeing stated "We need to start from assessment and engagement, proper structure." This evoked intensive discussion.

FG2 was more direct in that they stressed that the counselling or the therapeutic role of social work as currently evidenced in health care settings is neglected. This they stressed was largely due to the fact that service delivery is quantitatively driven with the expectation that all social workers in health care settings should meet a 1:60 target per month. This referred to social workers in health care has to have recorded interventions with 60 new patients every month. This is not taking into account the follow-ups or other patients that they need to offer services to. The result is that referral is used for patients or and families for counselling. This is also linked to the workload that social workers must carry. All participants mentioned that one social worker will have to offer services to several units or wards therefore the focus is on attending to all referrals as the MDT demands and not on offering qualitative services. FG1 also indicated that the size, length of hospitalisation and the speciality of the setting, ward or unit impact on the offering of counselling. Those

settings like the specialist or rehabilitative settings which involves long hospitalisation enables the therapeutic role. These settings are however limited and most social workers work under extreme circumstances with short hospitalisation periods.

9.4.1.1.3 Competence of the social work profession

All participants were very vocal in that social workers are well trained and competent to deliver services. Participants highlighted that they are very well trained and can also offer counselling on a level comparative to psychologists. The issue is that psychologists are acknowledged for their role and does not carry the same workload as social workers. Their (psychologists) services in health are qualitatively driven and encompass a structured and planned nature. The competence of social workers extends to social needs and wide range of services that needs to be offered.

As part of this discussion cultural competences were mentioned and it was highlighted despite the lack of models to guide social workers, social workers are skilled in delivering services to a diversity of patients. FG1 Participant 4 indicated that at the core social work has the respect for others and this enables the cultural competence of social workers.

> I think that the issue in the health sector is about competency. But competency of course you know you are dealing with various cultures. You cannot take that away. But the main focus should not be on the cultural aspect of it. It should just be about competency. Are you competent enough to carry out the duties that we are given to you? (FG1 Participant 4)

9.4.1.1.4 Challenges with social work in health care settings

All participants indicated that there are several challenges with practicing social work in health care. The type of setting was mentioned as major factor. To support this FG1 Participant 1 stated that "All the methods that you have to do; it depends on the environment where you are placed."

Due to differences in settings, services offered also differs. FG1 was clear that the size of the setting, the stay and the speciality associated with the setting, ward or unit all impact the service delivery. With the result there cannot be one framework or SOP that will be suitable for all. In this lies the challenges of service delivery but also influence the perception of social work as a non-cohesive profession. Health care settings within communities allows also for social workers to be more hands on with the offering of community work services. Tertiary health care settings often have enormous coverage areas that may cross provincial borders and as a result limits community involvement. Referral to community resources is usually the result.

FG1 Participant 2 shared the challenges of offering counselling and stated ". . . the settings we are in we rather refer."

Participant1 of FG1 also added "Now the settings that you are in… you rather refer to the other organisations. If you are in tertiary; you refer to district or other organisations."

FG1 Participant 3 further elaborated on this and the diverse service delivery offered by health care settings by stating

> Firstly, it will also depend on what type of hospital you are in. Secondly, how long do you stay there in the hospital. For example, a patient admitted in ***[hospital X]*** stays for a long time. You can plan in providing counselling. . . . Other times your intervention will be short. You are getting pressure from the doctor or whoever,

> that you need to get this done. And the following day you go to ward – now the patient has been down referred of discharged. So, you might have had a plan, but the setting does not allow you to give the services as you wished. (FG1 Participant 3)

The focus on offering quantitative services results in the neglect of the therapeutic role. This gives the MDT, the impression that social work is an occupation and not a profession that uses therapeutic interventions. Due to the perceived role of social work, the need for social work services is considered late or rather upon discharge. Participant 2 of FG2 indicated that social work is seen as an *exit profession*. This implies that social work services are only considered when the patient is to be discharged. Due to the time constraints the social workers work under tremendous pressures to complete the discharge within the time constraints the MDT provides. This notion as an exit profession, according to FG2 also implies that social work profession does not have equal standing with other professionals.

FG2 Participant 2 shared "Social workers are there at the bottom. . . . Social workers are not well developed in the health sector."

FG1 participants were extremely vocal about the impact of the profession's requirement to enter the client's (patient's) world. This adjusting to the level of the client (patient) diminished the social work profession or social workers to establish themselves as a viable and equal member of the MDT. In communicating on the level of the patient also encouraged that social workers are less likely to present information to MDT in an academic and professional manner.

There also seems to be limited opportunity for social workers to really develop their medical knowledge base due to the focus on quantity service delivery and the immense workload each social worker carries. In addition, limited time is available for in depth exploration of the therapeutic role. These constraints also result in referral for service delivery. By implication this also sends the message to the MDT that social work is not a profession, does not offer counselling and that psychologist are the counsellors.

Lack of culturally competent models therefore complicates cases where there is cultural explanation evidenced for patient's behaviour. Even though the Constitution of South Africa and the SDA indicate right to self-determination, the legislation in health is lacking. There were several participants that were familiar with offering services to patients with mental health challenges as according to the Mental Health Care Act. They were clear that this Act does not provide for patients to be discharged during observation periods. Social workers are usually called to navigate such difficult matters.

9.4.1.1.5 Feelings of unappreciation and lack of recognition

The participants also stated that due to their perceived standing in the team, when and what type of referral is made and not acknowledging the input of social workers, they feel unappreciated and unrecognised in the MDT and health care settings. Participant 3 of FG2 shared that she was first qualified as a psychologist but decided to enrol as a social worker. She indicated that in her opinion, social work attends to clients better than psychology on its own. At the same time, she indicated that in the MDT "Social workers are there at the bottom."

Participant 2 FG2 further stated that "We are not equal to other professions in health." This referring to the hierarchy in the MDT and health settings. This is in line with what

Participant 1 FG2 stated about that the MDT needs continual education regarding the social work role.

FG1 Participant 4 indicated that social workers are not consulted about policy implementation. This lack of consultation seems to be indicative of a lack of recognition. Participant 1 in this group highlighted that social workers do not have a voice to represent them. To this Participant 4 responded to as "Our voice is not even there." All laughed at this response, but this seemed to indicate that social work is not acknowledged and are helpless in health care settings. FG2 Participant 2 furthermore added that in health there is top-down approach, which limits social work practice and undermines social work.

Due to workload and time constraints of social workers, they are involved in a lack of reflective practices important for self-development. As these reflective practices does not occur, limited growth may be evident.

9.4.1.1.6 Impact of the welfare roots of social work

Participants from both focus groups introduced and discussed the history of the social work profession. The participants indicated that the welfare connection and how the profession emanated are still perpetuating the perception that social work is only *'welfare'* and not a profession. This perception is then further reinforced by the lack of counselling offered to patients and families and how social workers represent themselves in the MDT. This therefore seems to be a vicious cycle which continues.

FG1 Participant 1 "Ja,.. the history. So, everybody thinks that social workers are only doing welfare. You get the referral: patient needs home. Patient does not have money."

FG2 also highlighted the impact of the concept of welfare and that it represents a lack of empowerment. This group highlighted the importance of empowerment as according to SDA.

9.4.1.2 Theme 2 - Macro Strategies

This theme refers to community involvement or greater stakeholder or policy involvement that results in services delivery to patients. The three sub themes for this section are community practice in health care settings, the value of community awareness strategies and community work's empowerment agenda in line with SDA.

9.4.1.2.1 Community practice in health care setting

FG2 Participant 2 indicated that

> From my experience . . . our community work is more on making awareness of the general public about various health issues. In the health sector there is a health calendar that focuses on certain illnesses. So, if it is a cancer awareness campaign week, they are dealing with or educate generally about cancer. . . so I think . . . that our macro work is focused on is psychoeducation and awareness. (FG2 Participant 2)

All participants indicated their involvement in macro strategies. Community work is being offered but this is however setting dependent. What was evident from both groups was that community work practices are reactive. This the participants highlighted occurs as based on the findings of the monthly statistics provided. The monthly statistics records the types of problems that social workers have encountered and based on this, awareness programmes are offered. The use of the health calendar to plan information, prevention or

awareness programmes were highlighted. The absence of sustainable programmes or community development strategies evident.

The participants from FG1 were very detailed in outlining the different types of community work that would be enabled in different settings. FG1 Participant 1 shared "Now the settings that you are in… you rather refer to the other organisations. If you are in tertiary you refer to district or other organisations."

Health care settings in the CBD will have greater difficulty in implementing community work that is community oriented. The use of health calendar and awareness programmes were indicated to be most suitable for such settings. The group also highlighted that health care settings in communities may utilise other community work strategies that may be more sustainable and less reactive. Social workers in such setting may implement programmes with communities.

Both groups highlighted the value of liaising with external stakeholders and referring patients to benefit from other community work services.

9.4.1.2.2 The value of community awareness strategies

Participants from both focus groups were in unison that community practices or involvement in macro strategies occur. This is a part of the job description of all social workers. The diversity in its application due to the diverse health care settings should be noted. As FG1 comprised of supervisors and managers, this group were able to critically view the diverse community work strategies that may be applicable to diverse setting. It was clear that the implementation of community work especially with reference to community development was lacking. However, even though the community may be considered reactive and according to the health calendar, participants felt that the projects

carry value and is of importance. The biggest motivator is that such community projects provide information to clients and attempts to empower. This was seen as useful and needed. In this regard FG2 Participant 3 stated

> Empowerment also goes with awareness. So, the focus should not be on giving information and people do not know what to do with it. But you give information that empowers the person even in your absence there will be some sort of continuance. . . so you do more empowerment than a lot of community work. (FG2 Participant 3)

9.4.1.2.3 Community work's empowerment agenda in line with the SDA

All participants highlighted the aim of community work as the empowerment of clients. As such they felt strongly that this empowerment agenda linked well with the SDA.

FG2 Participant 3 highlighted the link as

> The link with the social development approach is empowerment. Remember with social development the link with the then social welfare with the current social development; because when you empower one links it with social development. It speaks to people being able to do things for themselves and not create dependency. (FG2 Participant 3)

From the participants' point of view even if the community work strategies do not always occur as community development or social action the aim of SDA is met.

9.4.2 Category 2: SDA

This category focuses on the exploration, description and explanation of the SDA and how it is implemented currently in health settings. From the discussions three themes emerged namely delineating the SDA in health care, rotation and competence.

9.4.2.1 Theme 1 - Delineating the current SDA

This theme explored how the SDA is applied in a health context and the essential components that participants felt necessary. Below are some reflections from participants about the SDA.

FG1 Participant 1 "Wellbeing of the marginalised groups. "

FG1 Participant 2 "Striking a balance between equity and social injustice."

FG1 Participant 3 "It is also about empowering individuals."

FG1 Participant 4 "It is looking at the general social and economic needs and coming with programmes that will address the needs."

FG2 Participant 1 "It involves outreach programmes."

FG2 Participant 2 "Social development has to do with taking services to the people."

FG2 Participant 3 "Meeting them at their point of need."

The above indicates that both participants from both focus groups had a comprehensive overview of what the SDA entails.

9.4.2.1.1 Indication of the SDA in social work in health care

All participants were very confident about the use and the application of the SDA in social work in health care. FG1 participants indicated that the SDA is represented in offering integrated services to patients. These specifically referred to addressing the socio-economic needs of patients. They also highlighted the SDA as the wellbeing of marginalised groups. Furthermore, this group elaborated that the SDA is achieved by offering holistic psychosocial services with the emphasis on empowerment for individuals thereby striking the balance between equity and social justice. The SDA requires the integration of services and as a result services cannot be offered in isolation in hospital settings. Linking with communities and resources are imperative. In fact, the group

identified that the SDA as offered in hospital settings requires a critical reliance on others to complete holistic service delivery to patients and families. They were in unison that their role incorporates dominant aspects of the SDA, but it is not reflected in the daily, weekly and monthly statistics that are completed.

Participants of FG2 agreed that the SDA is reflected on the empowerment strategies that is offered to clients. This group had an in-depth discussion of the requirement of the SDA of "…taking services to the people.", as highlighted by FG2 Participant 2. The dilemma identified is who should be responsible in offering service to communities as social workers in tertiary health care settings may have difficulties in accessing communities. FG2 Participant 3 shared

> But then do we need to go out? Then I would say we need to make good use of the structures that are there for example you will look at your clinic levels. . . for us in a hospital setting it is no longer a preventative pillar of health. It is more to do with the clinics. Yes, I agree we need to go but my question would be who? We need to use the structures that is there we cannot all go out. (FG2 Participant 3)

The group agreed that social workers in primary and secondary health care settings are better positioned to offer community work and outreach programmes.

From both focus groups it was distinct that SDA in terms of its tenets i.e., being rights based, self-determination, participation, linking with communities and stakeholders, and the use of empowerment and social justice principles occur. Difficulty in the actual application of macro strategies like community work and specifically community development is challenging depending on the category of health care setting.

9.4.2.1.2 DSD owner of the SDA

In discussing the challenges with the implementation of the SDA, both groups highlighted that according to their perception the ownership of the SDA is the DSD.

FG2 Participant 3 highlighted

> If think social development approach; you think DSD. Yes, it is their core. Because … working at a hospital and DSD… I want to say that those are two different fields of speciality. But even in health you do make use of the social development approach. But for me it goes back to the collaboration. (FG2 Participant 3)

By virtue of this they identified that social workers in health as well as their *'voice'* are not recognised. FG 1 alluded that the impact of this was that in Government social workers in health has 'lost' their designated powers referring to statutory powers.

FG1 Participant 2 shared his discontent regarding this matter

> Here I am in a hospital, I do not have the power to proceed and act and cannot move forward because I am not designated. . . so what qualifies one?… Is it just because I am there *[DSD]*? What is so special about someone being designated with statutory powers without any special training? (FG1 Participant 2)

FG2 shared that the SDA are better implemented in the DSD. The DSD uses programmes which the SDA mandates as part of service delivery. The example offered by Participant 2 of this group was that of substance abuse programmes.

FG2 Participant 2 indicated "DSD work their programmes are more on empowering. There are those that are doing programmes on substance abuse. They go out to empower their communities."

Both groups acknowledged that the DSD and Department of Health are two varied specialities. At its core, the DSD embodies the SDA whereas in health setting the SDA is incorporated and seen in the use of the tenets, empowerment and referral by social workers.

9.4.2.1.3 Social work as the catalyst of the SDA in health care settings

FG1 termed that the social worker is the catalyst of SDA in health care as this approach is not familiar to the MDT. The social worker fulfils this role particularly due to the knowledge they have about it and is the key role player for referral and stakeholder involvement. The social worker is actively involved in multisectoral collaborations, occupies an active role of identifying psychosocial stressors of patients and attempts to resolve it for treatment compliance. This FG2 stressed as the empowerment role of social workers in health. Further elaborated this implies that social workers are cognisant of the psychosocial stressors and being the catalyst resolves these aspects through appropriate and responsive liaison with community resources to enable treatment compliance.

9.4.2.1.4 Importance of multisectoral collaborations

FG1 Participant 2 highlighted

> Stakeholder type of forum that includes everybody. Multisectoral collaboration; I am able to link them. . .so that it alleviates that psychosocial stressors that they have so that if they come back to the hospital, they are able to comply . . . .so it becomes like you cannot work in isolation. (FG1 Participant 2)

FG2 Participant 3 “We network in the communities. So, it is more of a collaborative venture.”

FG1 emphasised that the offering of integrated or comprehensive services to patients are imperative. As a result, multisectoral collaborations are instrumental. This was elaborated on as involving liaison with stakeholders, getting to know resources and building relationships. The aim of this is to offer holistic services to patients. FG2 highlighted that programmes offered in communities may benefit clients hence the importance of liaising with communities and referring patients. As a catalyst in ensuring compliance, the knowledge of psychosocial stressors and resolving it with liaising with appropriate stakeholders are imperative for ensuring the empowerment and wellbeing of patients. From both groups at the core of the multisectoral collaboration seems to be not only empowering of patients but ensuring compliance to treatment. This here seems very suggestive of addressing the SDH.

9.4.2.1.5 Challenges with the SDA

Even though both groups acknowledged their involvement and the importance of the SDA, several challenges were highlighted. As part of the mandate of the SDA, the involvement in communities is noted. This produces a dilemma of who should offer the services in the communities. Social workers in health are stationed at hospitals. Some health care settings may be far removed from the communities of the patients. This is especially true for tertiary health care settings. Both groups highlighted that social workers in primary health care settings are better situated to directly connect with communities.

FG2 Participant 3 stated “The SDA does not bring therapy into our daily practices.”

FG2 indicated that SDA does not embody the therapy role. This role seems to be neglected as emphasis according to the SDA is on programmes which does link well with the needs to the MDT and the health care setting. This group highlighted that the training of social workers revolves on counselling but that the SDA does not embody this aspect.

Both groups also highlighted that the SDA does not make provision for diversity of settings and service delivery. Not all health care settings can be involved in programmes. Diversity should be acknowledged. Social work in health care fall under the ambit of Department of Health and the SDA of the DSD. These are seen as two different distinct settings which complicates the application of the SDA even more. The health care setting itself may not also lend itself well to facilitate programmes due to the restrictions of the setting and service delivery; whereas social workers at the DSD may have the resources and mandate to do so. In fact, according to the groups, the mandate of the DSD is that their social workers should be involved or develop programmes.

The focus on the SDA and using generalist practice encourage the undermining of the social work profession. FG2 indicated that term of ***'generalist practice'*** should be removed from social work practice. Both groups acknowledged that even though generalist practice enables social workers to offer services in any setting and to any persons, it does not acknowledge the skills and speciality involved in social work in health care. FG1 offered very strong opinions that social work in health care should be a speciality and the practice or employment in a health care setting need have to a qualification or specialisation courses. This should be in addition to the general in-service training offered by the health care setting. FG2 acknowledged the skills of social workers, encourage the removal of the term generalist practice but felt strongly, in opposition to FG1, that further training or specialisation is not needed. They did acknowledge that generalist practice enables social workers to practice in any setting therefore further specialisation was not needed. They did agree with FG1 that social work in health is a speciality. These arguments almost seem in opposition especially considering their feelings of removal or the term of generalist practice.

FG1 also indicated that with the DSD being the owner of the SDA that social workers in health care have 'lost' certain powers. This refers specifically to statutory powers that social workers in health care are not permitted to execute. They highlighted the confusion that a newly qualified social worker with limited experience have statutory powers but not experienced social workers in health. By implication, a social work degree allots statutory powers to any social worker. The SDA as implemented by the DSD seems to purposively marginalise social workers in health care. This aspect therefore also compounds the notion of all social workers being generalist practitioners, but certain powers are removed from social workers due to where they are employed.

With the term generalist practice the social worker is seen as an exist member of the MDT, as according to FG2. Therefore, the social worker will be consulted when the patients' needs to be discharged.

FG2 Participant 3 shared her discontent with the term generalist practice by stating

> It has always bothered me even during my studies. … When we say we are generalist practitioners; that is why we are being treated as people who are neither here nor there. You know when there is this expectation of you being a jack of all trades. (FG2 Participant 3)

9.4.2.2 Theme 2 - Rotation

Rotation is a theme that creates a great deal of discussion and apprehension. Both groups indicated that rotation is an integral part of the SDA as it revolves around empowerment. This is one aspect of the SDA that is extensively complied with in hospital settings. Views on rotation were shared as below.

It is actually good in the sense that you don't have a single person working for example in the psychiatric ward. If we rotate, we are actually going to empower ourselves in the absence of *[X];* the services will not stop. At the same time, I also don't think it is a problem if I am interested in HIV, for example, and I want to be a champion in that; that should not be a problem. We do need people who do have that expertise. (FG1 Participant 3)

Rotation is necessary to take place. Even though it does not develop society as a whole; it empowers the individual. . . .So I think the rotation goes back as to say this individual needs to be empowered . . . for me to be exposed to various specialities within the health department. To know how do I work in this kind of speciality. . . . it is for me to be exposed to another speciality. . . . So, rotation brings in knowledge, brings in skills. (FG2 Participant 2)

9.4.2.2.1 Necessity of rotation

Both groups agreed that rotation is needed in health care settings. FG1 portrayed rotation as the empowerment of social workers, the enablement of expertise and the commitment to learning. FG2 characterised rotation as knowledge and skill development. This they specified as part of the SDA. FG2 asserted that the very empowerment driven nature of the SDA demands rotation. Essentially the groups viewed rotation for exposure, to develop knowledge and skills. The absence of rotation represents stagnation and a negative impact on own development. Rotation empowers and enable social workers to address challenges. Rotation also ensures consistency and continuation of services. This was unpacked in terms of where social workers in particular areas are absent, then others may continue the service in the area. It therefore ensures continued professionalism.

FG1 comprising out of supervisors and managers, concurred that being exposed to different areas impacted on their skill and knowledge to be effective in their supervision role. This group agreed that a supervisor who has rotated and has knowledge of different sections are more competent and will enable the social workers to adjust and function in diverse wards and units.

The wellbeing of social workers, the prevention of burn out and depression were highlighted as another important aspect of rotation. In this regard FG1 Participant 1 stated "To stay in one place for more than three years is exhausting." FG2 Participant 3 further stated "How do you pour from an empty cup?". This was stated in relation to social workers being burnout due to not rotating.

9.4.2.2.2 Dilemmas with rotation

FG2 Participant 2 stated that "Rotation does not work for units, but it works for social workers." This was explained that in MDT, relationships are built and with rotation a loss of stability occurs which compromise the unit. With rotation the very nature of the MDT is also changed.

Both groups indicated that some social workers are also resistant to due to fears and discomforts or feelings of being forced. FG1 highlighted that there were times where social workers who were reluctant to operate in certain areas had to be removed to prevent medicolegal issues. This also caused further unhappiness within the department.

Further challenges associated with the reluctance of rotation is the perception of rotation. If it is seen as a punishment or the exertion of power, the more reluctant and unhappy social

workers are. In addition, social workers reluctant to rotate may be emotionally drained and embody limited growth.

9.4.2.2.3. Need for different models of rotation

Even though all agreed that rotation is important, both groups attested the need for different rotation models depending on the setting, the needs of departments and social workers should be considered. FG1 Particpant1 however warned about where different models operates alongside each other by stating “It is good to have both, but it won’t work, because others would want to move others do not want to move. . . To stay in one place for more than three years is exhausting.”

Currently there are different models in operation such as a release system and the system where all rotate irrespective of the needs. The consultative process for this was stressed. This the groups indicated that this consultative process and different models of rotation should also be part of the framework of this study. The most common rotation occurs every 2 or 3 years.

9.4.2.3 Theme 3 - Competence

This theme evoked a great deal of discussion especially with regard to how social workers are perceived in the health care settings. It was acknowledged that social workers are indeed competent and very skilled in dealing with diverse matters. In addressing this, five subthemes were identified namely: acknowledging the competence of social work, pitfalls of comparisons with psychologist, need to enhance language use, need for cultural understanding and models and challenges with unifying cultural perspectives with medical settings.

9.4.2.3.1 Acknowledging the competence of social work

Both groups were very passionate about the competence of social workers. Social workers work under extreme difficult situations and settings and encounter various demands.

FG2 Participant 2 shared “I think social workers come out of their undergraduate training well equipped to work wherever. . . If you are a social worker, you are well qualified to work in health.”

FG2 emphasised that social workers are well trained to work in any setting. The social workers’ knowledge base extends to incorporate proficiency of legislation and its application. The roles of social work are countless and may entail assessment, offering counselling, empowerment, problem solving and liaising with stakeholders. FG2 was impassionate that MDT cannot operate without a social worker. Social workers enable the compliance of patients with treatment. The counselling training highlights the skills of social workers to explain conditions and treatments to patients on their level. Without social workers perhaps the lack of compliance will be noted. Social workers also respond timeously to referrals despite their workloads.

9.4.2.3.2 Pitfalls of comparisons with psychologist

Social workers are always compared not only with members of the MDT but specifically with psychologists. Both groups identified that psychologists are seen as the counsellors and not social workers. FG2 referenced this to the neglect of the therapeutic role. The MDT then experiences social workers as non-professionals and the exist member of the team who deals with discharge issues solely. The lack of esteem of social work is therefore enforced with the team. Due to the comparison with psychologists, social workers do not

receive the same respect. To highlight the above FG1 Participant 2 “MDT perceives psychologist only do counselling.”

9.4.2.3.3 Need to enhance language use

Both focus groups identified that social workers perhaps at times does not use the medical language or terminologies appropriate for the medical settings. This, FG1 attributed to adapting to the level of the patient. In a sense, social workers forget their skills. Another factor that influences the lack of medical language use is the workload. Social work in health is quantitatively driven and therefore limits self-reflective practices. This, both groups also linked to undergraduate training where these competencies were instilled but due to the demands of the settings, the self- reflective practices are problematic. The workload was also indicated as a reason for the lack of self-development. FG1 imparted that to ensure that social workers maintain the professional medical language perhaps the continual professional development (CPD) and an exam route should be actively pursuit. The suggestion was to consider the medical team’s approach to developing the members.

9.4.2.3.4 Need for cultural understanding and models

Cultural competency was stressed as an important aspect. Knowledge and understanding of different cultures are important. The participants highlighted that the respect and dignity at all times with all patients should be highlighted as the start of being culturally sensitive and competent. Being culturally competent is also becoming increasing difficult with globalisation as there are numerous foreigners accessing the public health care system. All participants belaboured the need for culturally competent models.

9.4.2.3.5 Challenges with unifying cultural perspectives with health care settings

Both groups acknowledge the importance of recognising the influence and value of cultural, religious, spiritual or traditional beliefs and views of patients. This in itself does not pose a challenge but the practice of certain traditions or beliefs in the setting does.

FG2 Participant 2

> As practitioners in the health settings, we are stuck between rock and hard place when it comes to cultural competence. Am I allowed to promote it? . . . You do not have a problem with counselling them, but they want to practice it in the health setting. It is not allowed. It is a problem . . . they want to burn incense. . .It is not allowed. (FG2 Participant 2)

FG2 Participant 3 shared: "I think then it talks to the legislation part of things."

The challenges are evident with legislation and the enactment thereof in medical settings. Even though the Constitution pronounces the right to self-determination the legislation in hospital settings does not always allow for this. One example that was discussed was the Mental Health Care Act which requires a 72 hours of observation period and does not allow for the mental health care users to enact the right of self-determination during this time. Furthermore, cultural or traditional beliefs may contain valid explanations and requirements to attend to a patient with mental health challenges. The family of the patient may require the patient to be discharged for the performance of rituals. Legislation may not permit this. FG2 encouraged that this aspect should be explored further especially the role of the social worker.

9.4.3 Category 3: SDH

This category explored two themes namely the SDH indicated in social work in health care and the NHI and determinants.

9.4.3.1 Theme 1 - SDH indicated in social work in health care

This theme explored the understanding and application of the SDH in health care. Even though SDH encompasses health it seems to be very poorly manifested or addressed in health care. The participants were aware of the concept and the meaning. Four subthemes are discussed.

9.4.3.1.1 Delineating the SDH

FG2 Participant 2 “The determinants are social justice and social inclusion. Every health fraternity is there to correct some injustice. Something has to be corrected or aligned for the benefit of a particular person.”

FG2 Participant 3

> Literacy with financial aspect you find of our population, 80% are illiterate. . . . They are disadvantaged. They become very disempowered in this sense. So, you know you are not well; You go to the hospital you are told you have this big word. . . . All you think is that I am dying. . . . Those are some of the things that really affect our patients. (FG2 Participant 3)

Both groups identified SDH as containing numerous factors such as inclusion of all irrespective of nationality, and highlighted factors such as literacy, economics, any environmental factors, migration, family cohesion and education. The FG2 specified the SDH is about social justice and inclusion of all into the health care system. FG2 specifically addressed the difficulty in managing SDH with regard to the foreigners. Foreigners are excluded from accessing non-emergency public health care in South Africa. This according

to FG2 Participant 2 is social injustice that has been noted but no recourse to address it has been tabled due to the legislation preventing services to non-South African citizens. Both groups had knowledge about the SDH but indicated that it is not readily used in health care settings.

9.4.3.1.2 SDH in relation to psychosocial factors

The language or terminology of the SDH is not readily used in social work or in health care settings. Generally social workers are familiar with psychosocial components that may affect a patient's wellbeing and compliance. The terminology in line with psychosocial assessment are readily used and conveyed in practice and report writing. The aspects associated with the SDH are not at the forefront of daily use. However, the participants in both groups could identify a clear resonance with it. It was clear that the social workers' role on a daily basis considers the SDH to prevent or enhance compliance with treatment adherence. It is just not identified as the SDH but psychosocial factors. Typically, psychosocial assessments will elicit information on support, residence, understanding and literacy, and employment. Both groups agreed these to be in line with the SDH. They reiterated that they are knowledgeable about the SDH, but that it is not use it is not common in the mandate of the health care settings.

9.4.3.1.3 Hospitalisation accentuates the SDH

Both groups indicated that it is during hospitalisation or encounters of patients with a health care setting that the SDH become pronounced. In addition, these SDH highlights the plight of poverty stricken or marginalised groups. The contact with the health care setting also offers an opportunity to address social conditions not addressed before. FG2 indicated that there is a clear correlation with the psychiatric wellbeing of patients and the SDH. They indicated that patients become more unwell when there are challenges with the SDH.

Another example that was shared by FG2 is government's stance that all health care users should pay for services. The administrative staff will demand patients to pay before accessing health care. This they highlighted is not possible when patients are unemployed. This is a social injustice as it deters the access to health care. Both groups also highlighted that bread winners being hospitalised or the level of education amongst other factors present as challenges for patients and family to comply with treatment. Both groups highlighted that the MDT recognise the difficulties of patients in terms of compliance with treatment and call on social workers to sort out the dilemmas. Therefore, from both groups the contact point with any health care setting offers and opportunity for social workers to address the SDH which in a country like SA is linked with poverty and complicated social circumstances.

9.4.3.1.4 Link between the SDA, the SDH and social work

A clear link between the SDH, the SDA and social work with regard to empowerment, social justice, inclusion and participation were highlighted. Social workers play an active role in clarifying process and procedures for patients as well as enabling them to comply with treatment. Due to perhaps a lack of information about conditions, social workers offer an explanation to patients that is understandable. In this manner they are able to make an informed choice. This example indicates the role of the social worker in acknowledging social justice and inclusion (SDH) and the self-determination and participations well as enhance the patient's rights (SDA). According to the groups the SDA and the SDH is well represented in social work in health care even though the activities and roles of social work may not adhere to the terminologies associated with these two frameworks.

9.4.3.2 Theme 2 - NHI and determinants

FG2 Participant 2 “Our health facilities should take care of everyone... we only cater for locals. We do not cater for foreigners. . . . The new health insurance; may this NHI come with certain determinants for service delivery.”

Due to the nature of the SDH encompassing social justice and inclusion, FG2 felt it important to address the purpose of the NHI for non-SA citizens. Currently non-SA citizens are excluded from public health care unless it is emergency health care. They expressed the hope that the NHI will address the SDH and the impact on non-SA citizens and that it will resolve the current difficulties experienced in current public health care settings.

9.4.4 Category 4: Policy Implementation

This category specifically explores the view of the participants of policy in health care settings. One theme i.e., policies and SOP implementation was identified.

9.4.4.1 Theme 1 - Policies and SOP implementation

Both groups indicated that they seldom get the opportunity to input in policies and that SOPs are usually what they deal with on a daily basis. Four subthemes were identified namely reactive policies, role changes due to policies and SOPs, lack of social work consultation and absence of SDA and SDH framework.

9.4.4.1.1 Reactive policies

Both groups highlighted the reactive nature of policies and SOP. With regard to policies, FG1 indicated that at times when there are political changes and policies are created that should be implemented. Both groups also highlighted if tragedies or incidences occur then SOP are developed to address the tragedy or incident and prevent future issues. FG2

Participant 2 made the example of before the Life Esidimeni tragedy policies neglected the discharge of patients. After this tragedy effective discharge planning and home visits where necessary are required to ensure social justice. The reactive policies were not authored by social workers but others who assign social workers to these roles. By implication it is noted that social workers roles are dictated by others who do not seem to understand the profession. It would seem wherever and whenever there is a rift between policies and services to be delivered; then social work is automatically considered to address the gap.

9.4.4.1.2 Role changes due to policies or SOP

Both groups identified that there is no regard on the impact of the role and for social workers when policy changes are made that affects the social workers directly especially the impression of the 'no voice of social work but also the helplessness of social work. FG2 particularly stressed that social workers need to be more proactive.

9.4.4.1.3 Lack of social work consultation

Both groups identified the lack of 'voice' of social workers in health care. It would seem that policies and SOP are made without proper consultation. Participant 2 and 4 of FG1 indicated that they are consulted about SOP. FG2 highlighted that they are seldom approached for opinions or about matters that affect social work. They identified top-down approaches used does not encourage consultation.

In addition, both groups highlighted the lack of 'power' and lack of involvement in advocacy strategies for the profession itself. The role of social work seems not to be determined by social workers but influenced by others. FG2 also highlighted that there are social workers on national levels that seems to have forgotten their social work role and responsibility, and therefore is letting the profession down.

9.4.4.1.4 Absence of a SDA and a SDH framework

All participants identified the lack of a framework evident for the implementation of the SDA and the SDH in health care. The gaps make it confusing for the implementation.

A comprehensive framework is necessitated to clearly identify and negotiate the role of social work in health care. This gap causes great complications. A sense of disenfranchisement is observed which the participants also expressed as a sense of isolation experienced.

