

**PARTICIPATORY RESEARCH WITH HOSPITAL SOCIAL
WORKERS IN A PRIMARY HEALTH CARE CONTEXT**

by

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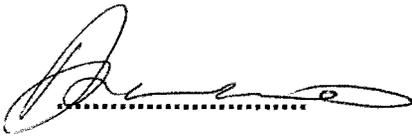
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JANUARY 1999

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I declare that * **PARTICIPATORY RESEARCH WITH HOSPITAL SOCIAL WORKERS IN A PRIMARY HEALTH CARE CONTEXT** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

A handwritten signature in black ink, appearing to read 'A. Sihlobo', written over a horizontal dotted line.

Signature

MRS A. Sihlobo

A handwritten date '1999/03/23' written in black ink, positioned above a horizontal dotted line.

Date

(I)

"There is no burden of proof. There is only the world to experience and understand. Shed the burden of proof to lighten the load for the journey of experience", Malcom's evaluation laws (in Patton 1990: 7).

Staticians try to measure IT.

Experimentalists try to control IT.

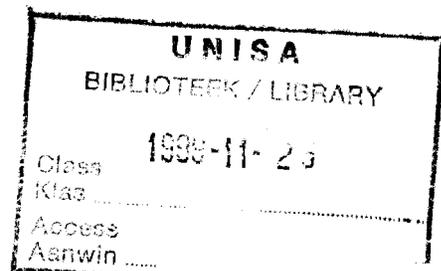
Evaluators value IT.

Interviewers ask questions about IT.

Observers watch IT.

Participants observers do IT.

And researchers in participatory inquiry cultivate the most useful of all human capacities - the capacity to learn from others, Malcom's Evaluation Laws (In Patton 1990: 7).



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In reflection of my dearest mother, Betty Mpinki Mqedlana, who passed away during this study.

(III)

SUMMARY

We conducted the study to explore and define the role of the social worker in Primary Health Care. The medical care model on its own is viewed as inappropriate for developing countries. We see Primary Health Care as holding the key to improving the health status of the many disadvantaged communities in South Africa. The Primary Health Care approach demands those health care providers, including social workers work collaboratively to provide the best possible services to the communities. Social Work is a profession concerned with the disadvantaged. However, social workers are assigned a very limited role in Primary Health Care. Since participants are concerned about subjective and experiential realities, participatory research was the appropriate research method. The major findings and conclusions were that, social workers have a role in Primary Health Care. They have to be assertive and tell others what is it that they do to find a place in Primary Health Care.

Key Concepts: Primary Health Care, Social Work Research, Social Work in Health, Social Work Role, Participatory Research, Human Inquiry, Dialogical research, Collaborative Research, Experiential Research, Participatory Inquiry.

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CHAPTER 1: PROBLEM STATEMENT

1.1 Introduction

The study focuses on the role of the social worker in Primary Health Care (PHC). PHC is a comprehensive care model concerned with the maintaining the health of a person as a whole and not just treating an acute illness. Since its inception, medical social work has concerned itself with a patient's social situation and with the understanding that the patient's social situation is intrinsically tied to his physical well-being. Thus, the principle of a person in situation is central to clinical understanding and action.

The generalist approach to social work practice assumes that social work has an eclectic theoretical base, uses a system framework and is oriented to multi-level intervention. The PHC setting is viewed as fertile ground for the development of a variety of social work practices. However social workers are assigned a very limited role in PHC, as it is not known exactly what their role is.

1.2 Objectives of the study

- To explore the role of social work in PHC through participatory research.
- To identify the tasks that social workers need to be involved with in PHC.
- To define the role of a social worker in PHC so as to motivate for social work involvement in PHC as a member of the multi-disciplinary team.

1.3 Background Information

In 1995, the Gauteng Provincial Government (Department of Health) experienced a financial crisis. The top management of the hospitals had to come up with ideas on how to reduce expenditure. In Natalspruit Hospital in Gauteng Province, the top

management said that they were going to recommend that the departments rendering "non-essential services" should be closed to reduce expenditure. The Social Work Department of the hospital was one of the departments listed as rendering non-essential services. *The 1978 World Health Organization strategy for Primary Health Care* was adopted as a strategy for the provision of health care in March 1992 by the South African government. The plan of this strategy is "attainment of health for all by the year 2000", refocusing the direction of health policy from curative base to one of prevention with a primary health care model at its core. "Reorientation of the health system away from medical illness focus to a broader social health focus" (Shapiro Cartwright & Macdonald 1994:222).

The shift in emphasis from illness to health was as a result of the recognition that the world's health problems could not be resolved only by reforms in the health delivery system. Health does not only involve health services but is related to broader environmental and socioeconomic issues that require a comprehensive and continuous health care provision by a variety of health care providers.

Social workers in the hospital regarded the shift in emphasis from medical care to PHC as a positive move. Social work with its focus on the influence of psycho-social factors in determining health status has long advocated a holistic approach to health care. Social workers regard PHC as a key to improving the health status of many disadvantaged communities as PHC advocates an approach to health care based on the principles that allow people to receive the care that enables them to lead socially and economically productive lives (Strategy for Primary Health Care 1992:5).

The principles and values on which PHC is based are similar to those on which social work is based (Drower 1989:27). They both value the quality of the life of individuals, individual self-determination and the belief in the dignity and worth of individuals. The principle of continuous care is emphasized by both social work and by PHC. Social workers in hospitals thus regard their functioning as fitting with PHC. *The Primary Health Care Strategy* (1992) was regarded as something that would guarantee the continued

existence of social workers in hospitals as they would then be rendering "essential services". However, the *White Paper for the transformation of the Health System in South Africa* (16 April 1997) depicts social workers in health care as having a very limited role in PHC while other health care providers were to assume a greater role. In *The White Paper for the Transformation of the Health System in South Africa (1997)* social work services are limited to counselling of clients and families affected by mental illness, and substance abuse, as well as rendering medical social work services, while rehabilitative services, health education and preventive services, care of the terminally ill, communicable and chronic care services are specifically assigned to other health care providers.

When social workers raised a concern about this policy, the Assistant Director for Special Groups in the Department of Health Gauteng Province, stated that social workers in hospital settings could not be involved in PHC as they were allocated to render services specifically in the hospitals. The Assistant Director later indicated that social workers were not given much responsibility in PHC as it was not clear what their role could be. She concluded that social workers need to spell out clearly what their role would be in PHC if they wanted to be fully involved.

Social Work practice is rooted in contemporary values and attitudes that are forever changing.

"One of the most important qualities of social work is that it, perhaps more than any field of practice, is systematically related to the social scene" (Dean 1977:369). Ironically the changing health care system threatened the continued existence of social workers in PHC.

The Assistant Director in the social work Sub-directorate Department of Health in Gauteng Province arranged a meeting to address this matter where all social workers were to be involved in the analysis of the situation and in planning for action to correct the situation.

After the first meeting, in which social workers were involved only in reflection, a task team that consisted of departmental heads was established to take the process further but nothing happened.

When I requested feedback from our departmental head who was an elected member of the task team, she mentioned a number of reasons that had led to the failure of the project. First the task team became discouraged and resentful when they realized that they were being "used" for the benefit of someone's MA Studies. The task team was involved in collecting data from the social workers about how social workers could assist clients in PHC to develop self reliance. However, the task team was not involved in the data analysis and, they, together with social workers who had provided the data were not provided with any information about the results.

They then concluded, perhaps wrongly, that the research was done to meet the needs of the researcher. Another reason for the project failure was that the Assistant Director moved to another job so the process stopped. A third possible reason for the failure of the project is that the social workers' jobs in the hospital setting were no longer threatened because the provincial budget was adjusted. The social workers felt that there was no need to continue with the project.

Despite the fact that PHC emphasizes a multi-disciplinary approach, social workers in health care are excluded and they are not satisfied because they regard themselves as having a significant contribution to make. Social workers feel excluded as *The Strategy for Primary Health Care (1992)* does not provide clear guidelines on how social workers should be involved in the service provision as a part of a multi-disciplinary team. *The Strategy for Primary Health Care (1992)* states that social workers have a role in Primary Health Care but at the same time imposes restrictive policies that limit the functioning of social workers in health care to the hospital setting. Constructivists state that "we cannot conceive that which we cannot distinguish, because knowing depends upon recognizing differences and relationships between differences" (Fisher 1991 :25).

This proposition is mentioned to illustrate the extent of exclusion of the hospital social workers in PHC. For example, the health care professionals, such as the occupational therapists and the physiotherapists in the hospital, are granted permission to do outreach projects and to be involved in PHC while social workers are restricted to curative services within the hospital. Social workers interpret their exclusion as marginalization and as a threat to their status.

Social workers are also not satisfied about the high number on the caseloads they must deal with totalling +/- 200 clients per month per social worker. They attribute the high caseload to the emphasis on medical treatment only which focuses on the treatment of symptoms in the hospital setting when they should be involved in the preventive programmes in PHC addressing the causes of illnesses.

In his analysis of dialogue (Freire 1970: 75) concludes that *“within the word we find two dimensions, reflection and action, in such radical interaction, when one is sacrificed, the other immediately suffers. When a word is deprived of its dimension of action, reflection automatically suffers, and the word is changed into idle chatter, into verbalism. In this case it becomes impossible for transformation to take place”*.

This statement suggests that both reflection and action should be employed if meaningful change is to occur. Social workers were only complaining and not taking action. They were involved in reflection without action. The social workers did not see their needs as a motivation to act and they just gave up. Max-Neef (1991: 23) states that "human needs are to be expressed as deprivations and as a potential to act, because needs, narrowly conceived as deprivations, are often restricted to that which is physiological, however, to the degree that needs engage, motivate and mobilize people, they are a potential and eventually may become a resource".

Van Rooyen and Gray (1995 : 91) mention that the facilitator should create an awareness of the resources that people have within themselves and of their ability to

mobilize and take action to correct their situation. The facilitator is also regarded as creating a consciousness of the collective potential of the people. In order to get recognition as health providers who could render valuable contribution in PHC, hospital social workers need to be motivated to take action. It is against this background information that I decided to be involved in participatory research with the social workers.

My personal view on why social workers may feel marginalised is that social work is an ancillary service in a host setting whose primary function is the provision of medical care. Another possible reason may be that social workers have no definite role in the hospital as their role depends on the needs of physicians and is always related to primary requirements of medical treatment. This is, however, my interpretation of the situation and not objective reality.

