THE EXPERIENCES OF SOCIAL WORKERS WORKING IN MULTI-DISCIPLINARY TEAMS IN STATE HOSPITALS IN THE WATERBERG DISTRICT, LIMPOPO PROVINCE

by

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DECLARATION

I Tsemeng Jack Legodi (student number: 37323008), declare that THE EXPERIENCES OF SOCIAL WORKERS WORKING IN MULTIDISCIPLINARY TEAMS IN STATE HOSPITALS IN WATERBERG DISTRICT, LIMPOPO PROVINCE is my own original work and has never been submitted either in part or in totality for examination at any institution for any other qualification. I also declare that all referral sources that I have consulted have been acknowledged under in text referencing in the study and under bibliography.

TSEMENG JACK LEGODI

 ***NOVEMBER 2022***

DEDICATION

This dissertation is dedicated to my late sister Ledile Merriam Legodi, her instant passing left me with a long-term trauma, even though it is currently twenty-three (23) years ago. The pain of a brief thot about the day and the incident seems like it happened yesterday Through her perseverance and the sacrifices she made for me to ensure that I have a better life and education, will always be remembered by me until the the end of my days. The courage and motivation for me to complete any activity comes from my memories of her, which will always be there. May her precious soul through God, continue to rest in eternal peace.

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ABSTRACT

Following South Africa's independence in 1994, the number of hospital social work posts in state hospitals were substantially increased. Subsequently, unprecedented contextual changes have affected hospital services, including hospital social workers. This study focused on the experiences, challenges and coping strategies of social workers working in multi- disciplinary teams in state hospitals in the Waterberg District, Limpopo Province, amidst these changes.

A qualitative approach using a phenomenological research design, augmented by exploratory, descriptive and contextual research designs was used. The purposive sample of ten social workers based in eight state hospitals in the Waterberg District were interviewed using semi-structured interviews facilitated by an interview guide. The analysis of the data was achieved using Tesch's eight steps in coding (1992:117). The bioecological systems approach (Bronfenbrenner 2005) and the Life Model theory (Gitterman & Germain 2008) were combined to frame the study. The data collected were supported by a virtual online discussion forum. Guba and Lincoln's (1981) concept of trustworthiness: principles of credibility, transferability, dependability and neutrality were used to verify the data. Ethical principles of informed consent, confidentiality and anonymity, beneficence and careful management of data upheld the ethical integrity of study and the safety of research participants.

KEY TERMS

Corona virus; COVID-19; Experiences; State hospitals; Limpopo Province; Multidisciplinary teams; Professional identity; Professional roles; Social Work; Waterberg District;

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ADDENDA

LIST OF ACRONYMS AND ABBREVIATIONS

AHPCSA	**Allied Health Professions Council of South Africa**
ANC	**African National Congress**
COVID-19	**Coronavirus**
CPD	**Continuous Professional Development**
CSG	**Child Support Grant**
DHA	**Department of Home Affairs**
DoH	**Department of Health**
DSD	**Department of Social Development**
HIV/AIDS	**Human Immune Virus/ Acquired Immune Deficiency Syndrome**
HOSPERSA	**Health and Other Services Personnel Trade Union of South Africa**
HPCSA	**Health Professions Council of South Africa**
HRM	**Human resource management**
ICU	**Intensive Care Unit**
MDR	**Multi-Drug Resistance**
NEHAWU	**National Education, Health and Allied Workers Union**
PMDS	**Performance Management Development System**
PPE	**Personal Protective Equipment**
SACSSP	**South African Council for Social Service Professions**
SANC	**South African Nursing Council**
SOP	**Standard of Operational Procedure**
TB	**Tuberculosis**
WHO	**World Health Organisation**

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CHAPTER 1

GENERAL INTRODUCTION, PROBLEM FORMULATION AND ORIENTATION

1.1 INTRODUCTION

The introduction to this research about the experiences of social workers working in multi-disciplinary teams in state hospitals in the Waterberg District, Limpopo Province, offers an overview of the background about why this study was chosen and how it was conducted. It describes the background and problem formulation, theoretical framework and research questions, goal and objectives of the study. This is followed by explaining the research methodology, research methods, data collection and data analysis, before explicating the maintenance of the study's trustworthiness. The ethical considerations, key concepts used in the research report and the format of the thesis are expounded. In conclusion a summary of the chapter is presented.

1.2 BACKGROUND

This section introduces the reader to first section of Chapter 1, the introduction and the reasons for undertaking this study. The topic of social work in multidisciplinary hospital settings, the advantages and limitations of these teams and the reasoning behind including social workers as allied professionals within multidisciplinary teams are discussed to orientate the reader to the research topic. This is followed by a description of developments in the field of social work and health care that could potentially affect the original conception of the social worker's role in a multidisciplinary team in a hospital setting, and challenge the role of social workers, their professional identity and their ability to fulfil their professional mandate in hospital settings. Subsequently, information is offered about the context of the study. These themes explain the gaps the researcher detected in existing literature related to the experiences of social workers working in multidisciplinary teams in a state hospital in the Waterberg District in Limpopo Province. The introduction sets the stage for the formulation of the research problem, the problem statement and shares the researcher's motivations for embarking on this study.

1.2.1 Social work and the purpose of adopting a multidisciplinary approach in health care

For more than a century a multidisciplinary team approach has received positive acclaim in the health sector based on the notion that inter-professional collaborative practices improve health outcomes for patients in the health care system (Albrithen & Yalli 2016:129; Ambrose-Miller & Ashcroft 2016:101; Craig & Muscat 2013:7; Morley & Cashell 2017:207). To be effective, multi-disciplinary teams, particularly in hospitals, must achieve good inter-professional teamwork between the medical personnel and the allied professionals, which include social workers (Albrithen & Yalli 2016:129). Whilst the multidisciplinary team consists of an assortment of specialised health care professionals, some scholars include the patient and his or her family as team members too (Morley & Cashell 2017:207). The role players are expected to work together in a cooperative and coordinated manner for the benefit of the patient's wellbeing (Eaton 2018:854).

Social work and the purpose of adopting a multidisciplinary approach in health care are discussed in terms of the role of social workers in health care settings; definitions of multidisciplinary teams in health care; and the value and limitations of multidisciplinary teams within health care.

1.2.1.1 Role of social workers in health care settings

Current publications offer guidelines about the main tasks social workers in healthcare settings perform, which include having to –

- facilitate communication between health care team members, patients and their families (Kirschbaum 2017:6);
- advise and motivate for appropriate services for patients and their families (within the hospital and the broader community) (Limon 2018:1);
- render psycho-social services to patients in specialised care wards and emergency trauma units (Estelle 2017:31);
- monitor post-operative rehabilitation of patients (Steyn & Green 2010:3);
- impart information to both patients and multi-disciplinary team members to improve decision making about the patients' health care (Steyn & Green 2010:3);
- represent patients' wishes in terms of advance directives, patient rights, and 'do-not resuscitate' orders (Eaton 2018:853; Kirschbaum 2017:6); and

- source relevant services for patients to facilitate their rehabilitation after their discharge (Eaton 2018:853; Kirschbaum 2017:6).

In addition, social workers in hospital settings render services in general and specialised wards such as paediatrics, oncology, nephrology, organ transplants and emergency trauma (Estelle 2017:31; McLaughlin 2015:6). They link the patient and patient's family with relevant community resources and monitor their post-operative rehabilitation (Steyn & Green 2010:3). They are also facilitators of communication between health care team members and the patient and patient's family (Kirschbaum 2017:6). All these activities advance the general quality of patient wellbeing.

The roles that social workers fulfil in hospital settings are not limited to direct face-to-face interactions with patients. Social workers also fulfil duties that are desk-based, such as working with computerised data, or conducting management functions, as well as administrative and undertaking research tasks (Estelle 2017:31; Hennessey 2010:2; Olckers 2013:17). The role that social workers play in coordinating and facilitating the communication and coordination of responsibilities within multi-disciplinary task teams is also noted (Albrithen & Yalli 2016:129; Giles 2016:30; Robinson 2012:1).

1.2.1.2 Definitions of multidisciplinary teams in health care

A descriptive definition of a multidisciplinary team as presented by Finlay (cited by Albrithen & Yali 2016:131) describe a multidisciplinary team as "a group of individuals with varying backgrounds, perspectives, skills and training who work together towards the common goal of delivering a health or social outcome." This definition acknowledges the value of integrating the professional expertise of different health care providers, nurses, social workers, psychologists, pharmacists, physiotherapists, dieticians and so forth (Albrithen & Yali 2016:129; Ambrose-Miller & Ashcroft 2016:101) to support the physician's role so that different areas of professional knowledge are combined to advance the holistic care of patients (Briggs, Fronek, Han, Kim, Kim et al. 2017:126; Ndoro 2013:724). Each professional member contributes specialised information and interventions that are coordinated with those of the other team members, in a collaborative manner, based on the assumption that no single specialisation has all the answers (Ndoro 2013:724). One expects the different team members to enjoy equal status within such multidisciplinary teams (Dale, cited by McAuliffe 2009:126).

Different terms are used interchangeably in the literature to refer to multidisciplinary team professional' and 'inter-disciplinary' (Sellman & Snelling cited by Ndoro 2013:724). However,

some authors assert that the term inter-disciplinary, has a more distinctive meaning than the other terms, “work where groups make adaptations to their role, to take account of and interact with the role of others” (Hogston & Marjoram cited by Ndoro 2013:724). This definition highlights the transactional nature of multidisciplinary team members as they influence and are influenced by other team members. For the purposes of this research, the researcher uses the terms ‘multidisciplinary work’ and ‘multidisciplinary teams’, because these terms are generic and relevant to this study.

1.2.1.3 Value and limitations of multidisciplinary teams within health care

The advantages and disadvantages of multidisciplinary teamwork have been discussed in literature. The following advantages of multidisciplinary teamwork are highlighted by several authors (Albrithen & Yalli 2016:131; Eaton 2018:853; Dobriková, Hromkova, Letovancova, & Slana 2016:83; Kirschbaum 2017:7; Ndoro 2013:726; Bowden, Corcoran, Crowe, Crowe, Costell et al 2016:56):

- Team members are better informed about one another’s activities and roles which improves inter-professional communication.
- Team members work collaboratively, which results in the rendering of better high-quality care to patients, higher survival rates and shorter treatment times.
- Better connections are established between team members, namely patients, their caregivers, and medical and allied disciplines which ensure that information is more easily shared and trust between team members is higher.
- Team members accrue more knowledge and skills which benefit the patients, increasing their access to care and resources, and making more treatment options available to them.
- Teamwork reduces in-patient hospital stays and premature admissions and discharges.
- Teamwork contains hospital spending and increases organisational efficiency.
- Team members enjoy greater career mobility when healthcare circumstances change.
- Research outputs on relevant health care issues increase because different professionals combine their expertise which creates new information.
- More innovations in health care emerge from the cross-fertilisation of creative ideas from the different disciplines.

- Better decisions are taken for patients with problems because different professional disciplines review the positives and negatives of treatments collectively and with thorough consideration.
- The mutual support demonstrated between team members makes it easier for them to deal with difficult cases and or adapt to challenges they jointly experience in the hospital.
- When team maturation occurs, the hospital functions more effectively.
- Team members experience greater work satisfaction.
- The staff's adherence to clinical guidelines improves.
- Inter-professional learning improves practice which has increased health benefits for patients.
- Comprehensive collaborative diagnoses of patients positively contribute to higher survival rates.

Despite the list of advantages of multidisciplinary teams, such teams are never without challenges. Some implicit limitations are highlighted in several articles (Beddoe 2011:35; Bowden et al 2016:70; Craig & Muskat 2013:8; Ndoro 2013:727:). These limitations include the following:

- Conflict between individuals and groups within the hospital setting.
- Inadequate communication amongst team members.
- Longer times are taken to make decisions about patient care and treatment that must be offered.
- Miscommunications taking place because of team members disseminating incorrect facts amongst themselves.
- Lack of trust within the team.
- Obscurity about roles and responsibilities within the multidisciplinary team.
- Conflicting goals or objectives based on the diverse professional expertise and professional values of the different disciplines.
- Poor action plans when team members fail to collaborate and cooperate with one another.
- Poor leadership or unstable leadership because of professional rivalry and or the 'bosses' delivering different directives that confuse team members.
- Inequality of decision-making and power delegated to the different disciplines that make up the team.