9.4.5 Category 5: Vision

This category explored the opinion and views of participants regarding their vision for social work. One themes and five subthemes are discussed.

9.4.5.1 Theme 1 - Future of social work in health care

This theme aimed to explore the participants views and opinions about the future of social work in health care. Most of the interactions were positive but some concerns were also shared. Participants identified the need for social work but that it needs to be reframed as a specialist area of practice. Definite threats to the acknowledgement and value of the profession were observed. Most of the concerns regarding the profession the participants highlighted that a framework for social work in health care should be developed. This give rise to; should the framework focus on the application of the SDA to social work in health care or a framework for social work in health where all aspects are addressed and incorporated.

9.4.5.1.1 Necessity of social work

All participants echoed that social work is an important profession that is needed in all sectors of South Africa. They highlighted the importance of the role of social work with

regard to empowerment, assessment, counselling, problem solving, ensuring social justice and liaising with stakeholders. The role of social workers should be recognised as a crucial and equal member of the MDT. The MDT needs to recognise and be made aware of this instrumental role that social workers play in the wellbeing of patients and enable the treatment process. The social work role should also be quality driven. To ensure this the participants suggested that more social workers should be employed in health care settings. This is largely due to the impact of encounters with health care settings and hospitalisation pronounces the SDH that social workers need to address. Employing more social workers will also enable effective counselling of patients.

9.4.5.1.2 Reframing the position of social work

Both groups felt strongly that the position or role of social work needs to be reframed. FG1 addressed the terminology of social work as support staff of the MDT. They referenced this as an incorrect assumption. The example of the Mental Health Care Act was shared in that it addresses all the members of the MDT as ***mental health care practitioners***.

FG2 Participant 2 shared his view about the social work position in the MDT

> We are fit to work in health but when we look at the treatment we receive as compared to other professionals; the treatment is not equal. That is my problem. We are not treated equal to OT's to psychologists; but we are professionals. (FG2 Participant 2)

FG1 Participant 1 also indicated that social workers do so much more than their psychology counterparts, yet the recognition of social work as a profession is lacking.

FG2 Participant 3 also indicted that at times the messages of social workers such as '…social work is calling'. According to FG2 Participant 3 such statements are misleading

as it takes away from the fact that it is a profession and the importance of studying four years to become a social worker. FG2 indicated the solution to addressing the position of social work rest on the influence of academia. Social work academics therefore has to play an instrumental role in repositioning and reframing social work as a fundamental pivotal service and profession in health settings.

FG2 also indicated if the emphasis and the expectation from being quantity driven i.e., 1:60 be changed to rather focus on quality service and encouraging counselling; the role and perceptions of social work may be changed. FG2 Participant 3 indicated that social work should be regarded as the revered profession that it is.

FG1 also indicated that social workers need to present themselves professionally within health care setting and teams to encourage their position.

9.4.5.1.3 Resource constraints

FG1 Participant 1 shared details of the experienced resource constraints.

> You [queue] for the phone. You have several other clients waiting for you. Truly speaking these issues of resources does not only affect service rendering; it affects social workers. Their wellbeing, their emotions too. You find others being grumpy. You think the person is moody. No; the person is frustrated. The person cannot work. So, it affects everything. (FG1 Participant 1)

Both groups identified the constraints or difficulties that social workers work under. The quantity driven focus and being seen as an exist worker are challenging and places enormous stress on social workers. Both groups agreed that more social workers are required. Apart from this, FG1 Participant 3 also indicated the difficulty that social workers

in district and primary health care settings work under. He highlighted a number of social workers do not have offices. This has major implications for offering counselling and issues regarding confidentiality and privacy. In certain clinic settings there are only one telephone. The social worker with others has to queue to use a telephone. This also has major implication for confidentiality as the calls are made in public areas. Most often social workers in the primary health care settings make use of their own transport to visit patients. All social workers are required to submit daily and monthly statistics. Due to the lack of office space, access to email and or fax machines; social workers use their own data to submit their work. These costs are not reimbursed by the employer. These challenges seem to negatively affect the social workers.

9.4.5.1.4 Social work under threat

Even though both groups were optimistic regarding the future and need for social work; FG2 also highlighted the threat to the existence of the social work profession. FG2 Participant 2 indicated that the future of social work in health care is also bleak in that the scope of practice for social work has stagnated. He shared that he feels Government is diminishing social work. He highlighted that the new performance-based management system seems to be rewarding the very best and exclude most. He seemed to suggest that if the social worker performs according to acceptable standards i.e., the expected norms, Government may suggest deployment of the social worker. This seems to create a great deal of fear. The criteria have been changed to such an extent that it is very restrictive making it difficult for social workers to be recognised. Furthermore, the OSD seems to be '… a carrot that is dangled…' (FG2 Participant 2) but this is also empty promises. The focus on employing more auxiliary workers also seems to suggest that less social workers will be needed. This is especially a valid threat as social workers are not seen as counsellors or on equal standing with other team members, but only resolving discharges or placement.

Discharges and placements may be attended to by auxiliary workers. FG2 Participant 3 also expressed her dismay with the SACSSP that historically could not regulate one profession effectively i.e., social work; yet it (SACSSP) is creating so many occupations that is threatening the role of social work. Occupations that threaten the social work profession include community developers, child and youth care workers, lay counsellors, and all auxiliary workers. FG2 concluded that the overall future of social work is bleak.

9.4.5.1.5 Social work in health care as a speciality

FG2 Participant 3 indicated that in the Department of Justice, social work is an esteemed profession where a judge will not rule without a social work report. In that setting social work is treated as a science. The speciality and the professionalism of the profession is acknowledged.

Both groups indicated that social work in health care is a speciality and should be recognised as such. For this to occur the term generalist practice, as suggested by FG2 needs to be done away with. Social workers themselves should start to challenge policy makers and implement social action. FG2 Participant 3 underscored that social workers are not being proactive in addressing these denunciations by instating campaigns.

From the above discussion it evident that social work is a speciality and should be acknowledged, be treated as such, and the role should not be dictated by others.

9.4.6 Category 6: Framework for social work in health care

During the group discussions all participants indicated some aspects to consider for a framework that will be suitable in health.

9.4.6.1 Theme 1 - Framework of the SDA for social work in health care

Through the discussion of the current application of the SDA in health care. Both groups made suggestions as to what should be included in the framework. The subthemes are essentials of the framework, role of academia and challenges that the framework should address. From this discussion it was clear that the SDA is very confusing. Due to the expertise and competence of the participants they could identify the complexity of the implementation of the SDA and were able to highlight these as challenges to be addressed.

9.4.6.1.1 Essentials of the framework

Both groups reiterated that due to the lack of consultation a bottom-up approach is required. It is Government's responsibility to consult social workers about the framework and how it should be applied in health care. Special consideration should be on the diversity and complex health care settings and the manifold roles to be played by social workers. Instead of dictating the roles for social work in health care social workers should be at the fore front of enacting their roles.

The SDA is achieved by the application of the principles, referral, community liaison and stakeholder collaborations. This should embody the centrality of the SDA framework for social work in health care. The framework will need to be comprehensive yet clear. It will need to offer clear direction for all concerned. Social work roles as dictated by each type of setting should be identified. The framework should attempt to encourage social workers as equal members of the MDT.

This framework should acknowledge the uniqueness and centrality of social work in health. In addition, social work in health care should be declared a speciality. In aiding this

speciality and the establishment of a speciality course for social work in health which all entry social workers should enrol for.

The therapeutic counselling role of social work should be encouraged, and the focus should be quality driven. To achieve this as well as adhere to the demands of services in health care settings and satisfying the demands of the SDA, the need for more staff was highlighted.

9.4.6.1.2 Role of academia

FG2 Participant 3 “We can team up with academia to make it stronger to say how do we go forward to campaign”

Both groups indicated that academia should play a strategic role to reposition social work in health care as a speciality. This was in terms of courses but also to lobby for the acknowledgement of social work in health care as a speciality.

9.4.6.1.3 Challenges that the framework should address

The framework may be difficult to establish due the complex health settings but also the challenge will be with connecting policies. There are numerous acts, policies and SOP; the integration of this in a framework for social work may be unachievable. This also raises an important question should the framework focus of the application and implementation of the SDA in social work in health care or should this be a framework for social work in health care that takes into account all the aspects raised from the survey, interviews and focus group like rotation, competence, SOP, the SDH and so forth? If the integration were achieved this framework will need to be regularly updated with the application of changes.

Within health there are different disciplines and to unify these disciplines to a common vision and strategy may be a challenge. It should be noted that social worker in health care is the only profession in Department of Health that has knowledge of the SDA and its implementation. This is largely due to the connection they have with the DSD. Therefore, this framework should address the fragmentation. The challenge of the framework is to outline best practice consultation procedures that all should adhere to. To enforce the bottom-up approach is considered a challenge especially if policies are directed by political agendas.

Diversity of settings, services and peoples should be acknowledged and as such further actions to deal with diversity should be sought. Currently the presence of foreigners in health care settings are complicating service delivery especially where legislation is prohibiting the treatment of non-South African citizens. Legislation is not always in line with the SDA and creates enormous obstacles that social workers are unable to resolve. Where there is the contradiction of legislation and service delivery further resolutions and resources should be in place. This in itself may be difficult to resolve as well as considering our resource-stricken country.

Another challenge is who dictates the social work role. Currently the role and expectations for social work is decided by non-social workers. This in itself will need to be discouraged.

The discussion of the possible framework has proven helpful and important. It however glaring highlights the immense complexity of developing a framework for social work in health care considering the diverse South African context, health care settings and challenges that the profession in health care face. It is speculated if the framework should focus on repositioning social workers in health as a speciality.

9.5 Summary

This chapter provided an overview of the data unearthed via the two focus groups. Cohesive and dynamic interactions enabled the gaining of a wealth of information with regard to the current application of the SDA, the SDH, policy implementation, information for a guideline and the role and value of social work in health care. The social work role highlighted counselling as a dominant role which is neglected due to high workload, the quantitative driven demands of the profession that is enforced by provincial government and responding to the demands of the MDT. Social work in healthcare fulfils a precarious role of support, secondary or exit worker yet being a valuable member of the MDT. The very nature of the role of social work is in addressing the SDH in ensuring compliance of patients, yet the participants viewed this initially as only awareness. The SDA was confirmed via the principles and the myriad empowerment and advocacy strategies employed to ensure social justice of patients. SOP and policy consultation processes are varied and dichotomous resulting in social workers feeling marginalised and devalued. Participants' hopefulness of the role of social work are endearing but added that the position of social work in the MDT needs to be strengthened. The participants in their interaction highlighted that a guideline for offering services, considering rotation and other demands are needed and not solely on the application and implementation of the SDA. The next chapter offers the discussion of the findings presented in chapters 7, 8 and 9. A possible guideline conspiring the input of the participants of the focus groups will be offered.

CHAPTER 10: DISCUSSION OF FINDINGS

10.1 Introduction

The findings from the sequential explanatory mixed methodology have been profound. The findings of the experiences of the respondents and participants represented in the three methods will be interrogated. It will be concluded that the study population was well experienced and was therefore suitably positioned to offer in-depth descriptions and explanations of the SDA and its application in social work in health care. Thereafter the discussion will occur via the categories and acknowledging the themes as evidenced in the survey, interviews and focus groups. This reflection on the findings will be linked with relevant literature. The suggested guideline is offered, described and diagrammatically represented. Included in this is Payne's (2005, 2014) typology of service delivery that is suggested to be utilised in analysing service delivery as per the health care setting. In conclusion a brief validation of the study's use of mixed methodology is offered. It will be concluded that the study was useful and makes valuable contributions to the SDA, the SDH and social work in health care.

10.2 Profile of the participants

The population of the survey represented all age categories, experience levels and all types of health care settings. Several reasons for the 15% response rate were provided of which apathy and the lack of reward seemed the most relevant. Engel and Schutt (2014), Nari (2006), Neuman (2014) and Sue and Ritter (2012) also mentioned rewarding participants for survey completion. The GDH's policy on remuneration prevented this. Despite this response, the extent of data collected was indicative of data saturation.

Out of those who completed the survey, 78% ***(n=35)*** had from 4 years to 20 years of experience in the current health setting. They were therefore ideally situated to respond to the matter. All

hospital settings were presented in the survey with 75.6% (***(n=34***) being tertiary health care settings, 11.1% (***(n=5)*** secondary health care settings, 8.9% (***n=4)*** clinics, 2.2% (***n=1)*** specialist and rehabilitation health care settings each.

The participants for the interviews which comprised out of 10 participants and two key informants, were dominantly from tertiary health care settings with one participant being from a secondary health care setting. The one key informant represented social work on a provincial level and the other was employed at a regional level. Apart from one participant, all other participants and key informants had more than five years of experience. Two participants in this method had 21-25 years of experience in health care. So even though not all health care settings were represented the participants with extensive experience as well as the key informants were knowledgeable about the different health care settings. Key informant 1, in particular due to her position in the GDH, had extensive knowledge about the different health care settings and roles to be fulfilled.

Participants in both focus groups had a minimum of 7 years of experience in the employ of a health care setting. Both groups were represented by participants in either tertiary or district health care settings.

The population for this study was well experienced and all health care settings were represented with tertiary hospital settings being the best represented.

10.3 Discussion of findings

This discussion is initiated by offering a brief summary of the findings as according to the different phases. Thereafter the data will be discussed and triangulated according to the different phases by drawing on categories to facilitate the discussion across the different methods. This will aid the triangulation.

10.3.1 Summary of Phase One

The survey research design answered the aim, the indicated objectives and confirmed the two-tailed hypothesis that the SDA is applied in social work in health care. The survey indicated that therapy or counselling was the most important service to be offered, with 51.1% (23 respondents), in health care settings in the GDH. AASW (2016a), Browne (2006), Dhooper (2012), Gehlert (2006), Riaz and Sharfaraz (2015) and Segal et al. (2018) not only highlighted the uniqueness of social work in health care but also the focus on the clinical or therapeutic role.

A description of the explanation of the perceptions and implementation strategies of the SDA, descriptions and explanations of the application of the SDH, policy implementation and its effects on social workers in health care provided invaluable information. Even though the SDA is applied by social workers in health care, the disparity in the understanding of the SDA and the SDH seems to indicate that gaps exist. These variant views align itself with what Gray (2014) postulated regarding the intangibility and open-endedness of the SDA. The continual development and adjustment made to this field (Dlangamandla, 2010; Gray & Lombard, 2008; Hölsher, 2008; Midgley, 2001, 2014; Patel, 2015) adds to the complexity of the SDA. This continual change to the field adds to the confusion experienced. It is clear that the role of social work in acknowledging ethics, values and social justice successfully fulfils the principles of the SDA. The differentiation between the role of social work and that which encompasses the SDA needs greater exploration. This is particularly noted about community work.

Generally, the respondents had difficulty in distinguishing macro from meso or micro strategies. This is perhaps not such an indiscretion because as Gray (2014) and Masuka (2015) detailed that developmental social work should embrace all these methods. The community work strategies that are necessitated by the SDA focus largely on community development and securing economic investments (Gray, 2014, Lombard, 2008; Midgley, 2014, Noyoo, 2015a, 2015b; Patel 2015). This

was not identified by the respondents. This linked with the expression for training on the SDA as well as the focus on training regarding economics. This continuous need for training is in line with the diversification of the field (Dlangamandla, 2010; Gray & Lombard, 2008; Hölsher, 2008; Midgley, 2001, 2014; Patel, 2015) and specifically in line with the findings from both Dlangamandla (2010) and Hölsher (2008) of social workers, even in the DSD, requiring continual training on the SDA. Perhaps this is suggestive of the complexity of the SDA but also perhaps about the training offered. Kaseke (2015) highlighted that social workers need to be appropriately trained regarding the SDA. Social workers in health care are struggling with correct and appropriate implementation of community work. Most projects were implemented as according to the health calendar or awareness projects or workshops. Social workers in health care also utilise referral to community resources as well a liaison with stakeholders. Patel (2015) developed a multimodal approach that addresses not only community work or development but also poverty alleviation, social investment strategies and entrepreneurial endeavours. The application of the multimodal approach to health care would be interesting but very challenging in complex health care settings, especially tertiary or specialist health care settings.

Regarding the accounts on the SDH the participants were less successful in conveying meanings, but the suggestions offered seem to indicate that the respondents seem to connect it with the SDA. Respondents however indicated that as with the SDA, the SDH was imperative for the role of social work in health care. This is in line with Moniz (2010) who confirmed social work is ideal to address the SDH. It may be concluded that the SDA and the SDH is not enormously different from each other. The respondents also pointed out strong relationships between transformation, the impact on role, the knowledge of the SDA and the SDH, their perceived competence as well as a relationship between the SDA and the SDH. Job satisfaction was also in relation with where the respondents felt valued and consulted. In addition, where the managers or supervisors advocated for staff, so an increase in job satisfaction and role performance with a decrease in

frustration was evident. Formal strategies on the SDA and the SDH are not implemented by government. The lack of strategies or perhaps the respondents' lack of awareness of such strategies are not surprising when considering the limited response evident from the Government of South Africa as was outlined in chapter 4 and 5 about the SDA and the SDH.

The respondents indicated that they associated the SDA with their role as a social worker especially considering the ethics and values of the profession. Social justice was enacted with empowerment and the advocacy role that social workers fulfil for their patients. This could be in line with the precepts of developmental social work as highlighted by Gray (2014), Masuka (2015) and Nicholas (2014).

Sixty nine percent (69%) of respondents indicated that rotation do occur in their health care settings. The need for rotation was identified for exposure, growth and professionalism of social workers. Rotation is seen as supporting generalist practice and in contradiction with specialisation. Diverse applications of rotation were noted but the major concern is levied at managers having the sole decision-making power in this regard, as indicated by 44% of the population.

All respondents indicated to the use of their own experience and skills with regard to cultural competency in the absence of guidelines. Boyle and Springer (2001) articulated that cultural competence guidelines are imperative for sound social work practices. This gap therefore needs to be addressed.

The respondents indicated that there is a relationship with the SDA and the SDH even though they require a great deal of knowledge about it. The standard deviation for this association was *.823* and a Pearson correlation of *.481*, which seems to indicate a strong association. Even though the participants felt that they do implement the SDA they have indicated that they need training on the

SDA and that a framework should be developed for health care.

10.3.1.1 Hypothesis development

Considering the various associations and inferences highlighted in chapter 7 directional hypotheses maybe formulated to guide further research in these areas. Some of these formulations are listed below. This is by no means exhaustive.

i. The SDA and the SDH are interrelated
ii. Social work in health care implements the SDA and the SDH
iii. Knowledge on the SDA and the SDH impacts the competence of social workers in health care
iv. A competent supervisor and or manager affect staff job satisfaction and role performance
v. The SDA is essential in the role of social work in health care
vi. The competence of social workers is impacted by their knowledge and training of the SDA, the SDH and policies
vii. Rotation is imperative for exposure and growth as a competent social worker in health care
viii. Effective service delivery requires rotation of social workers
ix. Rotation reiterates generalist practice of social workers in health care
x. Rotation prevents specialisation of social workers in health care
xi. Best performance of staff is indicated where consultation is evident
xii. Job satisfaction is evident where social workers are consulted and valued
xiii. Formal SDA and SDH strategies are not implemented by government
xiv. The lack of strategies regarding the SDA and the SDH employed by the GDH complicates service delivery of social workers in health care

xv. The lack of strategies regarding the SDA and the SDH employed by the GDH confuses social workers in health care

xvi. The lack of strategies regarding the SDA and the SDH employed by the GDH impact social workers in health care

xvii. The implementation of policies and SOP in a non-consultative manner negatively affects social workers

xviii. Knowledge about the SDA and the SDH increases competence of social workers

xix. The SDA implementation resulted in social workers in health care being stripped from their designated powers

xx. The SDA implementation minimise the capacity and role of social workers in health care

10.3.2 Summary Phase Two and Four

The extensive data obtained from the interviews, it is evident that the goal and objectives were confirmed. The data obtained and presented according to five categories, various themes and subthemes satisfied the study's purpose.

As with the surveys, participants identified the importance of the counselling role of social work. This was in line with the indications from AASW (2016a), Browne (2006), Dhooper (2012), Gehlert (2006), Riaz and Sharfaraz (2015) and Segal et al. (2018).

As was noted the SDA is largely applied in social work in health care via the principles, empowerment, social justice, advocacy, referral to communities and liaison with stakeholders. The participants clearly highlighted how these aspects are understood and applied. The implementation of the SDA brought with it challenges for social workers in health care. These challenges were highlighted as the removal of designated powers, referrals to the DSD that remain unanswered for

long periods and social workers in health care not being consulted about matters that affect them. Some of the core aspects of the SDA are that of participation and inclusion (Gray, 2014; Lombard, 2008; Midgley, 2014; Noyoo, 2015a, 2015b; Patel 2015). All participants had a clear concept or understanding of the SDA but the dominant application of it according to the principles are noted. This application of the SDA seems to be in its infancy as several writers like Estes (1998), Midgley (2010, 2014), Noyoo (2015a, 2015b) and Patel (2015) all highlighted social investments, social capital, capacity building and so forth. A clear movement from individual to group to community empowerment is required. This was dominantly enabled via referral to community resources and liaison with stakeholders. Absence of the implementation of social investment strategies are noted.

Rotation was indicated by most participants as needed for growth, development and exposure. This links with the survey's findings. It should however be noted that divergent opinions of the value of rotation was noted. Some participants indicated that rotation may be counterproductive to offering specialist services delivery. An argument for centres of services excellence where rotation is not indicated was also made. The format of the rotation employed is also health care setting dependent. One model of rotation is therefore not a feasible option for health care settings in the GDH.

Governmental strategies that could be pointed out were not in relation to the SDA or the SDH. A number of SOP regulate social work practice in health care. These SOP are seen as both helpful but also affecting social workers negatively if they are not consulted or not timeously informed of the SOP. Borst (2010), Gregorian (2008) and the WHO Technical Brief (2008) all stressed the importance of proper consultation especially where transformation occurs. This makes changes more manageable.

With regard to macro strategies participants highlighted a clear absence of community development. As reported by the participants the type of community work seldomly involves community development. This and the investment strategies are identified for the SDA for effective community upliftment. This seems to be in line with Beytell's (2002) findings of community work strategies that are a challenge in secondary and tertiary settings. In responding to the challenge of implementing community work in health care settings, the participants highlighted their unique contribution of awareness campaigns, psychoeducation, referral and liaison with stakeholders like SASSA, the DSD, SAPS and Department of Education to ensure service delivery. This aspect is in line with the tenet of welfare pluralism of the SDA (Gray, 2014; Lombard, 2008; Midgley, 2014; Noyoo, 2015a, 2015b; Patel 2015). The awareness campaigns are also informed by community education strategies of community work as proposed by Weyers (2011). Stakeholder involvement and multisectoral collaborations have also been widely indicated as instrumental in the offering of effective comprehensive services to communities. These strategies should be regarded as valuable manifestations of the SDA, especially considering secondary and tertiary health care settings that experience difficulty in implementing community development.

10.3.3 Summary of Phase Three

The focus group discussions manifested in frank, honest, interactive and cohesive discussions that resulted in the offering of information about the social work profession, the application of the SDA, challenges and suggestions to be included in a possible framework. Both focus groups highlighted the core functions and the competence of social work in health care as well as the challenges in offering community work especially in tertiary settings and counselling. AASW (2016a, 2016b), Barber et al. (2007), Browne (2006), Dhooper (2012) and Gehlert (2006) acknowledged the importance of social work as well as the clinical roles. These descriptions of the

roles are also in line with Payne's (2005) typology of the services of social work which address the therapeutic and transformation services.

Even though community work may be described as a limitation, the participants were clear about the SDA application via the principles of the approach. Both focus groups highlighted the value and pivotal role of social work but also the devaluing of the professional standards due to time constraints, resource restriction, shortage of staff and high workload due to the quantitative stance employed by the GDH. Cleak and Turczynki (2014) acknowledged the workload of social work in health care settings and indicated that the preoccupation with the practical resolution of patients' needs like discharge planning negatively affect the counselling role of social workers. The hopefulness of the value of the social work profession were evidenced but a need for specialisation of social work in health care was stressed. In addition, emphasis was that the position of social work needs to be reframed from a secondary or support role to that of equal standing with the rest of the MDT. WHO CSDH (2007b) WHO (2007, 2014) reported that effective global and holistic health is dependent on the entire health workforce including professionals (like social workers). Both these reports acknowledge the value of all and did not distinguish one as more important. This aspect is perhaps what needs to be translated into the South African health context.

The two focus groups had different stances about how to achieve specialisation. FG1 felt a specialist course is needed and FG2 felt that due to the training which encompasses generalist practice, all social workers are experienced to work in health settings. This they concluded is in contradiction with wanting to do away with the terminology of generalist practice. It is well known that generalist practice has been the fundamental approach in the training of social workers according to the bachelor's degree for social work (Kirst-Ashman and Hull, 2010; Walsh, 2009). The application of the planned change approach has been used in conjunction with the SDA (Kirst-Ashman and Hull, 2010) but does not mean that the SDA has been the originator of thereof.

Perhaps the wording of the 'planned change process' as used to describe the generalist practice (Kirst-Ashman and Hull, 2010; Walsh, 2009), and Midgley's (1995) original definition of the SDA, seems to connect the generalist practice and the SDA. Walsh (2009) highlighted that generalist practice is the foundational training of all social workers. Thereafter social workers should obtain further qualifications for specialisation. Internationally it is a requirement to achieve a master's degree in social work in health care to practice in hospital settings (AASWA, 2016a; NASW, 2011; NFLASW, 2016).

Throughout the discussions the fundamentals of empowerment, social justice and advocacy seemed to embody the roles of social work in health care, the manner of application of the SDA and relevance with the SDH. Challenges with the implementation of the SDA in health care in more practical terms are levied at the type of health care setting and its mandate. The DSD being perceived as the designated owner and programmes offered by the DSD is more applicable with the SDA.

Rotation was identified as a vehicle for professional growth and development. Bearing this in mind rotation should be implemented but various models should be implemented as according to the health care settings. An absence of a unifying policy for rotation is noted. The impact of rotation on the specialist units needs further exploration. Ivry et al. (2005), Schmidt and Rautenbach (2015), Vassos and Connolly (2014) and Vassos et al. (2018, 2019) discussed rotation but solely as pertaining to students especially as part of field instruction. It would seem that literature does not readily acknowledge rotation of qualified staff especially in health care settings. This is perhaps the result of the specialisation required to function in health care settings. Furthermore, the feasibility and validity to implement rotation with a profession should be re-evaluated.

Both groups identified that the focus should be on competence rather than cultural competence. That being said, it was however stressed that cultural competence models are needed especially in acknowledging the impact of globalisation and cosmopolitan nature of patients who social workers may encounter at their health care settings. NASW (2015) particularly acknowledged the importance of cultural competence and has this as a mandatory field of ethical practice. South Africa and the SACSSP are lagging behind. The dilemma of acknowledging culture in hospital settings was also pointed out, particularly by FG 2. Even though social workers need to acknowledge culture with regard to self-determination, the legislation does not align itself to embody such decisions by patients especially with regard to the observation periods noted for patients with mental health challenges. Even though the SDH was not familiar in the daily use with social workers in health care both groups highlighted that this forms part of their psychosocial assessment process. It was stressed that when a patient has contact with a hospital setting, the SDH are pronounced. It must also be clarified the SDH in South Africa are not only in terms of access to health but also to general socio-economic challenges.

There are numerous policies in health, which are not always applicable to social work, devoid of consulting and enforced on social workers by non-social workers. Possible threats for the social work profession were where others attempt to perform the functions of the social worker, PMDS and OSD, which seems to undermine social work. The suggested ideals of the framework seem to demand an extensive overhaul of how current communication and implementation practices are occurring in the GDH with a heavy reliance on academia to be the driving force.

10.4 Triangulation of the data from Phases One to Four

With data analysis and presentation definite categories with various themes and subthemes were identified. As this discussion bridge both the findings of the quantitative and qualitative strategies

and in acknowledging the diversity of themes and subthemes, the discussion according to categories will be used in unifying the discussion and triangulating the data.

10.4.1 Category 1 - Nature of current social work practice

Data from all phases highlighted the diverse and extensive nature of social work practice in health care settings as well as the diversity of settings in which social work services need to be offered. Social work services were highlighted as unique and of a specialist nature and in line with the views of Borst (2010), Browne (2006), Dhooper (2012) and Segal et al. (2018). The survey indicated that 51.1% of participants felt that clinical practice or therapy or counselling as the most important services. This was confirmed by interviews and focus group discussions. In addition, the focus groups also identified empowerment, support and education as important roles. The interviews and focus groups highlighted the importance of empowerment in advocating for the rights and self-determination of patients. This focal role of empowerment has been well described by Doostgharin (2010) in enhancing patient wellbeing. Service delivery of social work in health care is diverse and versatile in its roles, all of which revolve around meeting the patient's needs. These roles of social work are echoed by AASW (2016a, 2016b), Borst (2010), NASW (2009) and NFLASW (2016). Winnett et al. (2019) drew attention to the continued commitment of the social work profession to empowerment of the vulnerable.

A further unique attribute of social work in health care is the continuous focus on empowerment and advocacy in ensuring social justice. As was noted from the data of all three methods, empowerment, advocacy and social justice exhibited itself in diverse applications from the social workers. This empowerment focus is central to the social work profession as this is focused on effecting change (Ashcroft, 2014; Ashcroft & Van Katwyk, 2016). This is in line with discussions offered on the SDA (chapter 4) and the SDH (chapter 5), where the link between social work, the SDA and SDH was indicated.

Even though the participants were clear about the roles to be embodied, from the interviews and focus groups, extreme challenges in enacting these roles were noted. The first challenge related to the perceived position of social workers in the MDT. Being a member of the MDT, both contributed to the unique role of social work in health care but also creates a number of challenges. This was reported by Borst (2010), Browne (2006) and Dhooper (2012) and confirmed in the research study. The challenges encompassed the hierarchy prevalent in the MDT, the perception that social workers are not really counsellors, but seen as 'exit' members of the MDT, support staff and fulfils a secondary role. It would seem that the designation of support or secondary role or exit worker negatively affected the value of social workers in health settings. Segal et al. (2018) and Skidmore et al. (1994) acknowledged that reciprocal relationships between social work and the MDT should exist. WHO (2007, 2014) has actively asserted that a workforce should comprise out of all role players to offer holistic health care. There the members of the MDT fulfil diverse roles in offering holistic service delivery for ensuring the wellbeing of the patient.

The counselling role is neglected due to workload, a quantity driven profession, the type of settings, extreme pressures to resolve matters due to late referral compound pressures for urgent discharges which enhance the perception of social workers are solely problem solvers involved with placements and discharge planning. Cleak and Turczynsky (2014) and Doostgharin (2010) indicated that discharge planning and seeking of placements are time consuming. Therefore, in the South African health context social workers are immensely pressurised by these aspects.

Apart from having limited time in offering counselling to patients, the focus groups explained that psychologists are viewed as the counsellors by the MDT. The focus groups as well as certain participants (interviews) were clear that psychologists are not necessarily better at counselling. Social work offers holistic person-in-environment counselling in that active attempts are made in resolving socio economic dilemmas of patients. These fundamentals are what elevate social work

in health to its uniqueness and the area of speciality (AASW, 2016a, 2016b; Borst, 2010; Dhooper, 2012; NASW, 2009; NFLASW, 2016). This Moniz (2010) emphasised as the social workers being ideally positioned to identify, address and resolve the SDH.

The social work profession in health care seems to have limited authority and ownership of the core fundamentals of their role. This was especially gauged with policy or SOP changes that impact the social work role. They experience a sense of powerlessness. Feelings not being appreciated or valued were identified in all phases where there is a lack of acknowledgement of social workers. Borst (2010) and Gregorian (2008) pronounced the importance of appropriate consultation with social workers and where this does not occur a sense of marginalisation is evident. The survey confirmed the positive associations between where social workers are consulted and valued, supervisor and managers are advocating on social workers behalf with contentment with their role.

Alarmingly, designated powers which are bestowed on social workers when graduating, are removed from social workers in health care settings. This, from interviews and focus groups were identified as a result of the application of the SDA. This, if indeed an application of the SDA, contravenes the Social Service Professions Act (Department of the Prime Minister, 1978), Social Service Professions Bill (DSD, 2008), Social Services Professional Bill (DSD, 2019b) and the general outcomes for the Bachelor of Social Work degree by removing the designated powers from social workers in health care. The removal of these powers needs further exploration, but the action minimises efficacy, competence and value of the social worker in health care.

Macro strategies in health care are evidenced as health talks, awareness programmes, outreach according to calendar, referral to community resources and liaison with stakeholders. This was duly noted as instrumental for holistic service delivery for clients. This may be linked to the

principles of welfare pluralism. In the focus groups it was particularly stressed that proper community practice may be facilitated by those social workers based at clinics or community hospitals.

10.4.2 Category 2 – SDA

The survey reported 88.9% of respondents had an idea of the concept of SDA. Diverse descriptions from phases two to four included wellbeing, quality of life, changes and social investments strategies. The strategies with regard to the application of the SDA varied from empowerment, advocacy, social justice, family preservation, placements, self-determination and referral to community resources. Here it should be noted the connection between advocacy of the SDA and social work.

From interviews the offering of holistic services were indicated and the necessity of referral to communities and multisectoral collaboration to complete the service delivery to patients. This the description was indicative of welfare pluralism. As based on the motivations of Gray (2014), Midgely (2014) and Patel (2015) more than one stakeholder involvement are necessary for effective service delivery and upliftment of others. The role of the social worker in this regard is therefore instrumental in linking the with the appropriate stakeholders.