1.3.1 Details of the community

The participants in this study are seven qualified social workers employed by Natalspruit hospital. All the social workers, with the exception of the Head of Department (HOD), are involved in the participatory research.

1.3.2 Research participants as a community

Shriver (1995: 453) provides various descriptions and definitions of communities. One of his descriptions is that of a "community as a way of relating". Here the focus is on the ways members relate to one another and on identification or feelings of membership by community members.

The author then cites elements that must be present for one to refer to the group of individuals as a community.

Some of the elements cited are the following:

1. A shared-ness.
2. Feeling of connectedness or a sense of "we-ness" or a "sense of community" and a sense of mutual responsibility that is shared by members.

I find this definition to be meaningful and as relating to the group of social workers participating in PR as some of the above mentioned elements are present.

1.3.3 Stakeholders

Stakeholders are those people not directly involved in the research but who have the influence on the situation being researched. It is important to contact stakeholders to gain their support. Swanepoel (1992: 42) states that the initiator has to be clear on whom to contact and about the purpose of contact.

In my case, stakeholders that I made contact with were the top management of Natalspruit Hospital and the Head of the Social Work Department and the social workers. Stakeholders may be sceptical about the research and refuse to authorise it if they feel that the research threatens the status quo. They also have the potential to block the research process if not approached cautiously, so I approached them carefully by openly sharing my intention of undertaking research about the role of social workers in PHC within the hospital. This was done in a non-threatening manner.

I then presented the proposal citing the benefits to the social work department and the possible benefits to the hospital by validating social work involvement in PHC, placing emphasis on the reduction of costs of care overtime in terms of the budget and time spent readmitting and treating clients who are not responding to medical treatments. Stakeholders were given an opportunity to raise whatever concerns that they had about the research so that these would be addressed. No concerns were raised, but the

management indicated that they had to be kept informed about the developments of the research. I was then granted permission by the top management of the hospital to do the research study.

1.4 Significance of the study

Studies on the role of social workers in PHC have depicted social workers as being assigned very limited roles in PHC. It has also been discovered that their roles were assigned to other health care workers. The limited participation is said to be due to the fact that social workers were not defining their role in PHC. Exploring the problem could enable the participants and other social workers in health care to develop an awareness of the situation, to realize how the failure to define their role is affecting them as social workers, and to take the necessary actions to correct the situation.

Social workers could take action by becoming actively involved in defining their tasks in PHC. The information produced from defining their tasks could make decision-makers aware of the value of social workers in PHC and increase social workers' involvement and utilization in PHC.

Through the knowledge developed, social workers could advocate for their inclusion in PHC, they could influence policy by informing policy makers about their role and motivating for their increased participation in PHC. The increased utilization of social workers in PHC could also prevent the threat of social work erosion in health and open up new areas for social workers in PHC.

1.5 Research Methodology

This study is based on participatory research (PR) which is described as a methodology for an alternate system of knowledge production rather than a specific research method (Reason in van Rooyen & Gray 1995: 87).

PR as a method based on the experiences of the research participants, was considered as the most suitable method for data collection. The PR method was considered as appropriate as it is a democratic process relevant to the current trend in South Africa (Collins 1997: 7). According to van Rooyen and Gray, (1995: 88) The Participatory Research Network define PR as "an approach to research which supports and contributes to the efforts of individuals, groups and movements which challenge social inequality and work to eliminate exploitation".

In this study PR was found to be relevant as it had the potential to challenge the culture of silence and indifference that was experienced by the social workers in the workplace. Through PR participants collectively investigated their reality and utilized the findings for their own purpose and in the process they became empowered.

CHAPTER 2: LITERATURE REVIEW:

2.1 Introduction

The literature review deals with PR, PHC and the role of social worker in PHC. The literature has been divided into two sections. The first section focuses on PR and the second section focuses on PHC and the role of Social Workers in PHC. The concepts that are relevant for the study are defined and the overview of PR provided.

Since the participants had other commitments, they were not in a position to review the literature. Because of the time constraints, I took the responsibility of reviewing the literature. This was done in agreement with the participants.

2.2 View on PR

Collins (1997: 98) views PR as a subjective research which describes the process as it occurs from the viewpoint of participants in the process. Hall (1981: 14) views PR as an integrated process of investigation, education and action. Holman (1987: 680) defines PR as a form of investigation which is primarily of use to those who carry it out, he prefers to use the term "research from the underside" as it is a bottom-up approach.

Mulenga (in van Rooyen & Gray 1995:88) defines PR as an approach that is emancipatory and empowering. van Rooyen and Gray (1995: 95) define PR as an experiential research process where people are collectively involved on an equal basis in collective action aimed at knowledge development, education, social change and empowerment.

Tandon (1988:12) views PR as a collective process of inquiry that leads to empowerment of those involved. His view is similar to that of Holman (1987) and van Rooyen and Gray (1995). In summary, there are many different views on PR.

Although there are some differences, there is an agreement that PR is a democratic approach to investigation and learning taken up by individuals and groups as a tool aimed at social change.

Mulenga's (in van Rooyen & Gray 1995:88) definition of PR was found to be relevant for this study as it embraced empowerment at the workplace by liberating the minds of the oppressed by helping them reflect on their situation, and to act in order to transform their situation.

2.2.1 The Goal of PR:

Bawden (1991: 22) mentions the exploration of issues for informed action as the goal of PR. De Koning and Martin (1996:222) view the goal of PR as empowerment of the people to take initiatives to improve their conditions. Graham and Jones (1992: 239) mention awareness raising and empowerment as the goal of PR. Hall (1981: 11) regards the work of PR as the mobilization of the oppressed to act on their own behalf, as well as the creation of popular knowledge by the individuals on their own reality. Rahman (in de Koning & Martin 1996: 42) mentions that the goal of PR is the stimulation of self reflected critical awareness on the part of the oppressed.

In summary, the researchers emphasize critical reflection and empowerment as the main goal of PR. I support the views held by the researchers and regard the goals of PR as relating to the research participants in this study, as they have to become critical of their reality in order to act and to become empowered.

2.2.2 Aims and processes of PR

Maguire and Mulenga (in van Rooyen & Gray 1995: 89) identified three principal aims of PR as the following:

- The development of critical consciousness;

- Improvement of the lives of those involved in the PR process;
- Transforming social relationships and societal structures.

Maguire and Mulenga see these aims as being achieved through intrinsically linked, interrelated processes:

- The collective investigation of problems involving active participation of those affected by them;
- The collective analysis of data to determine the nature and extent of problems.
- The collective decision making by participants about the action to be taken.

In summary the researchers place emphasis on the collective process. By its nature PR is opposed to the individualistic nature of research that is common in traditional research. The research participants can best attend to their concerns when they act collectively as "unity is strength".

2.3 Characteristics of PR

PR is a process of "knowing and acting" people engaged in PR simultaneously enhance their understanding and knowledge of a particular situation as well as take action to change their situation for their benefit (De Koning & Martin 1996:31).

PR is a collective education process for all those that are involved in the collaborative analysis of the causes of the problem. PR is aimed at empowering people. It draws on participants' experience and creates a context where participants are able to develop self awareness (Collins 1997: 98)

In summary, the development of critical awareness, mobilization of the oppressed to act on their behalf and empowerment are regarded as important elements.

2.3.1 Basic Assumptions of PR

Sohng (1996: 84) assumes that people have inherent abilities and the right to be their own agents in knowledge building and action. Reason (1994: 41) assumes that people are self determining therefore research cannot be done on them. People can only study persons when they are in an active relationship with each other. I support the views held by these researchers that people have a potential for self-knowledge and that they have to be involved.

2.3.2 Participation: defined

Burkey (1993: 59) defines participation as “an organised effort to increase control over resources and regulative institution in given social situations, on the part of the group and movements of those excluded from such control.” He also regards participation as a learning process and as a collective effort by the people concerned in an organized framework to pull these efforts together to attain objectives they set for themselves.

2.3.3 Researcher’s role in participation

Since PR aims at raising consciousness and helping people move beyond a culture of silence (Reason 1994:48). Burkey (1993: 55) mentions that as it is not always possible for participation to occur spontaneously. The researcher should conscientise the people rather than wait passively for action to take place on its own.

(Burkey 1993:55) defines conscientisation as “the stimulation of self reflected critical awareness on the part of the oppressed of their social reality and of their ability to transform reality by their conscious action”.

Graham and Jones (1992: 237), support the view held by Burkey, that the initiator is not to assume a passive role but has to be an "agent provocateur".

In summary, the view taken by these researchers is that participation does not always occur spontaneously. In such instances the initiator has to start the process. In this study the social workers were not taking action, so I initiated the process by challenging them to reflect on their situation and to act on their own behalf.

2.3.3.1 Evaluating the extent of participation

Chambers (in de Koning & Martin 1996: 58) suggest that evaluation of the extent of participation should be based on a continuum and not as a factor that is either present or absent. Participation can be seen, as more- or less-participatory rather than not participatory.

De Koning and Martin (1996: 3) argue that participatory research may not occur at all stages of the research as particular technical skills may be required which may not be possessed by some participants. Researchers suggest that participation should be viewed as a process, and as such, a process cannot be judged by dichotomous variables.

Rifkin (in de Koning & Martin 1996: 58) mentions that the key to evaluating participation is the extent to which power and control is gained. If participants gain more power and control over the research process such as the involvement of the participants in the definition of the problems, decision-making and the setting of objectives, then participation may be said to be present.

Holman (1987: 672) mentions that evaluation of the extent of participation should be related to the extent to which the marginalised are involved in the research about themselves, and the extent to which they utilize the findings for their own purpose.

In summary, the literature reviewed suggests that it is impossible to apply participation, in its purest sense, as there are instances where the initiator has to participate more than other research participants giving direction, sharing information and facilitating the process.

In this study participants who possessed certain technical skills contributed more than other participants. In other phases some participants had to share information on the Participatory Rural Appraisal methods which were not known to other participants. Thus they were participating more than other research participants. Although some social workers were not participating at certain stages of the research process, they were not dis-empowered but empowered, because they learned and gained new knowledge since information giving is empowering. They used the Participatory Rural Appraisal methods to analyse themselves and their situation.