Whilst many of these challenges are intra organisational, according to Leach, Leach, Morgan, Strand de Oliveira, Hull, Østbye et al. 2017. 18(1):124), issues situated within the larger social and policy contexts of hospital settings, can destabilise the effectiveness and efficiency of multidisciplinary teams in hospital settings. These factors create multiple challenges that undermine the functioning of the teams (Leach et al 2017:124). According to Raniga and Kasiram (2010:269), many of the challenges that affect the relationships between social workers and other team members are created by macrostructures that are responsible for developing financial, time and workplace policies. There appears to be a lacuna of information about what these challenges are and how they affect the occupational satisfaction and professional identity of social workers. The researcher therefore recognised the experiences of social workers working in multi-disciplinary teams in state hospitals in the Waterberg district, Limpopo province as a relevant topic for further study.

Limited research has been undertaken about social workers' experiences of how others in health care settings perceive them (Craig & Muscat 2013:7-8), particularly within South Africa. The researcher wanted to understand the meanings social workers ascribe to how they are acknowledged by hospital management and other team members in the multidisciplinary teams in which they function. Information was needed about how social workers are affected by the lack of clarity amongst other team members in the multidisciplinary team about the contribution social workers should be making in a hospital setting. The researcher assumed such dilemmas could affect the occupational satisfaction of social workers and their professional identity (Beddoe 2011:26). A locally specific understanding of the topic that focussed on social workers employed in state hospitals in the Waterberg District in Limpopo Province, was needed to understand how they should be discussed.

In being curious about external factors situated outside the multidisciplinary teams that affect social workers in hospital settings (Beddoe 2011:27) and being unable to find literature on the topic, the researcher found a chasm in the existing body of knowledge that required further exploration. Empirical evidence of how social work practice in hospital settings has evolved to adjust to overcoming external challenges that impact on social work and health care services, was clearly lacking. Some of the obvious unprecedented challenges or 'new realities' that may affect social work practice in hospital settings are mentioned next.

1.2.2 Changes in social work and health care experienced by social workers in hospital settings

Social workers have faced multiple changes in social work and health care over the years (Beddoe 2011:24). It remains unclear how the changes in health care have affected social workers in multidisciplinary teams (Nwanchukhu 2015:139). Craig and Muscat (2013:7) refer to the "stormy sea of change" and explain that these changes in health care include issues such as funding shortages in health care, escalating costs of life-saving approaches for chronic diseases, increased outlays on medication, increasing hospitalisations of patients, advancements in treatment of complex health conditions; and expanded treatment options and services for patients. Weiss (2005:3) asserted that the practice of social work in medical settings has not been revised since the 1930's. Whilst information is available about factors that influence job satisfaction among urban and rural health care workers in KwaZulu-Natal (Du Plessis, Tawana & Barkhuizen 2019:1), the job satisfaction of nurses in North West Province (Khunou & Davhana-Maselesele 2016:406), issues responsible for the turnover of nurses working in the public sector in Limpopo Province (Tshitangano 2013:6) and circumstances that demoralise paediatric rehabilitation professionals in under-resourced rural hospitals in Limpopo Province (Mathye & Eksteen 2017:406), it was a challenge to locate studies related to social work in the Waterberg District, Limpopo Province. Information about how the 'new realities' of health and welfare services within this district impact on the job satisfaction and professional identity of social workers working in multidisciplinary teams in state hospitals appeared to be non-existent. The researcher contemplated whether a failure of social work to adapt to new circumstances could negatively affect social workers in hospital settings.

The 'new' realities of health and welfare services mentioned in international and national literature (Drucker 2017:46; Heitkamp, Klinton & Oga-Omenka 2020) that potentially impact on social workers in hospital settings, are briefly mentioned. In this discussion the focus is on the industrialisation of social work subsequent to the 1990's; changes in the health care sector in the post- apartheid and colonial eras in South Africa; escalation in admission rates of previously disadvantaged people to state hospitals who have suffered intergenerational patterns of poverty and social exclusion; the recognition of social work as a specialised clinical service and proposed registration requirements; and lastly, the global pandemics of HIV and COVID-19.

1.2.2.1 Industrialisation of social work

Social work is reported to have become more industrialised in the early 1990's which has subsequently curtailed autonomous decision making of social workers; regulated the nature of the services they can offer; reduced many specialized services they used to deliver because they are expected to adopt a more generalist approach in service delivery, which according to Carpenter and Platt (1997) has resulted in the fragmentation of social work services. As noted by Kitchen and Brook (2005:3) generalist social work services are briefer, more solution focused and the case management models developed must be adhered to. Some suggest the changes make it difficult for social workers to respond effectively to the complex human issues they must manage, and challenge their ability to uphold social justice and the rights of their patients at all times (Strom cited by Carpenter & Platt 1997:338). This is a major blow for social workers, who are meant to focus on social justice issues, and advocate for the protection and well-being of marginalised people (Delobelle 2013:160).

The industrialisation of health care services challenges social workers to survive in multidisciplinary teams in hospital settings and demands that they become more assertive to protect and uphold the professional values that essentially define them (Beddoe 2011:24). Raniga and Kasiram (2010:271) support this by noting that it is difficult for social workers to assert themselves in such settings where they are afforded less power and status.

1.2.2.2 Changes in the health care sector

The South African health care system underwent major changes after the first free and fair democratic elections in South Africa in 1994 (Rispel 2016). The then newly inaugurated African National Congress was tasked to redress the post-colonial and post-apartheid social and economic inequities that existed (Rispel 2016). Previously disadvantaged people had to be granted accelerated access to health care services.

To deal with it, specific objectives were established to reform health care services, namely -

- the development of a clinic infrastructure programme in townships and rural areas to make primary health care services accessible to all;
- provision of free health care services to pregnant women and children under nine years of age at all clinics and public hospitals;

- dispensing of key drugs in all public health care facilities to secure good care for all patients; and
- the development of an extended immunisation programme (Coovadia, Jewkes, Barron, Sanders & Mclntyre 2009:825; Rispel 2016).

In addition, the number of social workers employed in state hospitals increased to expand psychosocial support services for hospital patients and address social factors responsible for poor health and social circumstances of patients (Beddoe 2011:24; Craig & Muskat 2013:7). However, despite the reformative efforts made, health and health care inequalities between the public and private health sectors, urban and rural areas, remain within districts in all nine provinces (Harris, Goudge, Ataguba, Mcltyre, Nxumalo et al 2011:123).

The expanded basic health care services in South Africa has significantly strained South Africa's health care infrastructure (Delobelle 2013:160). Public health facilities are under-resourced and poorly managed (Plaks & Butler 2012:138). Rispel 2016 proposes that three major fault lines are responsible for the poor health services within South Africa. Firstly, South Africa is too lenient in matters of incompetence, poor leadership and failure of managements and authorities, to deliver health programmes and services efficiently. Secondly, the district health system is only partially functioning and therefore fails to relieve the overburdened state hospitals. Hospitals experienced major budget cuts to allow funds to be diverted to expand the primary health programmes. Lastly, the South African government has failed to address the serious health workforce crisis. Because of these deeply rooted failures, patients, health professionals and policy implementation suffer. Little information is disseminated about how social workers working in multidisciplinary teams have been affected by the complicated socio-political dynamics of this health care crisis, particularly social workers in the Waterberg District state hospitals in Limpopo Province.

The researcher was curious about how issues such as inadequate leadership, limited manpower and resources in the health care sector have affected the occupational status and professional identity of social workers within this district. In going forward, one must discover whether the health care crisis has impacted on decisions made about what tasks must be assigned to social workers; how the health crisis has affected the relationships between social workers and other members of the multidisciplinary teams; if sufficient sources are made available to social workers for them to execute their professional role; and how the health crisis has affected the nature and number of opportunities available to social workers for their professional development.

1.2.2.3 Escalation of previously disadvantaged people admitted to state hospitals

The admission to state hospitals of previously disadvantaged people who suffer from intergenerational patterns of poverty and social exclusion, has increased considerably recently, particularly in the Limpopo Province (Delobelle 2013:160). This has caused a greater demand for social work services within state hospitals, without knowledge of whether social workers feel they are adequately equipped to service and manage the high volume of cases of patients suffering socio economic challenges which compromise the severity of their health conditions and affect their recovery plans.

The introduction of the White Paper for Welfare Services in South Africa (Department of Social Development 1997; Patel & Hochfeld 2013:2) and the Framework for Welfare Services in South Africa (Department of Social Development 2013) advocate a more developmental approach in social work and a reduction of clinical interventions. The purpose of the change is to dismantle historical social inequalities and break the cycle of poverty that undermines the wellbeing of a majority of the country's population (Delobelle 2013:160; Patel 2015:9). The researcher was curious to know whether the mandate of social workers in hospital settings has changed to encourage social workers to adopt a more developmental social work approach as they attend to clients in hospital settings (Patel & Hochfeld 2013:2).

1.2.2.4 Medical social work as a specialised social work service

A process is currently underway to recognise medical social work as a specialised social work service in South Africa and other countries (Herbst 2017:8). With reference to South Africa, regulations in terms of section 17C (2)(a)(ii) and 28(1)(ii) of the Social Service Professions Act, 2020 as amended, have been drafted to recognise and register clinical social work as a specialised social work practice in health care services, but must still be promulgated (Social Service Professions Act 2016:6). The proposed requirements for a social worker to qualify to register as a clinical social work medical social worker in a health care setting, will require that applicants must have a recognised qualification in social work, be registered as a social worker with the South African Council for Social Service Professions (SACSSP); and must have –

- an appropriate Master's degree that is related to social work in health care that has been approved by the SACSSP, plus at least two years appropriate and evidence based practical experience within the scope of health social work services; or

- an appropriate post graduate diploma or certificate in social work in health care as approved by the SACSSP, plus three years appropriate and evidence based practical experience within the scope of health social work services; or
- five years appropriate and evidence based practical experience within the scope of health social work services; provided that the applicant demonstrates expertise in social work in health care and satisfies the SACSSPs assessment criteria for determining whether the social worker concerned is competent to practice health social work (van Breda & Addinall 2021:1; South African Council for Social Services Professions 2020:8;

It is unclear what social workers in state-based hospitals in Limpopo Province think about social work being statutorily recognised as a specialised clinical social work service and the proposed requirements for registration as a specialist social worker in health care.

1.2.2.5 The global pandemics of HIV and COVID-19

In the space of forty years, The South African health care service has faced two global pandemics, namely the HIV and AIDS and the COVID-19 pandemics. By 2016 over seven million HIV/AIDS positive cases had burdened the South African health care system and its workers (Wouters, Sommerland, Masquillier, Rau, Engelbrecht et al 2020:2). This pandemic worsened because the stigma associated with HIV/AIDS severely delayed the roll-out and uptake of antiretroviral treatment (Treves-Kagan, Steward, Ntswane, Haller, Gilvydis et al 2016:2).

The over- extended South African health care system had to face a further burden when the World Health Organisation (WHO) declared the coronavirus (COVID-19) disease pandemic on 12 March 2020 (Sorensen, Boosert, Kersting, Staab & Wacker 2021:1). Due to the high prevalence of HIV/AIDS and TB which includes multi-drug resistance (MDR) patients, the risk of a high mortality rate in South Africa as a result of COVID-19 was high. It is pointed out that COVID-19 has further negatively affected the mental health of numerous South Africans (Joska, Anderson, Rabie, Marais, Ndwandwa et al 2020:1). Physical distancing, job losses, stigma and discrimination associated with the virus are recognised as precursors to mental problems affecting South Africans in response to the coronavirus pandemic (Frissa & Semo 2020:718). COVID-19 has placed a severe strain on medical personnel and hospital resources. COVID-19 has caused a disruption in the facilities for rendering medical services due to the need of having to limit admissions by only considering life threatening cases for admission due to lack of staffing, with many medical staff members having to isolate

themselves and being under quarantine, as well as the lack of resources to manage the pandemic (McQuaid, McCreesh, Read, Sumner & White (2020:1).