From the survey, 69% of respondents indicated that they do rotate in their current setting. A positive inclination, by 48% of respondents, towards rotation was indicated with 24% being neutral about it. The neutrality may mean a sense of powerlessness to express their view, placation with the enforcement thereof, unsure about how respond to it and apathy. Reasons for rotation from all data collection methods included exposure, gain experience, update skills and knowledge, professional growth and ensuring the wellbeing of the social worker. These descriptions resonated with some aspects of the Retention and Remuneration strategy (DSD, 2006a) which DSD

implemented in 2006.The rationale was that rotating social workers will ensure the retaining social workers. Conversely rotation may not be conducive for the MDT and may be counterproductive in specialist areas and where social workers have built relationships with both the MDT and patients. This last motivation, Borst (2010) highlighted in the roles played by social workers in the MDT. The value of rotation should be explored further in terms of rotation evidenced in the social work profession. As indicated by Irvy et al. (2005), Schmidt and Rautenbach (2015), Vassos and Connolly (2014) and Vassos et al. (2018, 2019) rotation is usually applied with students. Are these implemented rotation strategies contributing to the demeaning of the social work profession or is it just not well described for social work? Participants also indicated that rotation negate specialisation which is in line with the intention of the integrated service delivery model (DSD, 2006b).

Furthermore, diverse applications of rotation are evident. The survey reported that 44% of respondents shared that rotation is decided and enforced by management. Only 14% indicated that a discussion occurs. Rotation seems to be implemented every two to three years, via changing the social workers from units, a release system when others are on leave and when new posts become available. The focus groups indicated that provision should be made for the allowance of different models as required by the specific health care setting. What was alarmingly confirmed in all phases is that rotation enhances generalist practice in health care settings and discourages specialisation. Specialisation of social work in health are required in specialist areas like oncology, renal units, neurosurgery, cardiac units, amongst others (AASW, 2016a; Borst, 2010; Dhooper, 2012; NASW, 2009, 2011; NFLASW, 2016). The extent of enhancing specialist areas in the GDH needs further exploration.

An absence of culturally competent models in the GDH is noted. Participants highlighted that they use their own skills and knowledge to deal with diverse peoples. Cultural competence was also

identified as broader, complex and more than just speaking another person's language. This is especially of relevance considering globalisation and non-South Africans accessing the public health care system. During phase two the diversity of MDT members was indicated as a resource in dealing with patients from diverse cultures.

Even though the SDA is clearly implemented via its principles several challenges were highlighted in all phases. The concept SDA was highlighted as confusing and the application remain unclear. Via the principle of self-determination, deinstitutionalisation seems to be encouraged and this seems to be contradictory with patients with mental health challenges where institutionalisation seems to be needed. Further contradiction, as highlighted by participants, is with regard to patients' rights to exercise their own beliefs as influences by religion or culture, but the legislation does not permit this when a patient is admitted according to the Mental Health Care Act.

With the application of the SDA, the designated powers of social workers in health care settings were minimised. This is a gross violation of the core fundamentals bestowed upon all qualified social workers. The nature of the SDA emphasises inclusion, but this does not apply to the medical treatment of non-South Africans as the current legislation prevents more than emergency treatment. Participants clearly indicated that the DSD is the owner of the SDA and their social workers are ideally positioned to implement the community development strategies and programmes. This perhaps influence the jarring gaps of the SDA application within the health care settings. The perception that the DSD as the owner of the SDA needs also further exploration as the SDA should be an approach applied to the entire country. Despite the above perception social workers in health care remain the catalysts to enact the SDA in hospital settings.

10.4.3 Category 3 - SDH

The results from the survey indicated that 33.3% of the respondents strongly agreed that the SDH is applicable to social work in health. From phase one to four confusion regarding what constitutes the SDA and the SDH was observed. It was also mentioned that the SDH's terminology are not used or considered in health settings. Key informant 1 highlighted that the SDH was introduced and that perhaps issues with cascading the information to social workers were evident. Participants highlighted the relevance of the SDH but had difficulty in connecting with it. In further exploration and explanation, it was clear that the SDH was manifested in the biopsychosocial assessments especially when social workers consider living conditions, access to resources, equal access to health care, physical and mental health to enact treatment compliance. This use of the biopsychosocial assessment of social workers in health care is what Moniz (2010) identified as the proactive role of social workers to address the manifested SDH. Participants succinctly highlighted their strategies in addressing the disparities (SDH). So there seems to be clear indications that social workers in health care are actively addressing the SDH.

This study confirmed the inferences of Donkin et al. (2017), Keefe (2010) and Pockett and Beddoe (2015) that disparities are pronounced when people converge with health care settings or are hospitalised. This manifested inequalities social workers attempt to respond and resolve it. This resolution is consistent with empowerment but also ensuring wellbeing of patients and to ensure further treatment compliance. Perhaps this focus also influences the view of the MDT that social workers are only problem solvers and not counsellors. The MDT however needs to realise that the social workers' attempts to resolve the SDH, are to the benefit for the patient and the MDT. By virtue, social workers need to be embraced as equal members of the MDT.

From the descriptions offered about social work, the SDA and the SDH a clear connection was pronounced through the commonality of empowerment, social justice and advocacy. The

relationship between the SDA, the SDH, knowledge and competence were confirmed by the results from the survey.

10.4.5 Category 4 – Policies

Varied results about policy and SOP implementation were gathered. From the survey it was evident that social workers in health care are not consulted about policies. This was confirmed by the majority of participants. In all phases the dichotomy of consultation regarding polices or SOP were observed, where managers or supervisors affirmed consultation and social workers denied that consultation occurred. Participants viewed the lack of consultation as not being valued in health care. Some participants identified procedures of consultation. Key informant 1 was poised that clear procedures are outlined to consult social workers. Several challenges do exist with regard to cascading information to all social workers in the GDH. This is levied at either the neglect from supervisors or managers. Where this lack of consultation occurs some participants in the individual interviews and focus groups highlighted the consequences of not applying the SOP or policy. This leaves social workers frustrated and disillusioned. This lack of, or inappropriate communication or consultation was addressed by Borst (2010), Gregorian (2008) and the WHO Technical Brief (2008) as negating the effective adjustment to new policies and amenability to the change. In motivation of the above, the survey confirmed through the associations that exist between job satisfaction and transformation, with a standard deviation of *.869* and a Pearson correlation of *.299*, where consultations occurred. A Pearson correlation of .388 is also noted with policy implementation and job satisfaction. Appropriate consultation is therefore imperative for the wellbeing of social workers.

Challenges with policies and SOP included several aspects. Participants found it difficult to navigate the SDA and the SDH in health care due the absence of governmental strategies. This primarily confirms the view that the DSD is seen as the owner of the SDA as the DSD has provided

strategies or programmes. The value of all methods of social work in aiding patients should not be negated as suggested by Gray (2014).

It was identified that SOP are considered both versatile as it guides but also frustrating due to the number of SOP and how it affects social workers especially if social workers are not informed or consulted. Participants indicated that policies may affect their wellbeing. Further, it would seem that social workers are left to deal with the consequences of not implementing the SOP or policy correctly.

The impact of unilateral policy implementation was highlighted with the example of the Life Esidimeni tragedy which introduced major implications for social workers of which they had no input in. The policies that resulted from this tragedy aimed to deinstitutionalise patients at all costs, enforce discharge planning and social justice to patients, but ignored the complications for the social work role especially with regard to engaging patients who are mentally unwell, allowing them to exercise the right to self-determination and home visits that needs to take place. These aspects are not necessarily problematic, but participants felt that their professional opinions were at times superseded or ignored. This reinforced the feelings of a lack of appreciation. In addition, the home visits policy for social work is in conflict with nurses' policies, who are not permitted to accompany the social workers. Other policies are also influenced by the political agenda. It seems to be the norm that policies are aimed at different members of the MDT and are in contradiction. This contradiction seems to also be manifested in the lack of unity amongst departments. This reiterates the competing health care professions of which social work is of least importance but also view themselves as powerless.

10.4.5 Category 5 – Vision

All participants highlighted that they are hopeful about the future of social work. In addition, social work is to be viewed as fulfilling a central or pivotal role in the MDT. In fact, it was clearly echoed from participants in phases two to four that the MDT will not be able to function without a social worker. This seem also in contradiction of the view presented of social workers being seen as support staff or fulfil a secondary role. But despite the hopefulness and necessity of the profession in health care, the focus groups clearly articulated that the profession needs to be repositioned as an equal partner in the MDT and should be acknowledged as a specialist field.

Threats to the social work profession in health care were highlighted as the MDT members assume the roles of social workers, the PMDS and OSD. In addition, the SACSSP inability to advocate for social work was highlighted as a major threat.

10.4.6 Category 6 – Framework

In the survey 44 participants that is 97.8% indicated that an SDA framework for social work in health care does not exist. All the other participants from phases two to four indicated this as well. One respondent indicated the existence of a framework. It is not sure if this was the integrated service delivery model from the DSD (2006b). All participants indicated that a possible framework should include practical resolutions to aid patients. Currently the implementation of the SDA is via the SDA principles. These principles are not unfamiliar to the social work profession, but practical plans, steps or guidance are needed. Gray (2014), Lombard (2008), Midgley (2001, 2010, 2014), Noyoo (2015b) and Patel (2015) referenced the need for investment strategies and comprehensive multimodal approaches for the development of communities.

As part of the framework participants suggested the communication with and consultation of social workers should be mandatory. Linked to this is the requirement that the approach should be a bottom-up approach which will enhance ownership of the social work profession and how

intervention should occur. This will also allow for the social workers to author their own roles. Leadership i.e., supervisors and management should play an instrumental role but also be open to directives from social workers.

The biggest aspect in establishing a framework is to correct the view that the DSD is the owner of the SDA. This perception is not helped by the fact that with the implementation of the SDA, the DSD removed powers from social workers in health care. This is totally unacceptable and in contravention with the training of social worker and the associated act and bill. This act by the DSD remedy social workers to the level of occupations. This is a major contravention that needs to be reversed.

From what the participants posed, the researcher grappled with does social work in health care need a SDA framework or a framework for social work in health care, considering the numerous challenges encountered and shared by the participants. The framework should not solely focus on the SDA as based on the input of respondents and participants. From participants this framework should address workload, encourage a qualitative than a quantitative strategy, increased staff requirements, consideration of the workload, status in the MDT, a model of rotation, the SDA and SDH. The establishment of such a framework will require detailed work study and further research in the area. Below the researcher suggests a possible guideline that may be used to develop a future framework.

10.4.6.1 Suggested guideline

It is obvious that the suggested guideline should be multimodal due the complexity of the South African context but also due to the complex health care settings. The proposed start of the guideline should refresh the historical roots of the SDA and how this strategy even though it is perceived to be implemented by the DSD is actually a state driven process of

which the implementation was managed by the DSD. Midgley (1995, 2001) and Noyoo (2015a, 2015b) addressed this. There should be a greater commitment of the implementation of this approach to the rest of South Africa than only social workers and social service occupations. The approach should acknowledge the role of social work practiced in different contexts where the application of the SDA according to the principles are acknowledged. Furthermore, the application of the SDA should not be viewed punitively where the application occurs via the principles of the SDA, based upon the type of settings and the challenges associated with it of social work. This acknowledges the views of Gray (2014), Masuka (2015), Payne (2005, 2014) and Ornellas et al. (2016) who indicated that all services are required to attend to the clients but also that the typologies of service delivery encompass all service delivery as based on the setting.

The SDH should be considered as it complements the SDA in that it provides the practical component to address inequalities and disparities brought on by the contact with a health care setting. Social workers in health care are also in the ideal position to deal with and address inequalities as well as the SDH. This should also be a strong motivator to employ more social workers in health care settings.

In line with the principles of the SDA further attention should be giving to not only the development of culturally component models that are responsive to the South African context but also to the prevalent legislation. Here the treatment of non-South African citizens who access public health care needs to be considered. This requires attention to be given to the NHI but also the current legislation that precludes non-SA citizens form accessing current non-emergency public health care services.

Rotation practices that enhance and not punish social workers in managing the very demanding and complex South African context should be developed. Room for communication and negotiation should be evident, but also the acknowledgement of different rotation models that will enable development, growth and the creation of specialist in areas. Here skilled supervisors and managers are instrumental in enabling open discussions. A competent workforce that can operate in diverse units and settings in addition to developing and enhancing specialities and specialists should be the outcome.

Full ownership of the roles of the social worker should be levied with social workers in the GDH and not influenced by a political agenda or tragedy or just filling a gap. This has been the trend of the social work profession throughout history to adapt to the demands of others as indicated by Borst (2010), Browne (2006), Dhooper (2012) and Segal et al. (2018). The consultation process needs to be controlled and monitored by enabling a bottom-up approach. In addition, social workers in health care will need to become proactive in advocating for their own position and rights.

The researcher therefore suggests that a modified Payne's typology be used to analyse, describe and plot the social work services of different health care setting accordingly. As mentioned in chapter 3, Payne (2005, 2014) identified three social work discourses. The two editions refer to the three discourses under different names. These three discourses that identify the relevant social work services are (1) reflexive - empowerment discourses which encompasses therapeutic interventions offered to aid clients, in that both address helping clients and offering therapeutic interventions, (2) socialist - social change referring to social work strategies that uplift the vulnerable and oppressed, and (3) individualist – problem-solving discourses which focus on attending to individual needs (Payne, 2005, 2014).

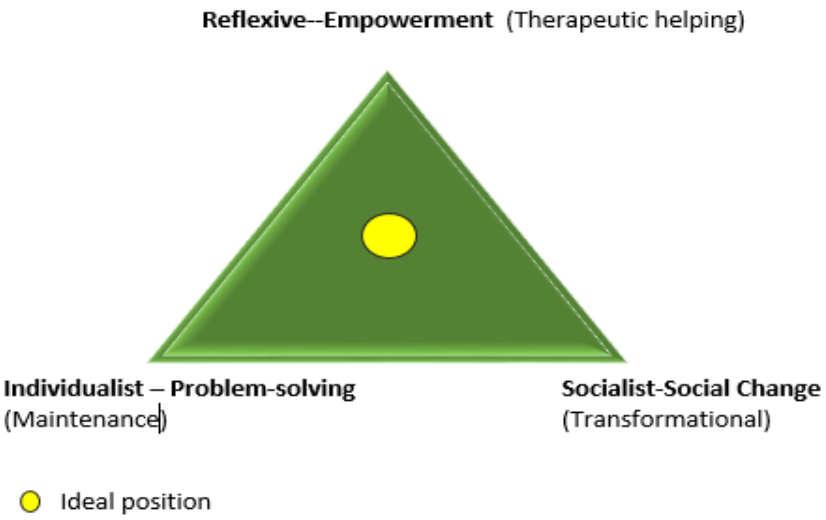


Figure 10.1: Payne's Modified Typology (2005, 2014)

Figure 10.1 is a representation of Payne's typology with the ideal position in the centre of the service delivery. Each angle houses the different discourses.

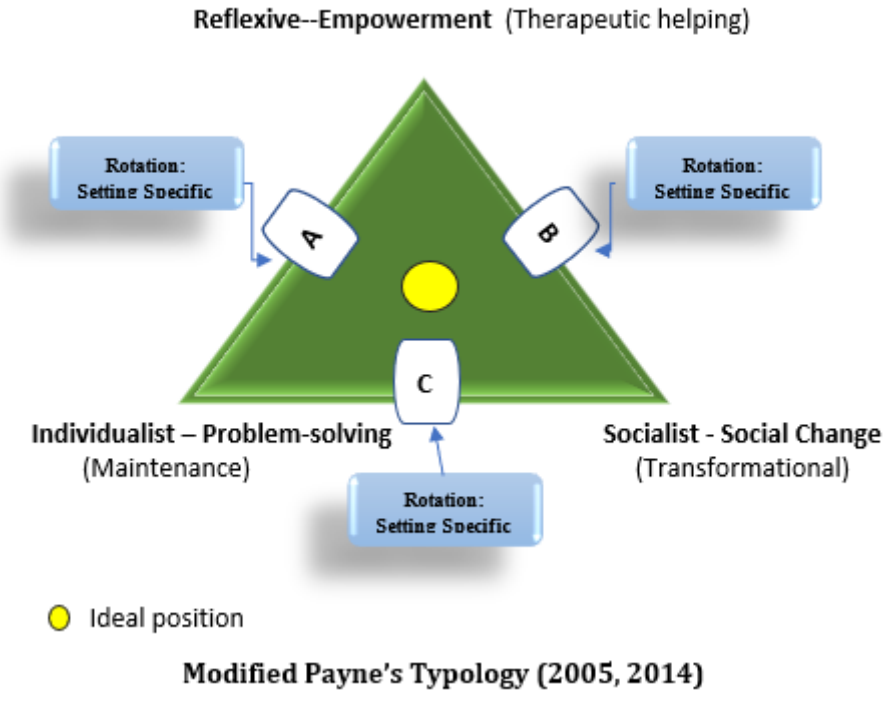


Figure 10.2: Payne's Modified Typology (2005, 2014) – Services

Table 10. 1 Service delivery dominance

Reflexive-- Empowerment	Tick	Individualist – Problem-solving	Tick	Socialist - Social Change	Tick
Counselling about the disease		Problem-solving individual needs by using task centred and solution focused approaches		Advocacy matters in ensuring social justice for patients with MDT and society	
Pre- and Post-surgical or treatment counselling		All aspects regarding placements		Mobilising patients to take action.	
Bereavement counselling		Discharge planning		Social actions and campaigns for patients, health care setting, communities and profession	
Counselling dealing with losses		Tracing of families and family re-unification		Community liaison, projects and development	
Counselling dealing with death and dying.		DGs, IDs and Births		Addressing discriminations, crime, GBV, exclusions, etc.	
Trauma and crisis intervention		Linking with and referral to resources		Communal health and wellbeing.	
Individual counselling		Stakeholder liaison and multisectoral collaborations		Training and development of staff and communities	
Couple's counselling		Information giving and empowerment		Specialist programmes and social investment strategies	
Family therapy and Family preservation		Family preservation (practical components)		Housing and settlement issues	
Developmental and therapeutic workshops		Awareness projects, psychoeducation and workshops		Strategising and policy formulation	
Therapy, growth, socialisation or support groups		Education and self-help groups		Task groups to address a specific mandate	
Specialist knowledge about the unit, ward, the disease or condition and treatment needed for effective and holistic service delivery needed		Specialist knowledge not necessarily needed for effective and holistic service delivery		Knowledge about anti-discriminatory and empowerment practices used more dominantly.	
Other:		Other:		Other:	
Total		Total		Total	

- **10 out 13 suggestive of dominance in a particular area**
- **Almost an equal selection of services in all three categories suggestive of the centre.**
- **Selection of two areas of services delivery then dominance of A, B, or C on Payne's typology.**

Figure 10.2 is the same typology as figure 10.1 but with the dominance of services indicated. Depending on the setting the ideal position will shift from the centre to be dominant therapeutic or transformational or responding to the needs of the patient. From what participants indicated the position for most settings will strongly align between reflexive - empowerment and individualist-reformist. This is indicated as A on figure 10.2. The services of those participants who indicated that they have neglected counselling roles but advocate for the vulnerable will locate their service delivery between individualist – problem-solving and socialist – social change. This is represented by C in figure 10.2. Participants did not indicate that they offer a combination of counselling services with community work or transformational services. If there are health care settings in the GDH that do offer this combination the service delivery will be located as B on the diagram.

Table 10.1 serves as a guide to the types of intervention that may constitute reflexive – empowerment, individualist – problem-solving and socialist – social change typologies. The social workers in the different settings may indicate the dominance of service delivery which should in turn indicate which type of services are dominant for the setting. The table is by no means exhaustive and each setting may modify it as according to the health care setting, based on the services offered at the health care setting, the aspects of the SDA to be applied and the rotation system most appropriate for the health care setting. This typology is then situated within the South African context acknowledging legislation and policies with special focus on the SDA and the SDH. The researcher suggests that if ten or more options are selected that this indicates the dominance of service delivery. Combinations may also be relevant as indicated in figure 10.2. Below are some combinations of service delivery with suggested rotation models.

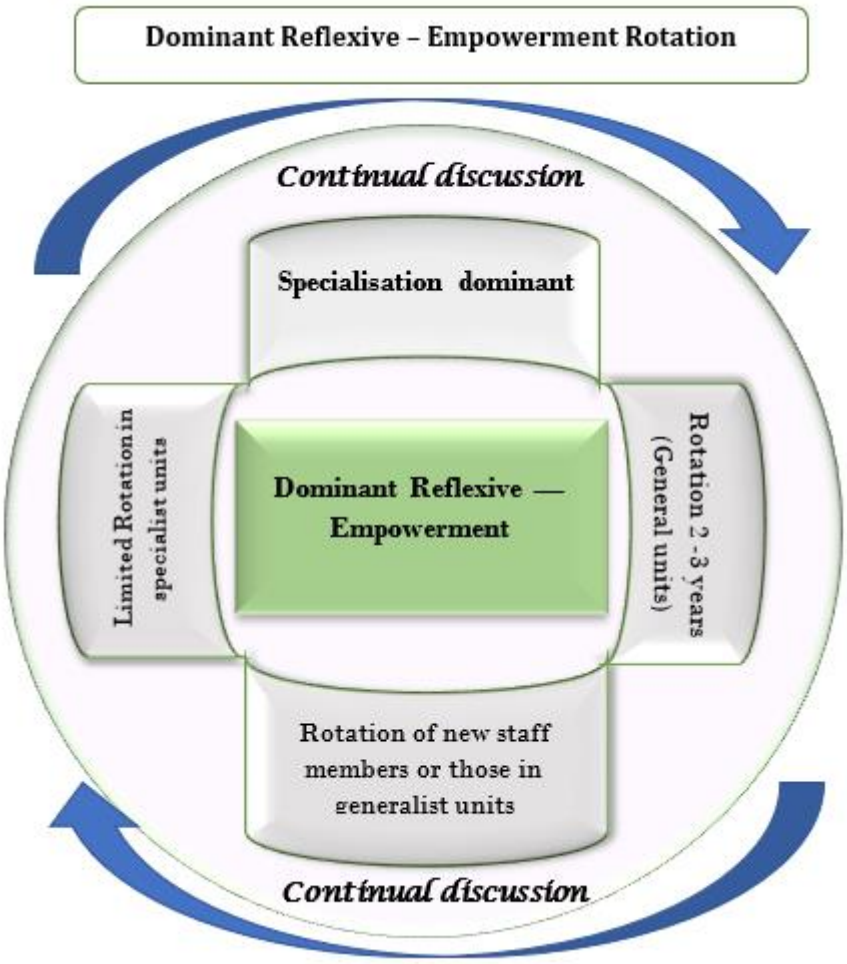


Figure 10.3 Dominant reflexive – empowerment rotation

Figure 10.3 represents those health care settings where the therapeutic or specialist services are dominant. These types of settings, which may include tertiary and quaternary healthcare settings, due its specialist nature, will perhaps focus on limited rotation and where rotation occurs it may be limited to those new personnel or staff that works in the generalist units or wards such as internal medicine, general surgery, casualty, general outpatient clinics and so forth. If rotation is implemented, then this may occur every two to three years according to that social work departments plan. It should be noted that this is situated in a bottom-up consultative framework that encourages open and honest sharing. The following two figures embody the two other dominant typologies as according to Payne's typology.

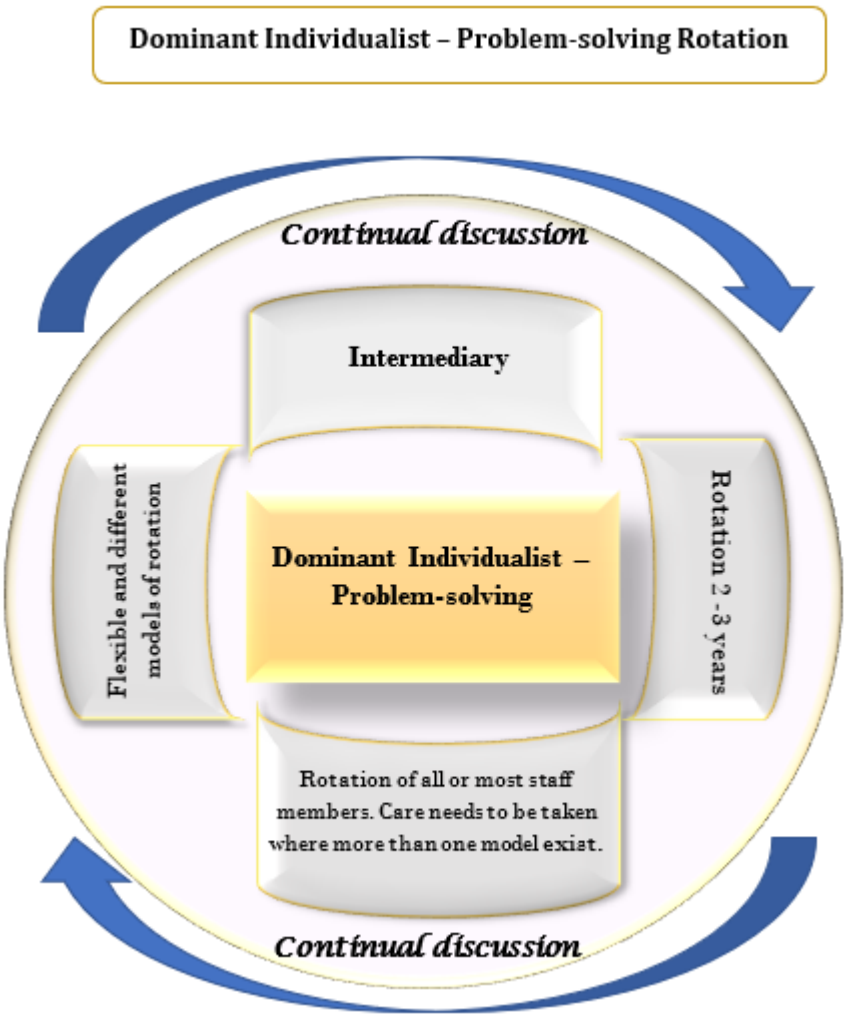


Figure 10.4 Dominant individualist – problem solving rotation

Figure 10.4 represents the rotation for those health care settings which dominantly offer individualist and problem-solving services. These services may not be setting specific; hence the researcher refers to it as intermediary rotation. Flexible as well as diverse models of rotation may be prevalent. Even though most staff may be compelled to rotate, care needs to be taken with regard to diverse rotation application in one setting.

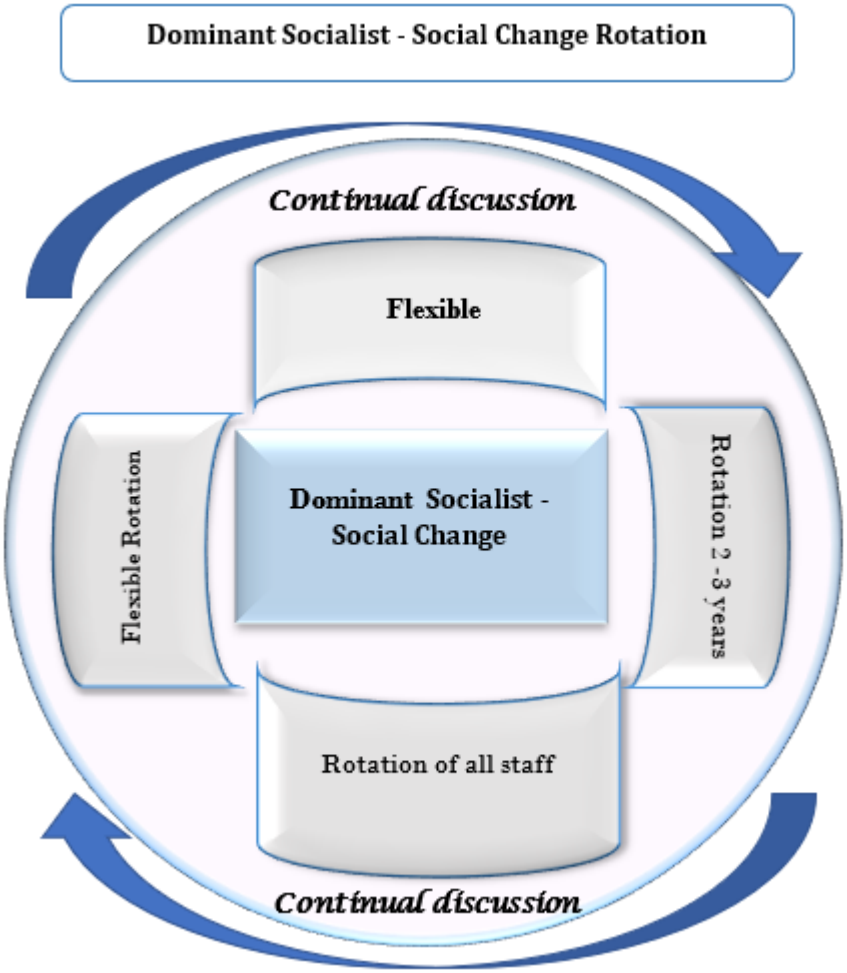


Figure 10.5 Dominant socialist – social change rotation

Figure 10.5 represents rotation practices for those settings that offer services solely based on transformation, anti-discriminatory practices, and community work. This may be inclusive of community development projects and social investment strategies. It must however be reminded that none of the participants and respondents (as based on the survey results) indicated that they solely offer these types of services. These types of services are ideal for settings and organisations within communities.

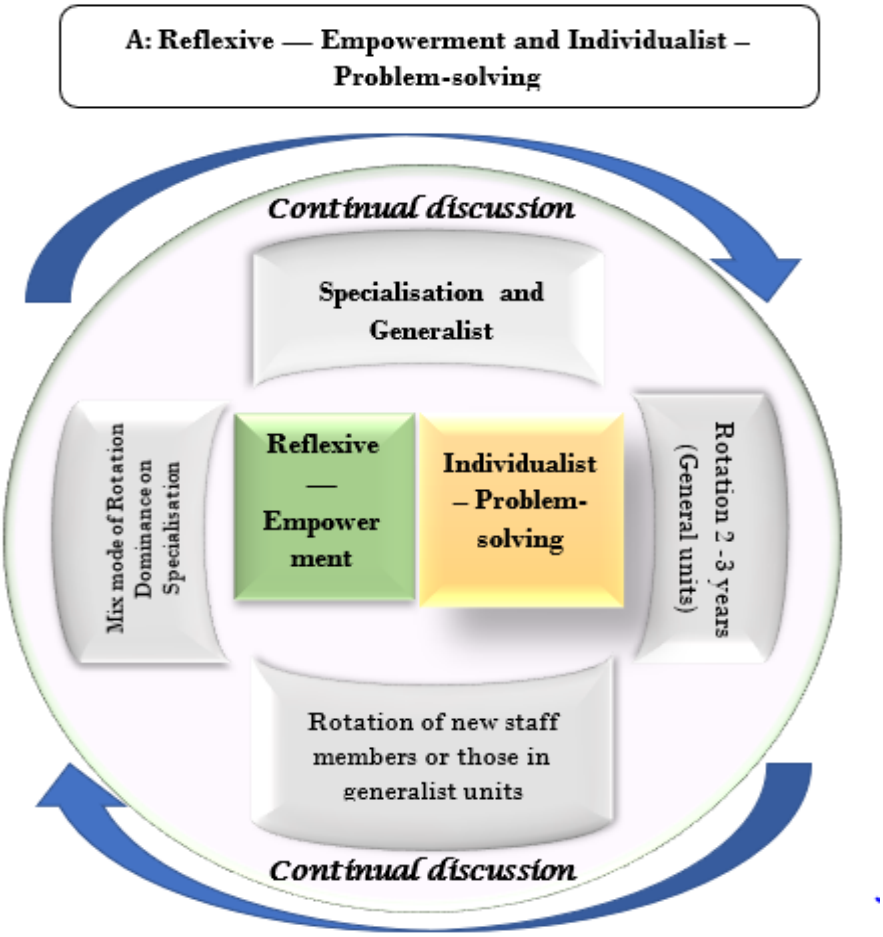


Figure 10.6 A: Reflexive – empowerment and Individualist problem-solving services

Figure 10.6 A depicts a combination of reflexive – empowerment and individualist problem-solving services. This is depicted as A on figure 10.2. Most participants indicated that their settings offer this combination of services. These units may offer specialist and generalist services delivery. A possible mix mode of rotation will be evident. The researcher acknowledges the need for centres and units of service excellence and hence suggests the rotation of new staff and those in general units. Those staff who has seniority and has rotated to most units or wards should receive priority with regard to specialisation.