2.3.3.2 Connectedness

According to Graham and Jones (1992: 239) "in traditional research the researcher acts individually selecting a sampling frame, identifying potential respondents who are not informed about who else is involved." Respondents are samples of unconnected individuals, because connectedness is regarded as unimportant. In PR, connectedness and interaction is regarded as important. The emphasis is on sharing rather than imparting information.

In summary, interaction and specifically dialogue is regarded as important in PR, hence the researcher works with the research participants who are connected. The participants interact and work collectively throughout the research process.

2.3.3.3 Validity

De Koning and Martin (1996: 2) state that in the literature about validity in qualitative research, a variety of terms such as "trustworthiness" and "credibility" are used to address the concept of validity.

These authors mention various ways that could be used in assessing validity. One way of assessing validity could be involving others who were not involved in the research.

Patton (1990: 2) mentions that, the credibility of qualitative inquiry depends on: (i) the techniques and methods of data gathering, (ii) the credibility of the researcher, which is dependant on training, experience, and presentation of self and (iii) The belief in qualitative methods.

Rahman (1993: 147) suggests that validity may be assessed by immediately checking data collected and verifying with other participants whether they agree.

Reason (1988: 299) mentions that the data collection processes that are most relevant to the participants determine its validity.

In summary, the view taken in this study is that involvement of participants in all the stages from data collection, interpretation of data and conclusion is important. This increases the chances of validity as participants have the chance of disputing or confirming the findings as accurate.

2.4 PRIMARY HEALTH CARE

Matthew, Yach and Buch (1989:10) define health in terms of "a physical, mental and social well being of the individual, and not merely as the absence of disease." This definition is the basis of PHC, and focuses on a positive state of well-being. The definition has removed "health" from the sole responsibility of the medical profession and has highlighted the importance of environmental and social context.

2.4.1 PHC - Defined:

The 1978 WHO defines PHC as follows:

"Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain

at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process". (*The strategy for Primary Health Care March 1992:1*).

The definition is long and has a wide range of implications, but for the purpose of the study, the focus will be on the fundamental components of the definition of PHC:

- PHC focuses on a positive state of well being of individuals;
- The definition recognizes that health problems are multi-causal and that they cannot be resolved only by reforms in the health delivery system. Therefore, PHC includes social and economic interventions;
- PHC involves community participation;
- PHC involves changes in the nature of health care delivery;
- PHC reflects and evolves from the economic conditions and socio-cultural and political characteristics of the country and its community;
- PHC include at least education concerning prevailing health process and the methods of preventing and controlling them.
- PHC involves all related sectors and aspects of national and community development in addition to the health sectors;

- PHC requires and promotes maximum community and individual self-reliance and participation in operation and control of PHC.

2.4.2 The role of the social worker in PHC.

Dennil, King, Lock and Swanepoel (1995: 1) view PHC as an approach to health care based on the principles that allow people to receive the care that enables them to lead socially and economically productive lives. The authors clarify the concept of PHC, as they regard PHC as more than health facilities and health personnel, and that PHC can only be successful if it is a part of community development.

Matthew et al (1989: 9) are also of the opinion that PHC includes such diverse interventions that it cannot be the sole responsibility of the medical profession. The authors suggest that a comprehensive integrated approach to health involving the provision of promotive, preventive, curative and rehabilitative services according to the main health problems in the region, as necessary to improve the health status of the communities. In this study, the multi-disciplinary team approach is emphasized.

I believe in the definition of health which defines health as not merely the absence of diseases but also as a state of physical, mental and social well-being of the individuals. This suggests that co-ordination of all sectors involved in health care, including social workers is important.

2.5 Contributions of social workers in PHC.

Brochstein, Adams, Tristan and Chenery (1979: 73) view social workers as having a great deal to contribute in PHC. Drower (1989: 26) maintains that the principles of PHC are very similar to social work. She also regards the social work methods of casework, group work and community work as equipping social workers to be better able to serve the clients within the framework of PHC. In this review the various researchers agree that social workers in health have a great deal to contribute in PHC. The importance of social work in PHC is supported by the results of this study.

In my view social workers have all the qualities and the knowledge to greatly improve service provision of PHC.

2.5.1 Mandate for participation

The *White Paper for the Transformation of the Health System in South Africa* (1997: 37-38) assigns a very limited role to social workers. Most of the services that are rendered by social workers are assigned to other health providers.

Drower (1989: 26) argues that social work participation in PHC is limited. Hookey (in Henk 1989: 32) states that only 3% of social workers participate in PHC nationwide. Gross and Eisenstein - Navesh (1983: 39) state that psycho-social problems are often medicalized and presented as medical problems, and as such, medical solutions provided to these problems are often unsuccessful. Thus, social workers are regarded as having a great deal to contribute in this area. Gross, Rabinowitz, Feldman and Boerma (1996: 87) regard social work intervention as an asset in PHC.

Kissel (in Henk 1989: 32) notes that social work is far from becoming a routine component of PHC because they are not defining their role. The authors' views on the extent of participation and recognition of social workers as valuable members in PHC differs. The view taken in this study is directly related to our study which is concerned with the exclusion of a social worker in PHC.

2.5.2 Identity of social workers in PHC

Drower (1989: 27) mentions that the fact that PHC deals with psycho-social problems does not automatically guarantee social workers either autonomy in determining the conditions of its own work, or the right to full membership in the PHC team, as other health care workers view themselves as playing a role with respect to psycho-social factors. Drower mentions that social workers should acknowledge that many of their skills are not the exclusive domains of its own practitioners.

However, the view of Gross et al (1983: 177) differs, since these authors regard social workers as having an area of specialized knowledge.

2.5.3 The role of social workers in PHC.

Gross et al (1983: 174) strongly criticise social workers for not defining their role. These authors argue that the definition of social workers' role in PHC is important if social workers are to find an acceptable place in PHC. Henk (1989: 11) also mentions that social workers need to be clear on the services that they can provide.

In summary, the view taken in this study is that social workers have to define their roles in order to have a place in PHC. These findings are consistent with the statement of the problem of our study. I support the views held by these researchers that social workers need to specify their role in PHC as it is not known what their role is.

CHAPTER 3: PARTICIPATORY RESEARCH METHODOLOGY

3.1 Introduction

In this chapter the focus is on participatory research (PR) methodology. The rationale for choice of PR will be explained, and information on how data was collected and recorded will be provided. Information on how credibility was ensured will also be given. As stated elsewhere in the report, PR research methodology, which directly involves the participants in knowledge generation from the perspective of not only the researcher but also the researched, was found to be well-suited for the study.

3.2 Reasons for the choice of PR:

PR is based on the principles of the person centred approach that I find meaningful and relevant. PR adopts a non directive approach and individual's right to self direction is respected, (Rogers 1978:20).

Rogers (1978:15) regards human beings as trustworthy organisms capable of acting to bring about positive change for themselves if the right climate is created, experts can therefore not do things for human beings without involving them. Freire (1970:47) places emphasis on trusting the people rather than performing thousand actions in their favour without that trust.

He also argues that pedagogy of the oppressed cannot be developed by the oppressor on behalf of the oppressed. Freire views this as false generosity. PR approach emphasizes doing research with and not for individuals. Rahman (in Burkey 1993:57) maintains that participation is a process whose course cannot be determined from outside, he regards ordinary people as capable of understanding and transforming their reality through participation.

PR fits with the basic principles of social work and places high value on the knowledge of the people.

PR assumes that individuals are self-determining and that research cannot be done on them (Reason 1994: 41). Freire (in Hope and Timmel 1984:12) states that "transformation is only valid if it is carried out with the people, not for them". PR assumes that people know their situation best and have their own comprehension of social reality and therefore have to be brought into the process of inquiry about their own situation. This is regarded as the essence of true participation (Burkey 1993: 52). PR validates participants as knowledgeable, active subjects capable of interpreting and changing their situation themselves (Tandon 1988:11). Collins (1997:98) states that PR draws on participants' experiences, meaning that the process of inquiry is informed by respondents.

PR is empowering to those involved in the process, it promotes empowerment through the development of common knowledge and critical awareness as it involves disenfranchised people as researchers in pursuit of answers to the questions of their daily struggle (Sohng 1996: 80). PR liberates participants minds for critical reflection and sharpens their capacity to conduct their own research in their own interest (Hall 1981: 11).

Collins (1997: 98) regards participatory research approach as "creating a context of energy for reflection and action that no questionnaire, interview schedule or observation can create". PR is based on the assumption that knowledge is constructed socially. PR has the potential of bringing isolated people together around common problems. Through collective self reflection on their experiences and problems, people become aware of the dimensions of their reality and what needs to be done by themselves to improve their reality (Burkey 1993:58). Since there is no single truth but multiple realities, PR has the potential to engage participants in the process of giving meaning to events in dialogue in order to develop new perspectives. Freire (1970:64) maintains that individuals co-construct reality through communication, are able to develop common themes about an issue and arrive at meanings through dialogue for shared action. Buber and Rogers (in Cissna and Anderson 1998:63) describe dialogue as "a moment where humans meet to reflect on their reality as they make and remake it".

From the background information, it is clear that social workers were not satisfied about being excluded from participating in PHC, but were not acting to transform the situation. It is for this reason that PR was viewed as an approach that could facilitate action. My intention was to create a context where participants would not only be involved in the development of critical awareness of their situation, but also to analyse the root causes of the unpleasant situation they find themselves in, in order to develop ways of acting to transform their situation.

3.2.1 My orientation in the use of PR.

Patton (1990: 14) states that in qualitative inquiry the researcher is the *instrument*, and that "Credibility, therefore hinges to a great extent on the skill, competence, insight and flexibility of the researcher."

I have undergone in-depth training in the person-centred approach at UNISA in my study as an M.A. Degree student. As a result of my training, I am able to start where people are and to move at their pace rather than rushing them. Rushing participants has the danger of blocking new ideas from developing and blocks the development of new meaning. I have been trained in communication skills which enable me to respond appropriately to feelings expressed. My training in group work provides me with analytical skills which enables me to be sensitive to the group dynamics and to intervene where necessary. I can adapt to situations, supporting participatory leadership rather than control.