Siedner, Kraemer, Meyer, Harling, Mngomezulu et al (2020:2) concur that South Africa as part of other Sub Saharian countries, resorted to reducing the visits to hospitals, and discouraging work, school, travel and leisure activities as much as possible as a means of trying to curtail the spread of COVID-19 infections

South Africa reported an estimation of 550 000 deaths in 2020 due COVID-19, which were higher than the predicted 485 000 deaths (Bradshaw, Dorrington, Groenewald, Laubscher & Moultrie 2021:1). Provincial deaths from 28 March to 3 July 2020, were a total of 3 088 casualties, with the Western Cape reporting 65.5%, Eastern Cape 16.8%, Limpopo 3% and Gauteng with 11.3% (Pillay-van Wyk, Bradshaw, Groenewald, Seocharan, Manda et al 2020:1).

There has been no published information about the above-mentioned contextual realities and their effect on social workers in the Waterberg District state hospitals in Limpopo Province, let alone the potential affects these changes have on their occupational satisfaction and professional identity and the way they function in multidisciplinary teams. A broader systemic perspective of the experiences of social workers based in state hospitals in the Waterberg District, Limpopo Province was therefore needed to understand how these social workers are affected by the new realities in their workplace, what roles and responsibilities they are allocated within the multi- disciplinary teams given the changes and discover whether they perceived their social worker roles as relevant and responsive to the new realities.

This curiosity, shaped the researcher's definition of the purpose of the study which was to develop an exploratory, descriptive and contextual understanding of social workers' experiences of working in multidisciplinary teams in state hospitals in the Waterberg District, Limpopo Province. A systemic approach was needed to highlight the intersectionality and interrelatedness of challenges that social workers face in their hospital settings and to identify the coping strategies they have developed to adapt to and deal with the unprecedented challenges as mentioned.

1.2.3 Context of the study

In describing the context of the research, information is provided about health care in Limpopo Province with reference to the Waterberg District state hospitals. This is followed by providing

information about the Waterberg District state hospitals and the social workers who are employed to work there.

1.2.3.1 Health care in the state hospitals in the Waterberg District, Limpopo Province

According to the Capricorn District Municipality 2021/22-2025/26 Integrated Development Plan (Capricorn District Municipality 2023) there are approximately 5.8 million people residing in Limpopo Province. The province is divided into five districts. The most populous districts are Vhembe and Capricorn, which together make up approximately half the total population of Limpopo Province. Waterberg is the smallest district that constitutes 13 percent of the population. The population in Limpopo Province, according to race, consists of 96.7 percent Africans, 2.6 percent Whites, 0.3 percent Coloureds and Indians/Asians (Day, Budgell & Gray 2011:4). The study focused on the Waterberg District which represents 13 percent of the population in Limpopo Province (Day et al 2011:05). A substantial increase in the Waterberg District's population in recent years has been reported, which is attributed to the high influx of illegal migrants from neighbouring countries, who have relocated to this district to improve their socio-economic circumstances and escape the political unrest in their countries of origin (Misago 2017:40).

The sociostructural challenges faced by the people of Limpopo Province are typical of most South African disadvantaged regions. They include crime, unemployment, poverty, HIV and AIDS, school dropouts, teenage pregnancy, poverty, unemployment, illiteracy and health issues, which more recently included COVID-19 (De Cock, D'Haese, Vink, Van Rooyen, Staelens et al 2013:276).

The financial problems experienced by the Limpopo Provincial Government and the high rate of poverty in the province impact negatively on the quality of health care that is delivered by the state hospitals (Delobelle 2013:162). The health system in Limpopo Province is overburdened (Phasa 2015:39). HIV and AIDS has placed strain on government expenditure in both health care and health educational services, and the whole health system (Bezuidenhout 2017:193). In addition, the public hospitals have a major workforce crisis that has not been decisively managed by the government (Rispel 2016:12). According to Phasha (2015:22) the health care crisis in Waterberg District is caused by poor working conditions, low staff morale and lack of promotional opportunities that have created a high turnover of staff. The manpower shortage has contributed significantly to the poor management of the state hospitals (Landman et al cited by Pasha 2015:39). The Limpopo Province is hard hit by the brain drain and has resorted to appointing non-clinicians as heads of hospitals (Pasha

2015: 2). Ineffective and inefficient service delivery, and the wide gap in management capacity between private and public sectors in the Limpopo region, are commonly reported by national and local media (Pasha 2015:2).

1.2.3.2 Social work in the state hospitals in the Waterberg District, Limpopo province

There are nine hospitals in the Waterberg District, each one employing between one and three permanent fulltime social workers. The newly qualified social workers report to more experienced in-house social workers. When there is only one qualified social worker at a hospital, he or she reports to a more experienced social worker who is based at the Waterberg District state hospital that is closest, however this is not gazetted but an internal arrangement between the social workers based in the state hospitals in the Waterberg District and may not apply to other districts.

The work that is expected of hospital-based social workers is mostly determined and prescribed by national legislation and the internal policies of the hospital such as the Standard of Operational Procedure (SOP) which is a common policy document for the province (Silence 2017:1). The operational roles currently assigned to social workers in South African public hospitals are largely based on the Functional Business Unit model (Silence 2017:1). Silence (2017:1) describes the functional unit model as a model where the multidisciplinary team members, except for nursing staff and social workers, report to a specialist medical doctor. The social worker reports to the matron responsible for the ward the social worker is designated to service. If there is only one social worker who is employed to service all wards in a hospital, the social worker reports to the allied manager who is responsible for hospital support services. This concurs with Healy's position (as cited by Beytell 2014:173) that there are various rules and regulations in place to manage the roles that social workers are assigned to in hospitals. Essentially, the roles of social workers are defined according to the needs of the hospital that has employed them. Social workers are expected to engage in multidisciplinary team ward-round discussions to contribute their expertise related to patient care progress and relevant treatment protocols needed to advance the patients' medical, psychological and social well-being, which is consistent with the role of social workers in hospital settings (Wale 2011:14).

The human resource management (HRM) in each hospital in the Waterberg District recruits and inducts the social workers. The HRM team are responsible for conducting the social workers' annual performance assessment review in terms of the Performance Management

Development System (PMDS). Social workers are expected to participate in the internal Continuous Professional Development (CPD) programme offered in the hospital where they are based. Most of the training consists of each department being given a turn to educate other departments about their discipline related interventions. The hospital CPD trainings do not qualify as CPD training as required and regulated by the South African Council of Social Service Professions (SACSSP). The researcher's experience is that social workers based in Waterberg District hospitals, in Limpopo Province are seldom afforded opportunities to attend social work CPD programmes which compromises their professional development as social workers. Social workers are entitled to join one of two labour unions that represent healthcare workers, the National Education, Health and Allied Workers Union (NEHAWU) and the Health and Other Services Personnel Trade Union of South Africa (HOSPERSA). There is no union that exclusively represents social workers in hospital settings nor social workers in South Africa.

1.2.4 Problem statement

The problem statement of any research project briefly explains an issue that requires further investigation or study (Babchuk 2017:79; Newman & Covrig 2013:73). It addresses the 'why is there a need for the study?' question. It clearly states the challenges and difficulties the researcher has had in trying to understand a specific context, which in this case are the experiences of social workers in multidisciplinary teams in state hospitals in the Waterberg District, in Limpopo Province (Nienaber 2012:14). In this section the researcher outlines the research problem addressed in this research and the focus he chose for this study.

As briefly alluded to in the introduction and as further elaborated on in Chapter 2, the literature review, social workers experience challenges in how their professional role in hospitals is interpreted by other multidisciplinary team members with whom they must collaborate. Amongst reported issues they face, are the lack of respect they receive from other team members in the hospital (Mason & Merino 2013:3) and the line of command they must follow in terms of reporting to non-social work professionals. Most of these issues are presented as intra-hospital issues, separate from individual factors unique to individual social workers and the broader external factors that impact on state hospitals and social workers employed there. The researcher wanted to develop a systemic understanding of what protective and prohibiting factors social workers encounter at each level of their bioecological realities. This holistic understanding would broaden the understanding of their experiences of their occupational satisfaction and professional identity associated with working in Waterberg District state hospitals. A holistic systemic account of social issues is required because the ecological

systems theory is one of the theoretical approaches that underpins social work training (Lindsay 2013:123). The researcher was therefore motivated to explore, describe and contextualise enabling and constraining factors based on the local social workers' frames of reference of working in a state-based hospital in the Waterberg District in Limpopo Province. The plan was to systematically examine how factors situate in each layer of the social workers' ecological system and how its micro-, messo-, exo-, macro- and chromo levels affected their occupational satisfaction and professional identity.

Locally, specific information was needed about the work situation and responsibilities of social workers in state hospitals in the Waterberg District because little had been documented about their experiences in those hospitals and the opportunities they have to validate their professional status and identity, expand their social work knowledge and skills through continuous professional development opportunities; and advance their careers and professional status as social workers. The researcher was unable to find any documented evidence to help him to find answers to the following questions:

- What roles are social workers assigned by hospital management in Waterberg District hospitals, and are the roles they are assigned aligned to the professional social work mandate as outlined in the Framework for Social Welfare Services (Lombard 2015:17)
- How do social workers feel about the way they are treated by other members of the multiprofessional team they work with, and do these social workers interpret their social work role in patient care similarly or differently to the ideas held by other members in their multidisciplinary teams?
- Do they consider their role in patient care to be contextually relevant, and are they given career progression opportunities within the Waterberg District state hospitals?

Unprecedented changes have affected social work and the health care system since the 1990s. The changes as explained in section 1.4, included the industrialisation of social work; changes within the South Africa's health care sector; escalation in the demand for hospital services from disadvantaged people who have suffered intergenerational patterns of poverty and social exclusion, the fact that hospital social work has been identified as a specialised clinical service in South Africa that will soon require social workers in hospital settings to be specially trained to fulfil registration requirements that will be legislated by the SACSSP; and the global pandemics of HIV and COVID-19. These changes, all externally situated, are likely to have had a bidirectional impact on the social workers based in state hospital settings in the Waterberg District and other significant role players in the hospitals where they are based. No

documented evidence could be located about how social workers in hospital settings have experienced these changes and if and how the changes have altered their roles and responsibilities in the settings where they are based, their levels of occupational satisfaction and the status of their professional identity.

The researcher therefore concluded that there was a need for more detailed, systemic, locally specific knowledge on the experiences of social workers based in the Waterberg District state hospitals that would explain their thoughts and feelings related to their professional identity as social workers, their power and their occupational satisfaction. A deeper exploration was necessary to identify factors impacting on them positively or negatively as they carried out their work commitments as social workers in state hospitals in the Waterberg District, Limpopo Province.

Against the above background, the research problem addressed was the following:

Based on the paucity of locally specific literature about social workers' perceptions and experiences of working in multi-disciplinary teams in state hospitals in the Waterberg District and the unprecedented changes affecting their profession and workplace, a qualitative study was needed to identify protective and prohibiting factors responsible for social workers' occupational satisfaction, professional identity and their ability to satisfy their professional mandate as social workers within the hospitals where they are employed.

The findings of such a study would lead to recommendations from research participants that could be directed to the management of state hospitals in the Waterberg District. It is trusted that the recommendations made at the conclusion of this research, will lead to changes that would enhance the service rendering, occupational satisfaction, professional identity and status of social workers in state hospitals in the Waterberg District. This is further explained in the discussion of the rationale for the study.

1.2.5 Rationale for the study

The rationale of a study provides a broad understandable explanation about what motivated the researcher to undertake this study (Chachere & Haymaker 2011:37). The rationale outlines the researcher's reasons for choosing to investigate the subject in-depth (Arch, Twohig, Deacon, Landy & Bluett 2015:81)

The researcher is employed as a senior social worker in one of the state district hospitals in the Waterberg District. His choice of the research topic arose from his practice observations as a senior social work manager in state hospitals and from the theoretical gap that he identified about it (see Chapter 2). Over time he was called on by different professional members of the multidisciplinary teams in Waterberg District hospitals, to mediate conflicts between social workers and themselves. Similarly, he received multiple complaints from social workers who complained of feeling coerced by multidisciplinary team members to perform work tasks that essentially were not consistent with their role as social workers. Social workers complained about the lack of understanding other team members had about their professional tasks, values, ethics and the approach they adopt in terms of patient care. Some social workers mentioned feeling resentful that they were forced to interject medical values and *modi operandi* consistent with the medical model adopted in their hospital settings, but inconsistent with their professional mandate.