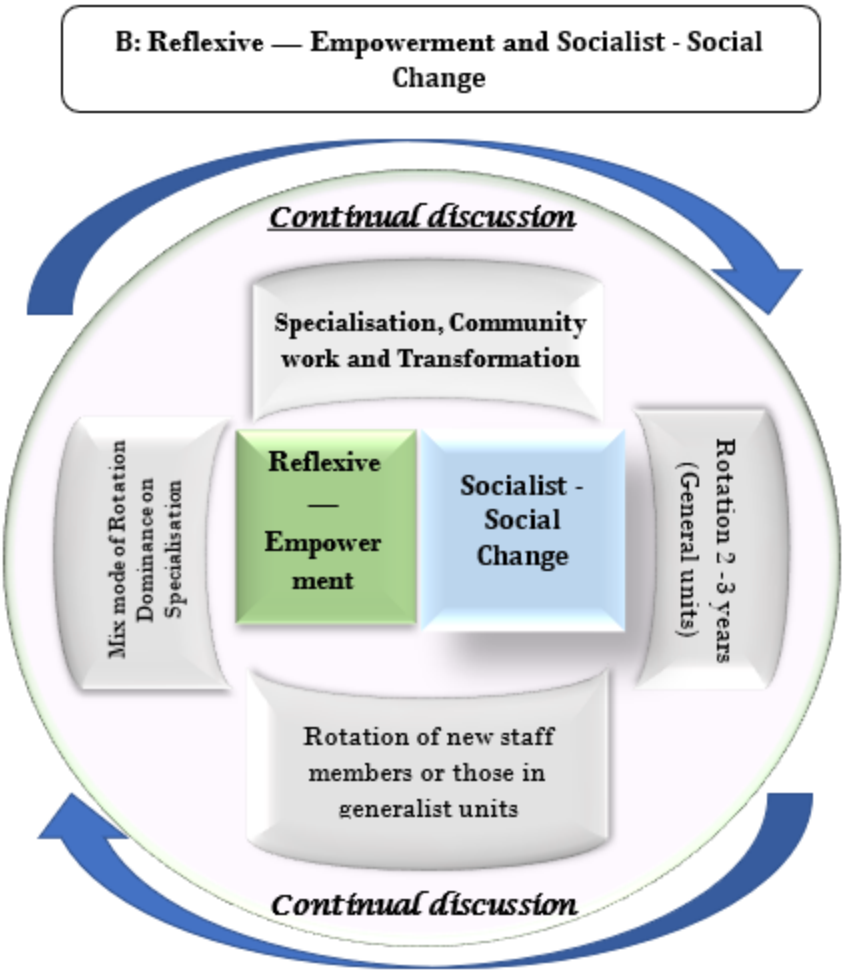


Figure 10.7 B: Reflexive – empowerment and socialist – social change services

Figure 10.7 represents the combination of reflexive – empowerment and socialist – social change services. Here a combination of counselling services (leaning towards specialisation), dominance of community work, implementation of programmes and involvement of transformational service delivery are evident. A mix mode of rotation may also be evident of new staff and those in general units and wards. This is depicted as B on figure 10.2.

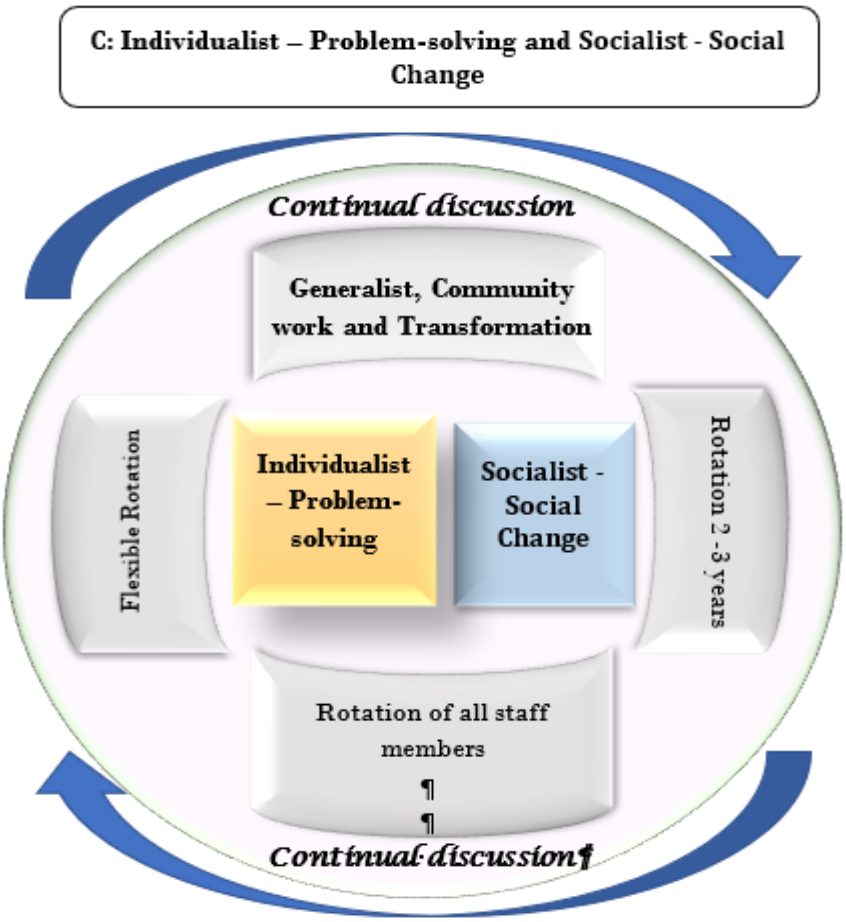


Figure 10.8 C: Individualist – problem-solving and socialist – social change services

Figure 10.8 represents the combination of services for a combination of individualist – problem-solving and socialist – social change services. As therapeutic services may not be dominant here, these services may be specifically geared at health care settings in or near communities. Here general practice (focussing on problem solving and addressing individual needs), community work and services focussing on transform may be dominant. In line with general practice flexible rotation may be evident.

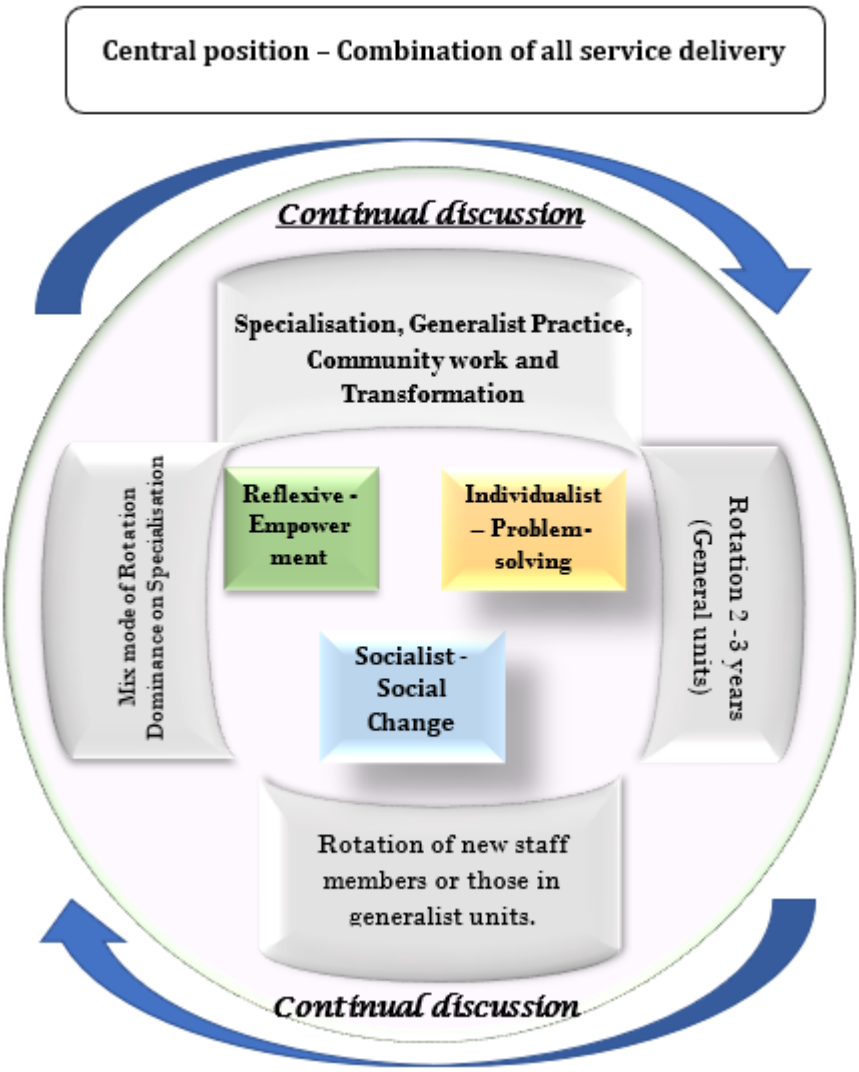


Figure 10.9 Central position – combination of all service delivery

Figure 10.9 represents the central position which serves as a combination of all services. This is the ideal position where all health care settings will offer all services. This is also depicted in the centre of Payne's typology as indicated in figure 10.1 and 10.2. As this contains a combination of services it may be prevalent in any health care setting. Diverse models of rotation may be evident within one health care setting. The researcher still suggests that new staff and staff in non-specialist units or those who would want to rotate should rotate. Those social workers wanting to specialise should be offered the opportunity

to do so. This should occur in an environment where open and honest bottom-up communication is asserted.

With the types of services dominant per setting the social work approaches, principles and actions of the SDA and the dominant SDH may be highlighted. Health care settings in or in proximity to communities will to a greater extent use individualist – problem solving and or socialist - social changes strategies and perhaps offer greater programmes and address poverty alleviation than the tertiary health care settings. Rotation practices here may be compulsory. This is depicted in figures 10.4, 10.5 and 10.8.

In tertiary health settings perhaps, greater emphasis will be on specialisation, therapeutic intervention and individualist-problem-solving services. Rotation in these settings may be absent or limited to new staff and staff assigned in general internal medicine, general surgery and paediatrics wards. This is depicted in figures 10.3, 10.4 and 10.6.

It should be the aim of all health care settings to offer a combination of different services to ensure holistic and effective service delivery. These services and rotation options were highlighted in figure 10.9. Each hospital setting should ensure that they have their unique blend of these three typologies. In line with this the application of the SDA and addressing of the SDH will be unique and diverse to each setting. In tertiary health care setting social workers may use empowerment and advocacy strategies in combination with the principles of the SDA and refer to community resources to resolve the prevalent SDH. Those health care setting in or close to communities may be involved in offering community work, upliftment programmes as well as be involvement in social investment strategies. These health care settings may receive referrals from social workers in tertiary health care settings as well as respond to a greater community need. Therefore, the researcher advocates for diverse applications of the SDA according to the unique service delivery

of each health care setting. The researcher furthermore offers a frame of reference or a guideline for highlighting the elements that may be included for a future framework.

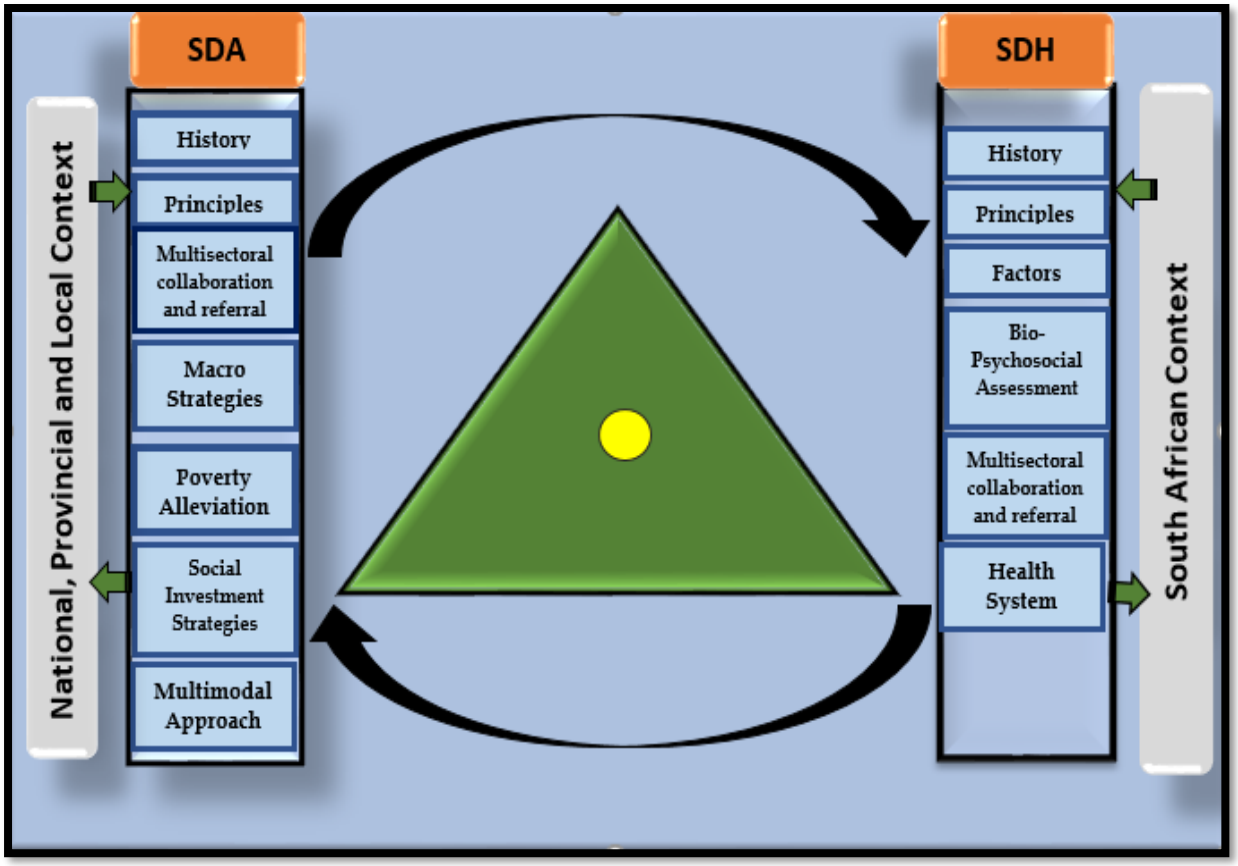


Figure 10.10 Diagrammatical Representation of the SDA and the SDH Guideline

A possible diagrammatical representation of the application of the SDA and the SDH is represented in figure 10.10. This depiction has in the centre social work in health care as represented by Payne's typology with ideal position for services delivery. As highlighted by the findings of this study the SDA and the SDH are linked and imperative to be applied by social work in health care. Each of these two approaches aligns itself to either side of the services typology.

The dominant elements highlighted for the SDA for social work in health care, are the history of the SDA, its principles, multisectoral collaborations, poverty alleviation

programmes, social investment strategies and multimodal approach. With history of the SDA, it is imperative, as highlighted in chapter 4 that the global history as well as the application of the SDA in SA should be clarified. This refers specifically to the Copenhagen summit and the White Paper on Social Welfare (Noyoo, 2015a, 2015b; Patel 2015). All the principles, summarised as rights-based, self-determination, democracy and participation, welfare pluralism, crossing the micro-macro divide and social investment strategies (Gray, 2014; Midgley, 2014, Noyoo, 2015b; Patel, 2015) should be clearly described with clear examples for health care. All social work departments within the GDH should be in contact with stakeholders, resources or be part of multisectoral collaborations to ensure the upliftment and wellbeing of the patients. Health care settings should be knowledgeable about poverty alleviation strategies, social investment strategies and programmes that patients may access. For these purposes, the researcher suggests that a resources and projects list be updated and circulated within the GDH. Those setting within communities may be actively involved in community development or social investment strategies that may be geared at the upliftment of patients and communities. The multi-modal approach should address various service delivery that may be relevant for particular patients and communities. This should be clearly formulated and continually interrogated, discussed and updated.

The dominant elements highlighted for the SDH which are imperative for social work in health care are the history of the SDH, principles, factors, bio-psychosocial assessment, multisectoral collaboration and the health system. This guideline should contain the historical development of the SDH and the mandate after the Rio Declaration. The three main principles of access and equity, distribution of power, money and resources, and to continuously monitor the impact of addressing the SDH (Bhattacharya, 2010; Craig et al., 2013; WHO, 2010; WHO CSDH, 2007a, 2007b), should be well described in this

framework. In addition, the particular health system or setting with its structures, challenges, service delivery and limitation should be clearly highlighted. The identified health care setting's referral health care settings and their services should be clearly indicated. The six factors with appropriate examples should be contained in this framework. These factors that should be included are economic stability, neighbourhood and physical environment, education, food, community and social context and the health system (with specific reference to geographical accessibility) (Bhattacharya, 2010; Craig et al., 2013; Davidson, 2015; Forde & Raine, 2008; Marmot, 2005; WHO, 2010; WHO CSDH, 2007a, 2007b). The bio-psychosocial assessment should be clearly described, and elements linked with the SDH. Here the researcher suggests the formulation of the bio-psychosocial assessment to the specifics needs of the MDT but also addressing the impact of the SDH. As with the SDA, multisectoral collaborations and referral to resources are of the utmost importance. These should also be well documented and circulated amongst all social workers.

From the diagram applying the SDA and the SDH particular social work services will be utilised. The type of services to be utilised are dictated by the individual's needs, issues of vulnerability and injustice, and the setting. Based on the focus of the setting the social worker in the health care setting will either resolve the matter or refer. Both arms, the SDH and the SDA, address multisectoral collaboration. It is therefore imperative that a continuous programme be established to enhance these multisectoral collaborations. Due to the commonalities of the two approaches as well as sustained by the findings as one addresses the SDH so one satisfies the SDA. The two arrows depict the flow between these two approaches. In implementing the approaches, one also has to be cognisant of the South African context, the health care context and dominant legislations evident. This guideline may be formulated by a task team comprising out of social workers. This should be viewed

as the generic overall guideline. Each guideline should then be modified according to their services typology. In this manner social work in health care in the GDH will have a uniform guideline that is flexible and adaptable which may be modified and changed accordingly.

10.5 Validation of relevance of the study's mixed methodology

Mixed methodology was inexplicably appropriate for this study due to the enabled of triangulation, complementarity, development, initiation and expansion as highlighted by Barnes (2012), Creswell (2018), Johnson (2004), and Leech and Onwuegbuzie (2009). Triangulation was noted amongst the data collected from phase one to four, the methodology, between the observer and researcher, theory and paradigms of this study. As presented above a clear triangulation of data could be noted and the validity of findings were strengthened and confirmed. The triangulation of the data and methodology resulted in a clear picture of how the SDA, SDH and policies have been applied to social work in health as well as challenges experiences.

The use of the pragmatic paradigm with mixed methodology enabled the fluidity of the findings and conclusions to be drawn. This strengthened the research exploration. Realistic and existential pragmatism were triangulated with the social constructivist paradigm and IPA in fostering a clear sense of inter-subjective reality, idiography of the experiences of the participants and how they make sense of the SDA application. This triangulation further extends to the two theoretical frameworks of this study. The ecological perspective clearly facilitated the understanding of the participants in terms of the different spheres and how these spheres impacted on them. There was also a strong link with Habermas's social reproduction theory which was highlighted in Chapter 2.

10.6 Summary

The wealth of information obtained throughout the four phases led to the in-depth discussion of the results affirming the validity and value of the mixed method study and triangulation of data, theories and paradigms. All three methods confirmed the application of the SDA via its principles, referrals to community resources and multisectoral collaboration with stakeholders as imperative for not only satisfying the ideals of the SDA but more importantly to address the plight of patients. Even though the delineation of the SDH from both respondents and participants were challenging, the relevance and importance of this was indicated. A major realisation was that the SDH are addressed via their use of psychosocial assessment and the subsequent resolution of all social problems that will prevent compliance. All three data methods highlighted that the SDA and the SDH are inextricably connected via its principles of which social justice, equality, equal access and empowerment are the core. Evidence of strong associations among job satisfaction and consultation, feeling valued, appreciated and where supervisors or managers advocate for social workers were noted. To this end the focus groups clearly identified that consultation should be a bottom-up approach. The unique, instrumental and central position of social work within health care are reinforced, yet social workers work under tremendous pressures, whose roles are undervalued and undermined by different role players. The following chapter offers a summary of the entire research study, represents key findings and conclusions, and recommendations.

CHAPTER 11: SUMMARY, CONCLUSION AND RECOMMENDATIONS

11.1 Introduction

This chapter provides an overview of the study process, key findings, conclusions and recommendations. In discussing the findings, the research objectives will receive consideration. The wealth of information obtained; several key findings and conclusions are posed. The recommendations are at geared the guideline for the application of the SDA and the SDH in social work and health care, the GDH, policy implementation, academia, SACSSP, social workers and for future research.

11.2 Summary of the study

11.2.1 Research questions

This study sought to answer the following questions:

1. How was the social development approach implemented in health care settings in Gauteng Department of Health?
2. What were the experiences of social workers and social work managers with regard to the implementation of the social development approach?
3. Was sufficient training and guidance provided to social workers and social work managers with regard to the implementation of the social development approach?
4. To what extent did social workers and managers participate in this policy implementation?
5. How are the social determinants of health applicable with the application of the social development approach to social work in health care?

11.2.2 Goal, objectives and hypothesis

11.2.2.1 Goal

The goal of the study was to explain the implementation of the social development approach to social work in health care in the Gauteng Department of Health.

11.2.2.2 Research objectives

The objectives of this study were:

1. To explore, describe and explain, as based on the understandings and perceptions of social workers, social work managers and key informants, the application of the social development approach to social work in health care in the Gauteng Department of Health.
2. To highlight the governmental implementation strategies of the social development approach as pertaining to social workers in health care in the Gauteng Department of Health.
3. To explore the relevance of the social determinants of health in relation to the application of the social development approach to social work in health care in the Gauteng Department of Health.
4. To explain the role of social workers in health care in the Gauteng Department of Health with regard to policy implementation.
5. To solicit contributions from social workers for the establishment of a future integrated guideline for the social development approach to social work in health care in the Gauteng Department of Health.

11.2.2.3 Hypothesis

The social development approach is applied by social work in health care.

11.2.3 Paradigms and theoretical framework

The pragmatic and social constructivist paradigms were utilised. Realistic and existential pragmatism resonated with the social constructivist paradigm where the focus was on the exploration of the inter-subjective lived experienced of participants. The social constructivist paradigm was instrumental in the exploration of the phenomena in terms of understanding of the participants' construction of their worlds. The pragmatic paradigm further encouraged the use of different theories in the exploration of the phenomena. Habermas' theory on social reproduction and the ecological perspective allowed for the understanding of the participants lived experiences through different spheres of social work in health care. The application of the paradigms and theories with regard to the understanding of the participants' experiences was highlighted in chapter 2.

11.2.4 Methodology

This sequential mixed method study underpinned by the pragmatic paradigm as the methodological paradigm, which enabled the fluidity between the two distinct approaches and resulted in triangulation of findings, theory and paradigms. The data collection and presentation of the study was divided into four phases. Phase one contained the quantitative approach where data was collected via a questionnaire (cross-sectional survey) and using survey research design. Forty-five questionnaires were analysed and presented via descriptive and inferential statistics. The statistics showed a number of strong associations between constructs that may be suggestive of possible cause and effect relationships.

Phases two to four encompassed the qualitative approach of the study. The research design for these phases was interpretative phenomenology. Ten participants took part in the interviews during phase two. Two key informants took part in phase three. Two focus groups were facilitated. IPA was used to analyse the data.

The wealth of data received from the four phases not only enabled triangulation but also validated the value of the research study.

11.3 Summary of findings according to the objectives

The findings gained from the study answered the goal the objectives and the hypothesis successfully.

Objective 1: To explore, describe and explain, as based on the understandings and perceptions of social workers, social work managers and key informants, the application of the social development approach to social work in health care in the Gauteng Department of Health.

This objective was informed by all data collection methods from phase one to phase four. Literature on the application of the SDA and social work in health care in the GDH specifically was limited. In chapters 3 and 4 the literature presented addressed social work in health care and the SDA respectively, but did not represent any sources on the views of social workers in the GDH. This was the gap that was identified. The findings of this study therefore contribute extensively to knowledge in this area. Clear descriptions of the understanding of the SDA were indicated. It was noted that this understanding covers a wide range of aspects that essentially revolve around the wellbeing and upliftment of others. Uncertainty regarding the approaches, determinants and application were highlighted. Yet convincingly all data methods enforced that the SDA is applied in the GDH. The main strategies of implementation of the SDA were through the principles of the SDA, awareness projects, psychoeducation, referrals to resources in communities and liaison with stakeholders. Several challenges with the application of the SDA were observed which spanned the change in the job description of the social workers in health care, the suitability of the health care setting for community practice, the conflict with the principles, such as the right of self-determination of the SDA with legislation, the requirement of deinstitutionalisation and policy

changes only relevant to social workers. Social workers were able to confirm that the SDA and social work are connected via empowerment, advocacy and social justice. Participants were actively addressing socioeconomic challenges of patients by referral and connecting with appropriate resources. By implication the SDH were addressed.

Objective 2: To highlight the governmental implementation strategies of the social development approach as pertaining to social workers in health care in the Gauteng Department of Health.

Chapter 4 offered an overview of the implementation of the SDA globally as well as in SA. Section 4.3 particularly offered the delineation of the SDA and section 4.4 the nexus between policy, the SDA and transformation.

A connection with social work in health care and the SDA as based on the principles of empowerment, social justice, self-determination and welfare pluralism were indicated. The literature review could not confirm any reported governmental strategies for the implementation of the SDA in the GDH. The findings as presented in chapter 8 (in specific sections 8.32 and 8.3.2.1.5) and chapter 9 (in specific 9.4.2.1.2) confirmed that the DSD is viewed as the owner of SDA and a clear absence of strategies of the application of the SDA to social work in health care were noted. This lack of strategies and guidance to practically implement the SDA, complicates the role of the social worker and does not enable the social worker to successfully navigate the application of the SDA. This was addressed in the findings in sections 7.6, 8.3.4 and 9.6.4 regarding policy implementation.

Objective 3: To explore the relevance of the social determinants of health in relation to the application of the social development approach to social work in health care in the Gauteng Department of Health.

Chapter five outlined the pivotal role social workers in health care play in addressing the SDH to ensure equal access to quality health care. The literature review clearly confirmed a relationship between social work, the SDH and the SDA. Literature that addressed the relevance of social work in health care was presented in section 3.4 and that connects the SDH to social work is section 5.4.3.

Data presented in sections 7.5, 8.3.3, and 9.4.3 outlines the SDH, its delineation and challenges. A noticeable confusion and uncertainty of what the SDH entails and how it is applied by social workers in health care were observed. Despite this, participants indicated that the SDH was relevant to social work in health care. Further exploration of this phenomenon during interviews and focus groups seem to confirm the assumption of when patients encounter a health care setting that the SDH are exposed and heightened. This was addressed in chapter 5 but also from the data in sections 7.5.2, 8.3.3.2.2 and 9.4.3.1.3 that indicated that hospitalisation or contact with a health care setting accentuates the SDH. Participants highlighted that their biopsychosocial assessment clearly links with identifying and addressing the SDH. This assessment (sections 8.3.3.1.2 and 9.4.3.1.2) enables social workers in health care to address and resolve the SDH in enabling treatment compliance. Even though in its true sense the SDH focus on enabling access to health by considering numerous factors; these factors also embody the challenges and plights of patients in their daily lives. So, in a sense addressing the SDH so the upliftment and wellbeing are ensured, which are aligned with not only social work practice but the SDA. This motivates the indication by Moniz (2010) that social workers in health care settings were ideally situated to promote addressing the SDH. The literature review therefore aided the understanding and application of the SDH as well as the pivotal role social workers play in addressing the SDH.

In addition, participants were able to highlight that the SDH, the SDA and social work share common fundamentals of empowerment, advocacy and social justice. This therefore confirms the

link between the SDH, the SDA and the social work profession. The researcher will go as far as to say that for social work in health care to satisfy the application of the SDA, the SDH should be addressed. The two should not be removed from social work in health care. The above was also confirmed by unpacking the dominant literature for the SDA and the SDH. Literature, i.e., sections 4.4 and 5.5, for these aspects highlighted the commonalities shared by both and with the SDG. This therefore enhances the relevance of these approaches.

Objective 4: To explain the role of social workers in health care in the Gauteng Department of Health with regard to policy implementation.

The role of social work in health care as well as the impact of policy implementation on the role of social work in health care were explored and discussed in chapter three. The literature review offered an understanding of social work in health care, the roles and how policy implementation and transformation should be addressed. Despite the wealth of information, a gap regarding the role of social work in health care in the GDH was highlighted. The study's findings substantially contributed to this area. From the findings the role of social work in health care finds itself in a precarious position. It would seem as policy changes occur, may it be influenced by a change in a political agenda, tragedy or changes in SOP, without any recourse for social workers, are devoid of consultation and enforced. Policies that inform and confirm the position of social work in health care as a support member and fulfilling a secondary role also influence their position in MDT. The SDA application with the DSD as the perceived owner, resulted in the removal designated powers from social workers in health care. Even though this contravenes the indicated acts, it also demeans social work in health care and also renders it to an occupation. The mandate of the social work role is not in ambit of the control of social workers. Several sections may be of references to the above. Section 7.3, the employment specifications, section 7.6.1 addressing policy and the role,

sections 8.3.1, 8.3.1.2.1, 8.3.4, 9.4.1 and 9.4.4.1.2 addressed the nature of current social work practice, the relevance of the role, challenges and the impact of policy implementation.

Greater consultation with regard to policy changes or SOP are required. Section 8.3.4.2.9 indicated that social work is not heard but ignored. This limited consultation was reiterated in section 9.4.4.1.3 within the focus groups. The approach of this consultation needs to be bottom-up considering and validating the input of social workers. Even though there are a versality of SOP which serves as guidance especially with regard to statutory cases, this is also the factor that impacts on the wellbeing of the social workers.

Objective 5: To solicit contributions from social workers for the establishment of a future integrated guideline for the social development approach to social work in health care in the Gauteng Department of Health.

The literature review of chapters 3, 4 and 5, indicated the absence of guidelines for the implementation of the SDA in health care settings. This was confirmed by the respondents and participants of this study in sections 7.5, 7.6, 8.3.4.1, 8.4 and 9.4.4.1.1. Participants were able to offer helpful input on what a possible guideline for the SDA application should contain. It became clear from the exploration that not only is such a guideline required for the application of the SDA to social work in health care, but a framework that addresses social work in health care in general. Section 9.4.6 highlighted the requests made by focus group participants about the inclusion of a framework for social work in health care. These requests expand the ambit of this study and the researcher offered a guideline, chapter 10 section 10.4.6.1, that may address some of the needs The SDA guideline needs to embody the history, principles, practical guidance on resolving patient dilemmas and challenges. With the specific needs identified by participants a general guideline for social work in health care should acknowledge rotation, consultation practices, cultural

competence, the role and position of social work in the MDT, the mandate of social work and specialisation. It was observed that the participants had distinct insights of the gaps and required assistance in resolving challenges.

11.4 Key findings and conclusions

Several key findings and conclusions about social work in health care, the application of the SDA, the SDH, policy implementation, experiences and challenges encountered by social workers in health care are made.

Key finding 1: Mixed methodology in unison with the pragmatic paradigm was useful and appropriate for this study.

Conclusion: This mixed methodology study delivered valuable information that manifested in the triangulation of data, theory, paradigms and between researcher and observer. The triangulation and fluidity were particularly enhanced by the usefulness of the pragmatic paradigm. A wealth of information was obtained which sustain definite assumptions. The use of mixed methodology also enabled the exploration, description and explanation of the phenomena from different viewpoints. The confirmation of findings by these various methods used, give greater credibility and validity to data gathered. Therefore, mixed methodology was a suitable and appropriate choice for this research study.

Key finding 2: Social work in health care is diverse, unique and instrumental.

Conclusion: Social work in health care is practiced in a wide range of diverse health care settings, with diverse clientele and in challenging situations that require the application of appropriate skills and knowledge. This reinforced the competence of this population. Social work in health care is central and pivotal to the functioning of the MDT and health care settings in delivering holistic

services to patients. This unique and diverse nature of social work should therefore be preserved as fulfilling instrumental roles and functions.

Key finding 3: The counselling role of social work services is limited.

Conclusion: Dominant social work services are counselling, empowerment, support and education. These services not only reiterate the competence of social workers in health care but address the needs of patients. Due to a shortage of staff, workload and being a quantity driven profession, the counselling role of social work are neglected. In responding to the needs of patients and the MDT with the limitations present, the dominant service delivery of social work in health care are problem-solving and solution focused. Social workers are also seen as being solely involved in discharge planning.

Key finding 4: The perceptions of the social work role in health care settings challenges the profession's value.

Conclusion: Social workers in health care are seen as support staff, exit workers and fulfils a secondary role. In addition, social workers are seen as non-counsellors in comparison to psychologists. Their designated powers were removed with the implementation of the SDA in the welfare sector. There is a lack of authority and control which enhances the sense of powerlessness when it comes to the social work role in health care. Social work in health care seems to fulfil a secondary or support role that undermines the profession's value. Social workers in health are viewed as unequal with the other members of the MDT.

Key finding 5: Policy implementation impacts the role of social work in health care.

Conclusion: Policy changes due to events, tragedies like Life Esidimeni and political agendas result in role changes that social workers have no input in. Social workers are marginalised by these actions and compelled to positively respond to these changes.

Key finding 6: Macro strategies challenges, referral and multisectoral collaborations are evident for social work in health care.

Conclusion: Community work is limited, devoid of programmes and community development in health care. Macro strategies are setting determined. Primary and district health care settings are better situated to implement community development and programmes. Secondary and tertiary settings are more suited for awareness projects. Despite this, a strong link with stakeholders and involvement in multisectoral collaborations are evident to offer appropriate holistic service delivery to patients. This aspect embodies the principle of welfare pluralism as related to the SDA.

Key finding 7: Contentment and job satisfaction of social workers in health care are influenced by being valued and protected.