3.3 Data Collection Method

In conventional research, the researcher exercises unilateral control over the process of inquiry, by constructing the research questions and setting predetermined answers. In contrast PR has a power sharing, and power shifting potential; therefore, the data collecting methods used are open-ended and participatory (Graham & Jones 1992: 239). De Koning and Martin (1996: 44) state that PR can employ both quantitative and qualitative methods for the purpose of knowledge creation.

The methods of data collection used were negotiated with the participants. All participants contributed ideas on what methods should be used. The methods of data collection which are qualitative in nature were found to be more appropriate to the PR process.

De Koning and Martin (1996: 67) further state that "the data collection methods used should be based on people's reality, reality in terms of their abilities, belief systems and their metaphors, it should relate to the people". The purpose of data collection was not merely to collect data but to actively engage participants in a process of enquiry, that is, exploring and presenting what they knew. Innovative techniques used within participatory rural appraisal methods were found to be relevant for the purpose of data collection as these techniques have the potential to open up dialogue and facilitate co-learning.

Chambers (in Davis 1994:19) describes participatory rural appraisal as an approach and method for learning about rural life and conditions from, with and by rural people. participatory rural appraisal enables people to share, enhance and analyse their knowledge of conditions, to plan and to act. The participatory rural appraisal methods were used in an adapted form to generate data.

The matrix, venn diagram and the thinking pen exercise were used. These methods were used according to their appropriateness. The methods of data collection differed in every meeting as they were used according to the purpose and the phase of the meeting.

3.3.1 Description of a matrix

A matrix is a scheme that can be used in the initial phase to generate data. Through this technique, participants are able to analyse the situation and determine how the various aspects interact. The value of the matrix exercise is that it is an educational, creative and participative exercise that brings about a state of deep critical awareness. The matrix exercise encourages discussions and often lead to the identification of issues that need further investigation (Pretty, Guijt, Sconnes & Thompson 1995:250).

A matrix was used in the initial phase of the research to collect and analyse data.

3.3.2 Description of a venn diagram

A venn diagram is a participatory rural appraisal technique used for a variety of activities. In this study, it was used by participants to prioritize the actions that were to be carried out by the participants. The visual technique encourages participation, also during the process participants are not only involved in communication but also in creative activities (Pretty et al 1995:242).

3.3.3 Description of a thinking pen exercise

The thinking pen exercise is a Participatory Rural Appraisal technique of brainstorming that encourages the generation of data. The technique ensures a democratic process as participants take turns and have equal chances of participation without any interruption as only the participant holding a pen is allowed to share information. The use of this technique ensures respect and encourages multiple realities of the participants, encourages different point of views and the creation of new forms of knowledge.

The thinking pen exercise was used to generate data.

Data collection was also through discussions with participants. In the initial phase participants talked about their experiences and feelings. Details on how the methods were used will be explained in the process that involved reflection and action.

3.4 The question of validity/credibility

Qualitative data is often considered not scientific, because they are not amenable to statistical testing inferences, validity and reliability testing. To ensure credibility, I immediately checked with the participants on the data collected for its accuracy, verifying with participants whether the information reflected the meanings participants have sought to convey. Participants could either confirm or dispute the data.

Confirming the findings increased credibility. The same procedure was followed with the interpretation and conclusions drawn. To enhance credibility, participants also invited other social workers in health care not involved in PR to share the research process and the results thereof. Feedback from colleagues helped the participants to become aware of gaps that they were not aware of.

3.4.1 Recording the data

Participants first made an agreement on the recording process. They took turns with the recordings of findings, action plans, decision-making and on actions taken. All the recordings were recorded on flip charts and record book. After the recording the scribe took the responsibility of checking with the participants to verify if the information was correctly recorded. This also formed the basis of evaluation for credibility. The records were checked before each meeting to ensure that all plans taken were carried out.

3.4.2 Point of entry

Tandon's (1988: 9) thinking which regard participants as capable of acting in order to transform their reality provided me with a point of entry. Hope and Timmel (1984: 35) also provided me with a point of entry as well as the point of leverage. Hope and Timmel's idea of looking for generative themes, that is, a process of carefully listening for, and observing the concerns of the people, was found useful. The concern about the threatened role of social workers in PHC provided me with a point of entry. According to Hope and Timmel the researcher has to listen to issues that are so important that they will generate enough energy to break through apathy and stimulate initiative in members. I listened for the issues that the social workers were feeling strongly about through the non-formal listening survey of Hope and Timmel (1984: 35). By reflecting these generative themes, that is, the things that the social workers were unhappy about, I managed to capture their attention. I then introduced the idea of PR to the group, with an invitation to join in.

I encouraged the group of social workers to be involved with me in PR.

The proposal for the formation of the inquiry group was presented in such a way as to appeal to the potential participants. I cited what those that would be involved in PR would benefit:

- Participants will be collectively exploring issues that affect them at the workplace;
- Participants will be involved as co-learners in knowledge generation, sharing knowledge and ideas as well as getting new information that would lead to their empowerment;
- Participants will be learning skills on how to conduct PR;
- They will also be learning together in a supportive environment.

The Head of the Social Work Department initially showed interest in taking part, but when she realized that PR was about power-sharing she felt threatened and withdrew. Her withdrawal was viewed as a threat as, from her position of seniority, she could easily jeopardise the participatory research project if she chose to. To alleviate the situation and to put her in a position of power, I informed her that she would be kept informed about all the developments of the project.

The existing problem as mentioned in the background information provided the initial motivation for engaging in PR. A total number of seven social workers including myself, and with the exception of the Head of Social Work Department at the hospital, committed themselves to the project. This could be called an availability sample, (Grinnell 1988: 251) as all the social workers available have availed themselves for the project.

CHAPTER 4: PARTICIPATORY RESEARCH PROCESS

4.1 Introduction

This chapter gives an account of the PR process starting from the introductory meeting up to the development of a job description that the research participants collectively produced. Participants were engaged in dialogue, that is “an act of creation which occurs through reflection and action to create reality” (Freire 1970: 77).

4.2 Introductory meeting

The participants held a total number of five meetings. The meetings were held once a month as agreed by the participants. The meetings were held during working hours as permitted by the management of the hospital.

As the participants knew each other well, we did not follow the normal procedure of making formal self introductions. Instead I spent time introducing the PR approach. Since the participatory method requires that the research participants collaborate to plan the agenda for each session (Collins 1997: 4), I made the participants aware that they could add on or modify what was on the agenda. This was done in order to encourage participation right from the beginning and to enable the group to own the process.

I had developed a tentative agenda which I shared with the group of social workers. I started by explaining the details on PR and how I came in contact with the approach. I mentioned to the participants that as I was involved with my studies at UNISA, I was expected to do research and to write a dissertation, and that the PR was a “new” approach that was introduced to us by our research lecturer. I also mentioned that I find the approach meaningful and relevant to the current situation in South Africa which advocates for involvement of the participants.

I stated that I identify with the PR approach as it fitted with the person-centred approach and with my personal style of working.

I thought that the research participants could be curious about how I was going to benefit as they were aware that I was involved with my studies. I then reiterated how the group would benefit, including my benefit as a co-learner and for my studies.

The group was provided with an opportunity to ask questions in order to get clarity. I then moved to explore mutual expectations, the group was encouraged to be involved in discussion about why they were interested to be involved in PR.

Some of the group rules were set by myself and agreed upon by the group members, others were set by the group members. This contracting was done right at the beginning to avoid confusion and to give direction to group members. Although I am working from a person-centred approach, I regarded the giving of structure to the participants in the initial stage as important so as not to create unrealistic expectations. Participants were encouraged to add on the list of ground rules.

The list of rules agreed upon are as follows:

1. Commitment to the group;
2. Giving each other equal opportunity to participate;
3. Respect for each other;
4. Openness;
5. Punctuality.

I gave clarity on items as requested by other group members, drawing in other members to share their views. Practical issues such as the frequency and length of meetings and the meeting place was discussed and agreed upon by the group.

As a group we decided to do evaluation at certain intervals. I stated that my role in the group would be that of a co-learner as well as research facilitator. Participants committed themselves and agreed to meet once a month for a period of five months for two hours per meeting between January and May 1998.

4.2.1 Theoretical orientation

As mentioned earlier, I follow the person-centred approach which places people as central, that is, valuing and respecting the people, their values, perceptions, needs and abilities. The person-centred approach regards people as creative and with a capacity to act in order to bring about a positive change in themselves if the right climate is created. I also share Freire's (1970: 77) view on dialogue. Freire regards dialogue as "an act of creation which occurs through reflection and action and not an act of depositing ideas to another". It is for this reason that I have created a conversational context that allows for mutual collaboration in the problem definition process. I consciously applied the principles of Rogers (in du Toit, Grobber & Schenck 1998:4) which state that the individual exist in a continually changing world of experience which is only known to the individual and that therefore, the facilitator is not to impose his own frame of reference or rush participants to an extent of hearing something which fits his perspective and believe it present the solution but has to talk to participants in order to determine their frame of reference.

In PR this principle suggest that the researcher is "not to steer the conversation towards a problem prejudged by the researcher to be a more useful definition, or move discussion towards a consensus problem definition". Instead researchers have to create the climate that facilitate elaboration of multiple realities about the problem as there is "no either/ or but multiple realities". The researcher has to encourage an open exchange of ideas in order to identify how participants perceive situations and what their concerns are as well as identify similarities and differences which form the basis for negotiation.

I therefore moved at the pace of the participants allowing for dialogue and encouraged an open exchange of ideas and the development of different points of view by stating that all ideas were equally valid. This introductory meeting was just to get the process started.

4.3 First meeting

The purpose of our next meeting officially called meeting 1, as agreed on by the participants was to conduct a situational analysis and describe our realities by sharing

our perceptions and experiences. As already stated, no time was allocated for getting to know each other, instead participants spent time identifying possible area of enquiry. The research question was formulated through the brainstorming exercise. All possible research questions were recorded on a flip chart and through negotiations we reached consensus on what was to be our research question: *Why are social workers in hospital setting marginalised?* Participants were not answering the research question that they themselves have set. Instead, there was a lot of reflection on experiences and expression of feelings.

Participants were angry that they were marginalised by the health authorities. They felt humiliated and unfairly treated by being excluded in PHC. Participants were also angry that their contributions had not been acknowledged, instead what they regarded as their area of specialization was assigned to other health workers in PHC. As an initiator I did not want to rush participants into action, I moved at their pace, allowing them enough time to ventilate their feelings. From the concerns that were expressed as a group we were able to come up with a Theme : hospital social workers are concerned about being excluded in PHC.