Some were dissatisfied that they seldom were invited to offer psychosocial counselling at the outset of a patient's hospitalisation, others felt used by their team members for rendering concrete services to patients such as financial support, placement and transport, which were not sustainable, nor empowering. They bemoaned the loss of their professional identity in the hospital setting and resented having to report to non-social workers in the workplace. Some mentioned feeling undermined and disrespected within the hospital setting, which contributed to their stress. Whilst the researcher suspected that the complaints were generic social work issues in the Waterberg District state hospitals, he needed to empirically validate this assumption, so that the Waterberg state-based hospital management would take them more seriously.

The literature found on medical social work or social work in hospital settings provided valuable insight into the dynamics experienced by social workers as members of multi-disciplinary teams (see Chapter 2). However, no literature could be located that offered a locally specific perspective of social worker's experiences of working in the Waterberg District state hospitals in Limpopo Province. A locally specific contextual understanding about stressors social workers in the Waterberg District state hospitals experience in working in multidisciplinary teams, whilst trying to fulfil their professional obligations was required.

Hence it was resolved to empirically validate the corridor complaints and confirm if the formal mediation matters that the researcher had dealt with, were commonplace in the state hospitals in the Waterberg District. It was concluded that an exploratory, descriptive and contextual qualitative study of the issues mentioned would serve this purpose. It was foreseen that the

emergent findings and participant recommendations would pave the way to address the contributing factors responsible for the dissatisfaction amongst social workers working in multidisciplinary teams in Waterberg District state hospitals.

1.3 THEORETICAL FRAMEWORK

The focus now falls on the theoretical framework adopted for the purposes of this study, which is presented in more detail in Chapter 2. Applying a theoretical framework in research provides a researcher with a 'lens' to enable him or her to make sense of the events and phenomena he or she investigates (Maxwell 2013:49). The theoretical framework also assists one to shape the research topic, research design, field work and data analysis (Trafford & Leshem 2008:24). The epistemology that was chosen for the study was systems theory. The researcher took this further by combining Bronfenbrenner's bioecological systems approach (2001) and Gitterman and Germain's life model theory (1976) to create the theoretical framework for this research.

The use of systems theory guided the researcher to develop a holistic understanding of the positive and negative factors that impact on social workers' experiences of working in state hospitals in the Waterberg District because systems theory -

- develops a holistic and dynamic perspective of organisational functioning, which was the purpose of this study (Barile, Lusch, Reynoso, Saviano & Spohrer 2016:654; Teater 2014:18);
- highlights systems or subsystems responsible for any disequilibrium in organisations to enable one to identify what must be rectified or changed to restore the organisation's equilibrium or function (Teater 201418);
- promotes the understanding of the complexities of organisational life (Barile et al 2016:654), which in this case was the delivery of social work services in multidisciplinary teams in state hospitals in Waterberg District (it would help to highlight internal and external protection and risk factors that have a direct and indirect impact on the functioning of social workers in multidisciplinary teams in the hospitals); and
- is an acknowledged epistemological and methodological research approach (Barile et al 2016:654).

Bronfenbrenner's bioecological systems approach and Gitterman and Germain's life model theory, were combined as will be explained.

1.3.1 Bioecological systems approach

The application of Bronfenbrenner's bioecological systems approach would bring greater specificity to systems theory and draw attention to the relationships social workers experienced with others in the Waterberg District hospitals and the quality of the transactional processes that occurred between themselves and others in and outside the hospital environment. The bioecological systems approach would help the researcher discover how factors situated outside the hospital such as politics, economics and social factors affected the delivery of social work services in the state hospitals in the Waterberg District. The protective and debilitating factors that would be identified could be arranged according to each of the five ecological systems levels, namely the micro-, meso-, exo-, macro- and chronosystems (Kirschbaum 2017:20-21). The bioecological systems approach will be expounded upon in the literature review (Chapter 2).

1.3.2 Gitterman and Germain's life model theory

Many systems theory concepts are shared by the bioecological systems approach and the life model theory as developed by Gitterman and Germain, for example the focus on the persons' interactions within and between their life contexts, and the persons' interconnectedness with the contexts wherein they are situated (Duerden & Witt 2010:110). Gitterman and Germain's life model theory offered specific concepts that were especially pertinent to the study (Teater 2010:26). These include the person-in-environment fit; adaptations; stressors; coping measures; relatedness; self-esteem; autonomy and coercive power. These concepts were relevant for understanding the experiences of social workers based in state hospitals in the Waterberg District and would explain the positions that social workers occupied and the nature and quality of their interactions with others who were connected to the state hospitals in the Waterberg District.

1.3.3 Reasons for combining the bioecological systems approach and Gitterman and Germain's life model theory

By combining the theories for the study, the researcher could highlight how leadership was structured in the hospital and identify what strengths and challenges existed within individual social workers, the multidisciplinary teams wherein they operated, and within the institution as a whole (Alexander & Hearld 2012:3). By understanding the opportunities and constraints that were experienced by social workers within the multidisciplinary hospital settings, initiatives

could be developed to improve operational and human factors, such as levels of trust, leadership skills and teambuilding. These changes would benefit the social workers and other team members, and improve the quality of patient care offered by the state hospitals in the Waterberg District at the same time (Alexander & Hearld 2012:3). The proposed initiatives would be contextually relevant and contribute to improved accountability and coordination of social work services and teamwork amongst hospital personnel, which would reduce stressors in the hospital settings that undermined patient care (Coovadia et al 2009:832).

The concepts of both the bioecological systems approach and the life model theory developed by Bronfenbrenner and Gitterman and Germain are explained in greater detail in the literature review (Chapter 2) together with the advantages and disadvantages of using the theories.

The researcher anticipated that in applying the theories, at the end of the study he would be able to inform others about internal and external factors that impact on the Waterberg District hospitals as a whole, the individuals that work there, the hospital departments, the hospital management, the broader macrosystem factors such as politics, economics and culture that affect the locally specific hospitals (Barile et al 2016:654).

1.4 RESEARCH QUESTION, GOAL AND OBJECTIVES OF THE STUDY

This section explains the research question addressed in the study and outlines the research goal and research objectives of the research. This delineates what the focus of the study was and serves as the prelude for the research methodology section.

1.4.1 Research question

The researcher wanted to explore the social workers' experiences of the bidirectional transactions they encountered and experienced at each level of the environmental ecosystem, namely the micro- meso- exo- macro- and chronosystems to understand their perceptions of working in a multidisciplinary team in state-based hospitals in the Waterberg District. The purpose was to investigate and find out how their experiences impacted on their professional identity as social workers and affected their occupational satisfaction. The intention was to develop an exploratory, descriptive and contextualized account of the complex realities experienced by social workers working in the state-based hospitals in the Waterberg District to understand how unprecedented changes in hospital social work impacted on them and the health sector. The researcher was curious to learn what coping strategies social workers used to adapt to their new realities.

Consistent with Creswell and Creswell's (2018:139) recommendation, the researcher commenced with a central, broad question about the overarching issue of interest in his phenomenological study. Being a qualitative study, the research question developed was exploratory and descriptive in nature to assist him to generate answers that would explain and describe social work in multidisciplinary teams in Waterberg District state hospitals and the meanings the participants ascribed to their experiences (Hesse-Biber & Leavy 2011:42).

The research question was therefore formulated as follows:

> **What are the experiences and challenges of social workers working in multidisciplinary teams in state-based hospitals in Waterberg District, Limpopo Province?**

This research question was broken down into five sub-questions:

- ***What are the social workers' experiences of job satisfaction working in multidisciplinary teams in state hospitals in the Waterberg District?***
- ***What are the social worker's experiences of the hospital organization and management of state hospitals in the Waterberg District?***
- ***What challenges do social workers experience working in multidisciplinary teams in state hospitals in the Waterberg District?***
- ***What coping strategies do social workers use to adapt to working in multidisciplinary teams in state hospitals in the Waterberg District?***
- ***What recommendations do social workers have for improving the occupational satisfaction of social workers in multidisciplinary teams in state hospitals in the Waterberg District?***

The answers to these questions would enable to the researcher to achieve the research goal as discussed next.

1.4.2 Research goal

Research goal refers to something that the researcher needs to achieve by conducting research (Fouché & De Vos 2011:94). As a qualitative research approach was chosen for this study, the research goal needed to be about deepening the understanding and exploration about some aspects of social life (Hesse-Biber & Leavy 2011:38). Applied to this study, it meant finding out how social workers in multidisciplinary teams based in state hospitals in the

Waterberg District experienced working in their hospital settings, whilst considering the nature of the challenges they faced in the daily execution of their professional mandate.

Hence the research goal for the study was the following:

> **To develop an in depth understanding of the experiences and challenges of social workers working in multidisciplinary teams in state hospitals in the Waterberg District, Limpopo Province.**

Pursuing the research goal kept the researcher focused on what had to be achieved by the end of the study (Lee, Locke & Latham 2015:299). The research goal was subsequently broken down into specific research objectives.

1.4.3 Research objectives

Research objectives refer to a measurable and attainable conception of the researcher's plan to achieve the desired goal (Fouché & De Vos 2011 2011:94). The research objectives chosen for the study were directly related to what had to be achieved to enable the researcher to answer the research question at the end of the research process (Hesse-Biber & Doody 2016:22) and to achieve the research goal. Consistent with a qualitative study, the researcher had to discover and make sense of the lived experiences of the research participants' and their circumstances relating to the matter being researched. That understanding could only be achieved by setting, executing and achieving specific research objectives (Ritchie, Lewis, McNaughton & Ornston 2013:4). The following research objectives were consequently set for the study:

- To explore the experiences and challenges of social workers working in multidisciplinary teams in state hospitals in the Waterberg District, Limpopo Province.
- To describe the experiences and challenges of social workers working in multidisciplinary teams in state hospitals in the Waterberg District, Limpopo Province.
- To contextualize the experiences and challenges of social workers working in multidisciplinary teams in state hospitals in the Waterberg District, Limpopo by analysing the data that are collected.
- To draw conclusions about the findings regarding the experiences and challenges of social workers working in multidisciplinary teams in state hospitals in the Waterberg District, Limpopo Province.

- To make recommendations that could be used to improve the occupational service delivery, satisfaction and professional identity of social workers employed in multidisciplinary teams in state hospitals in the Waterberg District, Limpopo Province, and share those findings with relevant audiences.

The focus of the next section is on the research methodology used to achieve the research goal and objectives.

1.5 RESEARCH METHODOLOGY

A qualitative research approach that combined a phenomenological research design with integrated exploratory, descriptive and contextual research designs was chosen to guide the research decision making process (Mack, Woodsong, MacQueen, Guest & Namey 2011:2). The main advantage of this choice was that the research methods planned for the study were consistent with the researcher's philosophical perspective about how 'meaning' should be constructed in a research study (Hesse-Biber & Leavy 2011:29).
In describing the research methodology employed in this research, the research approach and research design followed and applied in the research are related.

1.5.1 Research approach

Research approaches are the plans that the researcher designs to follow when collecting, analysing and interpreting data (Creswell & Poth 2018:31). Qualitative research refers to the exploration and understanding of participant's ascriptions to social problems, while on the other hand quantitative research focusses on testing objectives by examining the relationships among variables and mixed methods research involves the collection of both quantitative and qualitative data (Creswell & Creswell 2018:32). Mixed methods research refers to research that includes characteristics of both quantitative and qualitative research (Leedy & Ormrod 2021:454)

A qualitative approach was selected so that the researcher could interpret the research problem according to the participants' experiences and rely on the meanings they ascribed to working as social workers in multidisciplinary teams in state hospitals in the Waterberg District (Creswell & Creswell 2018:32; Creswell & Poth 2018:31; Denzin & Lincoln 2008:8). The research process needed to achieve a holistic understanding of the experiences and challenges of social workers working in multidisciplinary teams in state-based hospitals in the Waterberg District (Creswell & Creswell 2018:32; Creswell & Poth 2018:31; Denzin & Lincoln

2008:4). The findings had to produce personal and contextual information that would be gathered from multiple sources such as interviews with participants, the researcher's observations, existing literature, and hospital and social work documents (Creswell & Creswell 2018:32; Creswell & Poth 2018:31; Denzin & Lincoln 2008:4). Combined, this information would create a rich elucidation of the research topic (Denzin & Lincoln 2008:4). The researcher wanted to collect the information personally in the natural setting (the state hospitals concerned), whilst observing and engaging directly with the research participants over an extended period of time (July 2020 to July 2021). A lengthy time period was needed for the researcher to work in the field and engage directly with research participants. With the researcher being directly responsible for every aspect of the research process, he could immerse himself in the study and the data (Creswell & Creswell 2018:32; Creswell & Poth 2018:31).Based on the choice to use a qualitative approach, the researcher acknowledged that he would have to rely on inductive and deductive data analysis to uncover the meanings participants ascribed to their experiences, circumstances and situations (of working in the state hospitals) (Hesse-Biber & Leavy 2011:4;Tufford & Newman 2010:1). The qualitative approach would enable the researcher to identify rich data about social workers employed in multidisciplinary teams in state hospitals in the Waterberg District, and present a comprehensive account of their situations (Creswell & Creswell 2018:32; Creswell & Poth 2018:31). As the researcher could not predict what he would encounter when the research plan was applied, he needed an approach that was flexible and could be adjusted in accordance with the research conditions and needs of research participants once the research was underway (Creswell & Creswell 2018:32; Creswell & Poth 2018:31). Before starting the research, the researcher concluded that the study envisaged would fulfil the main characteristics of a qualitative approach as outlined by Creswell and Creswell (2018:32; Creswell & Poth 2018:31).