Conclusion: The survey confirmed that the contentment and job satisfaction are evident where social workers are acknowledged, valued, consulted as well as where supervisor and or managers to protect and advocate for them. Therefore, where social workers were consulted about policies or SOP, they felt that they were valued in the GDH. Government, the GDH and the DSD need to comprehend that all settings and sectors are equipped to implement social investment strategies and community development. The application of the SDA according to principles should be valued accordingly.

Key finding 8: Diverse SDA descriptions and applications are evident in social work in health care.

Conclusion: Diverse descriptions of the SDA were observed. The respondents and participants were able to identify various views of what constitutes social development. This ranged from ensuring wellbeing, social justice and attending to the needs of the most vulnerable. The SDA is applied via its principles and the various types of service delivery offered to patients and families. The dominant principles employed are that of being rights based and enforcing self-determination. The use of various empowerment strategies was identified as an important aspect of the SDA. Social justice is embedded in the SDA and also in social work.

Key finding 9: Social work in health care is ideally positioned to fully realise the SDA and addressing the SDH

Conclusion: From the findings it is apparent that when patients have contact with a health care setting any psychosocial challenges (the SDH) are pronounced. Social workers in health care utilise principles of the SDA in empowering, advocating for patients and addressing the psychosocial challenges (the SDH). In addition, they also utilise the bio-psychosocial assessment to highlight factors that may hamper a patient from complying with treatment regimes. The social workers then proactively resolve these factors to ensure the wellbeing of the patient. The matters may have never been resolved if the patient did not establish contact with the health care setting. The contact with social workers in health care settings are therefore invaluable in aiding the psychosocial wellbeing of patients.

Key finding 10: Social work as the catalyst to implement the SDA

Conclusion: Social work in health care is regarded as the catalyst for implementing the SDA. The MDT has limited knowledge about this approach. Social workers due their knowledge about the SDA and competence, are therefore ideally situated to implement the SDA. It was evident from

the findings that social workers in health care identifies when the SDA is being used in comparison with the MDT who are less aware of the approach.

Key finding 11: Challenges in the understanding and the implementation of the SDA in health care are evident.

Conclusion: The terminology of the SDA was considered confusing and clearer delineation of reframing this approach to distinguish itself from other approaches is needed. The concepts ***social development*** is confused with terminology of psychosocial theories. As was suggested by participants perhaps the concepts need to change to delineate the SDA from other approaches. It was also reported that due to limited guidance offered to social workers in health care and the absence of major governmental strategies regarding the SDA, social workers in health care are at times unclear how this approach is applied, the relevance of it in health care, and how to identify if the approach is used. In fact, applying the SDA via its principles is in line with common social work practice.

Key finding 12: Generalists versus specialists practice debate

Conclusion: This debate was particularly noted with the focus groups discussions. The terminology of social workers being ***generalist practitioners*** should be changed as this undermines the profession. Social work should be regarded as a speciality within health. The term ***generalist*** detracts from this speciality. At the same time, dichotomy exist between the encouragement of rotation for its growth and exposure, but also that it reiterates generalist practice. This duality of being a specialist who subscribes to rotation needs further exploration.

Key finding 13: Principles of empowerment, advocacy and social justice unifies the SDA, the SDH and social work.

Conclusion: The social work profession employs empowerment, advocacy and social justice with patients. The SDA through ensuring social justice to all, links with social work. The SDH focus on accessibility to health care services, equality and justice. The shared principles of empowerment, advocacy and social justice unifies the SDA, the SDH and social work. The assumption is therefore as social workers advocate for patients, employ the biopsychosocial assessment, address those factor that prevent compliance or the wellbeing of the patients (SDH) to ensure the upliftment and appropriate functioning of the patient, so the SDA is also addressed. The three areas seem interrelated.

Key finding 14: Need for training that clarifies the SDA and the SDH

Conclusion: Participants highlighted the need for training regarding the entire SDA approach. This stated need could be the reason why there were diverse descriptions of the SDA. Generally, participants suggested needs for various trainings that were not necessarily in line with that of the SDA. This could be explained as a result of lack of clarity on the SDA but also the need for training in strategic areas. What was also reinforced by the results from the survey was that gaining knowledge on the SDA and the SDH positively influence the competence of social workers in health care. This construct indicated a significant *.894* standard deviation.

Key finding 15: The value and perception of rotation is diverse.

Conclusion: Rotation within health care settings is regarded for exposure, growth, development and ensuring the wellbeing of social workers. Most participants were positive about rotation. Rotation was also considered as counterproductive for specialist units where the relationship and the experience in the unit adds to the competence of the social worker to navigate challenging situations. Having social workers rotate in such settings or units may diminish the effectiveness of

social work. The implication of rotation needs to be further explored and should be in line with the requirements of the MDT, unit or ward and health care setting. Where the application of rotation is necessitated, effective and appropriate consultation should be enacted. The survey indicated that 44% of participants highlighted that managers enforce rotation without consultation and only 14% indicated that discussions do occur. The rest of the population i.e., 42% was silent about this aspect. This is a concern especially if managers are the sole decision makers of this process. It was also evident that rotation should be setting dependent. This therefore includes the acknowledgement of the need for a speciality and best practice models for different health care settings. Therefore, flexibility and care in the application of rotation where effective bottom-up consultation should be necessitated.

Key finding 16: Models for cultural competence is needed in social work in health care.

Conclusion: Participants highlighted the need for cultural competence models. Health care settings seem to encounter and treat diverse clientele. These patients may also include non-South African citizens. Participants all indicated that in the absence of culturally competent models they utilise their own skills and experiences of which respect and dignity seem to be the core fundamentals. Participants also indicated that with cultural awareness, spiritual and religious views need to be incorporated.

A challenge with acknowledging culture, religious or spiritual views is that it is embraced by the SDA, especially with regard to self-determination but not enforced by legislation. This lack of models therefore places social workers in health care in a precarious position to navigate challenging situations.

Key finding 17: Hopeful vision and need for social work in health care

Conclusion: Participants were generally hopeful about the future of the social work in health care. The dominant perceptions were that the MDT will not be able to function without social workers. A strong expression for the conferment of social work in health care as an esteemed profession and a specialist field is required. The indication for more social workers to be employed in health care settings, is suggestive of more efficiency in addressing and the resolving the SDH and thereby addressing the SDA.

Key finding 18: Threats to the future of social work in health care are evident

Conclusion: Threats to social work in health care are influenced by social work in health care being viewed as a non-counselling profession and exit member of the MDT who is solely involved in discharge planning and placements. As a result, it was reported that MDT members assume the role of social work. Furthermore, the OSD and PMDS were highlighted as two distinct processes that aim to diminish social work in health care. As was highlighted the criteria for social work of the PMDS has diminished the role of social work to that of auxiliary workers. Hence, this gives rise to the perceived motivation to employ auxiliary workers rather than social workers.

Key finding 19: Guidelines for the application and implementation of the SDA and the SDH is necessary for social work in health care

Conclusion: Participants indicated the need for guidelines which provides clear guidance on the application of the SDA in the diverse health care settings. In addition, guidance in clarifying and addressing the SDH is needed. The guidelines will provide clarity, minimise uncertainty and enhance the application of the SDA and addressing the SDH by social workers in health care. This research study explored elements of a possible guideline. What was evident from respondents and participants were that the guideline should contain main assumptions of the approaches as well as practical indications of applications and implementations.

11.5 Recommendations

11.5.1 Recommendations for a guideline

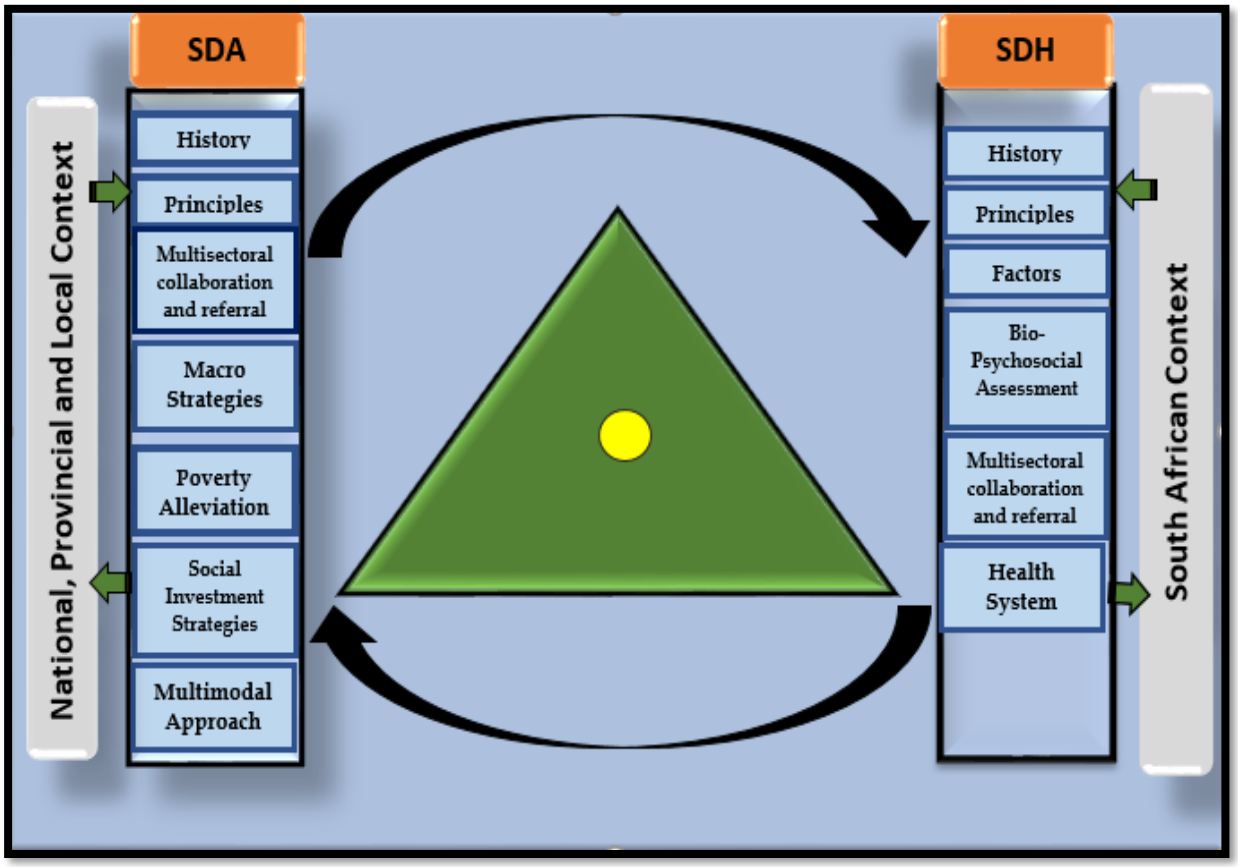


Figure 11.1: Diagrammatical representation of the guideline

As based on the needs expressed by the respondents and participants the researcher suggested that a possible guideline, as diagrammatically represented in figure 11.1, should encompass service delivery, rotation, cultural competence, policy implementation, consultation, a bottom-up approach to leadership, staffing, workload, becoming quality driven, acknowledgement of being a specialisation , being recognised as an equal member of the MDT, dictation of own roles and reaffirming the counselling role. The suggested guideline first acknowledges the policies, legislation and context of South Africa. These aspects are important for the enactment and expectations of the social work role in health care. Social workers therefore need to be well informed about these aspects. It should be noted as the South African context and legislation

changes so the guideline needs to be updated. The guideline is specifically necessitated for the implementation of the SDA and addressing of the SDH. Each side of the diagram highlights both the SDA and the SDH, the core fundamentals that should be clearly understood and applied. In the centre is the services typology as modified from Payne's typology (2005, 2014). Table 10.1 in chapter 10 aids health care settings to identify the dominant services offered. In addition, as per the request of the participants the researcher developed various models of rotation as pertaining to service delivery.

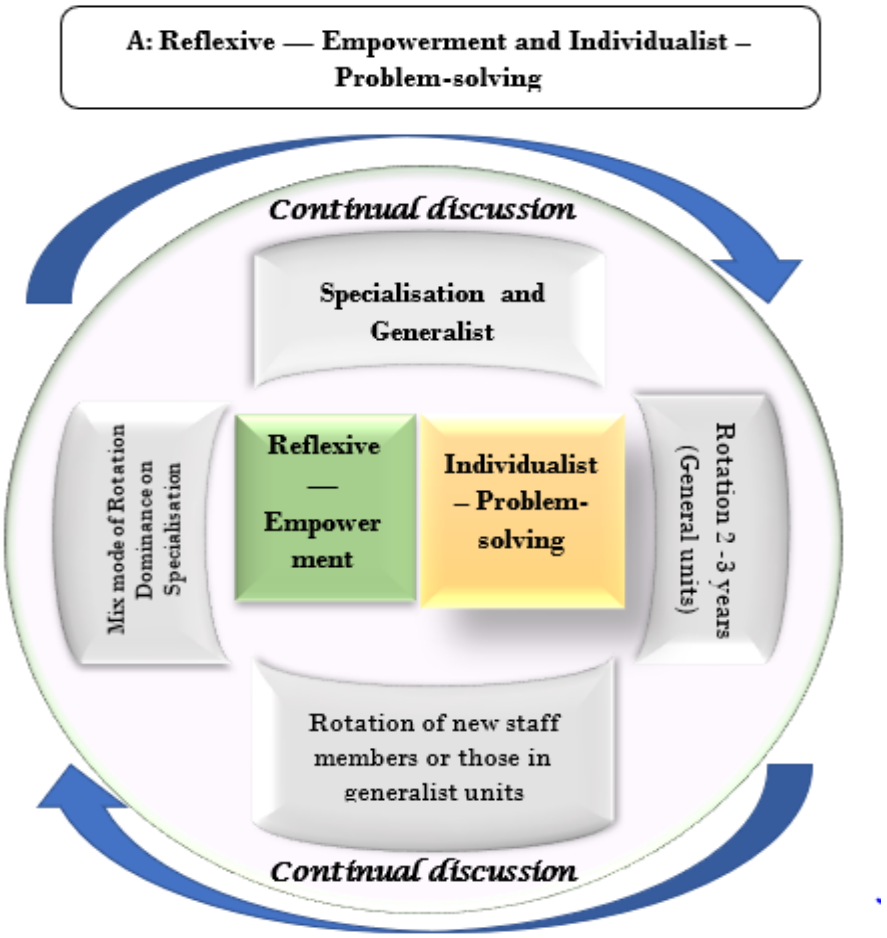


Figure 11.2 Reflexive – empowerment and individualist – problem-solving services

Figure 11.2 depicts the combinations of reflexive – empowerment and individualist – problem-solving services, according to the participants, is dominantly in the employ of the GDH. Linked to these services are the rotation models that may be employed.

This social work services may be offered depending on the health care setting and needs of patients within the South African context. Each health care setting will modify their own services typology and rotation plans. The core fundamental assumption of this guide is that social work services, the social work role, needs of patients, the application of the SDA and the SDH are all connected and influenced by the context. Several other options are provided in chapter 10.

Considering the above the research recommends that the formulations of services, rotation and essentials of the SDA and addressing of the SDH, as outlined in chapter 10 be considered for implementation.

11.5. 2 Recommendations for the GDH and policy implementation

Social workers in health care should be regarded as the experts of their profession and be consulted and not the DSD or other non-social workers. It is important that a bottom-up approach be used in addressing these matters especially in consulting social workers about changes regarding their roles but also to generally engage on their perceptions of their roles in health care and exploring how to position social work for the future.

In acknowledging and enforcing social work in health care as a profession and a specialist area it will be less likely that role changes will be enforced. Social workers need to be recognised as invaluable professionals. This will hopefully deter policy makers and officials to prescribe roles to social workers without prior consultation.

The matter of the removal of designated power should be investigated. If it is a matter of social workers in health care have difficulty enacting statutory work due to the health setting; then the '*non-use' or 'non-enactment'* of the statutory power is understandable. If this is the result that social workers in health care are stripped of these powers, then this needs to be urgently corrected

as this is a gross violation and a contravention of the basic powers bestowed by the social work degree. It is not logical that a newly graduated social worker may practice these powers and not an experienced social worker that is employed in a health care setting. Could this removal of designated powers be a punitive strategy to aggrieve social workers in health care to feel less valued and accomplished than their counterparts in the DSD? In this regard perhaps also the DSD needs to refrain from directing the roles of social workers in health care. The GDH needs to strengthen their team, currently under the Directorate Special Programmes, to direct the social work roles in health care.

Additionally, government or the GDH needs to explore the value of developing a framework to address the SDA and the SDH within health care. Firstly, these strategies should be linked with the entire transformation of the health sector and not just social work. Currently, the biggest source for contradiction and disconnect is the fact that certain policies or SOP are only levied at social workers. The result is that there is a disconnect with the rest of the team that does not enable these changes. The example of this is the home visits policy for social work that requires nurses to accompany the social worker and patient. The nurses however do not have permission or a policy in this regard.

It is also imperative that the GDH investigate the need for more social workers in health care. Social workers in health care work under extreme pressures in terms of high workloads and is quantity driven with a minimum ratio of 1:60 (i.e., one social worker to 60 new patients per month), thereby preventing social workers of expressing their counselling role. Social workers in health care are ideally placed to enact the SDA by addressing the SDH. It will therefore be worthwhile for the South African government to explore the feasibility of employing more social workers in health care to meet the social development mandate. Social workers in health care settings are ideally positioned to address the SDH, thereby implementing the SDA and uplifting the people.

This position needs to be capitalised upon. In considering the above, resource challenges such as office space for social workers in health care should be resolved.

An extensive training programme should also be either developed, encouraged or supported by the GDH to equip social workers with the knowledge of the SDA and the SDH as well as offer practical application geared at the different types of health care settings. The application of the SDH needs to be also clarified within the health care sector with the development of appropriate resource structures.

Further attempts should be made to generate appropriate culturally competent models or models for dealing with diversity that may include religion as well. These models need to be informative and provide clear directions for social work in health care. The link with appropriate legislation should be highlighted.

Due the differing opinions about rotation, the social work departments in the GDH should identify the areas, wards or units of each health care setting that should be highlighted as areas of specialities. Rotation should then be applied to those sections that do not offer specialist services. This will perhaps aid the development of service excellence centres. Additionally, rotation practices should be re-evaluated in terms of the impact it may have on the profession.

On a national level, Government, as in line with WHO regulations should explore the necessity of implementing HiAP. This implementation will ensure that nationally the principles and strategies of the SDH will essentially be applied to the entire South Africa.

11.5.3 Recommendations for academia

Participants were unequivocal that social work in academia will need to play an instrumental role in repositioning social work in health care. It is therefore suggested that academic departments reconsider the area of social work in health care to develop specialist courses and postgraduate degrees. In addition, academia will need to promote the social work profession as an instrumental profession in South Africa to enhance the application of the SDA by addressing the SDH. To fulfil this, academia will need to provide extensive awareness, training and development on these matters.

It is furthermore suggested that social work in academia liaise with the GDH and the SACSSP in the repositioning of social work in health care but also to empower the social workers in health care with the knowledge of the SDA and the SDH. In addition, social work in academia needs to clarify the position of the removal of designated powers and resolve this violation. The establishment of a multisectoral collaborative committee with the GDH and the SACSSP is suggested.

11.5.4 Recommendations for the SACSSP

Suggestions aimed at the SACSSP is to advocate for the social work profession and especially social work in health care. The SACSSP needs to be actively developing models of cultural competence and frameworks of how social workers in the various sectors (including health) should apply the SDA. The SACSSP needs to conclude that social work in health is an area of speciality but also work on more definite measures or formal qualifications to formalise this specialisation.

11.5.5 Recommendations for social work in health care

The social workers in health care need to become more proactive in voicing their opinion and demanding respect in their sector. Perhaps social action strategies should be considered in

redressing violations or enforcement of role changes. The need to advocate for their role by creating awareness amongst the MDT members. Social workers in health care should be personally committed to uplift the image of social work in health care by professionally presenting the profession and continually marketing the service delivery.

Further, the report writing process needs to be enhanced to include or highlight if the principles of the SDA and the SDH were considered or addressed. This may be a good reference guide for further exploration and application of the SDA and the SDH. This may also then enable social workers in health care to be more connected to the use of terminologies associated with these approaches.

The social work fraternity in health needs to ensure that correct procedures of consultation are followed and where this does not occur; measures should be reinforced to ensure this occurs. Open and honest discussion with social work management should be encouraged. The social work management should embrace effective and responsive leadership principles in leading social work in health care.

Flexible models of rotation that is setting responsive and dependent should be implemented. This needs to also be an open discussion. It is suggested that a development plan is developed by every social worker, where the social worker directs the process, take into consideration the needs, specialisation and growth. If the social worker is more experienced; specialisation should be encouraged versus an entry level social worker who still needs to adapt and learn. It is also suggested that entry level social workers are not placed in specialist units. The social work supervisors and managers should assist social workers where necessary in formulating developmental or growth plans.

Additionally, but importantly the supervisors and managers need to be trained about human resource management, management and effective leadership strategies. Compulsory training and continual assessment on these matters for supervisors and managers are suggested. Managers should be evaluated on these activities and where anomalies are indicated the GDH needs to address this. Empowering supervisors and managers with appropriate training will only strengthen the social work profession and its accountability in health care and with patients. Social work supervisors and managers should protect and enforce the value of the social work profession. This implies a proactive and zealous response to demands from the MDT, hospital management and the GDH, that may demean the profession. The supervisors' or managers' role should therefore not be to install punitive measures that may discourage staff but to uplift the social work profession by enabling the social workers.

Even though the GDH was levied with developing frameworks and models, the social work profession in health care should in the interim establish task groups that may start to compile models that may aid social workers. In addition, training may also be provided to social workers to clarify confusion and fulfil their needs. Linking with social work in academia may also aid this process.

11.5.6 Recommendations for future research

Future research may focus on how social work in health care may reposition itself from being viewed as an exit worker or non-counselling professional to an equal member of the MDT. Perhaps the exploration of official specialist qualifications to operate in health settings should be undertaken. Developed countries, like America has a specialist qualification as a requirement to practice social work in health settings. The feasibility of such structural changes to social work in health care in the South African context should be explored.

Further research in the application of the SDH to the health sector may be envisaged. In particular research on HiAP and its implication on the entire context should explore this.

Research on appropriate social work management skills required and training needed to reposition social work in health care as a specialist profession may also offer valuable contribution to the profession and on human resource management.

In acknowledging rotation, research may be facilitated to address the association of rotation with a specialised skilled profession. Considering different models that will not detract from the specialist nature of social work in health care will be imperative.

The strengthening of multisectoral collaborations with health care settings and diverse stakeholders that transcends boundaries, communities and provinces is required in offering holistic and comprehensive health care. This is specifically geared at those health care settings that treats patients from different areas that may be across provinces.

The role of the SACSSP in the application of the SDA and the SDH may also be explored. The SACSSP should represent the social work profession. Research in this area may further highlight the role and contribution to be made by the SACSSP.

REFERENCE LIST

Reference List

African Institute for Health and Leadership Development. (2015). *Minimum data sets for human resources for health and the surgical workforce in South Africa's health system.* Africa: African Institute for Health and Leadership Development.

Alase, A. (2017). The interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. *International Journal of Education and Literacy Studies, 5* (2), 9-19. http://dx.doi.org/10.7575/aiac.ijels.v.5n.2p.9T

Ali, M., & Rafi, M.A.S. (2013). Medical social work in Pakistan: A multi-model approach to collaborative practice in health care settings. *SAVAP International, 4*(4), 355-363. http://www.savap.org.pk/journals/ARInt./Vol.4(4)/2013(4.4-38).pdf

American Heritage Dictionary of the English Language. (2020). Health care. In *American Heritage Dictionary of the English Language* (5th ed.). Houghton Mifflin: Harcourt Publishing Company. Retrieved January 5, 2020, from https://ahdictionary.com/word/search.html?q=health+care

Ashcroft, R. (2014). An evaluation of the public health paradigm: A view of social work. *Social Work in Public Health, 29*(6), 606 – 615.

Ashcroft, R., & Van Katwyk, T. (2016). An examination of the biomedical paradigm: a view of social work. *Social Work in Public Health, 31*(3), 140-152.

Amukwelele, D. (2017). *Views of social workers on implementation of child maltreatment prevention services in Namibia*. [Masters Dissertation, University of Stellenbosch].

https://scholar.sun.ac.za/bitstream/handle/10019.1/101006/amukweele_views_2017.pdf

Ataguba, J. E.O., Day, C., & McIntyre, D. (2015). Explaining the role of the social determinants of health on health inequality in South Africa. *Global Health Action, 8* (10.3402/gha.v8.28865), 1-11, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4575416/pdf/GHA-8-28865.pdf

Auerbach, C., Mason, S.E., & LaPorte, H.H. (2007). Evidence that Supports the Value of Social Work in Hospitals. *Social Work in Health Care, 44* (4), 17 – 32. doi:10.1300/J010v44n04_02. http://swhc.haworthpress.com.

Auslander, G. (2001). Social work in health care: What have we achieved? *Journal of Social Work, 1*(2), 201–222.

Australian Association of Social Workers (AASW). (2016a). *Social work in hospital based health care*. Melbourne, Australia: AASW.

Australian Association of Social Workers (AASW). (2016b). *Scope of social practice: Hospital social work.* Melbourne, Australia: AASW.

Avert.org. (2020, March 19). *HIV and AIDS in South Africa*. https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/south-africa

Babbie, E., & Mouton, J. (2001). *The practice of social research*. South Africa: Oxford University Press.

Backwith, D., & Mantle, G. (2009). Inequalities in health and community- oriented social work. Lessons from Cuba. *International Social Work, 52*(4), 499–511. https://journals.sagepub.com/doi/abs/10.1177/0020872809104253?journalCode=iswb

Bamford, L.J., McKerrow, N.H., Barron, P., & Aung, Y. (2018). Child mortality in South Africa: Fewer deaths, but better data are needed. *South African Medical Journal, 108*(3a), s25-s32. DOI:10.7196/SAMJ.2017.v108i3b.12779

Bamford, T. (2015). *A contemporary history of social work: Learning from the past*. Bristol: Policy Press.

Barber, R. D., Coulourides – Kogan, A., Riffenburgh, A., & Enguidanos, S. (2017). A role for social workers in improving care setting transitions: A case study. *Social Work Health Care, 54*(3), 177–192. doi:10.1080/00981389.2015.1005273.

Barker, R.L. (1991). *The social work dictionary* (2nd ed.). USA: NASW Press.

Barnes, B.R. (2012). Using mixed methods in South African psychological research. *South African Journal of Psychology, 42*(4), 463 – 475. https://doi.org/10.1177/008124631204200402

Beauregard, R. A. (2012). What theorists do? *Urban Geography, 33*(4), 474 - 487.

Benatar, S.R. (1997). Health care reform in the new South Africa. *The New England Journal of Medicine, 336* (12), 891 – 895.

Bentley, K. J. (2002). *Social work practice in mental health*. America: Brooks Cole/ Cengage Learning.

Bernard, H.R. (2013). *Social research methods: Qualitative and quantitative approaches* (2nd ed.). Thousand Oaks: SAGE Publications.

Bertha Centre for Social Innovation & Entrepreneurship. (n.d.). *Country profile: South Africa a descriptive overview of the country and health system context including the opportunities for innovation.* Rondebosch: University of Cape Town.

Beytell, A.M. (1994). *Die ontwikkeling van 'n assesserings program vir geneeskundige maatskaplike werkers.* [Masters Dissertation, University of Johannesburg]. http://hdl.handle.net/10210/10118.

Beytell, A.M. (2002). *A community based model for health care social work.* [Doctoral Dissertation, University of Johannesburg]. http://hdl.handle.net/10210/1244

Bhattacharya, S. (2010). The World Health Organisation and the social determinants of health: Assessing theory, policy and practice. In S. Bhattacharya, S. Messenger, & C. Overy. *Social determinants of health assessing theory, policy and practice* (pp. 1 – 10). India: Orient Black Swan Private Limited.

Borst, J. M. (2010). *Social work and health care. Policy, practice and professionalism*. Boston: Allyn and Bacon.

Boyle, D. P. & Springer, A. (2001). Toward a cultural competence measure for social work

with specific populations. *Journal of Ethnic and Cultural Diversity in Social Work, 9* (3-4), 53 - 71. DOI: 10.1300/J051v09n03_03.

Bradshaw, D. (2008). Determinants of health and their trends: Primary health care in context. *South African health review,* 1 (1), 51 – 69. https://www.ingentaconnect.com/content/sabinet/healthr/2008/00002008/00000001/art00007

Bronner, S.E. (2011). *Critical theory: a very short introduction*. Oxford: Oxford University Press.

Brown, O., Goliath, V., Van Rooyen, D.R.M., Aldous, C. & Marais, L.C., (2018). Cultural factors that influence the treatment of osteosarcoma in Zulu patients: Healthcare professionals' perspectives and strategies. *Health SA Gesondheid, 23*(0), a1095. http://doi.org/10.4102/hsag.v23i0.1095.

Brown, M. & Neku, R. J. (2005). A historical overview of the South African social welfare system and social work practitioners' views on its current status. *International Social Work, 48*(3), 301 - 312. https://doi.org/1177/0020872805051733.

Browne, T.A. (2006). Social work roles and health care settings. In S. Gehlert. & T.A. Browne. (Eds). *Handbook of health social work* (pp. 23 – 42)**.** New Jersey: John Wiley & Sons Inc.

Bryant, A., & Charmaz, K. (2010) Grounded theory in historical perspective. In A. Bryant &

K. Charmaz (Eds.). *The SAGE handbook of grounded theory* (pp. 31 – 57). London: SAGE Publications.

Bryman, A., Bell, E., Hirschson, P., dos Santos, A., Du Toit, J., Masenge, A., van Aardt, I., & Wagner, C. (2014). *Research Methodology. Business and management contexts*. Southern Africa: Oxford University press.

Burr, V. (2015). *Social constructionism* (3rd ed.). London: Routledge Taylor& Francis Group.

Bywater, P., & Davis, C. (2012). Social work and Health. In L.M. Healy & R.J. Link (Eds). *Handbook of international social work* (pp. 217 - 230). Oxford: Oxford University Press.

Bywaters, P., & Ungar, M. (2013). Health and wellbeing In I. Shaw, K. Briar – Lawson, J. Orme & R. Ruckdeschel. *The SAGE handbook of social work research* **(**pp. 392-405**).** Los Angeles: SAGE Publications.

Carbonatto, C.L. (2019). Social work in health care in South Africa. In R. Winnett, R. Furman, D. Epps & G. Lamphear (Eds.). *Health care social work: A global perspective* (pp.173 -188). USA: Oxford University Press.

Carbonatto, C.L., & Du Preez, M.S.E. (2001). A guideline for the preparation of couples undergoing artificial fertilization with donor gametes. *The Social Work Practitioner-Researcher, 13*(2), 79 – 97.

Chipare, M. A., Mupazvihwo, T., Tapera, R., & January. J. (2020). The practice of clinical social work in Namibia: A review of literature. *Medical Journal of Zambia*, *47*(3), 235 – 240. https://mjz.co.zm/index.php/mjz/article/view/706

Chitereka, C. (2010). Hospital social work practice in Zimbabwe. *Social work in health care, 49* (9), 769 - 782. http://doi.org/10.1080/00981381003744957

Cleak, H.M., & Turczynski, M. (2014). Hospital social work in Australia: Emerging trends or more of the same. *Social Work in Health Care*, *53*(3), 199 - 213. https://pubmed.ncbi.nlm.nih.gov/24628115/

Coleman, H., & Unrau. Y.A. (2005). Analyzing qualitative data. In R.M. Grinnell, & Y.A. Unrau (Eds). *Social work research and evaluation: quantitative and qualitative approaches* (7th ed.) (pp. 403 – 420). Oxford: Oxford University Press.

Collins Dictionary. (2015). Medical social worker. In *Collins Dictionary*. Retrieved January 5, 2020, from http://www.collinsdictionary.com/dictionary/english/medical-social worker

Conmy, A. (2018). South African health care system analysis. *Public Health Review*, *1*(1), 1-8

Constitution of the Republic of South Africa. (1996). Cape Town: Constitutional Assembly.

Corcoran, J., & Secret, M. (2013). *Social work research skills workbook. A step by step guide to conducting agency- based research*. Oxford: Oxford University Press.

Craig, S.L., Bejan, R., & Muskat, B. (2013). Making the invisible visible: Are health social

workers addressing the social determinants of health? *Social Work in Health Care, 52(4),* 311 - 331.

Creswell, J.W. (2003). *Research design. qualitative, quantitative and mixed methods approaches (2nd ed.).* California: SAGE Publications.

Creswell, J.W. 2008. *Research design. qualitative, quantitative and mixed methods approaches (3rd ed.).* California: SAGE Publications.

Creswell, J.W. (2009). *Research design. qualitative, quantitative and mixed methods approaches (3rd ed.).* California: SAGE Publications.

Creswell, J.W. (2013). *Qualitative inquiry & research design. Choosing among the five approaches* (3rd ed). Thousand oaks, California: Sage Publications Incorporated.

Creswell, J.W. (2018). *Research design. qualitative, quantitative and mixed methods approaches* (4th ed.). California: SAGE Publications. http://fe.unj.ac.id/wp-content/uploads/2019/08/Research-Design_Qualitative-Quantitative-and-Mixed-Methods-Approaches.pdf

Cullen, A.F. (2013). Leaders in our own lives: Suggested indications for social work leadership from a study of social work practice in a palliative care setting. *British Journal of Social Work, 43,* 1527 – 1544.

Dant, T. (2003). *Critical social theory*. London: SAGE Publications.