4.3.1 Data generation

Participants were requested to share ideas on the method of data generation. A number of ideas were suggested but participants developed interest on trying out the matrix which is a participatory rural appraisal technique that I had suggested. They regarded it as a new method that they would like to learn more about.

How the matrix was used:

The matrix exercise was used for the purpose of data collection and analysing the situation. The matrix was used in an adapted form according to the needs of the participants. I first drew squares on a flip chart, explaining to the participants that the horizontal grids represented fundamental needs of the participants, for example, the need for identity, while the vertical grids represented the non-satisfier categories of needs.

To ensure equal chances of participation, participants decided to brainstorm using the thinking pen exercise. All the contributions made were recorded on a flip chart. At the end of the exercise, the participants had to analyse and organize the information in such a way that it accurately described their reality. The participants discovered that these needs were unmet because the health authorities were discriminating, imposing, undervaluing and oppressing social workers in health care.

They also discovered that the authorities were having unjust policies, centralized and repressive institution and discriminatory laws and in return social workers felt powerless, insecure and frustrated and in order to cope with situation they were indifferent, apathetic and silent.

Participants stated their fundamental needs as the need for participation, identity and recognition. The information was then arranged on the matrix, starting with the fundamental needs. The other information was arranged under the column of non-satisfiers of needs and classified according to the state of Having, Doing and Being.

Non-Satisfiers Fundamental Needs	Having	Doing	Being
Participants	Centralized Repressive Institutions	Imposing	Powerless, Non-assertive
Identify	Unjust Policies	Oppressing, Under-valuing	Insecure, Apathetic.
Recognition	Discriminatory Laws	Discriminating, Marginalysing.	Indiferrent

Figure 1: A diagram of the matrix.

The completed diagram was as a result of dialogue between participants, because participants had to provide motivation for contributions made as well as negotiate in order to reach consensus.

4.3.2 Data analysis

The completed diagram acted as a tool to encourage further discussions and further analysis. Participants were involved in reflection and action.

Freire (1970: 94) states that when individuals lack a critical understanding of their reality, "apprehending it in fragments which they do not perceive as interacting constituent elements of the whole, they cannot truly know the reality. To truly know reality individuals need to have a total vision of the context and to analyse it to achieve a clearer perception of the whole".

Before the development of a matrix, participants produced a linear view when they explained the experiences they were unhappy about. Analysing the matrix provided them with depth perception.

By adopting Rogers (in du Toit et al 1998:45) principle of wholeness, that is, the idea that all dimensions must be considered when analysing the situation that individuals find themselves in rather than focussing on one aspect. Participants discovered that by being non-assertive and apathetic, social workers were setting up conditions for being marginalised and discriminated against. This discrimination and marginalization was setting up the conditions for the feeling of apathy.

The findings also challenged participants to always regard themselves as part of the observed rather than an observing system. Through the process of dialogue, participants became aware of the connectedness of their problems. They discovered that they were marginalised, discriminated and undervalued as they were not assertive.

4.3.3 Findings

Through reflection participants concluded that social workers were partly responsible for the way they were treated as they were apathetic and never involved themselves in many of the activities. They were not involved in meetings organized internally by the multi-disciplinary team members to discuss issues of concern.

Social workers were also not always available for meetings organized by the Department of Health (Gauteng) where various professionals in health care were invited to make input on proposed policies and on issues affecting them. Reasons given by social workers for non-attendance were often unconvincing. Social workers were thus described as suffering from inertia, lack of assertiveness and indifference.

This description also applies to research participants as they are also part of the observed. Apart from developing self awareness, social workers discovered that the Department of Health policy regarding social work involvement in PHC was discriminatory, unjust and repressive. The findings and the conclusions made were first confirmed by the group before planning for action.

4.3.4 Planning for action

Freire (1970: 112) states that “conscientisation does not stop at the level of mere subjective perception of a situation, but through planning and action”. Participants were thus encouraged to come up with ideas on what had to be done to address the situation.

To encourage the expression of different opinions, participants were reminded that all opinions were equally important. They were involved in planning and exploring strategies for action. Through in-depth discussions participants were able to develop strategies for action. The resulting plans for action were as follows:

1. Social workers need to change their indifferent attitudes;
2. They were to be actively involved in whatever activities that they were expected to attend;
3. Participants had to train themselves in assertiveness and to give each other support and feedback in this endeavour;

4. Participants had to undergo training on assertiveness with the intention of confronting the Assistant Director with their concerns of being left out in PHC, expressing their feelings of dissatisfaction about the fact that decisions were made on their behalf without consultation.

Participants agreed to take turns with the recording of their ideas. The information decided upon and actions to be taken were recorded in the record book and the book was to be checked before the meeting. In the first meeting one participant volunteered to do the recording and I was involved in the recording of the information on the matrix on a flip chart.

4.3.5 Action

Participants have assigned one group member with the task of contacting the Training Section of the Department of Health to request for the training of the participants on assertiveness skills. After the skills training participants intend to reinforce the skills learned by supporting each other and by giving each other positive feedback. To further develop the skills learned, participants agreed that they would practice with each other.

4.3.6 Evaluation of the first meeting

Participants' involvement in the research has led them to develop self awareness and to have a broader picture of their problems, that is, how they were contributing to maintain the problems. This has motivated the participants to challenge themselves and to develop a plan on how to improve their behaviour.

The participants were all involved in interaction during the first meeting. As they were to evaluate the process, I reminded them that evaluations were to be honest and that participants were to be open when evaluating what was useful and not useful as they were all involved in a learning process. Positive feedback was received as members stated that they were learning how to conduct their own research in a relaxed atmosphere.

The evaluation of the extent of participation was done through participatory evaluation. The purpose of evaluation was to determine whether members were given equal chances of participation. All participants had to rate on blank cards scores ranging from 0-5 from more participation at 5, to little or no participation at 0. The ratings created an awareness and opened up a discussion on commitment on PR process. Participants were satisfied that no one monopolized the discussions as they all had a fair chance of participating. As it was in the initial stage, I realized that I participated more than other participant. I concluded to myself that I had to guard against this from becoming a pattern by involving other participants as much as possible.

4.4 Second meeting

The purpose of the meeting was to get feedback on the application made for assertiveness training and to further generate and explore concerns. The participants had agreed to work through a cyclical process of reflection, planning and action to address the concerns raised. They were, however, concerned about the limited time available as they were granted permission to conduct research on duty time only up to the end of May 1998.

Participants were involved in discussion on how to deal with the issue of time. Participants concluded that they had to list their concerns and the issues to be explored and try to speed up the process. They discovered that this might not be possible, and one participant suggested that a letter motivating for an extension of the time of the research be submitted to the Head of Department in Social Work Department. One member volunteered to personally contact the Head of Department to ask for an extension on the research project.

4.4.1 Reflection of previous meeting.

Participants reflected on the previous meeting, reiterating what they had learned, they stated that by analysing the matrix they developed new understanding as they could make a connection and see the interrelatedness of their concerns and reciprocal nature of their behaviours, that is, how their behaviour influenced and was being influenced

by the decision-makers.

4.4.1.1 Data generation

The participants explored the root causes of their problems using the thinking pen exercise to generate data. I was also involved in sharing information on what could be the causes of our problems and at the same time I acted as a facilitator using Freire's problem posing approach to encourage critical thinking.

The following concerns were generated:

- A social workers' image in health care is threatened as they are not defining their role;
- Social workers are assigned a very limited roles in PHC and at the same time restrictive policies are imposed upon them. They are not allowed to move out of the hospital setting. The Assistant Director for Special Groups need them to spell out clearly what their role would be in PHC;

This is regarded as discrimination and marginalization as other health care professionals such as the Occupational Therapists and the Physiotherapists within the hospital are allowed to move out into the communities to do out reach projects and to be involved in PHC;

- Social workers have the knowledge and skills, but they are underutilised. Instead other health care professionals are assuming roles such as community work that social workers are better suited to perform.

Since the initiator is said to be not neutral, I shared my opinions, but making participants aware that these should not be taken as final. From a number of concerns raised we were expected to come up with suggestions on what is the problem.

Maguire (in de Koning and Martin 1996: 44) states that "who controls the research problem controls a lot".

This statement clearly states that the problem cannot be decided independently by the researcher, but should be as a result of dialogue by the participants. In line with this statement, I encouraged participation and the expression of different point of views on what should be defined as a problem. From a number of possible research problems we managed to conclude on what should be defined as a problem. The problem was defined by the participants as the role of social workers in PHC.

All the concerns were written in the record book and on the flip charts by one participant and the information was presented visually for the group as a basis for opening up dialogue.

4.4.1.2 Data analysis and findings

By analysing the information on the flip charts participants discovered that they were excluded and undervalued as they were not marketing and asserting themselves. They also discovered that they were also not defining their roles. From these findings the participants had to develop action goals to address these concerns. The findings were first confirmed with the group before action plans could be taken.

4.4.2 Planning for action

I was involved with participants in deciding on methods that could be used to generate strategies for action. The participants agreed on using a brainstorming exercise. Strategies for action have been developed as follows:

- Analysing the definition of "HEALTH" as defined by the WHO and The Strategy for Primary Health Care in South Africa (1992);
- Inviting other social workers in health for discussion and input on the role of social workers in PHC;
- Developing a job description of social workers in PHC;

- Inviting other health care workers and providing them with information on our roles and how we link;
- Get training on community development skills;
- Providing decision-makers with job description of social worker for the purpose of motivation for inclusion in PHC.

A number of strategies for action have been developed by participants and due to the limited time prioritizing of actions to be taken could not be carried out but participants have agreed that these needed to be prioritised in the next meeting.

4.4.3 Evaluation of the process

Participants were satisfied about the progress made thus far. They shared that they have been concerned about a number of issues but they did not have a broader picture about the nature and extent of the issues and how they were interrelated. They have stated that by working collectively, they have developed an awareness of the situation.

4.4.4 My role in the meeting

I was gradually assuming the role of a co-learner, but still found that I had to assume a leadership role where necessary. I had to guide the process, giving the direction to the group where necessary, as well as giving support and encouragement to participants who were assuming a leadership role.