1.5.2 Research design

As required, a research design was chosen before the study commenced to plot the path or research steps that had to be followed and to ensure which research tools and techniques would be appropriate for operationalizing the study (Lune & Berg 2017:22). A research design guides one in terms of the kind of questions that need to be asked, the techniques needed to collect the data, what approaches are best for selecting the sample and the steps that must be followed to analyse the data (Thyer 2012:115; Bloomfield & Fisher 2019:28). Choosing a relevant research design helps to structure the research process to improve the research outcomes (Anderson & Shattuck 2012:14). The researcher opted to use a phenomenological research design integrating exploratory, descriptive and contextual research designs.

1.5.2.1 Phenomenological research design

The research design applied in this study had to bring focus to the participants' experiences of events, actions, ideas and images which determined their perceptions of their realities of the situations they found themselves in.

According to Chaplin et al (2015:150) qualitative research is consistent with the phenomenological research design which refers to an intellectual focus in interpretations and meaning making that is applied to understand the lived environments of people in a conscious level (Qutoshi 2018:1). In conducting the research, the researcher would need to deal with and focus on the participants' real experiences and meanings as personally shared by them. These shared meanings would be reconstructed into knowledge that would be grounded on a firmer footing, to benefit others (Pike et al 2010:45).

The following defining characteristics of the phenomenological approach as presented by Creswell and Poth (2018:76-77) and their application in this research, explain the researcher's motivation for selecting a phenomenological approach for this research design:

- A single concept, namely the phenomenon of the 'experiences of social workers working in state hospitals in the Waterberg District', would be explored.
- The group of individuals that would be studied would all have had to experience the phenomenon, as social workers who had worked in multidisciplinary teams in state hospital settings in the Waterberg District.
- The Waterberg district hospital social workers would be included in the research to share their subjective experiences and their individual versions or insider viewpoints which would be combined to achieve a comprehensive contextualized perspective of social workers working in multidisciplinary teams in state-based hospitals in the Waterberg District.
- Because of the researcher's personal experience of the phenomenon, he would have to to bracket himself out of the study. He would do this by purposefully setting his personal and professional experiences of the phenomenon aside to remain focused on the research participants' experiences and meanings and not on his own.
- Verbal statements of participants would be analysed systematically to firstly, identify narrow units of analysis (significant statements made by individual participants), then create broader units of meaning (themes), that at the end of the study would offer

detailed descriptions of what participants had experienced about the phenomenon under research and how they had experienced it.

- The researcher would have the responsibility to share a description of the essence of the research participants' experiences once the study was concluded.

The drawbacks of using a phenomenological design were noted and acknowledged before the study commenced. The research process would take longer than the execution of other research designs because participants would need time to be put at ease. The researcher firstly would have to establish rapport and trust with the participants for them to open- up during the research process (Lodico, Spaulding & Voegtle 2010:40). The research sample would only include social workers employed at eight of the state hospitals in the Waterberg District because the researcher was based at one of the hospitals with two other social workers, and in order to minimize potential ethical issues associated with interviewing his supervisees, they were excluded from the study. The small sample size would also reduce the potential generalisation of the study.The advantages of this were that this cohort were likely to have similar experiences, the participants were easy to access, that the sample would be small enough for the researcher to manage the volume of information that would be gathered during the study. This meant that the researcher had no intention of generalising the findings of this study which is in keeping with qualitative research (Lodico et al 2010:40). The greatest challenge of using this research design would be that the researcher would have to prevent his professional and personal experiences from affecting the research decisions that he would take during the study and guard against the possible contamination of research findings resulting from it (Ritchie & Lewis 2003:20). Several measures for increasing the researcher's neutrality during the study would need to be taken, as will be discussed under the heading data verification (see section 1.9).The researcher concluded that despite these obvious limitations of adopting a phenomenological research design for the study, the advantages of applying it would outweigh the disadvantages and necessary plans would be made to compensate and deal with the limitations as will be explained in the section in the chapter verifying the data.

1.5.2.2 Exploratory research design

Because it was difficult to find information about how the unprecedented changes in social work and health settings had affected social workers and their roles in multidisciplinary teams in hospital settings, it was necessary for the researcher to integrate an exploratory research design into his study. Exploratory research investigates a research topic that is under

researched, or under reported, when little is known about the phenomenon (Hesse-Biber & Leavy 2011:10; Creswell & Creswell 2018:32; Creswell & Poth 2018:31), because this is a good starting point for research about it (Thomas & Pierson 2010:40). The findings of exploratory research designs generate more complex research questions that can be investigated using more rigorous research designs at a later stage (Creswell & Creswell 2018:32; Creswell & Poth 2018:31; Strydom 2013:151).

Exploratory research designs can be easily recognized because they ask the 'what' question which deepens understanding of the selected social reality. In this instance, the researcher wanted to address the 'what' question by asking "what positive and negative experiences and challenges do social workers in multidisciplinary teams in state hospitals in the Waterberg District, Limpopo Province, experience?" and "what coping strategies do they use to manage the challenges they have experienced in working as social workers in multidisciplinary teams in state hospitals, in the Waterberg District, Limpopo Province?"

1.5.2.3 Descriptive research design

Gathering detail about the social reality of being a social worker in a multidisciplinary team in a state hospital in the Waterberg District, Limpopo Province, was the ultimate goal of the study. As the aim of descriptive research designs is to produce a comprehensive picture of the research problem and the phenomenon being researched (Rosa & Tudge 2013:247), the inclusion of a descriptive research design in this study became a motivating factor for this research. As noted by Neuman (2014:39) the research question can only be answered when the researcher has gathered sufficient descriptive information. In addition, using a descriptive research design ensures that different elements of the phenomenon under investigation are discovered (Hesse-Biber & Leavy 2011:10).

Descriptive research designs are associated with the 'how' and 'who' questions (Neuman 2014:39). In this research, the researcher wanted to find out how the participants' occupational satisfaction was affected by working in multidisciplinary teams in state hospitals in the Waterberg District, Limpopo Province; who or what was responsible for the stress amongst social workers working in multidisciplinary teams in the state hospitals in the Waterberg District; and how social workers working in multidisciplinary teams in the state hospitals were affected by the changes in social work and health care services.

1.5.2.4 Contextual research design

A contextual research design is a research design that gives consideration to the environment, framework, setting, or background of a situation where the phenomenon under investigation occurs (Creswell 2014:186). A contextual research design would have to be used to develop an assessment of the contextual realities of social workers working in multidisciplinary teams in state hospitals in the Waterberg District to develop a comprehension of how their realities were linked to the phenomenon under investigation (Creswell 2014:47). In the case of this study it meant finding out how contextual factors impacted on the occupational satisfaction and professional identities of social workers in multidisciplinary teams in state hospitals in the Waterberg District. The context of this study was central to the investigation because contextual factors were likely to have an impact on research participants (Daymon & Holloway 2011:6). The inclusion of a contextual research design would assist in uncovering how intrapersonal, interpersonal, professional, cultural and contextual factors were related to the participants' experiences, challenges and coping strategies of working in multidisciplinary teams in state hospitals in the Waterberg District, in Limpopo Province.

1.6 RESEARCH METHODS

Research methods are the methods the researcher plans to use to approach the research problem (Taylor, Bogdan & DeVault 2015:3) to ensure that the research questions set at the outset of the study will be answered (Khan 2014:298). The research methods to be used to collect, analyse and interpret the research findings are planned before the study commences (Carey 201725). This section details the research activities that were planned at the outset of the study. The research methods are presented sequentially to explain how the researcher planned to achieve the objectives of his study (Daymon & Holloway 2011:100).

1.6.1 Locating the site and participants

The chosen participants and research site had to be relevant to the phenomenon and the research question being investigated (Creswell & Creswell 2018:185-186). Following the guideline of Miles and Huberman (as cited in Creswell & Creswell 2018:186), four specific factors were considered when the research site and participants were chosen, namely the setting (the eight state hospitals in the Waterberg District, in Limpopo Province); the actors (social workers working in multidisciplinary teams in state hospitals in the Waterberg District); the events (intrapersonal, interpersonal, professional, cultural and contextual experiences that

affected social workers working in multidisciplinary teams in state hospitals in Limpopo Province); and the research process (engaging and interviewing social workers working in multidisciplinary teams in state hospitals in Limpopo Province). The setting and the participants were known to the researcher as he is a senior social worker in one of the eight state hospitals in the Waterberg District. As cautioned by Creswell and Poth (2018:154) there can be power issues and potential risks involved when conducting research in a researcher's own place of work, which could create an ethical dilemma for him or her. The researcher anticipated the precautionary measures that could be taken to manage these risks, as recommended by Creswell and Poth (2018:156-161). For this purpose he planned to exclude social workers employed at the hospital where he was based, as participants in this study; exercise multiple strategies to validate the research findings; employ triangulation during the study; practised reflexivity throughout the research process; build participants checks into the research process to confirm the findings; and create opportunities for research participants to collaborate with the researcher about the research process and methods that would be used in the study.

1.6.2 Gaining access and developing rapport with participants

Before a researcher commences with any form of data collection for a study, he or she must follow specific steps, including –

- gaining access to the setting;
- obtaining permission from gatekeepers;
- ensuring that voluntary consent to participate is received from each research participant;
- confirming that participants are informed early and clearly about the type of research project they will be involved in and what will be expected of them;
- alerting participants to the potential risks and advantages of participating in the study; and
- informing participants about what measures are planned to protect their interests and safety (Daymon & Holloway 2011:60-65).

As an employee of the Provincial Department of Health, Limpopo Province, the researcher would inform the Management Department of Health: Waterberg District by letter of his interest to undertake a study within the state hospitals in the Waterberg District. Once the researcher received confirmation from UNISA's Department of Social Work Scientific Review Council and

the College Research and Ethics Committee that he could proceed with the study, he would apply to the Department of Health: Waterberg District in a letter addressed to the chairperson of the Limpopo Department of Health Research Ethics Committee. Once permission was granted by the Limpopo Department of Health Research Ethics Committee for the researcher to proceed with the study, social workers working in multidisciplinary teams in state hospitals in the Waterberg district, Limpopo Province and their superiors would be informed about the nature and motivation for conducting the study, the outline of the research objectives and the selection criteria for participants (Creswell & Poth 2018:152). This would be covered at a meeting of the Waterberg District Forum for hospital social workers. All Waterberg District social workers attend this meeting. The researcher chose to use this non-pressurised opportunity to informed potential participants about the study and address their questions about the research (Creswell & Poth 2018:156). Individual meetings would be planned with each potential participant interested in participating and who satisfied the inclusion criteria. The individual meetings would consist of face-to-face meetings, conducted at safe and convenient places as selected by prospective participants (Jacob & Furgerson 2012:9).

As required, the research participants would be educated about the research procedures to be followed, their research rights and asked to complete a voluntary consent form, a critical research step in phenomenological studies (Creswell & Poth 2018:156). The planned protocol for obtaining the consent of research participants is expounded in the discussion of the ethical procedures applied in the research (see section 1.7.1).