Darnell, J.S., & Lawlor, E.F. (2006). Health policy and social work. In S. Gehlert. & T.A. Browne. (Eds). *Handbook of health social work* (pp. 123 - 152)**.** New Jersey: John Wiley & Sons Inc.

Davidson, A. (2015). *Social determinants of health: A comparative approach*. Canada: Oxford University Press.

Davis, C., Milosevic, B., Baldry, E., & Walsh, A. (2005). Defining the role of the hospital social worker in Australia. *International Social Work, 48*(3), 289 – 299. DOI:10.1177/0020872805051732

Dennill, K, King, L., & Swanepoel, T. (2007). *Aspects of primary health care* (2nd ed.). Oxford: Oxford University Press.

Denzin, N. K., & Lincoln, Y.S. (2018). Introduction: The discipline and practice of qualitative research. In N.K. Denzin & Y.S. Lincoln. *The SAGE handbook of qualitative research* (5th ed.) (pp.1 – 26). Los Angeles: SAGE Publication.

Department of Health. (1997). *White paper for the transformation of the health system in South Africa notice 667 of 1997*. South Africa: Department of Health. https://www.gov.za/sites/default/files/gcis_document/201409/17910gen6670.pdf.

Department of Health (2019) Annual report 2018/ 2019. Gauteng Province: Department of Health. https://provincialgovernment.co.za/department_annual/780/2019-gauteng-health-annual-report.pdf

Department of Social Development (DSD). (2006 a). *SA retention and recruitment strategy for Social Workers.* South Africa: Department of Social Development.

Department of Social Development (DSD). (2006b). *Integrated service delivery model*. South Africa: Department of Social Development.

Department of Social Development (DSD). (2008). *Social Services Professions and Occupations Bill*. South Africa**.** Department of Social Development **http://www.ci.uct.ac.za/sites/default/files/image_tool/images/367/Law_reform/SSPB_Jan_2008.pdf**

Department of Social Development (DSD). (2019a). *Department of Social Development. Annual report 2019.* Republic of SA: Department of Social Development. https://www.dsd.gov.za/index.php/documents/category/28-annual-reports

Department of Social Development (DSD). (2019b). *Social Services Practitioners Bill*. South Africa: Minister of Social Development. **https://www.dsd.gov.za/index.php/ssp-draft-bill?task=download.send&id=85&catid=43&m=0**

Department of the Prime Minister. (1978). *The Social Service Professions Act*. (1978). (Act No. 110 of 1978). Cape Town: Department of the Prime Minister. https://www.sacssp.co.za/documents/Social%20Service%20Professions%20Act%20110%20of%201978%20(2019).pdf

Department of Welfare. (1997). *White Paper on Social Welfare, Notice 1108 of 1997.*

Cape Town. Department of Welfare. https://www.gov.za/sites/default/files/gcis_document/201409/whitepaperonsocialwelfare0.pdf

De Vos, A.S., & Strydom, H. (2011). Scientific theory and professional research. In A.S. De Vos, H., Strydom, C.B., Fouché & C.S.L. Delport. *Research at grassroots* (4th ed.) (pp. 24 – 44). Pretoria: Van Schaik.

FindDX.org. (2020). *South Africa Healthcare profile*. South Africa. https://www.finddx.org/wp-content/uploads/2020/01/5A_South-Africa_Healthcare-profile.pdf

Fouché, C.B., & Delport, C.S.L. Introduction to the research process. In A.S. De Vos, H. Strydom, C.B. Fouché & C.S.L. Delport. *Research at grassroots* (4th ed.) (pp. 61 - 76). Pretoria: Van Schaik.

Fouché, C.B., & Schurink, W. (2011). Qualitative research design. In A.S. De Vos, H. Strydom, C.B. Fouché & C.S.L. Delport. *Research at grassroots* (4th ed.) (pp. 307 – 327). Pretoria: Van Schaik.

Dhemba, J., & Marumo, M. (2016) Social work practice in Lesotho's Ministry of Social Development. In M. Gray (ed.). *The Handbook of Social Work and Social Development in Africa (*pp. 49 - 58). London, UK: Roulegde.

Dhooper, S. S. (2012). *Social work in health care. Its past and future* (2nd ed.). Los Angeles: SAGE Publications.

Dlamini, T.T., & Sewpaul, V. (2015). Rhetoric versus reality in social work practice: Political, neoliberal and new managerial influences. *Social Work/Maatskaplike Werk, 50* (4) (1), 467 – 481. http://dx.doi.org/51-3-461

Dlangamandla, V. P. (2010). *The experiences of social workers regarding the implementation of a developmental social welfare approach within the Department of Social Development Gauteng Province.* [Master's Dissertation, University of Pretoria]. https://repository.up.ac.za/bitstream/handle/2263/27338/dissertation.pdf?sequence=1

Donkin, A., Goldblatt, P., Allen, J., Nathanson, V., & Marmot, M. (2017). Global action on the social determinants of health. *BMJ Glob Health, 3*(e000603), 1 – 7. doi:10.1136/ bmjgh-2017-000603. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5759713/pdf/bmjgh-2017-000603.pdf

Doostgharin, T. (2010). Inequalities in health care and social work intervention: The case of Iran. *International Social Work, 53*(4), 556–567. DOI: 10.1177/0020872809355363.https://journals.sagepub.com/doi/10.1177/0020872809355363

Drower, S. J. (2002). Conceptualizing social work in a changed South Africa. *International Social Work, 45* (1) 7 – 20.

Earle, N. (2008). *Social work in social change: The profession and education of social workers in South Africa.* South Africa: Human Sciences Research Council. http://hdl.handle.net/20.500.11910/5554

Eatough, V., & Smith, J.A. (2008). Interpretative Phenomenological Analysis. In C. Willig &

W. Stainton-Rogers. *The SAGE handbook of qualitative research in psychology*. (pp. 179-194). Los Angeles: SAGE Publications.

e.hospice. com. (2018, October 17). *Social workers' perception of their role in providing palliative care: Namibia*. https://ehospice.com/africa_posts/social-workers-perception-of-their-role-in-providing-palliative-care-namibia/

Elder-Vass, D. (2012). *The reality of social construction*. Cambridge: Cambridge University Press.

Elliot, D. (2012). Social development and social work. In L.M. Healy & R.J. Link. *Handbook of international social work* (pp. 102 – 108)**.** Oxford: Oxford University Press.

Engel, R.J., & Schutt, R.K. (2014). *Fundamentals of social work research* (2nd ed.)**.** Los Angeles: SAGE Publications**.**

Engelbrecht, L.K. (1999). *Introduction to social work*. Cape Town: Lanzo.

Estes, R.J. (1998, June 28 – July 2). Developmental social work: A new paradigm for a new century. *10th International symposium of the Inter-University Consortium for International Social Development*, Cairo, Egypt.

Eshetu, E.B., & Woldesenbet, S.A. (2011). Practice Points Are there particular social determinants of health for the world's poorest countries? *African Health Sciences, 11* (1), 108 - 115. http://www.bioline.org.br/pdf?hs11017

Fairfax, C.N., & Feit, M.D. (2015). How policy improves health. *Social work in public health, 30*(5), 410 - 422. DOI: 10.1080/19371918.2015.1034002. http://dx.doi.org/10.1080/19371918.2015.1034002

Farlex Partner Medical Dictionary. (2012). Medical care. *Farlex and partners*. Retrieved January 5, 2020, from http://medical-dictionary.thefreedictionary.com/medical+care

Forde, I., & Raine, R. (2008). Placing the individual within a social determinants approach to health inequity. *Lancet, 372* (9650):1694 – 1696. doi:10.1016/S0140-6736(08)61695-5.

Fort Cowles, L.A. (2003). *Social work in the health field: A care perspective* (2nd ed.). Oxford: Routledge.

Freeman, R.J. (2017). *Social workers' perceptions of their role in providing palliative care to patients with life- limiting illnesses: A qualitative study among social workers in primary care settings in Namibia.* [Doctoral Dissertation. UNISA, South Africa]. http://hdl.handle.net/10500/24340

Freeman, T. (2006). Best Practice in focus group research: Making sense of different views. *Methodological Issues in Nursing Research, 56*(5), 491 – 497**.**

Friel, S., & Marmot, M.G. (2011). Action on the social determinants of health and health inequities goes global. *Annual Review of Public Health, 32,* 225 - 236. doi: 10.1146/annurev-publhealth-031210-101220. https://www.annualreviews.org/doi/pdf/10.1146/annurev-publhealth-031210-101220

Gauteng Legislature. (2020). *Annual performance plan 2019/2020.* Johannesburg: Gauteng Provincial Legislature. http://gpl.gov.za/wp-content/uploads/2020/01/FINAL-ANNUAL-PERFORMANCE-PLAN-2019-2020-v6.pdf

Gauteng Provincial Government. (2019). *Annual report 2018/2019.* Gauteng: Gauteng Provincial Government.

Gavin, H. (2008). *Understanding research methods and statistics in psychology*. Los Angeles: SAGE Publications.

Gehlert, S. (2006). The conceptual underpinnings of social work in health care. In S. Gehlert. & T.A. Browne. (Eds). *Handbook of health social work* (pp. 1 - 22)**.** New Jersey: John Wiley & Sons Inc.

Greeff, M. (2011). Information collection: interviewing. In A.S. De Vos, H., Strydom, C.B., Fouché, & C.S.L. Delport. *Research at grassroots* (4th ed.) (pp. 341 – 375). Pretoria: Van Schaik.

Gribbin, R., & Sadana, R. (2010). A summary of key policy actions to address the social determinants of health. In S. Bhattacharya, S. Messenger, & C. Overy. *Social determinants of health assessing theory, policy and practice* (pp. 24 – 37). India: Orient Black Swan Private Limited.

Giles, R. (2009). Developing a health equality imagination. Hospital practice challenges for social work priorities. *International Social Work, 52*(4), 525- 537.

Glaister, A. (2008). Introducing critical practice. In S. Fraser & S. Matthews (Ed.). *The critical practitioner in social work and health care* (pp. 8 – 24). Los Angeles: SAGE Publications.

Gray, M. (2002). Developmental social work: A strengths' praxis for social development. *Social Development Issues, 24*(1), 4-14.

Gray, M. (2010). Social development and the status quo: professionalisation and the third way co potation. *International Journal of Social Welfare, 19* (4), 463 - 470. Blackwell Publishing Ltd.

Gray, M. (2014). Theories of social work practice. In L. Nicholas, J. Rautenbach & M. Maistry. *Introduction to social work* (pp. 75 – 103). Claremont: Juta and Company LTD.

Gray, M., & Lombard, A. (2008). The Post-1994 Transformation of social work in South Africa. *International Journal of Social Welfare, 17*, 132–145.

Grbich, C (2012). Qualitative data analysis: an introduction. London: SAGE Publications. https://www.sagepub.com/sites/default/files/upm-binaries/50313_Grbich_Chapter_1.p

Greeff, M. (2011). Information collection: interviewing. In A.S. De Vos, H. Strydom, C.B. Fouche & C.S.L. Delport. *Research at grassroots* (4th ed.). Pretoria: Van Schaik.

Gregorian, C. (2008). A career in hospital social work. *Social Work in Health Care, 40*(3), 1 - 14.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.). *Handbook of qualitative research* (pp. 105-117). Thousand Oaks, CA: SAGE Publications. https://eclass.uoa.gr/modules/document/file.php/PPP356/Guba%20&%20Lincoln%201994.pdf

Gubrium, J.F., & Holstein, J.A. (2008). The constructionist mosaic In J.A. Holstein & J.F. Gubrium. *Handbook of Constructionist Research* (pp. 3 – 10). New York: The Guilford Press.

Health Systems Trust. (2013). *The National health care facilities baseline audit: national summary report 2012.* Westville, SA: Health Systems Trust.

Hall, A., & Midgley, J. (2004). *Social policy for social development*. London: SAGE publications limited.

Harris, J., &White, V. (2013). *Oxford dictionary of social work and social care*. Oxford: Oxford University Press.

Heiman, H. J., & Artiga, S. (2015) *Beyond Health care: the role of social determinants in promoting health and health equity.* Washington: The Henry Kaiser family foundation.

Hesse-Biber, S.N., & Leavy, P. (2011). *The practice of qualitative research* (2nd ed.). Los Angeles: SAGE Publications.

Heywood, N. (2014, September 1). *The broken thread: primary health care, social justice and*

dignity of the health care worker. Johannesburg: WiSER, History workshop and Wits political studies.

Hill, M., & Hupe, P. (2014). *Implementing public policy. An introduction to the study of operational governance.* London: SAGE Publications.

Hochfeld, T., Selipsky, L., Mupedziswa, R., & Chitereka, C. (2009). *Research report: Developmental social work and education in Southern and East Africa*. Johannesburg: Centre for Social Development in Africa, University of Johannesburg.

Hölscher D. (2008). The Emperor's new clothes: South Africa's attempted transition to developmental social welfare and social work. *International Journal of Social Welfare, 17*, 114–123.

Homfeldt, H.G., & Reutlinger, C. (2008). Social Development. *Social Work and Society International Online Journal,6* **(**2). http://www.socwork.net/sws/article/view/70/372.

Houston, S. (2009). Jürgen Habermas. In M. Gray & S. A. Webb. *Social work theories and methods* (pp. 13 – 22). London: SAGE publications.

Hornsby, A.S. (2015). *Oxford advanced learners' dictionary* (9th ed). Oxford: Oxford University Press.

Hugman, R. (2009). But is it social work? Some reflections on mistaken identities. *British Journal of Social Work, 39***,** 1138 – 1153.

International Federation of Social Workers. (2020). *Global definition of social work*. Retrieved from http://ifsw.org/get-_involved/global-definition-of-social-work/

Irvy, J., Lawrence, F. P., Damron-Rodriguez, J., & Robbins, V. (2005). fieldwork rotation: A model for educating social work students for geriatric social work practice. *Journal of Social Work Education, 41*(3), 407 – 425. doi: 10.5175/JSWE.2005.020040428. https://doi.org/10.5175/JSWE.2005.020040428

Israel, M., & Hay, I (2006). *Research ethics for social scientists*. London: SAGE Publications.

Jack, G. (2012). Ecological perspective In M. Gray, J. Midgley, & S.A. Webb. *The SAGE handbook of social work* (pp. 129 – 142). Los Angeles: SAGE Publications.

James, W. (2002). *Pragmatism: A new name for some old ways of thinking.* The Project Gutenberg eBook of Pragmatism.

Jacques, G. (1993). Social work practice in Botswana: principles and relevance. *Journal of Social Development in Africa, 8*(1): 31 – 49. http://digital.lib.msu.edu/projects/africanjournals/

Johnson, P. L. (2004). Mixed methods, mixed methodology health services research in practice. *Qualitative Health Research, 14* (2), 259-271.

Johnson, S., Abonyi, S., Jeffery, B., Hackett, P., Hampton, M., McIntosh, T., Martz, D., Muhajarine, N., Petrucka, P., & Sari, N. Recommendations for action on the social determinants of health: A Canadian perspective. *Lancet, 372*, 1690–1693.

Jones, D. N., & Truell, R. 2012 The global agenda for social work and social development: a place to link together and be effective in a globalized world. *International Social Work 55*(4), 454 - 472. DOI:10.1177/0020872812440587

Jongman, K. (2014, August 26). A history of social work in Botswana – and why the future looks bleak. *Social care network.* https:// www.thegardian.co./social-care-network/2014/aug/26/social-work-bostwana-history-future

Jongman, K., & Tshupeng, M. (2020). Unregulated social work practice in Botswana: A risk to professional integrity and clients' welfare. *Journal of Education, Society and Behavioural Science, 33*(4), 1 - 10. https://journaljesbs.com/index.php/JESBS/article/view/30212/56689

Kar, N. (2011) Ethics in research. *The Odisha journal of psychiatry*, *18*(1): 23 – 28. https://journals.indexcopernicus.com/search/article?articleId=1855881

Kaseke, E. (1987, March). Social work in Zimbabwe. A short country statement ASWEA 6th Annual General Meeting. Abidjan. https://core.ac.uk/download/pdf/43540917.pdf

Kaseke, E. (1991). Social work practice in Zimbabwe. *Journal of Social Development in Africa*, *6*(1), 33 - 45. http://digital.lib.msu.edu/projects/africanjournals/

Kaseke, E. (2015). Repositioning social workers in South Africa for a developmental state. *International Social Work, 60*(2), 470-478. DOI: 10.1177/0020872815594216

Kautzky, K., & Tollman, S. M. (2008). A Perspective on Primary Health Care in South Africa. In *South African Health Review* (pp.17 – 30). South Africa Health Systems Trust. https://www.hst.org.za/publications/South%20African%20Health%20Reviews/2%20A%20Perspective%20on%20Primary%20Health%20Care%20in%20South%20Africa%20SAHR%202008.pdf

Keefe, R.H. (2010). Health disparities: A primer for public health social workers. *Social Work in Public Health, 25*, 237–257. DOI: 10.1080/19371910903240589

Keefe, R.H., Lane, S.D., & Swarts, H.J. (2006). From the bottom up. *Journal of Health & Social Policy, 21*(3), 55 – 69. http://dx.doi.org/10.1300/J045v21n03

Kirst – Ashman, K.K. & Hull, G. H. (2010). *Understanding generalist practice*. Australia: Brooks/ Cole Cengage Learning.

Krueger, R.A. (1998). *Moderating focus groups: focus group kit 4*. Thousand Oaks, California: SAGE Publications.

Kurevakwesu, W. (2017). The social work profession in Zimbabwe: A critical approach to the position of social work on Zimbabwe's development. *Afro Asian Journal of Social Sciences, 8* (1)(1), 1 – 19. *https://www.slideshare.net/WilberforceKurevakwe/the- social-work-profession-in-zimbabwe-a-critical-approach-on-the-position-of-social- work-on-zimbabwes-development*

Larkin, M., & Thompson, A. R. (2012). Interpretative Phenomenological Analysis in Mental Health and Psychotherapy. In D. Harper & A. R. Thompson (Eds.). *Qualitative*

research methods in mental health and psychotherapy: A guide for students and practitioners, (pp. 101 – 116). United Kingdom: John Wiley & Sons, Ltd.

Leech, N. L., & Onwuegbuzie, A.J. (2009). A typology of mixed methods research designs**.** *Quality & Quantity, 43,* 265–275.

Leroux. A. W. (1964). *'n Ondersoek van hospital maatskplike werk gebaseer op 'n ondersoek van dienste van die Nasionale Hospitaal te Bloemfontein, die Groote Schuur Hospitaal Kaapstad en die Algmene Hospital in Pretoria*. [M Dissertation University of Orange Free state Bloemfontein.]

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry.* Newbury Park, London: Sage Publications.

Lincoln, Y.S., Lynham, S.A., & Guba E.G. (2018) Paradigmatic controversies, contra dictations and emerging confluences, revisited. In N.K. Denzin & Y.S. Lincoln. *The SAGE handbook of qualitative research* (5th ed.) (pp.108 – 150). Los Angeles: SAGE Publication.

Liamputtong, P. (2012). *Focus group methodology: Principles and practice*. Los Angeles: SAGE Publications.

Litosseliti, L. (2003). *Using focus groups in research*. London: Continuum.

Loh, J. (2013). Inquiry into issues of trustworthiness and quality in narrative studies: A perspective. *The Qualitative Report, 18,* 1 – 15.

Lombard, A. (2000). Professional status of social work. *Social Work/ Maatskaplike Werk, 36* (4), 311 – 331.

Lombard, A. (2008). The impact of social transformation on the non-government welfare sector and the social work profession. *International Journal of Social Welfare, 17,* 124 –131.

Lombard, A., & Wairire, G. (2010). Social work academic, developmental social work in South Africa and Kenya: Some lessons for Africa. *The Social Work Practitioner-Researcher, Special Issue, April,* 98 – 111. http://www.researchgate.net/publication/268178816

Lopez, K.A., & Willis. D.G. (2004) Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative Health Research, 14* (5), 726 - 735. DOI: 10.1177/1049732304263638

Mckendrick, B.W. (2001). The promise of social work: Direction for the future. *Social work Maatskaplike werk, 31*(1), 105 - 111.

Mackenzie, N. & Knipe, S. (2006). Research dilemmas: Paradigms, methods and methodology. *Issues in Educational Research, 16.* http://iier.org.au/iier16/mackenzie.html

Manyeli, T. (2007) The Evolution of Social Welfare in Lesotho. *Lesotho Social Science Review, 11*(1 & 2), 21-32.

Marmot, M. (2005). Social Determinants of health inequalities. *Lancet, 365,* 1099 – 1104. https://www.ncbi.nlm.nih.gov/pubmed/15781105

Masuka, T. (2015). Transforming social work in Zimbabwe from social control to social change, Southern African. *Journal of Social Work and Social Development*, 27(2), 204 - 219. https://doi.org/10.25159/2415-5829/368

Margolis J. (2007). *Pragmatism without foundations. Reconciling, realism and relativism* (2nd ed.). London: continuum international publishing group

Matsoso, M.P., & Strachan, B. (2011) Human resources for health for South Africa: HRH strategy for the health sector 2012/ 13 – 2016/17. *South African Health Review, 2011* (1), 49 – 58**.**

Maundeni, T. (2009). Care for children in Botswana: The social work role. *Social work and society international online journal, 7 (1).* https://www.socwork.net/sws/article/view/41/344.

McLeod, S. A. (2008). *Likert scale.* https://www.simplypsychology.org/likert-scale.htm

Meyerovitz, S. G. (1988). *Adaptation of hospital social workers to work demands in general hospitals.* [MA dissertation University of Witwatersrand, Johannesburg].

Midgley, J. (1995). *Social development. The developmental perspective in social welfare***.** London: Sage Publications.

Midgley J. (2001). South Africa: the challenge of social development. *International Journal of Social Welfare, 10,* 267–275.

Midgley, J. (2009) The definition of social policy J. Midgley & M. Livermore (Eds.). *The Handbook of social policy* (pp. 3 – 20). Los Angeles: Sage Publications.

Midgley J. (2010). Global debates and the future of social development. *The Social Work Practitioner - Researcher, Special Issue,* 8 – 23.

Midgley, J. (2012). Welfare and social development. In M. Gray, J. Midgley & S.A. Webb. *The SAGE handbook of social work* (pp. 94 – 108)**.** Los Angeles: SAGE Publications

Midgley J. (2014). *Social development: Theory and practice*. London: SAGE Publications.

Midgley, J. & Conley, A. (2010). *Social work and social development*. Oxford: Oxford University Press.

Miller, R.M. & Minton, C.A.B. (2016). Interpretative phenomenological analysis: A contemporary phenomenological approach. *Boise State University Scholar Works, 1*(1), 1 - 11. https://scholarworks.boisestate.edu/cgi/viewcontent.cgi?article=1111&context=counsel_facpubs

Mindel, C. (2005). Designing measuring instruments. In R.M. Grinnell & Y.A. Unrau (Eds). (2005). *Social work research and evaluation: quantitative and qualitative approaches* (7th ed.) (pp.134 – 145)**.** Oxford: Oxford University Press.

Ministry of Health and Social Services. (2010). *National Health Policy Framework 2010-2020*. Ministry of Health and Social Services: Windhoek.

https://extranet.who.int/countryplanningcycles/sites/default/files/country_docs/Namibia/namibia_national_health_policy_framework_2010-2020.pdf

Ministry of Health and Social Services. (2011). *Regulations relating to the scope of Social workers, social auxiliary workers and students.* Republic of Namibia: Windhoek. https://www.hpcna.com/images/councils/social/Scope/4656%20Social%20Workers%20scope%20of%20practice.pdf

Modisane, D.S., & Carbonatto, C.L. (2001). Working with black SLE patients: a challenge to medical social work. *Social Work/ Maatskaplike Werk, 37*(2), 143 – 153.

Moniz, C. (2010). Social work and the social determinants of health perspective: A good fit. *Health and Social Work, 35*(4), 310 - 313

Morgan, D. L (1998). *The focus group guidebook.* Thousand Oaks, CA: Sage Publications.

Morgan, D. (2007). Paradigms lost and pragmatism regained. Methodological implications of combining qualitative and quantitative methods. *Journal of Mixed Methods, 1*, 48 – 57.

Morse, J.N., & Niehaus, L. (2009). *Mixed method design. Principles and procedures.* California: Left Coast Press.

Mosby's dictionary of medicine, nursing and health professions (7th ed.). (2006). United Kingdom: Mosby Elsvier.

Mosby's Medical Dictionary. (2009). Medical care. In *Mosby's Medical Dictionary (8th ed.)*. Elsevier. http://medical- dictionary.thefreedictionary.com/medical+care

Mouton, J. (1996). *Understanding social research*. Pretoria: Van Schaik Publishers.

Nardi, P.M. (2006). *Doing survey research: a guide to quantitative methods.* Boston: Pearson Education Incorporated.

National Department of Health. (2019). Uniform patient fee schedule: Classification of patients. South Africa: National Department of Health. www.health.gov.za › uniform-patient-fee-schedule › category

National Association of Social Workers (NASW). (2009). *Social Work & Health Care Reform.* Washington: National Association of Social Workers. **www.socialworkers.org**

National Association of Social Workers (NASW). (2015). *Standards and indicators for cultural competence in social work practice.* Washington: National Association of Social Workers.

National Association of Social Workers NASW Center for Workforce Studies and Social Work Practices. (2011). *Social workers in hospitals & medical centers: Occupational profile.* Washington: National Association of Social Workers.

National Planning Commission. (2011). *National Development Plan: Vision for 2030*. South Africa: National Planning Commission

Neuman, W.L. (2003). *Social research methods. Qualitative and quantitative approaches* ***(5th ed.)***. Boston: Allyn and Bacon.

Neuman, W.L. (2014). *Basics of social research: qualitative and quantitative approaches* (3rd ed.). Essex: Pearson Education Limited.

New Dictionary of Social Work. (n.d.). Parow, Cape Town: CTP Book Printers.

Newfoundland and Labrador Association for Social Workers (NFLASW). (2016). *The social determinants of health: A social work perspective.* https://nlcsw.ca/sites/default/files/inline-files/Social_Determinants_of_Health.pdf.

Nhapi, T.G., & Dhemba, J. **(**2020). Embedding the developmental approach in social work education and practice to overcome poverty: The case of Southern Africa. *Greenwich Social Work Review*, 1(1), 11 – 20. https://doi.org/10.21100/gswr.v1i1.1103

Nicholas, L. (2014). The history of South African social work. In L. Nicholas, J. Rautenbach & M. Maistry. *Introduction to social work* (pp. 40 – 47). Claremont: Juta and Company LTD.

Noon, E. J. (2018) Interpretive phenomenological analysis: An appropriate methodology for educational research. *Journal of perspectives in applied academic practice, 6* (1), 75 - 83.

Noyoo, N. (2015a). Introduction to the concepts of social development In L. Calvelo, R.

Lutz, & F. Ross. *Sozialarbeit des Südens Band 6*. Oldenburg: Paulo Freire Verlag. https://www.researchgate.net/publication/291832115

Noyoo, N. (2015b). Social development in Southern Africa. In L. Calvelo, R. Lutz, & F. Ross. *Sozialarbeit des Südens Band 6.* Oldenburg: Paulo Freire Verlag. https://www.researchgate.net/profile/Ndangwa_Noyoo/publication/291832087_Social_Development_in_Southern_Africa/links/56a722fc08ae997e22bb9aed.pdf

Okoye, U. O. (2013). *Trends and challenges of social work practice in Nigeria*. Research gate. https://www.researchgate.net/publication/267868332

Olver, C., Schaay, N., Sanders, D., & Kruger, V. (2011). *Overview of health sector reforms in South Africa.* London: DFID Human Development Resource Centre and UKAID.

Omotoso, K. O., & Koch, S.F. (2018). Assessing changes in social determinants of health inequalities in South Africa: A decomposition analysis. *International Journal for Equity in Health*, *17* (181), 1 – 13. https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-018-0885-y

Onwuegbuzie, A.J., Frels, R.K., & Hwang, E. (2016). Mapping Saldaňa's Coding Methods onto the literature review process. *Journal of Educational Issues, 2* (1), 130 – 150. doi:10.5296/jei.v2i1.8931. http://dx.doi.org/10.5296/jei.v2i1.8931

Ornellas, A., Spolander, G. & Engelbrecht, L.K. (2016). The global social work definition: Ontology, implications and challenges. *Journal of Social Work, 0*(0), 1 – 19. DOI.10.1177/1468017316654606

Padget, D.K. (2008). *Qualitative methods in social work research* (2nd ed.). Los Angeles: SAGE Publications.

Patel, L. (2010). *Social welfare and social development in South Africa*. Southern Africa: Oxford University Press.

Patel, L. (2015). *Social welfare and social development in South Africa* (2nd ed.). Southern Africa: Oxford University Press.

Payne, M. (2005). *Modern social work theory* (3rd ed.). United Kingdom: Palgrave Macmillan.

Payne, M. (2014). *Modern social work theory* (4th ed.). United Kingdom: Palgrave Macmillan.

Perlman, F. (2010). Reflections on the Final Report of the Commission on Social Determinants of Health. In S. Bhattacharya, S. Messenger, & C. Overy. *Social determinants of health assessing theory, policy and practice* (pp. 274 - 293). India: Orient Black Swan Private Limited.

Pecukonis, E. V., Cornelius, L., & Parrish, M. (2003). The Future of Health Social Work. *Social Work in Health Care, 37* (3), 1- 15

Petersen, L. (2015). Social Work in primary Health care In U. Brizay, R. Lutz, & F. Ross. *Sozialarbeit des Südens Band 5*. Oldenburg: Paulo Freire Verlag.

Pietkiewicz, I. & Smith, J.A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal, 20* (1), 7 - 14. DOI:10.14691/CPPJ.20.1.7

Pockett, R. & Beddoe, L. (2015). Social work in health care: an international perspective. *International Social Work, 60* (1), 126 - 139. DOI: 10.1177/0020872814562479. https://doi.org/10.1177%2F0020872814562479

Potgieter, A., & Hoosain, S. (2018). Parents' experiences of family reunification services. *Social Work/Maatskaplike Werk, 54* (4) (4), 438 – 451. http://dx.doi.org/10.15270/54-4-671

Puchta, C. & Potter, J. (2004). *Focus Group Practice*. London: Sage Publications.

Reiners, G.M. (2012). Understanding the differences between Husserl's (descriptive) and Heidegger's (interpretive) phenomenological research. *Journal of Nursing Care, 1* (5), 1-3. http://dx.doi.org/10.4172/2167-1168.1000119

Reyn, A. (2005). Ethical Issues. In C. Seale, G. Gobo, J.B. Gubrium and D. Silverman. *Qualitative Research Practice* (pp. 230 – 247). London: SAGE Publications.

Rescher, N. (2012). *Pragmatism: Restoration of its scientific roots*. New Brunswick (USA): Transaction Publishers.

Riaz, S., & Sarfaraz, S.D. (2015). Need and importance of medical social work practice in Pakistan with special reference to Karachi City. *Advance Social Sciences Research*

Journal, 2 (12), 73 - 80. https://journals.scholarpublishing.org/index.php/ASSRJ/article/view/1705/pdf_272

Rine, C.M. (2016). Social determinants of health: Grand challenges in social work's future. *Health Soc Work,41*(3), 143 – 145. doi: 10.1093/hsw/hlw028 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4985885/pdf/hlw028.pdf

Rispel, L., & Moorman, J (2010). Health legislation and policy: Context, process and Progress. *South African Health Review, 2010* (1) 127 – 141.

Rispel, L., & Nieuwoudt, S. (2012/ 2013). Mainstreaming the social determinants of health in South Africa: Rhetoric or reality? *South African Health Review, 2012.2013,* 89 – 101.

Robbins, S.P., Chatterjee, P., & Canda, E.R. (2012). *Contemporary human behaviour: A critical perspective for social work* (3rd ed.). Boston: Allyn and Bacon.

Ross, E., & Deverell, A. (2010). *Health, illness and disability psychosocial approaches* (2nd ed.). Pretoria: Van Schaik Publishers.

Rubin, A., & Babbie, E. (2005). *Research methods for social work* (5th ed). Australia: Thomson Brooks Cole.

Rubin, A., & Babbie, E. (2014). *Research methods for social work* (8th ed). Belmont, California: Brooks/Cole Cengage Learning

Ruel, E., Wagner, W. E., & Gillespie, B.J. (2016). *The Practice of Survey Research: Theory and Applications.* Thousand Oaks, California: SAGE Publications https://dx.doi.org/10.4135/9781483391700

Ruff, B., Mzimba, M., Hendrie, S., & Broomberg, J. (2011) Reflections on health care reforms in South Africa. *Journal of Public Health, 32*(1), 184 - 192 www.palgrave-journals.com/jphp/

Ruth, B.J., & Marshall, J. W. (2017). A History of Social Work in Public Health, *Am J Public Health, 107*(3), 236 – 242. doi:10.2105/AJPH.2017.304005

South African Council for Social Services Professionals (SACSSP) (2008). *SACSSP Final Draft.* https://www.google.co.za/?gfe_rd=ctrl&ei=EVk0U6WGE5Dd8geHs4DYCQ&gws_rd=cr#q= specialization+in+health+care+sacssp+

South African Council for Social Services Professionals (SACSSP). (2014). *Policy guidelines for course of conduct, code of ethics and rules for social workers.* https://socialdev.mandela.ac.za/socialdev/media/Store/documents/SACSSP-Code-of-Ethics.pdf

Saldaña, J. (2009). *The coding manual for qualitative researchers*. London: SAGE Publications.