4.5 Third meeting

The purpose of the meeting was to prioritize actions. Participants first reflected on the previous meeting. The record book was then checked for decisions and planning for the session. The participants had, in the previous meeting, agreed to continue where they had left off. Although plans were made, I was aware that planning and decisions made were subject to change as we had agreed that we were not going to stick rigidly

to procedures and plans made as decisions could be determined by the circumstances outside the group. I then checked with the participants whether they wanted to focus on some other issues that might have been excluded or whether they wanted to continue with the process as planned. The participants agreed that they had to continue from where they had left off in the previous meeting, and the purpose of this meeting was to prioritize on actions to be carried out.

I support Max-Neef's (1991: 17) systemic approach that needs/problems are to be understood as a system "the dynamics of which obeys no hierarchical linearities." This means that no need is more important, per se, than any other since human needs/problems are interrelated and interactive and that there is not fixed order of precedence in the hierarchy of the needs. I am also aware that as one of the research participants, I have the right to my own opinions as I have my own frame of reference.

But since Rogers (1978:14) state that the facilitator should avoid control over or decision making for individuals. I used my opinions not to control the process but as opportunities to initiate dialogue. I then shared the systemic approach on Max Neef's view about prioritizing for interest's sake in order to inform the participants about the "new" approach as well as to get their views. Participants did not show any interest in the new approach, instead they went on to prioritise. The strategies for action were then prioritised using the venn diagram which is a participatory rural appraisal method of prioritising.

4.5.1 How the venn diagram was used

Before the exercise one participant posted the flip chart with the list of strategies for action. Different sizes' paper cuttings were made available for use to rank actions to be taken in the order of their importance, with the big circle cutting representing the first and most important action to be taken to address the concerns, and the smallest circle cutting representing the least important action. The ranking of the actions to be taken was not a straight-forward exercise. Participants had to rank an action and explain to the other participants why she had decided on that ranking.

If other participants were not convinced, negotiations had to be made in order to reach consensus. At times actions were ranked as of equal importance and because PR emphasizes dialogue rather than voting which symbolizes power and powerlessness, participants had to dialogue in order to reach mutual agreement. It was discovered that although certain actions were of equal importance, the success of some particular action depended on the completion of the other action. This statement will be illustrated by means of a diagram and will become clearer after the actions to be taken have been prioritised.

4.5.2 Prioritised strategies for action

After a lengthy discussion in which all participants were actively involved in sharing different opinions on prioritizing we came up with the following list of prioritized strategies.

- Analysis of the definition of "health" and PHC;
- Define the tasks of the social worker in PHC by linking social work principle with the PHC strategy for Health in South Africa;
- Develop a job description of social workers in PHC;
- Invite other social workers in health care for the discussion of the job description to get their input and support.
- Provide the decision-makers with job description of social workers for the purpose of motivation of inclusion in PHC;
- Get skills training on community development;
- Invite other health care workers to share our roles and discuss where we link with the other health care workers.

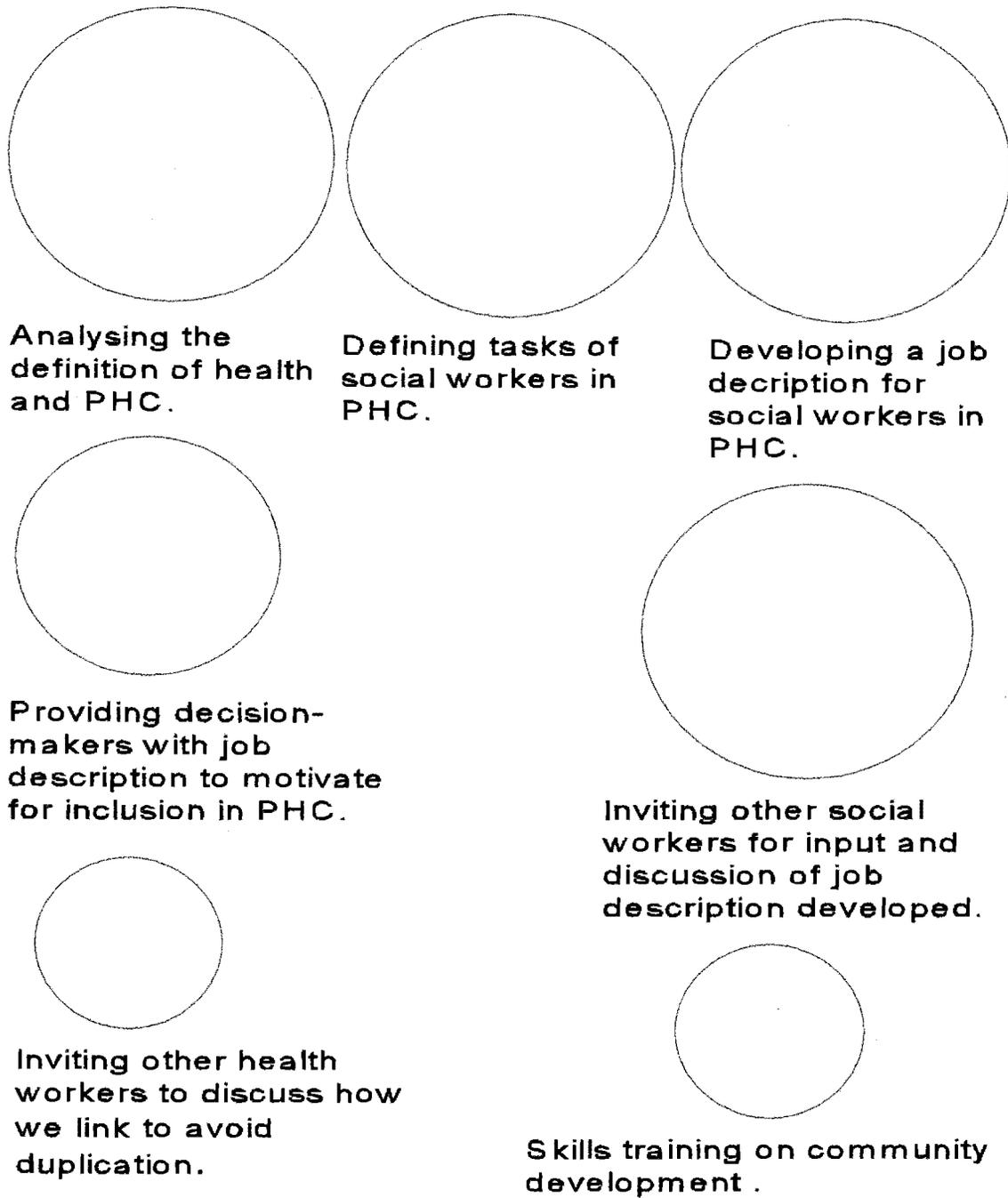


Figure 2 : Venn diagram.

KEY: Circles represent paper cuttings of different sizes.

The size of the circle indicates the order of importance of the action that is to be carried out by the participants. The bigger the circle, the more important the action.

By analysing the venn diagram it is clear that analysing the definition of health and PHC is the most important action to be taken as all other actions depends upon the successful completion of this action. The task of defining the tasks of social workers in PHC, developing a job description for social workers in PHC, inviting other social workers for input on the developed job description and providing the decision makers with the job description of social workers in PHC are of equal importance. The participants decided on the chronological order since the completion of some actions depends on the completion of other actions. For instance, providing decision-makers with the job description is of equal importance as developing a job description, but participants need to act in order to have a job description so that they can then present it to the decision-makers.

The list was too long and it was not going to be possible to implement the actions within the stipulated time of the research. Therefore, I negotiated with the participants about the possibility of prioritising the actions to be taken and that the first three actions decided upon to be given attention for the purpose of the dissertation. I also mentioned that all actions decided on were still to be attended to as the process would continue even after the final report has been forwarded to UNISA. It was important to state this to reassure the participants as the previous experience with a researcher who was attaining a Master's Degree had been seen as betrayal. Consensus was reached on the condition that the process would continue.

4.5.2.1 Planning for action

We first evaluated whether the actions decided upon were feasible using Egan's (1990:380) force field analysis, which enabled us to assess the facilitating and restraining forces. When the facilitating and restraining forces were compared, it was discovered that the facilitating forces out-numbered the restraining forces. Participants discovered that they had resources within and outside the group, as some of the participants possessed the skills needed to carry out the actions. Other social workers not involved in the PR were also identified as a resource. The evaluation motivated the participants to move on.

4.5.3 Action

The Strategy for Primary Health Care in South Africa (1992) was readily available for analysis. Matthew et al (1989: 10) provided the participants with guidelines on the procedure for analysis. The *White Paper for the Transformation of the Health System in South Africa* (1997) was also readily available for analysis. The action that the social workers were involved with was that of analysing the above mentioned documents.

4.5.3.1 Analysing the concept of health

This was done by analysing the definition of "health". As already stated on previous pages in this report, WHO defines health in terms of "physical, mental and social well-being of the individual" (Matthew et al 1989: 10). From the analysis, participants concluded that social workers did have a role in PHC as health was not only about medical cure, because spiritual, mental, and physical well-being of the communities which social workers were concerned about were of equal importance.

4.5.3.2 Analysis of Strategy for Primary Health Care

The analysis of the definition of PHC as defined in *The Strategy for Primary Health Care* was found to have principles and values that bear a striking resemblance to those on which social work is based.

These principles are summarized as follows:

- Equal distribution of resources;
- Active involvement and participation of the community;
- Preventive and promotive care, rather than only curative services;

- Belief in the worth and dignity of the individual;
- Respect for self-determination of the individual.

The principles of PHC were used as a basis to determine the role of social workers in PHC.

4.5.4 The principle of community involvement

Community participation is regarded as important in PHC and in social work, as it encourages the development of self-determination and self-reliance. Community members have the right and duty to participate in the planning, implementation and evaluation of their health care. This is the process of empowerment, but in reality involving the community in participation is not easy. Sekgobela (in Dennil 1995: 64) maintains that some professionals avoid involving the communities on the basis of their alleged ignorance, while other professionals are uncertain as to the how or when the community should be involved.

Max-Neef (1991: 12) feels strongly about the paternalistic attitude adopted by such professionals. He concluded that:

“we live and work according to the tenets of our formally acquired knowledge. Thus we see in so many leaders a pathological fear of peoples action and of freedom. The people are to be helped and guided by those who arrogantly ignore what the people need and want. We identify generosity with charity and participate with favours granted from above”.