Having established professional relationships with the social workers at the state hospitals in Waterberg District, the researcher was acquainted and known to the research participants (Zlazier 2016:5; Novick & Gris 2014:473; Brixey & Novick 2019:3). The researcher's professional experience of working in the Waterberg District prepared him for understanding and dealing with possible cultural, religious, gender and professional differences he could experience in working with research participants during the research process. The researcher was confident that he could embark on the research process with a reasonable knowledge of the healthcare systems in Limpopo Province, but would have to put his personal and professional perspectives about it aside to discover the research participants' individualised experiences and views in this regard.

1.6.3 Population

The research population is the total group or collection of people from which a sample is drawn for research purposes (Carey 2012:247). In most instances in research, it is impossible to

study a population completely, therefore the researcher has to decide how to select cases from the population in such a way that the research statements made at the end of the research process will refer more generally to the wider population of interest (Meier, Alich & Flick 2014:33). In this regard, Mason (2018:64) and Neuman (2014:69) refer to units of analysis, such as people, texts, settings and environments that are studied and analysed to reach conclusions about the phenomenon of interest. The proposed unit of analysis for this study and hence its research population, were social workers who shared the experiences of being employed in multidisciplinary teams as social workers in state hospitals in the Waterberg District (Creswell & Poth 2018:104; Mason 2018:64). Other demographic factors such as the gender, age, ethnicity of participants, were of lesser importance for this study (Mason 2018:63).

The nine state hospitals in the Waterberg District, employed thirteen social workers in total. In other words, the research population of the research consisted of ten social workers because the plan was to remove himself, and the two other social workers based at the hospital where the researcher worked, from this unit of analysis. As noted by some authors (Ritchie, Lewis, McNaughton & Ormston 2013:88; Robinson 2012:21) there are benefits in recruiting participants using established networks when conducting phenomenological research. As mentioned earlier, in this report (see section 1.5.2.1 Phenomenological research design), the established network of the Waterberg District Social Work Forum could be used to inform the social workers about the research and recruit participants at the Forum meetings.

1.6.4 Sampling

As explained by Mason (2018:53), in research the sample should be constituted from members of the research population from appropriate contexts, settings, timeframes and moments where the appropriate people are present, and interact so that the data sources are reflective of the population or units of analysis. Qualitative research is purposive in nature (Carey 2012:38; Creswell & Poth 2018:158: Barton, Lane, Tejay & Terrell 2016:177) and the researcher purposely selects participants who according to his or her judgement will provide the best data for the study (Bouma, Ling & Wilkinson 2012:140; Creswell & Creswell 2018:249). The participants have to be people with experience of the phenomenon being investigated so that the understanding of it can be extended or advanced (Bouma et al 2012:140). In other words, it was resolved that a non- probability sampling approach would be most suited to this study. The participants were drawn from eight state hospitals in the Waterberg district because they would have rich data about the matter being researched, based on their personal experiences that could be used to answer the research questions

(Carey 2012:39). Hence of being educated in the social sciences, the researcher was confident that the participants would be able to reflect on and express their experiences of working in multidisciplinary teams in state hospitals in Limpopo Province (Creswell & Poth 2018:153).

Two sampling strategies were planned for the study, namely typical case sampling and criterion sampling. Applying typical case sampling would enable the researcher to explore the phenomenon from the perspective of 'typical' or 'average' representatives of the affected population (Thought Co 2019:23). Employing criterion sampling required the researcher to predetermine the criteria that will be used to screen potential participants for inclusion in the study (Creswell & Poth 2018:159). The advantage of using this sampling technique is for it to improve the quality of data collected during the research process (Creswell & Poth 2018:159).

Selection criteria were set for inclusion in the sample of this research. To be included in the sample, participants had to –

- be in full-time permanent employment as a social worker in a multidisciplinary team in one of the state hospitals in the Waterberg District for longer than twelve months;
- provide voluntary written consent to participate in one or two interviews, conducted at a time and place convenient to them and their work schedule; and
- be willing to participate in a follow-up focus group discussion after the data collected from the individual interviews had been analysed.

Social workers who did not have the correct work experience at a state-based hospital, whose registration with the SACSSP were not up to date; and those who did not operate in a multidisciplinary team in the hospital would be excluded from participation in the research.

The plan was to use the same sample for both data collection methods, the individual interviews and the focus group discussion. Whilst it is common practice for phenomenological studies to consist of between eight and ten participants (Creswell & Creswell 2018:186), it is also noted that sample sizes in qualitative, phenomenological studies are determined by the principle of data saturation. Saturation being the point reached during the interviewing phase when no new themes emerge and the information gathered becomes repetitive (Creswell & Creswell 2018:186). The sample of the study was determined by the number of social workers employed in state hospitals in Waterberg district who were willing to participate in the study (ten participants, excluding the two participants who were used for pilot test and the

researcher). However, the researcher resolved that he would be parsimonious, and stop interviewing participants if the point of saturation was achieved during the interview phase.

1.6.5 Data collecting

The generation of data is the primary building block of any research study (Carey 2012:246). It involves several interrelated activities that must be properly planned to collect good information that will answer the research questions. Creswell and Poth (2018:149) refer to these activities as a circle of data collection activities, however for this research project was not according to these circles. For the purpose of this research project collecting and processing the data are described with reference to conducting interviews, focus group discussion, secondary forms of data collection, pilot testing, data analysis and data verification.

1.6.5.1 Developing an interview protocol

Several sources mention the value of developing an interview protocol to record the research data before the research commences (Creswell & Creswell 2018:190; Creswell & Poth 2018:164) in preparation for the data collection. An interview protocol helps to ensure that the interview phase is well-planned and standardises the process that must be followed for asking questions, recording the answers and recording handwritten notes (Creswell & Creswell 2018:190). In other words, an interview protocol helps to improve the accuracy of the content captured, enhance the clarity, validity and reliability of the findings and standardise language and interviewing procedures so that all participants receive the same cues (Ritchie & Lewis 2013:10). The protocol regulates how the researcher introduces himself to research participants, inducts them, asks the interview questions and how he brings the interview to a close (Creswell & Creswell 2018: 165; Mason 2018:121). The details of the research protocol that was developed for this research and how it was operationalized during the study, are expanded upon in Chapter 3 and touched on in sections 1.6.1 and 1.6.2.

1.6.5.2 Conducting interviews

Qualitative interviews are described by Mason (2018:109) as in-depth, semi- or loosely, structured interviews. The interviews for this study were face-to-face interviews assisted by an interview guide with open-ended questions, that would be conducted by the researcher with participants on an individual basis, followed by a focus group discussion.

These data collection methods, according to Mason (2018:110), share the following characteristics:

- They promote an interactional exchange, or dialogue, between the researcher and each participant.
- The interactional exchange is informal but not so informal that its purpose gets lost (Burgess in Mason 2018:110).
- The interactions are directed by ethical principles and the researcher's reflexivity.
- A few topics or themes are selected for the interview or focus group to encourage participants to share their experiences in a spontaneous manner and to provide them with space to share unexpected themes that are relevant to them.
- The research interviewer brings situational and contextual factors to the fore so that contextual knowledge can be generated.

In conducting the interviews, information would be collected to generate a profile of the participants' demographics. Following Moustakas' recommendation (cited in Creswell & Poth 2018:79) and according to the research plan, the questions to obtain information about the research topic started with the following three broad questions:

- "What are your experiences of practising social work in a multidisciplinary team in the state hospital where you are employed?"
- "What internal or external contextual factors or circumstances positively or negatively influence your performance as a hospital social worker in your work setting?"
- "What coping strategies enable you to fulfil your professional social work responsibilities as a hospital social worker in a multidisciplinary team in state hospital in Waterberg district given the situational or contextual factors you experience working there?"

As recommended, a number of other open-ended questions would be asked to obtain data to create a detailed textural and structured description of the experiences of social workers based in state hospitals in the Waterberg District (Creswell & Creswell 2018:187; Mason 2018:119). (See the interview guide, Addendum I).

Conducting the interviews would serve as the primary data collection tool for the study, because interviews are acknowledged to -

- yield rich and complex detail of the phenomenon (Carey 2012:109; Cavan, cited in Khan 2014:306; Creswell & Creswell 2018:187);
- offer an inexpensive, convenient and uncomplicated way of gathering detailed information in a relatively short time frame (Carey 2012:109);
- create an opportunity for the researcher to tune in to the verbal and non-verbal cues of participants signalling when questions need to be adapted or their sequence changed to suit participants (Carey 2012:110; Chan, Fung & Chien 2013:5) and
- position the participant as the expert during the research process (Carey 2012:110).

To structure the interviews, a qualitative interview guide with open-ended questions was planned for the participant interviews. A research interview guide assists the researcher to obtain required data for the research project in a semi-structured way (Qu & Dumay 2011:238) by asking and discussing the necessary suitable broad questions to gain insight in and understanding of each participant's situation (Castillo-Montoya 2011:813).

An interview guide would be compiled and used to facilitate a collaborative account of participants' perspectives (Daymon & Holloway 2011:225); make sure the researcher stayed in step with the participants' train of thought and tracked that which was of interest or importance to them (Edwards & Holland 2013:29); and the interaction during the interview remained purposeful and relevant to the study (Govender & Sivakumar 2019:45).

At the beginning the interview, participants' biographical information would be gathered by noting their gender and asking questions about their ages, years of employment in a state hospital in the Waterberg District, educational qualifications and number of years registered as a social worker. Apart from the demographic questions, the interview guide comprised of the following topical questions (see Addendum I):

1. What are your experiences of practising social work in the state hospital where you are employed?
2. What internal or external factors or circumstances positively or negatively influence your performance as a hospital social worker in your work setting presently?
3. What coping strategies enable you to fulfil your professional social work responsibilities as a hospital social worker given the current situational and contextual realities of working in a state hospital now?
4. What activities are you expected to perform as a social worker by other multi-disciplinary team members in the hospital where you work?

5. What are your thoughts regarding authority and decision-making processes within the multi-disciplinary team that you are part of in your hospital?
6. How does the hospital management facilitate or compromise your ability to fulfil your social work professional obligations to patients?
7. Please explain whether your voice as a social worker is heard or not in your work context.
8. What are the challenges that you are faced with as a social worker in the hospital where you are based?
9. What recommendations do you have for improving the occupational satisfaction of social workers in state-based hospitals in the Waterberg region?
10. How does the hospital where you work respect your professional identity as a social worker?
11. How do you rate your occupational satisfaction working as a social worker in a state-based hospital presently? Please explain your answer.
12. Explain whether your social work role in the hospital is consistent with the developmental approach to social work.

The researcher planned to use the following interviewing skills during the interviewing process, to assist the interview process to be more effective:

Open-ended questions - The questions used in the interview guide would be open-ended questions in keeping with the qualitative approach of the study (Dikko 2016:523). Questions would be asked in such a way that they would elicit in-depth and detailed responses related to the views and experiences of participants and produce clear themes relevant to the research topic (Creswell & Creswell 2018:187; Flick 2014:208).

Probing - The researcher would use probes in response to the participants' answers to lead them to offer more detail, depth and examples of the phenomenon being investigated (Flick 2014:208). Using probes would also assist the researcher to clarify any answers that were unclear or needed more detail (Carey 2012:116).

Listening - The nature of the listening skill in research is such that intense concentration is required to ensure that the researcher can pick up on a thread of conversation that is relevant and return to it later in the interview, when the timing is right (Carey 2012:122; Mason 2018:124). The researcher's use of minimal encourages and active listening to the participants' experiences would confirm that he was listening. As advised by Carey (2012:116)

the researcher would listen so intensely to t participants so that he would be able to “read between the lines” to discover what was being stated “beneath the surface”.

Understanding – The researcher would ensure that he understood participants by reacting and responding to their responses and reflecting his understandings of what was said in his own words. The researcher considered it imperative that he would stay attuned to the sensitive issues the participants shared (Creswell & Poth 2018:173).

Paraphrasing – By repeating what participants shared the researcher would make sure that he understood what they had said. As defined by Khrismawan and Widiati (2013:136) paraphrasing means using different words to refer to the same statement.

Clarification –Participants would be asked to clarify any statements they made which were not clear; because of the importance of verifying the participant’s intended meaning (Carey 2012:116).