Saloner, K.L. (2002). Rising to the challenge: The critical role of social workers in the face of the HIV/ AIDS pandemic. *Social Work/ Maatskaplike Werk, 38*(2), 154 – 160.

Sapsford, R. (2007). *Survey Research* (2nd ed.). London: Sage Publications

Schild, D. R., & Sable, M.R. (2006). Public Health and Social Work. In S. Gehlert. & T.A. Browne. (Eds). *Handbook of health social work* (pp. 70 – 122)**.** New Jersey: John Wiley & Sons Inc.

Schmidt, K., & Rautenbach, J.V. (2015). Field instruction: is the heart of social work education still beating in the Eastern Cape? *Social Work/Maatskaplike Werk, 52* (4) (8), 589 – 610. http://dx.doi.org/10.15270/52-2-532

Schneider, R. L., & Netting, F. E. (1999). Influencing social policy in a time of devolution: Upholding social work's great tradition. *Social Work*, *44*(4), 349 – 357

Schurink, W., Fouché, C.B., & De Vos, A. S. (2011). Qualitative data analysis and interpretations. In A.S. De Vos, H. Strydom, C.B. Fouché & C.S.L. Delport. *Research at grassroots* (4th ed.) (pp. 397 – 424). Pretoria: Van Schaik.

Scott, V., Schaay, N., Schneider, H., & Sanders, D. (2017) Addressing social determinants of health in South Africa: The journey continues, *South African Health Review*, *2017* (1), 77 – 88. https://www.hst.org.za/publications/South%20African%20Health%20Reviews/8_Addressing%20social%20determininants%20of%20health%20in%20South%20Africa_the%20journey%20continues.pdf

Schrecker, T., Labonté, R., & De Vogli, R. (2008). Globalisation and health: The need for a global vision. *Lancet*, *372*, 1670 – 1676.

Segal, E.A., Gerdes, K.E., & Steiner, S. (2018). *An Introduction to the profession of social work. Becoming a change agent* (6th ed.)**.** Australia: Cengage Learning.

Segen's Medical Dictionary. (2012). Hospital social worker. In *Segen's Medical Dictionary* Farlex, Incorporated. Retrieved January 5, 2020, from http://medical-dictionary.thefreedictionary.com/hospital+social+worker

Shah, S.R., & Al-Bargi, A. (2013). Research paradigms: Researchers' worldviews. Theoretical frameworks and study designs. *Arab World English Journal*, *4*(4), 252 – 264.

Shaw, T.C. (2012). Beyond Access: Extending Our Thinking on Health Policy Social Work. *Public Health, 27* (6), 554 – 566. DOI: 10.1080/19371910903183128

Steketee, G., Ross, A.M., & Wachman, M.K. (2017). Health outcomes and costs of social work services: A systematic review. *American Journal of Public Health, 107*(3), 256 – 266. doi:10.2105/AJPH.2017.304004. https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304004

Skidmore, R.A., Thackeray, M.G., & Farley, O.W. (1994). *Introduction to Social Work*. Englewood USA: Prentice Hall International, Inc.

Sloan, A., & Bowe, Brian (2014). Phenomenology and hermeneutic phenomenology: The philosophy, the methodologies and using hermeneutic phenomenology to investigate lecturers' experiences of curriculum design. *Quality & Quantity, 48* (3), 1291 - 1303. doi:10.1007/s11135-013-9835-3

Smith, J.A. (2011) Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, *5* (1), 9 – 27. https://doi.org/10.1080/17437199.2010.510659

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* Los Angeles: SAGE Publications.

Smith. L. (2013). *Social work education: Critical imperatives for social change.* [Doctoral Dissertation University of Witwatersrand, Johannesburg]. http://wiredspace.wits.ac.za/bitstream/handle/10539/12875/PhD%20Thesis%20Linda%20Smith%20first%20part.pdf?sequence=1

Smith L. (2014). Historiography of South African social work: challenging dominant discourses. *Social Work/Maatskaplike Werk, 50 (*3) (1), 305 – 331. http://dx.doi.org/10.15270/50-2-401

Somekh, B., & Lewin, C. (2011) *Theory and methods in social research.* Los Angeles SAGE publications.

Southern African HIV Clinicians Society. (2014). Guideline adult antiretroviral therapy guidelines. *SAJHIVMED, 15* (4), 121 - 143 https://sahivsoc.org/Files/2014%20Adult%20ART%20Guideline%20(Dec%202014).pdf

Spies, M. (2007). *The biopsychosocial factors influencing HIV/ AIDS patients in adherence to antiretroviral (ART): A social work study*. [Doctoral thesis. University of Pretoria, Pretoria.]

Stewart, D. W., & Shamdasani, P.N. (2015). *Focus groups theory and Practice* (3rd ed) Thousand Oaks, CA: SAGE Publications.

Stewart, D. W., Shamdasani, P.N., & Rook, D.W. (2007). *Focus groups theory and Practice* (2nd ed) Thousand Oaks, CA: SAGE Publications.

Steyn, H., & Green, S. (2010). The Laryngectomy Patient's view of work support services in a hospital setting. *Social Work/ Maatskaplike Werk, 46*(1), 88-106.

Strydom, H. (2011). Ethical aspects in the social sciences and human services professions. In A.S. De Vos, H., Strydom, C.B., Fouché & C.S.L. Delport. *Research at grassroots* (4th ed.) (pp. 113 – 129). Pretoria: Van Schaik.

Sue, V.M., & Ritter, L. A. (2012). *Conducting online surveys*. Los Angeles: SAGE Publications.

Tammivaara, J., & Shepard, K.F. (1990 Theory: The guide to clinical practice and research physical therapy. *Physical Therapy, 70*(9),578 - 582. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.573.1953&rep=rep1&type=pdf

Tanga, P. T. (2013) Challenges of social work field training in Lesotho. *Social Work Education-The International Journal*, *32*(2), 157 - 78.

The Concise Oxford Dictionary. (1997). Oxford: Oxford University Press.

Rossouw, J. (2017 February 16). Why social grants matter in South Africa: They support 33% of the nation. *The Conversation*. https://theconversation.com/why-social-grants- matter-in-south-africa-they-support-33-of-the-nation-73087

Farlex. (2020). Social worker. In *The Free Dictionary***.** Farlex Incorporated. Retrieved January, 5, 2020, from http://medical- dictionary.thefreedictionary.com/social+worker

The Oxford Concise Dictionary. (2010). Oxford: Oxford University Press.

Toseland, R. W., & Rivas, R. F. (2017). *Introduction to Group Work Practice (*8th ed.). Boston: Pearson.

Truell, R., & Jones, D. N. (2012) *The global agenda for social work and social development: extending the influence of social work.* International Federation of Social work (IFSW). http://cdn.ifsw.org/assets/ifsw_24848-10.pdf

United Nations (UN) General Assembly. (2011). *Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non- communicable Diseases.* New York: UN. https://undocs.org/en/A/66/L.1

United Nations (UN) General Assembly. (2013). *Resolution adopted by the General Assembly on 12 December 2012 [without reference to a Main Committee (A/67/L.36 and Add.1)] 67/81. Global health and foreign policy*. New York: UN. https://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/67/81

United Nations (UN). (2019). *The sustainable development goals. Report 2019*. New York: UN. https://unstats.un.org/sdgs/report/2019/The-Sustainable-Development-Goals-Report-2019.pdf

University of Minnesota. (2012). *Dictionary of Social Work.* Retrieved from http://health.umt.edu/socialwork/Master%20of%20Social%20Work/Curriculum/SocialWorkDictionary_booklet_updated_2012_Oct23.pdf

Vassos, S., & Connoly, M. (2014). Team-based Rotation in Social Work Field Education: An Alternative Way of Preparing Students for Practice in Statutory Child Welfare Services. *Communities, Children and Families Australia, 8*(1), 49-66.

Vassos, S., Harms, L., & Rose, D. (2018). Supervision and social work students: relationships in a team-based rotation placement model. *Social Work Education, 37,* (3),328 – 341. https://doi.org/10.1080/02615479.2017.1406466

Vassos, S., Harms, L., & Rose, D. (2019). Exploring Rotation Placements for Social Work: A Focus on Student and Supervisor Experiences. *Journal of Social Work Education, 55 (2), 280 – 283.* https://doi.org/10.1080/10437797.2018.1520666

Venturino, M. (2013). *Health care reform in the US and in South Africa: Does new policy cure the disease or merely alleviate the symptoms? Policy brief Africa*. South Africa: Institute of South Africa.

Walsh, J. (2009). *Generalist social work practice. Intervention methods*. USA: Brooks/Cole Cengage Learning.

Williams, M., Tutty, L., & Grinnell R.M. (2005). Analyzying quantitative data. In R.M. Grinnell, R.M. & Y. A. Unrau, (Eds). *Social work research and evaluation: quantitative and qualitative approaches (7th ed.)* (pp. 353 – 3690). Oxford: Oxford University Press.

Weyers, M. (2011). *Theory and practice of community work: A Southern African perspective* (2nd ed.). Potchefstroom, South Africa: Keurkopie.

Winnett, R., Furman, R. Epps, D., & Lamphear G. (2019). An introduction to health care social work. In R. Winnett, R. Furman, D. Epps & G. Lamphear (Eds.). *Health care social work: A global perspective* (pp.1 - 18). USA: Oxford University Press.

World Health Organization (WHO). (2007). *Counting health workers: Definitions, data, methods and global results.* Department of Human Resources for Health, World Health Organization. https://www.who.int/hrh/documents/counting_health_workers.pdf?ua=1

World Health Organization (WHO). (2008). *Commission on Social Determinants of health final report: Closing the gap in a generation.* World Health Organisation.

https://apps.who.int/iris/bitstream/handle/10665/69832/WHO_IER_CSDH_08.1_eng.pdf;jsessionid=7E56AB3E1EC67C3D65FD000F746DA3D7?sequence=1

World Health Organization (WHO). (2010). *Equity, social determinants and public health programmes.* World Health Organisation. https://books.google.co.za/books?isbn=9241563974

World Health Organization (WHO). (2011 October 21). *Rio Political Declaration on Social Determinants of Health*. Rio de Janeiro, Brazil: WHO. https://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf?ua=

World Health Organization (WHO). (2014). *A universal truth: No health without a workforce.* World Health Organisation. https://www.who.int/workforcealliance/knowledge/resources/GHWA-a_universal_truth_report.pdf?ua=1

World Health Organization (WHO). (2015). *Global action on the social determinants of health to address health equity. Supplementary report on progress in implementing the Rio Political Declaration on social determinants of health and WHA65.8.* https://www.who.int/social_determinants/implementation/WHA68_sdh-resolution65-8-May2015.pdf

World Health Organization (WHO) Commission on Social Determinants of Health (CSDH). (2007a). *Achieving health equity: from root causes to fair outcomes*. Switzerland: Commission on Social Determinants of Health, WHO. ww.who.int/**social_determinants**/en/

World Health Organization (WHO) Commission on Social Determinants of Health (CSDH). (2007b). *Final report knowledge network on health systems*. Switzerland: Commission on Social Determinants of Health (WHO). www.who.int/**social_determinants**/en/

World Health Organization (WHO) Technical Brief No 1. (2008). *Integrated health services. What and why?* World Health Organization. *www.who.int/**health**systems/technical_brief_final.pdf*

APPENDICES

APPENDIX A

HUMAN RESEARCH COMMITTEE ETHICAL PERMISSION

Appendix A: Human Research Ethics Permission

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Research Office

HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)
R14/49 Petersen

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: H18/02/32**
PROJECT TITLE	Social Work in Health Care: A social development approach
INVESTIGATOR(S)	Ms L Petersen
SCHOOL/DEPARTMENT	Human and Community Development/
DATE CONSIDERED	16 February 2018
DECISION OF THE COMMITTEE	Approved
EXPIRY DATE	20 June 2021

DATE 21 June 2018 **CHAIRPERSON** J-Meijer (Professor J Knight)

cc: Supervisor : Dr E Pretorius

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University. Unreported changes to the application may invalidate the clearance given by the HREC (Non-Medical)

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to completion of a yearly progress report.**

Signature Date 21/06/2018

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

APPENDIX B

PERMISSIONS FROM DEPARTMENT OF GAUTENG HEALTH

City of Ekurhuleni

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

EKURHULENI HEALTH DISTRICT RESEARCH PERMISSION

Research Project Title: Social Work in Health Care: A Social Development Approach.

NHRD No: GP_201901_009

Research Project Number: 14/02/2019-05

Name of Researcher(s): Ms Laetitia Petersen

Division/Institution/Company: University of Witwatersrand

Date of review by the EHDRC: 14 February 2019

DECISION TAKEN BY THE EKURHULENI HEALTH DISTRICT RESEARCH COMMITTEE (EHDRC)

- This document certifies that the above research project has been reviewed by the EHDRC and permission is granted for the researcher(s) to commence with the intended research project.
- Facilities approved for the research: Ekurhuleni Metropolitan Municipality Offices.
- study period and when disseminating the findings.
- No resources (financial, material and human resources) from the health facilities will be used for the study. Neither the district nor the health facilities will incur any additional cost for the study.
- The study will comply with Publicly Financed Research and Development Act 2008 (Act 51 of 2008) and its related regulations.

- The EHDRC must be informed in writing before publication or presentation of research findings and a copy of the report/publications/presentation must be submitted to the EHDRC
- The district must be acknowledged in all the reports/publications generated from the research.
- The researcher will be expected to provide the EHDRC with
  - Six monthly progress updates including any adverse events
  - The final study report in electronic format
  - Present the final research findings at the annual Ekurhuleni research conference if possible.
- The EDHRC reserves the right to withdraw the approval, if any of the conditions mentioned above have being breached
- The research committee wishes the researcher(s) the best of success.

DR. J. SEPUYA

DEPUTY CHAIRPERSON: CITY OF EKURHULENI

Dated: 14/02/2019

Dr. R. Kellerman

CHAIRPERSON: GAUTENG DEPARTMENT OF HEALTH (EKURHULENI HEALTH DISTRICT)

Dated: 14/02/2019.

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enq: Mpho Ngubane
016 950 6255
016 950 6210
E-mail: Mpho.Ngubane@gauteng.gov.za

TO : **MS. L. PETERSEN**
WITS UNIVERSITY

FROM : **MR. C. MATSANENG**
CHIEF DIRECTOR: SEDIBENG DHS

DATE : **05 NOVEMBER 2019**

SUBJECT : **PERMISSION TO CONDUCT RESEARCH – SOCIAL WORK IN HEALTH CARE: A SOCIAL DEVELOPMENT APPROACH.**

Please be informed that permission has been granted for you to carry out the abovementioned research at Sedibeng District Municipality Offices. It is noted that you have already obtained Provincial Ethics Committee as well as the WITS University Research Ethics Clearance.

Kindly note that a copy of the report on the findings (especially) that concerns Sedibeng District must be submitted to the Chief Director's office at the completion of the study.

This permission is also subject to the conditions stated in the protocol and any change in design and methodology must be communicated to the Chief Director.

We wish you success in your research endeavours.

RECOMMENDATION

- It is recommended that with the condition that the survey tool, will be distributed by the Researcher or Research Assistant and not employees of the District or Department of Health (DOH).
- The Researcher should be mindful of the research fatigue as she/he will repeatedly use the same participants group for the different phase/interviews in the study.
- On the bases above, the Researcher is advised to use the services of the Research Assistant to minimise time of service interruption

RECOMMENDED/NOT RECOMMENDED/ RECOMMENDED as AMENDED

PROF. B. OMOLE
CHAIRPERSO: SEDIBENG RESEARCH COMMITTEE

APPROVED/ NOT APPROVED/APPROVED as AMENDED

MR. C. MATSANENG
CHIEF DIRECTOR: SEDIBENG DHS
DATE: 15/11/2019

RESEARCH PROPOSAL DETAILS: GP_201901_009

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Mpho Moshime-Shabagu
Tel: +27 12 451 9036
E-mail: Mpho.Moshime@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE: CLEARANCE CERTIFICATE

DATE ISSUED: 28/08/2019
PROJECT NUMBER: 53/2019
NHRD REFERENCE NUMBER: GP_201901_009

TOPIC: Social Work in Health Care: a Social Development Approach

Name of the Researcher:	Laetitia Petersen
Name of the Supervisor:	Dr Edmarie Pretorius
Facilities:	Tshwane District
Name of the Department:	University of the Witwatersrand

NB: THIS OFFICE REQUEST A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE AND

NOTE THAT RESUBMISSION OF THE PROTOCOL BY RESEARCHER(S) IS REQUIRED IF THERE IS DEPARTURE FROM THE PROTOCOL PROCEDURES AS APPROVED BY THE COMMITTEE.

DECISION OF THE COMMITTEE: APPROVED

.....
Mr. Peter Silwimba
Deputy Chairperson: Tshwane Research Committee

Date.....30/8/19

.....
Mr. Mothomone Pitsi
Chief Director: Tshwane District Health

Date: 2019.09.02

Annexure 1

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DECLARATION OF INTENT FROM THE PHC MANAGER FOR TSHWANE PROVINCIAL CLINICS

I give preliminary permission to **Ms *Laetitia Petersen*** to do his or her research on **"*Social Work in Health Care: a Social Development Approach*"** in **Tshwane Offices**

I know that the final approval will be from the Tshwane Regional Research Ethics Committee and that this is only to indicate that the clinic/hospital is willing to assist.

Other comments or conditions prescribed by the PHC Manager to the Researcher are

The researcher to have an entry meeting with potential facilities before starting with the data collection.

DR. SL PHOSHOKO
ACTING PRIMARY HEALTH CARE: TSHWANE
Date:

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Dr. M.C. Louw
Tel: 011 531- 4305
Fax: 011 531-4377
Date: 11 September2019

Laetitia Petersen

RE: SOCIAL WORK IN HEALTH CARE: A SOCIAL DEVELOPMENT APPROACH

The study "Social Work in Health Care: A Social Development Approach" has reference.

Social Work in Health Care: A Social Development Approach is supported and permission is granted for the study (GP_201901_009) to be conducted at Sizwe Tropical Disease Hospital.

Kind regards

Dr. M.C. Louw
CEO: Sizwe Tropical Disease Hospital

GAUTENG HEALTH DEPARTMENT
Sizwe Tropical Disease Hospital
Private Bag X2
Sandringham
2131
DR. M. C. LOUW
Chief Executive Officer
Date: 11 September 2019

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

SOUTH RAND HOSPITAL
1 Friars Hill Road, Rosettenville, 2149

ENQUIRIES:
Office of the CEO
T: 011 681 2004
M: 071 872 6649
E: Nobantu.Maleka@gauteng.gov.za

To: Laetitia Petersen

RE: RESEARCH STUDY IN SOCIAL WORK IN HEALTH CARE: A SOCIAL DEVDELOPMENT APPROACH

The above noted study has been noted and approved. The research may be undertaken at South Rand Hospital. South Rand Hospital pledges to provide the required support in terms of access as well as guidance should it be required.

Regards.

Dr M.N. Maleka
CEO: South Rand Hospital
Date: 27 August 2019

South Rand Hospital
Friars Hill Rd

APPENDIX C

PARTICIPANT INFORMATION SHEET - SURVEY

Appendix C: Participant Information Sheet - Survey

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3, Wits, 2050 • Tel: 011 717 4472 • Fax: 011 717 4473 • E-mail: socialwork.SHCD@wits.ac.za

Social Work in Health Care: A Social Development Approach

Dear Potential Participant

My name is Laetitia Petersen, a doctoral student at the University of the Witwatersrand, Johannesburg. My doctoral research focuses on the exploration of the implementation of the Social Development Approach to Social Work in Health Care. It is hoped that this exploration will provide clarity regarding how the Social Development Approach has been implemented in health care settings or how it should be implemented as well as your experience with regard to policy implementation. From the exploration it is hoped that a guideline will be developed that may highlight essential aspects that relate to social work in health and the appropriate implementation of the Social Development Approach.

I therefore wish to invite you to participate in my study. Your participation is entirely voluntary and refusal to participate will not be held against you in any way. You will be required to complete a questionnaire that may take you 30 minutes to complete. Hard copies of the questionnaires will be provided to you with the permission of EXCO and distributed via your HOD. You may complete the forms and return the questionnaire by posting it in the included self-addressed envelope. If you agree to take part, you need only to sign the consent form. The questions that will be asked will focus on your experience about the implementation of the Social Development Approach. You may withdraw from the study at any time and you may refuse to answer any questions which you do not feel comfortable in answering.

The data will be kept for two years following any publications of the study or for 6 years if no publications emanate from the study.

In the event of questions or clarity regarding the study you may contact me on 011 011717 4474 or laetitia.petersen@wits.ac.za or my supervisor, Dr. Pretorius on Edmarie.Pretorius@wits.ac.za or 011 717 4476.

If you have any comments, concerns or questions about the ethics of the study you are welcome to contact the Human Research Ethics Committee (Non-Medical) of the University of Witwatersrand. The contact details are:

Chairperson: Jasper.Knight@wits.ac.za or
The administrator: Ms Shaun Schoeman
Telephone number: 011717 1408
Email address: hrec-nonmedical.researchoffice@wits.ac.za/ Shaun.Schoeman@wits.ac.za

Thank you for taking the time to consider participating in the study.

Laetitia Petersen

APPENDIX D

INFORMED CONSENT - SURVEY

Appendix D: Informed Consent – Survey

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3, Wits, 2050 • Tel: 011 717 4472 • Fax: 011 717 4473 • E-mail: socialwork.SHCD@wits.ac.za

Social Work in Health Care: A Social Development Approach

I agree to take part in the study by completing this paper-based questionnaire.

Signed: _____

Date: _____

APPENDIX E

PARTICIPANT INFORMATION SHEET – SEMI -STRUCTURED INTERVIEWS

Appendix E: Participant Information Sheet – Semi- structured interviews

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3, Wits, 2050 • Tel: 011 717 4472 • Fax: 011 717 4473 • E-mail: socialwork.SHCD@wits.ac.za

Social Work in Health Care: A Social Development Approach

Dear Potential Participant

My name is Laetitia Petersen, a doctoral student at the University of the Witwatersrand, Johannesburg. My doctoral research focuses on the exploration of the implementation of the Social Development Approach to Social Work in Health Care. It is hoped that this exploration will provide clarity regarding how the Social Development Approach has been implemented in health care settings or how it should be implemented as well as your experience with regard to policy implementation. From the exploration it is hoped that a guideline will be developed that may highlight essential aspects that relate to social work in health and the appropriate implementation of the Social Development Approach.

I therefore wish to invite you to participate in my study. Your participation is entirely voluntary and refusal to participate will not be held against you in any way. If you agree to take part, I shall arrange an interview with you at a time and place of your convenience. The interview will last approximately 1 hour. The questions that will be asked will focus on your experience about the implementation of the Social Development Approach. You may withdraw from the study at any time and you may refuse to answer any questions which you do not feel comfortable in answering.

With your permission, the interview will be tape-recorded. No one other than my supervisor and I will have access to these recordings. The tapes and interview schedules will be kept for two years following any publications of the study or for 6 years if no publications emanate from the study. Please be assured that your name and personal details will be kept confidential and no identifying information will be included in the final report. You will be provided with a pseudonym that only I will link to your interview. All data will be stored in a password protected computer.

In the event that some questions may evoke some emotional distress, debriefing has been organized with Ms. Lorna Wridgway a social worker in private practice. She may be contacted

on 072 4422 357 or email address marionway500@gmail.com. Please be assured you will not incur the cost for this debriefing.

In the event of questions or clarity regarding the study you may contact me on 011717 4474 or laetitia.petersen@wits.ac.za or my supervisor, Dr. Pretorius on Edmarie.Pretorius@wits.ac.za or 011 717 4476.

If you have any comments, concerns or questions about the ethics of the study you are welcome to contact the Human Research Ethics Committee (Non-Medical) of the University of Witwatersrand. The contact details are:

Chairperson: Jasper.Knight@wits.ac.zaor
The administrator: Ms Shaun Schoeman
Telephone number: 011717 1408
Email address: hrec-nonmedical.researchoffice@wits.ac.za/ Shaun.Schoeman@wits.ac.za

Thank you for taking the time to consider participating in the study.

Laetitia Petersen

APPENDIX F

INFORMED CONSENT – SEMI - STRUCTURED INTERVIEWS

Appendix F: Informed consent for Semi – structured interview

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3, Wits, 2050 • Tel: 011 717 4472 • Fax: 011 717 4473 • E-mail: socialwork.SHCD@wits.ac.za

Consent form for the participation in the study

Social Work in Health care: A Social Development Approach

I hereby consent to participate in the research study and to tape-recording of the interview. The purpose and procedure of the study have been explained to me.

I understand that:

- My participation in the study is voluntary and I may withdraw from the study without being disadvantaged in any way.
- I may choose not to answer any specific questions asked if I do not wish to do so.
- There are no foreseeable benefits or particular risks associated with participation in this study.
- My identity will be kept strictly confidential, and any information that may identify me will be removed from the interview transcript.
- If you do agree to be part of the study, please note that when data analysis and write –up of the research study is complete, the audio recording of the interview will be kept for two years following any publication of for six years if no publications emanate from the study.
- Direct quotes from my interview, without any information that could identify me may be cited in the research report or other write-ups of the research.

- I understand that my response will be used in the completion of a PHD degree and may be used for future research, be presented at conferences, in journal articles or books.

Name of participant: _____

Date: _____

Signature: _____

APPENDIX G

INFORMED CONSENT TO AUDIOTAPING OF SEMI - STRUCTURED INTERVIEWS

Appendix G: Informed consent to Audiotaping of Semi structured interview

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3, Wits, 2050 • Tel: 011 717 4472 • Fax: 011 717 4473 • E-mail: socialwork.SHCD@wits.ac.za

Consent form for the audiotaping of the interview

Social Work in Health care: A Social Development Approach

I hereby consent to the tape-recording of the interview. The purpose and procedure of the study have been explained to me.

I understand that:

- My audio recording and interview transcript will be stored permanently in a password protected computer, which will only be accessible by the researcher and the research supervisor.
- The recording will be transcribed and any information that could identify me will be removed.
- When data analysis and write –up of the research study is complete, the audio recording of the interview will be kept for two years following any publication of for six years if no publications emanate from the study.

- I understand that my response will be used in the completion of a PHD degree and may be used for future research, be presented at conferences, in journal articles or books.

Name of participant: _____

Date: _____

Signature: _____

APPENDIX H

PARTICIPANT INFORMATION SHEET – SEMI – STRUCTURED INTERVIEWS - KEY INFORMANTS

Appendix H: Participant Information Sheet – Semi- structured interviews Key Informants

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3, Wits, 2050 • Tel: 011 717 4472 • Fax: 011 717 4473 • E-mail: socialwork.SHCD@wits.ac.za

Social Work in Health Care: A Social Development Approach

Dear Potential Participant

My name is Laetitia Petersen, a doctoral student at the University of the Witwatersrand, Johannesburg. My doctoral research focuses on the exploration of the implementation of the Social Development Approach to Social Work in Health Care. It is hoped that this exploration will provide clarity regarding how the Social Development Approach has been implemented in health care settings or how it should be implemented as well as your experience with regard to policy implementation. From the exploration it is hoped that a guideline will be developed that may highlight essential aspects that relate to social work in health and the appropriate implementation of the Social Development Approach.

You were highlighted by your colleagues in health as a key informant in the field. Due to your expertise in this field, you are therefore invited to participate in my study. Your participation is entirely voluntary and refusal to participate will not be held against you in any way. If you agree to take part, I shall arrange an interview with you at a time and place of your convenience. The interview will last approximately 1 hour. The questions that will be asked will focus on your experience about the implementation of the Social Development Approach. You may withdraw from the study at any time and you may refuse to answer any questions which you do not feel comfortable in answering.

With your permission, the interview will be tape-recorded. No one other than my supervisor and I will have access to these recordings. The tapes and interview transcripts will be kept for two years following any publications of the study or for 6 years if no publications emanate from the study. Please be assured that your name and personal details will be kept confidential and no

identifying information will be included in the final report. You will be provided with a pseudonym. All data will be stored in a password protected computer.

In the event that some questions may evoke some emotional distress debriefing has been organised with Ms. Lorna Wridgway is a social worker in private practice. She may be contacted on 072 4422 357 or email address marionway500@gmail.com. Please be assured you will not incur the cost for this debriefing.

In the event of questions or clarity regarding the study you may contact me on 011 011717 4474 or laetitia.petersen@wits.ac.za or my supervisor, Prof Pretorius on Edmarie.Pretorius@wits.ac.za or 011 717 4476.

If you have any comments, concerns or questions about the ethics of the study you are welcome to contact the Human Research Ethics Committee (Non-Medical) of the University of Witwatersrand. The contact Details are:

Chairperson: Jasper.Knight@wits.ac.za or
The administrator: Ms Shaun Schoeman
Telephone number: 011717 1408
Email address: hrec-nonmedical.researchoffice@wits.ac.za/ Shaun.Schoeman@wits.ac.za

Thank you for taking the time to consider participating in the study.

Laetitia Petersen

APPENDIX I

INFORMED CONSENT SEMI – STRUCTURED INTERVIEW - KEY INFORMANTS

Appendix I: Informed consent Semi – structured interview- Key Informants

Private Bag 3, Wits, 2050 • Tel: 011 717 4472 • Fax: 011 717 4473 • E-mail: socialwork.SHCD@wits.ac.za

Consent form for the participation in the study

Social Work in Health care: A Social Development Approach

I hereby consent to participate in the research study and to tape-recording of the interview. The purpose and procedure of the study have been explained to me.

I understand that:

- My participation in the study is voluntary and I may withdraw from the study without being disadvantaged in any way.
- I may choose not to answer any specific questions asked if I do not wish to do so.
- There are no foreseeable benefits or particular risks associated with participation in this study.
- My identity will be kept strictly confidential, and any information that may identify me will be removed from the interview transcript.
- If you do agree to be part of the study, please note that when data analysis and write –up of the research study is complete, the audio recording of the interview will be kept for two years following any publication of for six years if no publications emanate from the study.
- Direct quotes from my interview, without any information that could identify me may be cited in the research report or other write-ups of the research.

- I understand that my response will be used in the completion of a PHD degree and may be used for future research, be presented at conferences, in journal articles or books.

Name of participant: _____

Date: _____

Signature: _____

APPENDIX J

INFORMED CONSENT TO AUDIOTAPING OF SEMI STRUCTURED INTERVIEW – KEY INFORMANTS

Appendix J: Informed consent to Audiotaping of Semi structured interview – Key Informants

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3, Wits, 2050 • Tel: 011 717 4472 • Fax: 011 717 4473 • E-mail: socialwork.SHCD@wits.ac.za

Consent form for the audiotaping of the interview

Social Work in Health care: A Social Development Approach

I hereby consent to the tape-recording of the interview. The purpose and procedure of the study have been explained to me.

I understand that:

- My audio recording and interview transcript will be stored permanently in a password protected computer, which will only be accessible by the researcher and the research supervisor.
- The recording will be transcribed and any information that could identify me will be removed.
- When data analysis and write –up of the research study is complete, the audio recording of the interview will be kept for two years following any publication of for six years if no publications emanate from the study.

- I understand that my response will be used in the completion of a PHD degree and may be used for future research, be presented at conferences, in journal articles or books.

Name of participant: _____

Date: _____

Signature: _____

APPENDIX K

PARTICIPANT INFORMATION SHEET – FOCUS GROUPS

Appendix K: Participant Information Sheet – Focus Groups

Private Bag 3, Wits, 2050 • Tel: 011 717 4472 • Fax: 011 717 4473 • E-mail: socialwork.SHCD@wits.ac.za

Social Work in Health Care: A Social Development Approach

Dear Potential Participant

My name is Laetitia Petersen, a doctoral student at the University of the Witwatersrand, Johannesburg. I have previously been a social worker in Department of Health, Gauteng. My doctoral research focuses on the exploration of the implementation of the Social Development Approach to Social Work in Health Care. It is hoped that this exploration will provide clarity of how the social development approach have been implemented in health care settings or how it should be implemented as well as your experience with regard to policy implementation. From the exploration data it is hoped that a guideline will be developed that may highlight essential aspects that relate to health and social development.

I therefore wish to invite you to participate in a focus group discussion in my study. Your participation is entirely voluntary and refusal to participate will not be held against you in any way. If you agree to take part, I shall arrange an interview with you and your colleagues at a common place. You will be part of one out three focus groups that will be arranged for Department of Health. One group will be with six social workers in primary health care, the second with six social workers in secondary health care settings and the third with six social workers in tertiary health care settings. The focus group will last approximately two hours. The questions that will be asked will focus on your experience about the implementation of the Social Development Approach. You may withdraw from the study at any time and you may refuse to answer any questions which you do not feel comfortable in answering.

With your permission, the interview will be tape-recorded. No one other than my supervisor and I will have access to these recordings. The tapes and interview schedules will be kept for two years following any publications of the study or for 6 years if no publications emanate from the study. Please be assured that your name and personal details will be kept confidential and no identifying information will be included in the final report. The six group members in a focus group will be requested to keep the identities and comments made by participants in the group confidential. It

is hoped that in this manner all participants will remain anonymous. All data will be stored in a password protected computer.

In the event that some questions may evoke some emotional distress, debriefing has been organized with Ms. Lorna Wridgway is a social worker in private practice. She may be contacted on 072 4422 357 or email address marionway500@gmail.com. Please be assured you will not incur the cost for this debriefing.

In the event of questions or clarity regarding the study you may contact me on 011 011717 4474 or laetitia.petersen@wits.ac.za or my supervisor, Prof Pretorius on Edmarie.Pretorius@wits.ac.za or 011 717 4476.