The participants concluded that barriers to community participation may be due to the highly centralized health planning process where most programmes are in a form of a blueprint, developed nationally and implemented throughout the country.

The concept of community participation is not foreign to social workers. Social workers are process-oriented and not task-centred. They are able to move at the pace of the people. Social workers have the skills to facilitate community participation. They could then be involved with promoting community participation, by assuming an advocacy role and educating communities about their right, since participation is a basic right of all people.

Social workers can assume an enabling role, allowing people to plan for their health needs. The social workers' approach is different from the other health care workers approaches in PHC as social workers regard individuals as having the potential and the knowledge which must be utilized by health experts to plan for their health needs.

4.5.5 The principle of prevention and promotion

Health education is viewed as a central tool in health promotion. Educating the community is regarded as equally important by the *The Strategy for Primary Health Care* (1992). Social workers in health care share the same view. There is an agreement that education is the essence of any attempt to improve the quality of life of the communities. However, no education is ever neutral; "it either empowers or domesticates as one tames an animal to obey its master's will" Freire (in Hope & Timmel 1984: 8).

Through discussions the participants concluded that health educators in PHC adopt a "banking" type of education which assumes that the health professional is an expert and that the community knows nothing and must be taught (Freire 1970: 59).

Thus health education is decided by the health authorities, and preventative messages employed are based on medical priorities. Individuals are motivated to accept interventions or act according to the advice of the health workers. For instance, HIV/AIDS campaigns are launched to persuade people to use condoms without taking into consideration the knowledge and skills that the communities possess.

Communities are treated as passive, ignorant recipients and the professionals as active, informed distributors of knowledge. Thus “upliftment”, and development approaches are aimed at providing them with amenities that *we think they need* and instruct them on how to use these amenities. Also, awareness campaigns/programmes are developed “for” and not “with” the communities.

Developing “awareness” campaigns assume that those who suffer are not aware of their suffering (Max-Neef 1991: 12). The action of deciding for communities also deny them of their self determination. Although participants work from a person centred approach they embrace Maturana’s (in Dell 1985: 6) cybernetic, epistemological assumption that “living systems are autonomous and informationally closed and that we cannot change in an instructive way any other system”. Participants also support the view held by Hope and Timmel (1984: 25) that community education alone does not empower communities.

People also need to gain self-confidence and to feel that what they think and know is important and valued. Social workers work from a people-centred approach not a skills- or information-centred approach. Social workers believe that learning should be a two-way process. They embrace the idea of adult learning and believe that communities should participate in determining their learning programmes rather than having experts decide for them what their educational needs should be. Social workers are able to involve communities in participatory learning.

Because they trust and respect the community and regard their knowledge as important and valued, social workers are able to build on what the people already know and have. They are able to start where people are, actively involving people in the critical exploration of issues as well as involving them in seeking desirable improvements to problematic situations rather than impose. They are sensitive to, and respect the culture, beliefs and traditions of the people.

Social workers respect the people's right to self-determination and regard them as having inherent potential. It is for this reason that the participants have concluded that social workers are well suited for involving people in the prevention and promotive programmes in PHC.

4.5.6 Comprehensive approach to PHC

There is recognition that health problems are multi-causal and that intervention to improve health requires a series of interventions inside and outside of the health sector. A comprehensive approach is regarded as necessary to improve the health status of the community. Community development, which is intervention at community level, practised by different disciplines to improve the quality of life of the communities is regarded as imperative if PHC is to be successful (Dennil et al 1995: 3).

Social workers are well-placed to use a community development approach because of their training to use an integrated approach. Apart from rendering counselling services around psycho-social problems, social workers can involve communities in income generating, employment generating schemes and other relevant programmes according to the needs of the communities to enable communities to develop self reliance. From analysing *The Strategy for Primary Health Care (1992)*, the social workers discovered that they did have a role in PHC and that they have a valuable contribution to make. The participants also decided to analyse current social realities in health to determine where they would fit in.

They focussed on the following areas:

- Tuberculosis, a preventable and curable disease, was found to be a killer disease as well as a disease associated with poverty. Social workers concluded that they could be involved in communities providing basic information on ways that people can improve their living conditions and by involving communities in self-help schemes;

- Fighting the HIV/AIDS epidemic is important and cannot be separated from development activities such as improving living conditions of those affected, creating job opportunities and educating women especially sex workers. Advocating for the rights of the victims, by fighting against discrimination and stigmatisation of people with HIV/AIDS. Social workers could also establish support groups with the victims to enable them to cope with their condition.

- Malnutrition, a disease associated with poverty, is on the increase. Studies by Miller (1988: 156) have revealed that there is no medical solution for malnutrition and that there is an interrelationship between poverty, development and health. This study also supports the fact that social workers could provide a valuable contribution in PHC by involving communities in development programmes because they have skills in working with communities, they could facilitate community development programmes that are sensitive to the communities' needs.

4.5.7 Recording

The information that emanated from these discussions was recorded on the flip charts by participants who took turns assisting each other with the recordings. Participants have agreed that the recorded data had to be kept in a safe place as the participants were going to use data for the purpose of developing a job description. Data collected was verified with the group for confirmation, and the following conclusions were recorded:

1. It is evident that social workers have a definite role to play and that they can contribute to the provision of comprehensive services.

2. By way of participatory research, the participants realized why they were excluded in PHC. They discovered that by not assuming a pro-active role, they could not define their role in PHC. Thus others were making decisions for them as to what their role should be, assigning them very little in PHC.

3. The participants also realized that they were not assertive about their role and that this created limited situations. They had specialized knowledge and were specifically trained to use the integrated approach and were better-suited than other health care providers to address health needs through community development in PHC, but were not marketing or asserting themselves. Thus, they could not take the responsibility to move into their position as competent professionals with a valuable contribution.
4. The participants realized that they could be better utilized if decision-makers knew what their roles could contribute in PHC. They identified the causes of their problems as well as how they were contributing to its existence.
5. Participants have taken the necessary action to correct the situation and have committed themselves to act in order to correct the situation.

4.5.8 Evaluation of the process

Since participatory research by its nature is said to be a learning process, it was important to evaluate whether there was any learning and to specify what was learnt. The feedback received from individual participants was that they felt that they had learned to view themselves as resourceful and as having the ability to do things for themselves, rather than as complaining and not acting or waiting for outsiders to do things for them.

They regarded the ability to analyse *The Strategy for Primary Health Care* (1992) on their own as growth and development on their part. All participants were actively involved in analysing *The Strategy for Primary Health Care* (1992) and contributing valuable ideas without being prompted. The leadership role was shared among the participants. My role was that of a co-learner as we were all intensely involved with the analysis. Participants have agreed that they needed to develop a job description. This was the focus for the next meeting.

4.6 Fourth meeting

The purpose of this meeting was to develop a job description for social workers.

4.6.1 Reflection on the meeting

Participants felt that, although they had described their role in PHC, they needed to be more specific about their role, if what they intended to do in primary health care was to make sense to others not involved in the participatory research process.

4.6.2 Planning for action

There was a lot of information that was generated by participants that needed to be organized in order to develop a job description.

4.6.3 Action

Participants had to answer this question:

What do health social workers do in Primary Health Care?

Participants analysed the information on flip charts, shared ideas to contribute to the development of the job description. The information generated was used as a basis for the development of the job description, and we came up with the following:

Job description of social workers in PHC.

Social workers involved in PHC can help with the following tasks:

- Facilitating and supporting the development of community initiatives within the sphere of health;

- Facilitating the process of community involvement in decision-making in health matters affecting the community;
- Providing an enabling role to communities in identifying and planning on how their health needs are to be met;
- Promoting the development of self-reliance through community development projects such as income- and employment-generating programmes;
- Becoming involved in preventive and promotive programmes by developing educational programmes with the communities to develop awareness on health issues;
- Advocating for the health rights of the communities by communicating with the employers and the significant others when there is a need.

See the Appendix for the final version (summarized) of the job description.

4.6.4 Evaluation of the process

My role was of a co-learner, providing and gaining information from the participants. Participants were taking an active role and we were all participating on an equal basis. Participants identified themselves as researchers as they were able to focus their attention on the identified concern and come up with a product namely, the job description.

Participants regarded the group as providing them with a learning experience as they were able to learn in a supportive environment by focussing on common interests. They realized that they were capable of tackling problems and coming up with solutions on their own that they initially thought they could not attend to. They felt empowered. This experience has motivated them to move on to the exploration of other issues that they are confronted within the field.

Participants have decided that other social workers in health who were not involved in the PR were to be invited so that research participants could share with them about the PR process and about the job description which they had developed. Participants would then request evaluation and input from the other social workers.

The participants saw the involvement of other social workers in evaluation of the job description as important as they could receive valuable contributions to correct possible shortfalls and improve the quality of the product. The social workers' involvement would also increase the chances of them identifying with and adopting the job description as their own product.

The participants were also aiming at gaining the support of more social workers by involving them, as the invited social workers could then provide support by forming part of the delegation that would present the job description to the Assistant Director for Special Groups in the Gauteng Region. Planning for the meeting involved planning for the date of the meeting as well as about how the social workers were going to be invited.

A decision was to be made on which social workers were to be invited to the meeting.

Through discussions, the conclusion was reached that only social workers in health in the East and West Rand regions were to be invited. The reason for inviting social workers from the East and West Rand was that because of the geographical area it was going to be convenient to maintain contact with them. Another reason for the limited number of social workers invited was that since evaluation had to be done participatorily, it would be better to work with a manageable group. Decisions made were recorded in the record book. And the volunteer phoned the hospitals inviting social workers for a meeting.

4.7 Fifth meeting

4.7.1 Purpose of the meeting

The purpose of the fifth meeting was to present the PR process that participants were involved with as well as to present the job description for evaluation to social workers who were not part of the PR process.

Only nine social workers attended the meeting but the participants were motivated to continue with the meeting, since the process and not numbers were regarded as important. The purpose of the meeting was explained of the group of social workers who attended. They were then all provided with the opportunity to introduce themselves. The research participants shared the presentation amongst themselves.

One participant presented the historical background of the group by stating why and how the group was formed. I took the responsibility of presenting the findings from the literature review highlighting how the findings linked with what we were doing: namely, explaining the role of social workers in PHC.