Attending to verbal and non-verbal cues – The researcher recognised the importance of observing both verbal and non-verbal cues during the interview process and planned to consciously demonstrate this by using actions to show he was actively listening and attending to what was said. As mentioned by Carey (2012:116) these actions allow the researcher to remain in the background of the interview and eliminate unnecessary chatter, whilst still making participants feel that they are being heard.

1.6.5.3 Focus group discussion

The data obtained from the semi-structured interviews would be supported by additional information gathered from a second data gathering method, the focus group discussion. The intention of planning the focus group discussion was to create a platform to verify and further contextualise the data gathered from the interviews by facilitating dialogue between the members of a group of social workers.

A focus group discussion is a research procedure for which a group of research participants are invited to discuss the phenomenon under investigation to extend the research findings (Flick 2014:537). It is also described as a small in-depth group interview of preselected participants who share similar characteristics that are brought together to discuss questions related to a phenomenon that is of mutual interest to them (Bouma et al 2012:282; Carey

2012:127, 246). Focus group discussions usually invite between four and fourteen members to participate (Bouma et al 2012: 282: Carey 2012:130) which appeared to be perfect for this research, because the researcher did not anticipate having more than eight participants involved, depending on the principle of data saturation, as explained in the discussion about the sample size and due to the small research population (Carey 2012:130).

Because the focus group is usually facilitated by one or more facilitators (Bouma et al 2012:282; Carey 2012:127) so that one person can document participants' responses, whilst the other manages the interview and group (Flick 2014:243), the researcher planned to use an external facilitator to assist with this process. The services of this person, a social worker experienced in facilitating group discussions, would be obtained to facilitate the focus group discussion and allow the researcher to focus on capturing the information and the group dynamics (her details are included under Addenda G and H). The plan was to use the focus group's discussion to enable the facilitator to verify the findings that emerged from the transcribed interviews. The selection of a neutral facilitator who was not linked to the Waterberg District state hospitals was deliberate. The person was a senior social worker in a state-based hospital in another district in Limpopo Province, which faced similar socio-political issues than those discussed in the section describing the context of the study (see section 1.6.5.3 Focus group discussion). In addition, this person was familiar with the policies and procedures in state hospitals in Limpopo Province that had to be followed in cases of unfair labour practices which could be useful for the research participants.

The kind of focus group discussion used in this study is referred to as a complementary focus group (Carey 2012:127). In such a focus group discussion the researcher starts with the assumption that the invitees have things in common, such as in this case, their work experience in state hospitals, similar job descriptions and that their ideas are likely to be complementary (Carey 2012:128).

Several steps consistent with recommendations for focus group discussions, identified in research sources (Carey 2012:129: Flick 2014:247-248) were considered for the focus group discussion. The researcher and facilitator would decide on the questions that would be asked before the focus group, which according to authors Bouma et al (2012:282) serves as a form of an interview guide.

The plan for the focus group discussion was as follows:

- At the start of the discussion participants would be asked to introduce themselves.
- The research topic would be introduced.
- Ethical ground rules would be set for the session.
- One or two non-threatening warm-up questions would be asked to facilitate discussion and make participants feel relaxed about sharing their views in the group context.
- Participants would be asked more focused questions to lead into the questions central to the research process.
- The researcher and facilitator would summarise the proceedings and thank participants for their engagement.

The following main research questions were identified for the focus group discussions:

- "What are your experiences of practising social work in a multidisciplinary team in the state hospital where you are employed?"
- "What internal or external contextual factors or circumstances positively or negatively influence your performance as a hospital social worker in your work setting?"
- "What coping strategies enable you to fulfil your professional social work responsibilities as a hospital social worker in a multidisciplinary team in state hospital in Waterberg district given the situational or contextual factors you experience working there?"

Factors motivating the use of a focus group discussion for the study included that -

- focus groups are time-saving and economical and produce a rich variety of data (Carey 2012:131; Flick 2014:243);
- they are effective when exploring issues such as people's motives, attitudes and group experiences (Carey 2012:131);
- some participants prefer to share their feelings and experiences in a group rather than on a one-on-one basis (Carey 2012:131);
- focus group discussions can be used with diverse populations (Linhorst cited by Carey 2012:133);
- they are an effective measure for raising consciousness and empowering participants (Linhorst cited by Carey 2012:133);

- they advance the person-in-environment perspective (Linhorst cited by Carey 2012:133);
- they are successfully used with other methods, such as the one-on-one interview (Carey 2012:133);
- they help to pinpoint relatively consistent views as shared by several people simultaneously (Flick 2014:243);
- participants in focus group discussions are stimulated by the ideas of others, which often remind them of events or facts they overlooked or had forgotten (Flick 2014:243); and
- focus group discussions offer a cross-section of ideas from a group of participants where the researcher can observe different parties reacting to one another's opinions (Bouma et al 2012:232).

Whilst all these factors would benefit the study, the main motivation was to use the focus group discussion as a confirmatory vehicle to support the findings of the one-on-one interviews. Triangulation by using this additional data source to increase the credibility and validity of the research findings, is regarded as being important in instances where the researcher researches the organisation for which he or she works (Creswell & Poth 2018:156).

The potential problems that may be experienced when using focus group discussions were considered. This included the possibility that the dynamic nature of the focus group discussion may become difficult for the researcher to manage and may result in inaccurate recording of data (Flick 2014:248). As mentioned above, this would be mitigated by enlisting the support of a neutral facilitator to enable the researcher to focus on making field notes of the session and on operating the digital recorder. Consideration was given to focus group discussions requiring thorough organisation, meticulous planning and coordination to ensure that the desired research objectives were achieved (Carey 2012:133). As mentioned, the focus group discussion would be arranged to coincide with the Waterberg District Social Work Forum Meeting. This was done for the convenience of participants and because the necessary infrastructure required for such a meeting was already in place in the form of a data projector, comfortable venue, appropriate ablution facilities and a kitchen to prepare refreshments. Permission to obtain the use of the venue for the purposes of the focus group discussion would be obtained from the Limpopo Provincial Coordinator of Hospital Social Services. The number of issues for exploration would be limited in comparison with one-on-one interviews because discussing each question in a group conversation is more time-consuming (Bouma et al

2012:232; Carey 2012:133). For the group discussion the researcher only planned to ask three questions developed for and discussed in the individual interviews:

- "What are your experiences of practising social work in the state hospital where you are employed?"
- "What internal or external factors or circumstances positively or negatively influence your performance as a hospital social worker in your work setting presently?
- "What coping strategies enable you to fulfil your professional social work responsibilities as a hospital social worker given the current situational and contextual realities of working in a state hospital now?"

As confidentiality can easily be compromised in any group context (Carey 2012:133) the researcher would insist that participants and the facilitator co-opted to facilitate the focus group discussion, sign confidentiality forms prior to their participation in the focus group discussion (see Addendum G). With the permission of the group members, the researcher planned to use a digital recording device for the focus group discussion and a flip chart paper board to capture key themes raised by participants. He would make notes about the group process and dynamics as observed when the discussions were underway.

Two other sources of information would be used in this study.

1.6.5.4 Secondary forms of data collection

In preparing for the study it became evident that a research journal and existing organisational documents such as human resource policies and procedures relevant to the research topic, were needed to do the research properly, in addition to conducting the interviews and the focus group discussion.

With reference to the research journal, the researcher realised that as this was a qualitative study it would be important to keep track and make notes of his feelings, experiences and interpretations in a journal so that he could remain reflexive throughout the research process and could intercept any attitudes and feelings he had, before they influenced any interpretations of the findings and research decisions he had to make, or undermined any of the research participants' perspectives (Bouma et al 2012:187; Creswell & Poth 2018:163). Therefore, the researcher resolved to enter his field notes in the journal as the research progressed, to capture his experiences and observations apropos to the unfolding of the research process and preliminary perceptions he formed along the way.

Organisational documents, such as the hospitals' human resource policies and procedures that addressed topics such as work conditions, job descriptions and staff development, would provide an additional source of information relevant to the research topic (Creswell & Poth 2018:163).

1. 6.5.5 Pilot testing

Before conducting research interviews, a trial run of the research protocol and research questions in the form of a pilot test should be conducted by means of a pilot test (Dikko 2016:522). A pilot test is conducted in preparation for the full-scale study to pre-test the research instrument (Dikko 2016:522). A pilot test helps to identify flaws, limitations, or other weaknesses within the interview design so that the necessary revisions and corrections can be made before the actual research processes of data collection and analysis commence (Turner 2010:757).

For this study the interview protocol and interview guide were to be piloted using the two social workers based at the hospital where the researcher worked, because whilst they satisfied the selection criteria, they could not form part of the research sample for ethical reasons. These social workers could provide valuable insight regarding the feasibility of the questions constituting the interview guide and were readily accessible (Creswell & Poth 2018:165). The questions and the data collected from the interviews with the two social workers would be analysed to determine whether the questions generated relevant information for answering the research questions. Their valuable and honest feedback would be used to inform the final revisions and adjustments that were needed for the interview protocol and interview guide (Creswell & Creswell 2018:154).

1.6.5.6 Data analysis

Data analysis is that part of the research process where the researcher looks out for leading themes, recurring language and beliefs situated in the participants' stories, by closely examining what they have shared about their situations (Anfara, Brown & Mangione 2015:30). The researcher must 'make sense of it' and report 'what is going on', to advance an informed understanding of the phenomenon researched, in this case about the experiences of social workers in state hospitals. His intention was to offer his first-hand knowledge of 'what it was like' to be there with the research participants (Bouma et al 2012: 236-239). He planned to

divide the data up, take it apart and put it back together again (Creswell & Creswell 2018:190). It is pointed out that in the case of focus group discussions, data analysis is difficult and time-consuming because of the number of participants who are involved (Carey 2012:133).

The steps planned for managing the analysis of data for this study consisted of the following six steps as recommended by Creswell and Creswell (2018:192):

Table 1.1: Steps taken in data analysis (Creswell & Creswell 2018:192)

Step 1	The researcher would arrange and prepare the data for analysis by transcribing the interviews with participants and the focus group's discussion and typing up the field notes.
Step 2	The typed transcriptions would be read and reread by the researcher to get an overall idea of what participants had said. The tone of their ideas would be noted. Notes would be made in the margins of the transcripts and field notes if participants' ideas and experiences seemed to concur. The researcher would look out for what social workers observed and heard, how they felt, reacted and behaved as they tackled their daily duties as social workers in the state hospitals in the Waterberg District (Bouma et al 2012:239). This would alert the researcher to identify possible themes that were immerging and be the start to develop codes for the analysis (Creswell & Poth 2018:186).
Step 3	Participants' sentences would be segmented into chunks of data that appeared to be significant statements related to the contextual realities of working as a social worker in a state hospital in the Waterberg District. Creswell and Poth (2018:199) refer to this as descriptions of the essence of the phenomenon. Each chunk of data would represent a separate category that would be labelled, using a word, or term, as used by another participant or participants. A list of the code categories and descriptions would be kept. The transcription of each interview would be read, and the developed codes would be assigned to relevant sections of the transcribed text.
Step 4	The categories would be grouped into themes, which, according to Creswell and Creswell (2018:192) should amount to approximately seven themes. Each theme would represent a different concept that had been identified in the interviews and used as the headings for the findings section. The themes would represent significant statements or units of meaning about the phenomenon of working in state-based hospitals in the Waterberg District.

Step 5	After reworking the interview transcripts, subthemes (with categories) related to each theme would be identified so that the researcher would have a list of descriptions associated with each theme.
Step 6	Excerpts from the transcriptions would be chosen to illustrate each theme and subtheme to build a contextual understanding of the phenomenon. By using the theoretical framework, the researcher developed for the study, an interpretation of the data would be made.

Data would be collected and analysed concurrently. Once a preliminary understanding of the themes and subthemes had been achieved, a social work researcher would be engaged as an independent coder to codify the data. A consultation with the independent coder, the researcher and the researcher's supervisor would be arranged to reach a consensus about what codes and themes would be used for the data analysis phase. The advantage of using an independent coder served to strengthen the verification of the findings. The results of the analysed data are presented in the research report to produce an empirical account of the experiences, challenges and coping strategies of social workers in multidisciplinary teams in state hospitals in the Waterberg District. The report offers a textual description of what happened, how the social phenomenon was experienced by social workers portraying the essence of what it was like for them to be a social worker in a state-based hospital in the Waterberg District as asserted by Klonek, Quera and Kauffeld (2015:270).