If you have any comments, concerns or questions about the ethics of the study you are welcome to contact the Human Research Ethics Committee (Non-Medical) of the University of Witwatersrand. The contact details are:

Chairperson: Jasper.Knight@wits.ac.za or
The administrator: Ms Shaun Schoeman
Telephone number: 011717 1408
Email address: hrec-nonmedical.researchoffice@wits.ac.za/ Shaun.Schoeman@wits.ac.za

Thank you for taking the time to consider participating in the study.

Laetitia Petersen

APPENDIX L

INFORMED CONSENT - FOCUS GROUPS

Appendix L: Informed consent - Focus groups

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3, Wits, 2050 • Tel: 011 717 4472 • Fax: 011 717 4473 • E-mail: socialwork.SHCD@wits.ac.za

Consent form for the participation in the study

Social Work in Health care: A Social Development Approach

I hereby consent to participate in the focus group discussion of the research. The purpose and procedure of the study have been explained to me.

I understand that:

- That I will be part of a focus group discussion with five other members.
- I agree to keep my colleagues' identities and participation in the study confidential.
- My participation in the study is voluntary and I may withdraw from the study without being disadvantaged in any way.
- I may choose not to answer any specific questions asked if I do not wish to do so.
- There are no foreseeable benefits or particular risks associated with participation in this study.
- My identity will be kept strictly confidential, and any information that may identify me will be removed from the interview transcript.
- If you do agree to be part of the study, please note that when data analysis and write –up of the research study is complete, the audio recording of the interview will be kept for two years following any publication of for six years if no publications emanate from the study.
- Direct quotes from my interview, without any information that could identify me may be cited in the research report or other write-ups of the research.
- I understand that my response will be used in the completion of a PHD degree and may be used for future research, be presented at conferences, in journal articles or books.

Name of participant: _____

Date: _____

Signature: _____

APPENDIX M

INFORMED CONSENT TO AUDIOTAPING OF THE FOCUS GROUPS

Appendix M: Informed consent to Audio Taping of the Focus groups

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Private Bag 3, Wits, 2050 • Tel: 011 717 4472 • Fax: 011 717 4473 • E-mail: socialwork.SHCD@wits.ac.za

Consent form for the audio taping of the focus group discussion

Social Work in Health care: A Social Development Approach

I hereby consent to the audiotaping of the focus group discussion of the research study. The purpose and procedure of the study have been explained to me.

I understand that:

- The audio recording and interview transcript will be stored permanently in a password protected computer, which will only be accessible by the researcher and the research supervisor.
- The recording will be transcribed and any information that could identify me will be removed.
- When data analysis and write –up of the research study is complete, the audio recording of the interview will be kept for two years following any publication of for six years if no publications emanate from the study.

- I understand that my response will be used in the completion of a PHD degree and may be used for future research, be presented at conferences, in journal articles or books.

Name of participant: _____

Date: _____

Signature: _____

APPENDIX N

SURVEY

Appendix N: Survey

SURVEY
SOCIAL WORK IN HEALTH CARE: A SOCIAL DEVELOPMENT APPROACH

SURVEY
SOCIAL WORK IN HEALTH CARE: A SOCIAL DEVELOPMENT APPROACH

FOR OFFICE USE ONLY

Thank you for taking time in your busy schedule to complete this survey. There are no right or wrong answers.

Where indicated please use the rating scale provided where ① ***refers to strongly disagree,*** ② ***disagree,*** ③ ***neutral,*** ④ ***agree and*** ⑤ ***strongly agree***

A. DEMOGRAPHICS

Please select the appropriate options that are applicable to you.

1. **Age range**

22 – 25 yrs	☐	26 – 30 yrs	☐	31 – 35 yrs	☐
36 – 40 yrs	☐	41 – 45 yrs	☐	46 – 50yrs	☐
51 – 55 yrs	☐	56 – 60 yrs	☐	61 yrs +	☐

2. **Gender**

Female ☐ Male ☐ Other:_____

3. **Race**

Black ☐ Coloured ☐ Indian ☐ White ☐

Other: _____

B. EMPLOYMENT BACKGROUND

Please answer the following questions to the best of your ability by marking the suitable answer.

1. **Please specify the number of years you have experience as a practicing and registered social worker. This implies from the first time registering as a social worker up until now.**

1 – 3 yrs	☐	4 – 6 yrs	☐	7 – 10 yrs	☐
11 – 15 yrs	☐	16 – 20 yrs	☐	21 – 25 yrs	☐
26 – 30 yrs	☐	Other: Please Specify:_____			

2. **Please specify the number of years that you have experience in working in a health care setting (clinic, hospital, etc.).**

1 – 3 yrs	☐	4 – 6 yrs	☐	7 – 10 yrs	☐
11 – 15 yrs	☐	16 – 20 yrs	☐	21 – 25 yrs	☐
26 – 30 yrs	☐	Other: Please Specify:_____			

3. **Please specify the number of years that you experience in the current health care setting (clinic, hospital, etc.).**

1 – 3 yrs	☐	4 – 6 yrs	☐	7 – 10 yrs	☐
11 – 15 yrs	☐	16 – 20 yrs	☐	21 – 25 yrs	☐
26 – 30 yrs	☐	Other: Please Specify:_____			

1 Survey

4. Please specify your current social work rank or grade.

Grade 1 ☐ Grade 2 ☐ Grade 3 ☐

Manager ☐ Other:_____

5. Please specify the type of health care setting where you are currently employed in.

Clinic ☐ District Hospital ☐ Secondary Hospital ☐

Tertiary Hospital ☐ Rehabilitation Center ☐

Other: _____

6. Please specify your supervision or managerial responsibilities:

6.(a) I am involved in supervision:

Yes ☐ No ☐

If Yes complete 6(b) and 6(c)

6.(b) I supervise: Students ☐ Social Auxiliary workers ☐

Social workers ☐ All staff ☐

6.(c) Total number of supervisees: _____

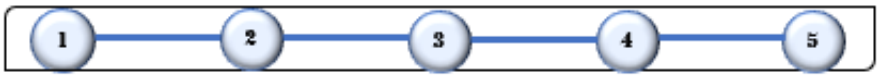
6.(d) I am involved in managing the social work department:

Yes ☐ No ☐

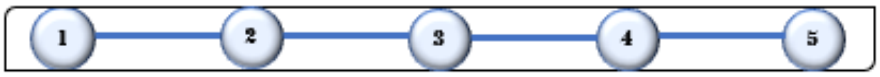
6.(e) Rate the following with an X

① ***refers to strongly disagree,*** ② ***disagree,*** ③ ***neutral,*** ④ ***agree and*** ⑤ ***strongly agree***

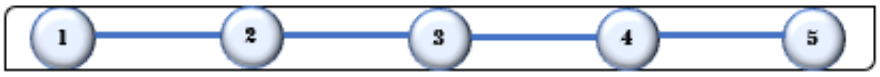
6.(e)(i) I am content with my supervision responsibilities



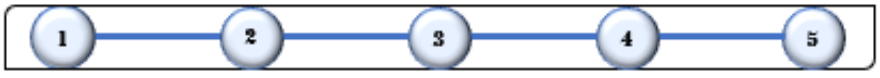
6.(e)(ii) I am content with my managerial responsibilities



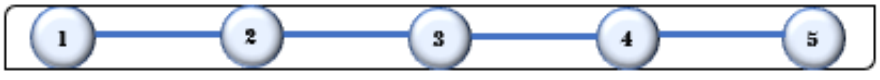
6.(e)(iii) I feel appreciated in the role I fulfil



6.(e)(iv) I know I can implement innovative strategies in my roles



6.(e)(v) I am recognised for my innovative strategies



7. **Identify in which area/ unit/ ward/clinic are you currently employed**

_____

8. **Describe the core areas of your job description. List the area and what it entails.**

_____

_____

_____

9. **Which service (s) do you think is/are the most important to meet the needs of your clients.**

_____

_____

_____

10. **What macro strategies (such as community work, etc.) are you employing on a daily basis in your work?**

_____

_____

_____

_____

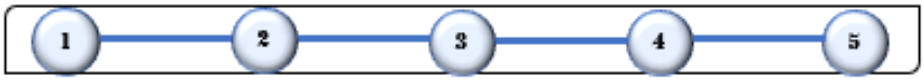
11. **Indicate how often do you use macro work strategies with your clients?**

(a) With every client	☐	(b) Once a week	☐
(c) More than twice a week	☐	(d) Once a Month	☐
(e) Not regularly	☐	(f) Not applicable	☐

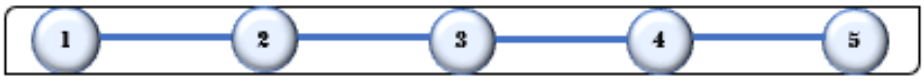
12. **Rate the following:**

① ***refers to strongly disagree,*** ② ***disagree,*** ③ ***neutral,*** ④ ***agree and*** ⑤ ***strongly agree***

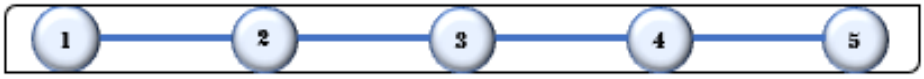
12.(a) Generally I am content with my job as a social worker



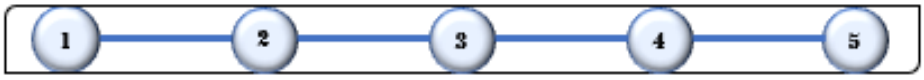
12.(b) I have been frustrated in my job due to rules and policies of the social work department



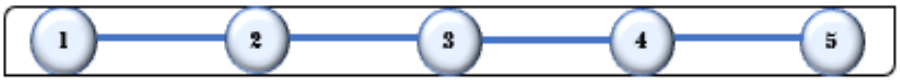
12.(c) I have been frustrated in my job due to policies from the Gauteng Health



12.(d) My innovative strategies are valued in my department



12.(e) I have shared my frustration with family or friends



C. SOCIAL DEVELOPMENT APPROACH

1. **What is your understanding of the Social Development Approach?**

_____
_____
_____

2. **Do you think that it is necessary to know about the social development approach in your work setting?**

Yes ☐ No ☐

Please clarify your answer:

_____

3. **Please provide (a) an example of how the Social Development Approach was implemented in government.**

_____
_____

OR

(b) I do not have an example ☐

4. **Please identify (a) examples of how you employ the Social Development Approach in you work.**

_____
_____
_____
_____

OR

(b) I do not have an example ☐

5. **How have you ensured social justice for a client?**

_____
_____
_____

6. **In your Department do you have staff rotation?**

Yes ☐ No ☐

If yes; How often is rotation required in your Department?:

_____

7. **What do you think is the reason for the rotation?**

_____
_____
_____

8. **How is rotation communicated or agreed in your Department?**

_____

_____

_____

9. **How does this rotation make you feel? Select all the options relevant for you.**

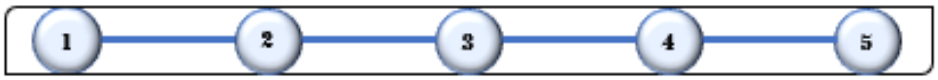
(a) Happy ☐	(b) Excited ☐	(c) Relieved ☐	(d) Hopeful ☐
(e) Indifferent ☐	(f) Neutral ☐	(g) Impartial ☐	(h) Disinterested ☐
(i) Frustrated ☐	(j) Anxious ☐	(k) Ambivalent ☐	(l) Reluctant ☐

10. **Training on the Social Development Approach:**

Answer the following by making a mark (X)

① ***refers to strongly disagree,*** ② ***disagree,*** ③ ***neutral,*** ④ ***agree and*** ⑤ ***strongly agree***

10.(a) Training received on the Social Development approach has been helpful and enough

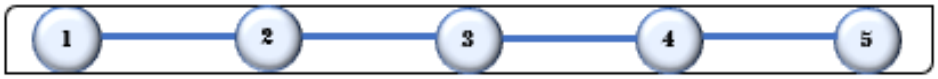


Please clarify your response

_____

_____

10.(b) The training received on culturally competent models for the South African context has been helpful and sufficient

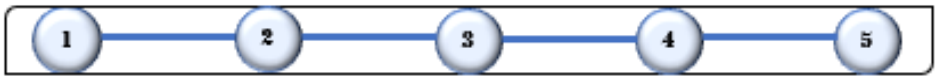


Please clarify your response

_____

_____

10.(c) I have implemented my own culturally competent models with my clients

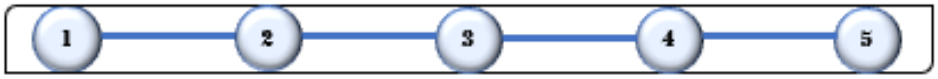


Please clarify your response

_____

_____

10.(d) My manager/ supervisor clarified the Social Development Approach for me



11. **Please specify what would your training needs are regarding Social Development Approach?**

_____

_____

_____

12. **How is success with regard to your role as a social worker measured?**

_____

_____

D. SOCIAL DETERMINANTS OF HEALTH

1. In your opinion what do you understand about the Social Determinants of Health in relations to your role as a social worker?

_____

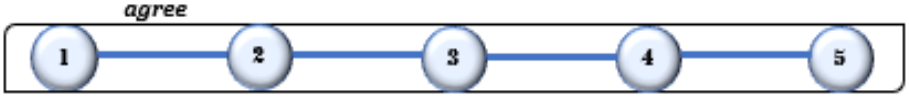
_____

_____

2. Do you think that the Social Determinants of Health is of application to social work?

Answer by making a mark (X)

① *refers to strongly disagree,* ② *disagree,* ③ *neutral,* ④ *agree and* ⑤ *strongly agree*



3. Please (a) describe how government has enforced the Social Determinants of Health.

_____

_____

_____

OR

(b) **I do not have an example** ☐

4. Please provide (a) an example from your intervention with clients where you addressed the Social Determinants of Health.

_____

_____

_____

OR

(b) I do not have an example ☐

E. POLICY IMPLEMENTATION

1. Have you encountered any policy changes that had impacted your role as a social worker?

Yes ☐ No ☐

If yes please elaborate.

_____

_____

_____

2. Please mention which policy was implemented and describe how it has affected you.

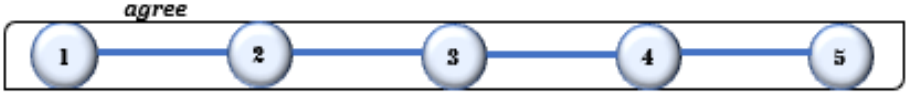
_____

_____

_____

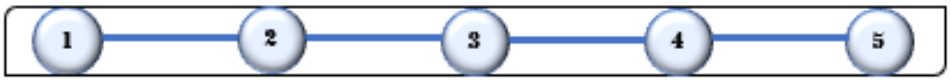
3. Policies that affect my role as a social worker have always been implemented in a consultative manner. Answer by making a mark (X)

① *refers to strongly disagree,* ② *disagree,* ③ *neutral,* ④ *agree and* ⑤ *strongly agree*

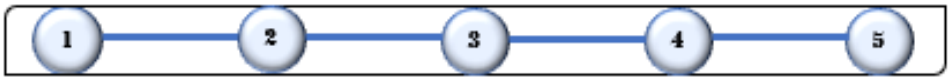


4. Government values and listens to my input for policy implementation.

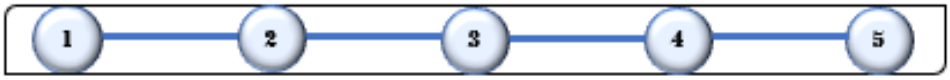
5. Policies changes are generally appreciated.



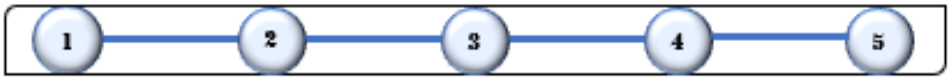
6. Policies changes have reiterated the value of my role as a social worker.



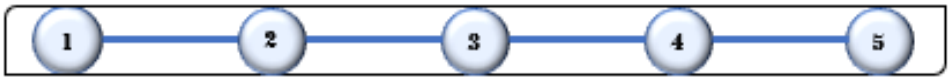
7. Policies changes have been in line with the transformation of South African context.



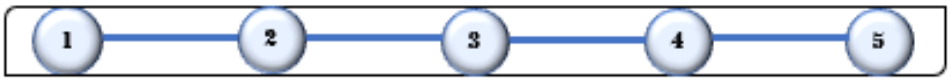
8. Policies implementation has been always clear.



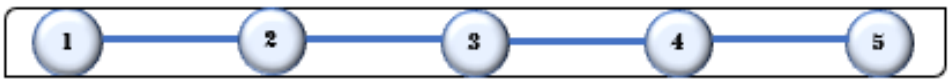
9. Where policies were implemented my supervisor/ manager competently clarified it.



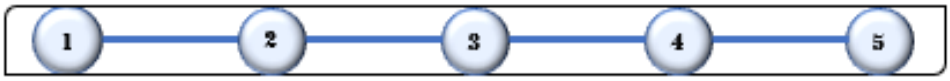
10. Policies have always been correctly understood, without confusion, amongst colleagues.



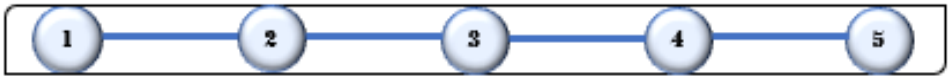
11. My supervisor/ manager advocates for me regarding unilateral policy implementation.



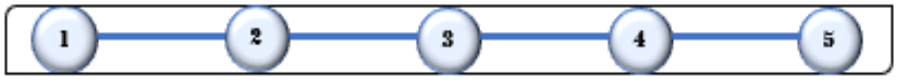
12. My supervisor/ manager always questions the appropriateness of policies before policy implementation.



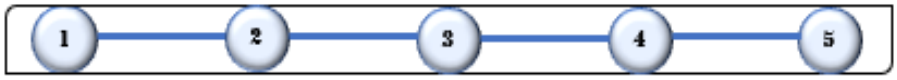
13. In your opinion, to take social action against policy implementation has proven or will prove effective in voicing your opinion about policy implementation.



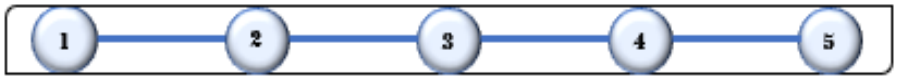
14. My role has been relatively unaffected by policy implementation.



15. There is a strong relationship between my job satisfaction and policy implementation.



16. There is a strong relationship between my job satisfaction and how transformation is enacted in Gauteng Health.

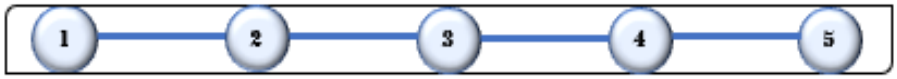


17. Considering the last policy implementation, how long did it take to come to grips with the policy?

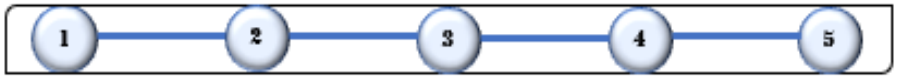
Less than a month ☐ 1 -2 Months ☐ 3 – 4 Months ☐
5 – 6 Months ☐ Other: _____

F. ASSOCIATIONS

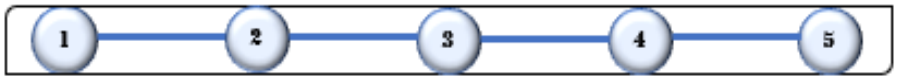
1. There is a strong relationship between social development approach (SDA) and the social determinants of health (SDH).



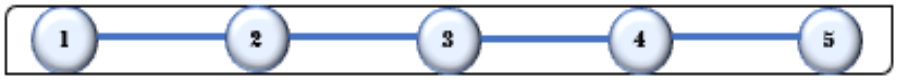
2. Knowledge of SDA and SDH improves my competence as a social worker.



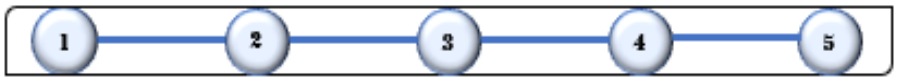
3. SDA and SDH have no real bearing on my role as an effective social worker.



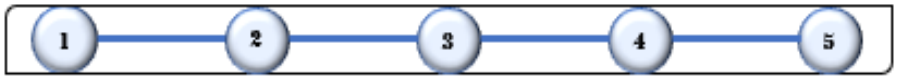
4. Policy changes have improved my role as a social worker.



5. I have successfully implemented the strategies of SDA in my role as a social worker.



6. I have successfully implemented the strategies of SDH in my role as a social worker.



G. COMPONENTS OF A SOCIAL DEVELOPMENT FRAMEWORK

In your opinion what should a social development framework include? Please list all aspects that you deem important.

H. KEY INFORMANTS

In your opinion who in Department of Health may be considered as an expert with regard to the Social Development Approach, the Social Determinants of Health and Policy Development and Implementation. Please provide the person's contact details.

I. OTHER

Please feel free to make any other comments:

J. VOLUNTEERING FOR INTERVIEWS AND OR FOCUS GROUP DISCUSSION

If you are interested in being part in the interview and or focus group discussion of this research, you may list your name and contact details here or send me an email.

Thank you for completing this survey.

Laetitia Petersen
Email: laetitia.petersen@wits.ac.za
Tel: 011 717 4474

9 Survey

APPENDIX O

INTERVIEW SCHEDULE – SEMI -STRUCTURED INTERVIEWS

Appendix O: Interview Schedule

A. GENERAL

1. What makes your health centre and social work services unique?

2. Which service (s) do you think is the most important to meet the needs of your clients?

3. How does macro strategies that you employ aid meeting your clients' needs? Is this in line with the Social Development Approach?

4. How do you perceive your role as a social worker in the health care setting? Do you feel valued?

B. SOCIAL DEVELOPMENT APPROACH

1. Describe what you consider the Social Development approach to be and how it is of relevance to your work.

2. Please provide examples of how you have implemented the Social Development Approach in your daily work.

3. Clarify the relevance and purpose of rotation in relation to the Social Development approach?

4. Discuss the relevance of being culturally competent in your services and how your supervisor or manager have been able to address or clarify this.

5. Please provide examples of how you have used social justice with your clients.

6. Describe the governmental strategies of implementing the Social Development Approach in your hospital
Setting and how you supervisor of manager has addressed or clarified this.

C. SOCIAL DETERMINANTS OF HEALTH

1. Describe what you consider the Social Determinants of Health to be and how is it of relevance to your work.

2. Please provide examples of how you have implemented the Social Determinants of Health in your daily work.

3. Describe the governmental strategies of implementing the Social Determinants of Health within social work and how your supervisor or manager has addressed or clarified this.

D. POLICY IMPLEMENTATION

1.How has policy changes impacted on your role as a social worker?

2. Describe how policy implementation occurs and your role in the consultative process.

3. In general how do you and your colleagues react to policy changes?

4. How would you describe your supervisors/ managers or director's role in the policy implementation process?

5. In your experience with policy implementation could you give input that was considered?

6. Describe how policies have been both helpful and frustrating.

E. VISION

1. What do you think is the vision and value of Social Work in Health care in the South African context and for the future?

F. OTHER COMMENTS

1. Any other comments

_____
_____
_____
_____
_____
_____

Thank you

APPENDIX P

INTERVIEW SCHEDULE – SEMI- STRUCTURED INTERVIEWS KEY INFORMANTS

Appendix P: Interview Schedule: Key informants

A. GENERAL

1. You were identified as a key informant by your colleagues. Why do you think your colleagues identified you?

2. What makes your social work in health care unique?

3. How do you perceive the role of social work in health care? |Is it of importance?
4. Please tell me about your employment in your health care institution and the areas of your job description.

5. Which service (s) do you think is the most important to meet the needs of clients?

6. How does macro strategies that social workers employ aid meeting your clients' needs?

B. SOCIAL DEVELOPMENT APPROACH

1. Describe what you consider the Social Development approach to be how it is of relevance to your work or that of social workers.

2. Please provide examples of how you or social workers have implemented the Social Development Approach in your/ their daily work.

3. Discuss the relevance of being culturally competent in the social workers' services and how you have been able to address or clarify this.

4. Please provide an overview of how you or social workers have used social justice with clients.

5. Clarify the purpose of rotation in relation to the Social Development approach.

6. In your opinion what is the way forward for social work in health care based on governments developmental plan?

C. SOCIAL DETERMINANTS OF HEALTH

1. Describe what you consider the Social Determinants of Health to be and how is it of relevance to your work or that of social workers.

2. Please provide examples of how you or social workers have implemented the Social Determinants of Health in your or their daily work.

3. Please discuss the governmental strategies of implementing the Social Determinants of Health within social work and how you have been able to address or clarify this.

4. Considering the Social Determinants of Health in your opinion what is the way forward for social work in health care based on governments developmental plan?

D. POLICY IMPLEMENTATION

1. Discuss how policy changes impacted on your role or the roles of social workers.

2. Describe how policy implementation occurs and your role in the consultative process.

3. In general how do you and your colleagues react to policy changes?

4. How would you describe your or director's role in the policy implementation process?

5. In your experience with policy implementation could you give input that was considered?

6. Describe how policies have been both helpful and frustrating?

E. OTHER COMMENTS

1. Any other comments

_____
_____
_____
_____
_____
_____

Thank you.

APPENDIX Q

FOCUS GROUP GUIDE

Appendix Q: Focus Group Guide

A. INTRODUCTION AND GENERAL

1. Please introduce yourself, your area of work and length of employment to the group.

2. Please share which service (s) do you think is the most important to meet the needs of your clients.

3. Please indicate which macro strategies are you employing on a daily basis in your work?

B. SOCIAL DEVELOPMENT APPROACH

1. Please describe what you consider the Social Development approach to be and how relevant it is to your work.

2. Please provide examples of how you have implemented the Social Development Approach in your daily work.

3. Please discuss the relevance of being culturally competent in your services and how your supervisor or manager have been able to address or clarify this.

4. Please provide examples of how you have used social justice with your clients.

C. SOCIAL DETERMINANTS OF HEALTH

1. Please describe what you consider the Social Determinants of Health to be and how relevant it is to your work.

2. Please provide examples of how you have implemented the Social Determinants of Health in your daily work.

3. Please discuss the governmental strategies of implementing the Social Determinants of Health within social work and how your supervisor or manager have been able to address or clarify this.

D. POLICY IMPLEMENTATION

1. Please discuss how policy changes impacted on your role as a social worker

2. Please describe how policy implementation occurs and your role in the consultative process.

3. In general how do you and your colleagues react to policy changes?

4. How would you describe your supervisors/ managers or directors' role in the policy implementation process?

5. In your experience with policy implementation could you give input that was considered?

6. Can you describe how policy has been both helpful and frustrating.

E. KEY INFORMANTS

1. Who in Gauteng Department of Health can you identify as an expert with regard to policy implementation, the Social Development Approach and Social Determinants of Health who may be considered to be interviewed?

   _____
   _____
   _____
   _____
   _____
   _____

F. OTHER COMMENTS

1. Any other comments.

_____
_____
_____
_____
_____

Thank you.

APPENDIX R

EXAMPLE OF CODING, CATEGORISING AND THEMING

Appendix R: Example of Coding, Categorising and Theming

EXAMPLE OF CODING, CATEGORISING AND THEMING

Interviewer: How do you perceive your role as a social worker here and do you feel valued?

Transcription	Codes	Categories	Themes
Participant 1: So,..I see myself in coming into this environment from my previous one which was very different. The interview was how do you work as a team? [little laugh]. Huh, I'm not sure but I think realising in this setting that the MDT is really important. So I see my role as part of the multidisciplinary team. I know that some times we have challenges around people understanding their specific role and sometimes we have people overlapping role, people that may not have clear enough boundaries but I think for me knowing as a social worker I contribute in a certain way to the team and I think that is my role. I can talk about the work that I do..uhm so I work with parents and the family, I run groups with adolescents around life skills, uhm, where there are allegations of abuse I do assessment of those circumstances. We don't report all forms of corporal punishment because we get children that are being smacked every single day by almost every parent that walks in here. So we do intervention by saying there are other ways, try it, this is what you do, it is not okay. And this was clarified with the Department of Social Development that I can't send them every single person that have slapped a child as they will be inundated with cases. So we do the psychoeducation here, then we monitor the behaviour of the children still at risk and refer. Aah…I think for me also educating the other disciplines about the work that we do, and educating them about the children's act we all it is quite important as our role as social workers at XYZ.	Initial Different environment Team Work MDT Part of MDT Descriptive Certain way/ part Parent & Family Assessment, abuse, life skills Intervention Causation Psycho education Education of MDT of role Emotive	Descriptive Team Work MDT Role and Intervention Education of clients and team	Importance of MDT Instrumental part of MDT Role – Intervening and linking with service users and community Education of services users and team important
Participant 2: so I think my role in this setting obviously there are different roles is very much to be the link between the family and the community and the setting and I think that is mostly what I do it's a lot of discharge planning cycle education psychoeducation we do a lot of practical interventions of social relief and grants we deal with things like substance use and difficulties I know my colleagues in other areas do different things so in my case specifically I don't always have the opportunities because I work with very unwell patients and and their families supporting families supporting patients and then we do groups as well so then meso intervention and then obviously also community work I do think I feel valued as I said earlier I work in a multidisciplinary team with one another I think unfortunately there is always a hierarchy there are times where I feel that your opinion is not necessarily valued but I don't know if that if that is towards social work or just anybody mostly makes do with all team members	Initial Role link between family and community Discharge planning Education Unwell patients Community work MDT Hierarchy Descriptive Opinion not valued Causation	Role link with community Discharge planning Education Community MDT and Hierarchy Emotive Not valued (if not heard)	Discharge planning, family and community linking important. MDT and Hierarchy Feelings of not being valued due to not being heard
Participant 3: Well let's say from social workers in the department. I think that it is good to be valued beside managing seen as a source of support. And ….And at times when people approach you, make appointment with you to discuss certain things that is when you realise that okay it is fine. Even though if wouldn't want to be seen as for every problem. Because you can't be seen for a similar problem today and tomorrow. You can't do the same thing. To me can't learn anything. So I will always want to prevent the issue of dependency. So it is not all about me. So even if I feel that I am valued; I do not want to be valued in that way where you have to give all the time. So I must be happy for you to give me a report of what you have done and learnt. JA	Initial Good to be valued Management source of support Descriptive Avoidance of Dependency Causation Selflessness Valued	Emotive Good to be valued Support Avoidance of Dependency Selflessness Valued	Importance of being valued for the right reason Management – support and selflessness

Initial Code | Emotive Code | Descriptive Code | Causation Code

APPENDIX S

EXAMPLE OF DIFFERENT TYPES OF CODING APPLIED

Appendix S: Example of Different Types of Coding Applied

DIFFERENT TYPES OF CODING APPLIED TO THE TRANSCRIPTIONS

Transcription	Codes
Participant 1: So,..I see myself incoming into this environment from my previous one which was very different. The interview was how do you work as a team? [little laugh]. Huh, I'm not sure but I think realising in this setting that the MDT is really important. So I see my role as part of the multidisciplinary team. I know that some times we have challenges around people understanding their specific role and sometimes we have as a social worker I contribute in a certain way to the team and I think that is my role. I can talk about the work that I do..uhm so I work with parents and the family, I run groups with adolescents around life skills, uhm, where there are allegations of abuse I do assessment of those circumstances. We don't report all forms of corporeal punishment because we get children that are being smacked every single day by almost every parent that walks in here. So we do intervention by saying there are other ways, try it, this is what you do, it is not okay. And this was clarified with the Department of Social Development that I can't send them every single person that have slapped a child as they will be inundated with cases. So we do the psychoeducation here, then we monitor the behaviour of the children still at risk and refer. Aah…I think for me also educating the other disciplines about the work that we do, and educating them about the children's act we all it is quite important as our role as social workers at XYZ	Descriptive Code Processes roles actions Interventions Causation Emotive Education of other disciplines about role bring value
Participant 2: So I think my role in this setting obviously there are different roles is very much to be the link between the family and the community and the setting and I think that is mostly what I do it's a lot of discharge planning cycle education psychoeducation we do a lot of practical interventions of social relief and grants we deal with things like substance use and difficulties I know my colleagues in other areas do different things so in my case specifically I don't always have the opportunities because I work with very unwell patients and and their families supporting families supporting patients and then we do groups as well so then meso intervention and then obviously also community work I do think I feel valued as I said earlier I work in a multidisciplinary team with one another I think unfortunately there is always a hierarchy there are times where I feel that your opinion is not necessarily valued but I don't know if that if that is towards social work or just anybody mostly makes do with all team members	Descriptive Code Processes discharge planning Causation Feel valued by community Feel not valued by MDT if opinion not heard Emotive Opinion not heard not feeling valued
Participant 3: Well let's say from social workers I the department. I think that it is good to be valued beside managing seen as a source of support. And ….And at times when people approach you, make appointment with you to discuss certain things that is when you realise that okay it is fine. Even though if wouldn't want to be seen as for every problem. Because you can't be seen for a similar problem today and tomorrow. You can't do the same thing. To me can't learn anything. So I will always want to prevent the issue of dependency. So it is not all about me. So even if I feel that I am valued, I do not want to be valued in that way where you have to give all the time. So I must be happy for you to give me a report of what you have done and learnt. JA	Descriptive Code Process of being valued Causation Independence Causes happiness Staff progress Emotive Happiness and value due to staff progress

Initial Code