The other two research participants presented the processes that the participants were involved with and the experiences of the group. Two participants briefly presented the methods that were used to collect data. We also shared how the job description was developed. Then the invited social workers were allowed enough time to go through all the points listed on the job description. The invited social workers were later provided with the opportunity to evaluate the job description and to provide comments, inputs, questions or suggest modifications where necessary.

Some of the comments made were the following:

- Acknowledgement of the work done, but the concern was raised as to how this was going to make a difference in terms of influencing policy because other regions who are affected were not involved in the process.

I then thought of the project that involved all the social workers in the Gauteng Region that had failed, and realized the importance of starting “small” however, I refrained from responding to the comment as I did not want to sound defensive.

- One participant mentioned that PR by its nature was a small scale project. Therefore, it was not going to be possible to involve a larger group. She further stated that research participants were willing to facilitate a PR process in other areas should there be a need. In this way the work started by one group could be distributed throughout the region.

A lot of questions were asked concerning the intended meaning of some of the items on the job description, leading to the modification of these items. Evaluation of the job description initiated a dialogue as all those present participated in different ways, providing insight and asking questions, verifying information and providing insight and making suggestions. All the information that was contributed was recorded on a flip chart, and was later used to amend some parts of the job description. The product was then regarded as suitable for presentation to the Assistant Director for Special Groups in the Gauteng Region.

4.7.2 Planning

Participants agreed that the job description had to be presented to the Assistant Director to enable her to have a clear view on the role of social workers in PHC so that she can involve them as valuable service providers. Some participants, together with some of the social workers present, were nominated to present the job description to the Assistant Director.

4.7.3 Action to be taken

The date of the presentation of the job description was to be finalized after an appointment had been made with the Assistant Director. Decisions made and actions to be taken were recorded.

4.7.4 Evaluation of the process

My leadership role was decreasing as most members were taking responsibility, assumes leadership roles.

Participants and social workers were together involved in evaluation. All were satisfied about the progress made thus far. All were satisfied about the extent of participation and also recognised that through participation they developed something in common in order to make input and to have something in common by mutual consent that they could present to the Assistant Director. The social workers who were not part of the group adopted the job description and indicated that similar meetings needed to be held where other real life issues could be tackled through PR. How this is to be done is still to be discussed.

Active participation from all the participants was noted. Participants' confidence in the project had been increased. They participated freely sharing and gaining information about the research and they were all involved in learning. They also freely took up leadership roles and supported each other.

4.7.5 Evaluation of the extent of learning

Korten's (1980: 498) principles of learning guided the process of evaluation. According to Korten, participants need to become aware of what they have learned and participants need to consolidate their gains in order to move forward. I also consciously applied Korten's learning process approach assumptions that "for learning to take place, participants need to embrace error". I did this by urging participants to be honest when evaluating whether there was learning or not. The participants were to evaluate what was helpful and not helpful about the whole process, thus far, as these issues were to be brought to the fore and corrected for further learning to take place. Some participants mentioned the strength of working collectively because combined they were able to achieve what none would alone. Other participants mentioned the importance of awareness of the situation if action is to take place.

The analysis of the job description by a larger group made them develop new insight and to also analyse the finished product critically and to identify gaps.

The participants decided that in the next meeting they needed to have an in-depth evaluation, evaluating where they are, what they have achieved and whether they still needed to continue with the process. I negotiated with the participants that I had to present the dissertation to UNISA before the 15th of June 1998. Even so, the participants decided that the participatory meetings were to be continued with the following aims:

- Inviting other health care workers to a workshop to explain our role and to identify how we can link;
- To do an overall evaluation and an overview of the conclusions.

4.8 Disseminating information

Unlike in traditional research where the researcher has unilateral control over the production of knowledge, the dissemination and the use of information, in participatory research, people have control over the whole process, including dissemination of information. As negotiated with the research participants I took the responsibility of writing up the report with the assistance of the participants who provided me with the ideas on what to write and what to leave out. Participants were also provided with an opportunity of reviewing the report for approval before it was submitted to UNISA.

CHAPTER 5: CONCLUSION

5.1 Introduction

The aim of this chapter is to present the limitations and the major findings of participatory research as well as the conclusions drawn and recommendations made by participants. A final reflection by the researcher on the whole process is also presented.

5.2 Limitations

- Participatory research is time-consuming and demanding. It seems to be a never-ending process as the identification and exploration of concerns lead to the identification of other issues. The danger of the never-ending process is that other members might lose commitment to the project or move to a new job.
- Because of the "newness" of the approach, valuable information might have been left out. Other valuable information such as the non-verbal communication, could not be recorded as such information is not amenable to recording.
- Since there is no objective reality, the findings cannot be generalized to individuals not involved in the Participatory Research process. Thus, even the job description is open to negotiation and re-negotiation.

5.3 Major findings

It was discovered that social workers in health care were not assertive. Hence decision were made for them by authorities not in the social work profession. Social workers were not defining their role in PHC. Therefore, it was difficult for decision-makers to assign them tasks, as it was not known what social workers do in PHC. Social workers were also found to be apathetic. Social workers needed to break through apathy and to take action to correct the situation.

5.4 Conclusions

Participatory Research is indeed empowering. Since its inception, social work has been devoted to empowerment of the people. It is ironic that although social workers are concerned with the empowerment of people, they were unable to empower themselves. A social work historian observed and concluded that social workers often "returned power or had it taken away from them in the process of empowerment of the people" (Henk 1989:27). Through participatory research these social workers were empowered. Participatory research can thus be recognized as having the potential to return power to the people.

The participants also concluded that social work is relevant in PHC. By analysing the major findings, the participants concluded that the inability to define their role in PHC had dysfunctional consequences for the social work profession in health care. The image and identity of social workers in health care was threatened.

The continued existence of the profession was threatened as health authorities were deciding for them what their role is in PHC assigning them limited tasks while most social workers tasks in PHC were assigned to other health professionals who did not have the specialized knowledge. The lack of action to prove that they could render valuable contributions in PHC nearly cost the social workers in health their jobs, and this was going to have negative implications to the social work profession in general.

5.5 Recommendations

From a number of ideas contributed, the participants came up with the following recommendations. Since PR is based on the principles of a people centred approach and emphasizes the bottom up approach, PR is recommended as an appropriate method of research which is relevant to the current trend in South Africa which requires active involvement of all those that are concerned.

It is recommended that PR be used more, since the approach has the potential to mobilize people for collective reflection and action. PR is recommended as it is a more useful approach in the generation of knowledge. PR is also recommended as it fits within the basic principles of social work. The use of PR in social work practice have some benefits. Social workers learn skills to do their own research, share and gain information and in the process, they get empowered. PR could be useful and have similar benefits in other governmental and non-governmental settings as well.

What was learned?

By working collectively, participants learned skills to conduct their own research. PR provided a safe environment where participants could share and gain information and in the process they became empowered. I, as researcher-facilitator, learned the importance of working collectively. Hope and Timmel (1984: 17) clarify this by quoting the following Madagascar proverb, "cross the river in a crowd and the crocodile won't eat you". By joining in solidarity and taking collective action, these participants were able to share and build their own channels of expression, negotiate from a position of strength and challenge the status quo.

Initially these social workers were complaining and not acting and their dissatisfaction remained constant. Freire (1970:35-37) argues that individuals cannot wait patiently for oppression to disappear by itself. "A mere perception of reality not followed by critical intervention will not lead to a transformation that "nothing will come of nothing" is "true" as reflection without action will not lead to change.

It was only after the participants engaged themselves in reflection and action that they were able to critically look at the situation that they found themselves in and to act in order to correct the situation and ultimately to produce a product namely, a job description for social workers in PHC. (See Appendix)

Future Planning

The developed job description will be posted to social workers in hospital setting who

did not avail themselves for evaluation of and input on the job description, with a request for their input.

Should the job description developed be accepted by other social workers and the Assistant Director for Special Groups, it will then be tested in practice. Other health professionals are to be invited for the purpose of presenting the job description of social workers in PHC, so that they have clarity on what the roles of social workers are so as to avoid role confusion.

5.6 Final Reflection

PR is a discovery, a learning experience where each individual involved learns by doing and learns with others.

Not only did I learn how to conduct research by doing it I also learned with others. To re-phrase Rogers (1978: XII) definition of the person-centred approach, "It is not that this approach gives power to the people, it never takes it away". PR never takes power from the people, the action leaves the people empowered.

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APPENDIX A : SUMMARIZED JOB DESCRIPTION
JOB TITLE : SOCIAL WORKER
DIVISION : PRIMARY HEALTH CARE

A. BASIC PURPOSE OF THE JOB

To render an integrated social work services to clients in order to promote their well-being.

B. KEY TASKS

DESCRIPTION OF TASKS

1. Receive referrals from other health care professionals.
2. Plan first contact with clients.
3. Make first contact to assess the situation and the need for social work intervention.
4. Provide counselling services to clients, families and groups regarding illness and the underlying psycho-social problems.
5. Write process notes of all contacts made.
6. Assess how the social situation of client(s) affects his/her physical well-being and provide information to the health team for informed decision making.
7. Liaise, consult and or correspond with any internal or external source pertinent to clients being dealt with.
8. Take part in the discharge planning of clients.
9. Conduct home visits to assess the coping abilities of clients.
10. Equip clients and their families with coping skills to ensure that progress is maintained.
11. Conduct follow-up visits to ensure continuity of care.
12. Protect the human rights of clients, particularly those with special needs.

COMMUNITY DEVELOPMENT

13. Advocate for the community's right to participate.
14. Sensitize other health workers about the importance of community participation.
15. Encourage the development of self-determination and self-reliance of the community by developing the capabilities of the community to participate in determining and planning for their own health needs.
16. Address the main health problems in the community by developing and providing

health promotion and illness prevention programmes with the community.

17. Advocate for health education that is participatory in nature.
18. Reach out to the community by providing education concerning prevailing health problems.
19. Establish support groups according to the needs of the community.
20. Establish and assist self-help groups to develop income-generating and job-creation projects to improve the general socio-economic situation.
21. Facilitate and support the development of community initiatives and strengthen the community's efforts at meeting health needs.
22. Assist the community in the optimum use of health care programmes.
23. Develop capacity building by training lay counsellors to deal with the HIV/AIDS epidemic.
24. Socialize and humanize programmes in the interest of the community's needs.