1.6.5.7 Data verification and maintaining the trustworthiness of the study

The researcher planned to apply Guba and Lincoln's (1981) well-known model of trustworthiness as discussed in Lietz and Zayas (2010:443) for the verification of the data in this qualitative study, because validity and reliability are less applicable in qualitative research (Carey 2012:41; Koonin 2014:253). Trustworthiness focuses on four elements in a study, namely the truth value of the findings (credibility); its applicability (transferability); its consistency (dependability); and its neutrality (confirmability) (Krefting 1991:216-217). The purpose or goal of this research was to promote understanding of the phenomenon of the experiences of social workers working in multi-disciplinary teams in the Waterberg District state hospitals rather than to generalise results about a broader population (Koonin 2014:258).

A theoretical explanation of the data verification, with the theoretical concepts translated into the research actions that were planned to strengthen the trustworthiness of the findings and research process is given in Table 1.2. Table 1.2 outlines the actions that were planned to

uphold the credibility, transferability, dependability and conformability of the study, the four criteria and techniques advocated by Guba and Lincoln for this purpose (Anney 2014; Creswell & Creswell 2018; Creswell & Poth 2018:487; Flick 2014:487; Loh 2013:5).

Table 1.2: Lincoln and Guba's steps for ensuring trustworthiness criteria and techniques for establishing trustworthiness (Anney 2014; Creswell & Creswell 2018; Creswell & Poth 2018:487; Flick 2014:487; Loh 2013:5).

CRITERIA	TECHNIQUES	APPLICATION IN THE STUDY
Credibility The researcher's confidence about the honesty and accuracy of the findings (Creswell & Poth 2018:259 – 261; Hooimeijer & Nieuwenhuis 2016:321) which confirms the congruence between participants' views and the researchers' interpretations (Padgett 2017:210).	Prolonged engagement and persistent observation in the field, triangulation of different methods, using different researchers and different data collection methods.	People with credible information would be selected as participants and the researcher would refrain from interviewing social workers based at his place of work so that all participants could feel free to share their perspectives spontaneously. A clear description of sampling methods and the sample chosen would be given. One or two lengthy interviews of about an hour and a half long would be conducted with participants so that accurate detailed descriptions could be gathered about the social workers' contextual experiences, challenges and coping strategies. A focus group discussion of approximately three hours was planned with participants to firstly, create an opportunity for participants to verify the findings and secondly, to deepen contextual understanding of how social workers in multidisciplinary teams experienced working in state hospitals, what challenges they experienced and how they coped with these challenges in a group setting. The data would be accurately recorded using a digital audio recorder, detailed field notes would be kept in a research journal,

		and the researcher planned to cross-check all data as collected to create details of the participants' perspectives. A neutral facilitator would be engaged to facilitate the focus group discussion and allow the researcher to focus on accurately recording the discussions. The purpose of conducting the focus group discussion by using an independent facilitator was for triangulation purposes to validate the findings of the individual interviews and ensure that the participant's perspectives were the focus and not his own. The independent facilitator would verify the accuracy of the findings. Using this form of triangulation would confirm that the findings were independent and credible. Detailed situational specific information is presented to develop a rich contextual description of social workers' experiences, challenges and coping strategies. The researcher would use *verbatim* quotations when presenting the findings to give readers the exact information as presented by participants.
	Peer debriefing.	The researcher would engage with his supervisor, the independent facilitator and the independent coder to ensure that the descriptions that would be presented were complete and devoid of his personal perceptions and values about social work in state hospitals in the Waterberg District. Regular debriefing sessions with the supervisor would be scheduled to help the researcher identify and eliminate his

		possible blind spots and any possible biased interpretations of findings. The researcher would try to stay as close to the participants' actual experiences rather than to his own (Creswell & Poth 2018:271).
	Appropriateness of the terms of reference and interpretations, and their assessment.	An independent coder would be engaged to verify the codes and themes as identified in the raw data. The insights presented would be more than the taken-for-granted assumptions. A consultation would be arranged between the independent coder, the supervisor and the researcher to reach agreement on the terms of reference and consistent interpretations.
	Member checks,	The researcher planned a follow-up meeting with each participant after the transcripts for each interview were completed, to validate their accuracy. A summary of the findings of individual interviews would be presented at the focus group discussion for participants to verify.
	The analysis of negative cases.	The researcher would present all conclusions whether he agreed with them or not, relying on the supervisor and independent coder to make him aware of any failure on his part to do so. The plan was to try to interview as many participants as the researcher could (by taking the principle of data saturation in consideration) to eliminate the risk of missing different perspectives. He would report on extreme and/or negative cases

		that he came across during the study and not just on the status quo.
Transferability The degree to which the findings can be applied to similar contexts and settings or to other groups of people (Anney 2014:277; Creswell & Poth 2018:495-496)	Thick description to ensure that readers are clear about the sample and context (Koonin 2014:258; Padgett 2017:210).	A clear description of the purposive sample of social workers selected for the study is presented. Details are provided about all research processes applied during the study from the point of sampling, data collection, data analysis and the production of the final research report. This offers clear explanations so that others interested in the study could replicate it if they wanted to. A thick description of the context of state-based social work services in the Waterberg District is presented.
Dependability Making sure that the research is conducted in a constant and reliable manner (Daymon & Holloway 2011:86; Korstjens & Moser 2017:435).	Provide adequate detail of the research procedures used (Creswell & Creswell 2018:201; Creswell & Poth 2018:488).	Every step of the study is detailed in the final research report, to explain how the research instruments were developed and amended after the pilot test, and in response to research realities encountered during the study.
	Check transcripts to make sure that no errors are made during the transcriptions (Creswell & Creswell 2018:201).	Completed transcriptions would be checked against the audio recordings and members would be asked to verify that the transcriptions were an accurate account of what was discussed during the individual interviews.
	Develop an interview protocol which the research team will	The research protocol as discussed in section 1.1.1.3 of this chapter would be

	adhere to throughout the study (Creswell & Creswell 2018:202).	finalized after the appraisal of the pilot interviews.
	Procedural dependability audit.	All raw data records would be stored securely in a locked cabinet for the prescribed period, after which it will be destroyed. The summaries, theoretical notes, memos and field notes would be saved for cross-checking purposes and are also stored securely in a locked cabinet for the prescribed period, after which it will be destroyed. The report of the themes developed from the findings is saved.
	Create an opportunity for participants to review the findings and recommendations of the study, offering verification that they are authentic (Daymon & Holloway 2011:86). Examine the process of the inquiry (how data were collected; how data are kept; accuracy of data).	The plan was to present the consolidated findings at a focus group discussion to ensure the participants' verified the perspectives that informed the recommendations for this study.
Confirmability The neutrality of findings is of paramount	Filtering out any research bias (Chan et al 2013:2).	Bracketing would be used to filter the researcher's beliefs, values knowledge and experiences out, to avoid any contamination on the part of the researcher. A record would be kept of the researcher's thoughts, ideas and feelings and

importance (Gunawan 2015:4) The research findings must be reliable before they are presented to the public (Connelly 2016: 435).		observations throughout the study to ensure that participants' perceptions and experiences would not be distorted. Regular supervision would be used as a safety-net to remove any bias during the research process. The role of the supervisor in this regard, would be to hold the researcher accountable for capturing possible contaminated data and developing the analysis of findings with neutrality. The use of an independent coder would contribute significantly to the neutrality of the research findings.
	Ensure that the final product reflects the fact that the findings and their interpretations are genuine and accurate.	Care would be taken when recording information, transcribing and reporting participants' responses in their own words. The commitment was to only report information that was genuinely there.
	The recommendations must evolve from and be supported by the data.	The interpretations that originated from the findings would be consistently explained and demonstrated throughout the research report (Mason 2018:240). Consistent transparency about the methods and methodology would strengthen the researcher's conclusions and recommendations in the study.

1.7 ETHICAL CONSIDERATIONS

Ethical considerations in qualitative research refer to the researcher's moral behaviour whilst conducting the research (Resnik & Finn 2011:1241; Wilese 2013:4). According to Creswell (2014:131) research ethics are meant to protect the research participants from any harm that might occur during the research process, secure participants' trust, uphold the scientific integrity of the research and guard against misconduct and impropriety that might negatively

implicate the institutions involved in the study. It is emphasised that the moral integrity of the researcher contributes significantly to the trustworthiness and validity of the research study (Hesse-Biber & Leavy 2011:58). Typically, ethical principles in qualitative research include confidentiality, informed consent and anonymity (Wilese 2013:4; Resnik & Finn 2011:1). The researcher understands ethical considerations to mean the moral good practices that should underlay all his research plans, and their operationalization, to protect the participants and the integrity of his research. The ethical principles of qualitative research as presented by Polit and Beck (2010:121-125) and as outlined by the South African Council for Social Service Professions (SACSSP) as outlined by (Londt 2018) are the main terms of reference that guided the researcher's efforts to uphold the moral integrity of this study. The SACSSP is the statutory body that governs the provision of social welfare services in South Africa under Act No 110 of 1978, as amended (Engelbrecht 2014:7). The focus of this discussion is on the ethical considerations applied in this research, namely informed consent, confidentiality, anonymity, beneficence, debriefing of participants and management of information.

1.7.1 Informed consent

Informed consent ensures that every subject's participation in the study is fully intentional (Wilese, Crow, Heath & Charles 2008:3). Three research actions contribute to participants' voluntary consent according to Polit and Beck (2010:127), namely participants' need to be properly informed about the research process planned, ongoing reassurance that their participation is voluntary and reminders that they may withdraw at any time they choose from participating in the research without consequences. Additionally, participants should only be included in a study if they can offer information relevant to the study (Polit & Beck 2010:127). The way the researcher applied these three prerequisites are explained next.

A consent form would be issued to participants prior to their interviews so that they could read through it and think about it to decide whether they would participate in the research (see Addendum C). The form explains how participants' confidentiality would be respected. Participants would be encouraged to ask questions about the study and to raise any concerns they had about being part of the study (Gibson 2013:7). They would be informed about what the study is about, its purpose, its risks and benefits, how long the study would take, the composition of the research team and how the researcher would use the findings (Hesse-Biber & Leavy 2011:64; Ritchie & Lewis 2013:66). Participants would be reassured throughout the research process that their participation was voluntary and that they could withdraw from the research process at any time (Hesse-Biber & Leavy 2011:64; Ritchie & Lewis 2013:66). Any form of coercion from the researcher or other participants, to secure a person's participation

would be avoided (Polit & Beck 2010:127). Participants would be reassured that there will be no relational nor occupational repercussions should they decline the invitation to be involved in or withdraw from the study at any stage during the research process.

Private individual meetings would be planned with potential participants where they would be made to feel comfortable and encouraged to ask questions and share their misgivings about participating. The concept of informed consent would be explained. An information letter about the study was issued to each potential participant (see Addendum C). Once the written consent form confirming their voluntary agreement to participate in the study and allowing the interview to be digitally recorded was signed, the interview could commence (see Addenda D and E). The same informed consent form would be used for participants who chose to be part of the focus group discussion.

1.7.2 Confidentiality

Researchers have an obligation to safeguard each participant's identity, location and as far as possible, the research location (Polit & Beck 2010:129). This was particularly important in this study as participants could feel that disclosing their experiences could expose them to some risk of retaliation from other colleagues or their superiors in the state hospitals in the Waterberg District. A coding system would be developed so that codes could replace the names of participants and their personal details would not appear on the field notes, printed transcripts or labels of the digital recordings. The codes assigned to each participant would be stored in a password encrypted file on the researcher's computer. Care would be taken when presenting the findings so that others would not be able to identify any participant or any specific hospital where participants are based. The researcher had to accept that it would be impossible to disguise the reality that the study was based on the Waterberg District state-based hospitals in the Limpopo Province. Printed transcripts and other miscellaneous research documents would be locked in a cabinet in the researcher's home. All research participants and others assisting in the research would have to sign a confidentiality form (see Addendum G) The independent coder, focus group facilitator and debriefer would therefore complete the same confidentiality agreement (see Addendum G). In accordance with the prescribed five-year rule set by the SACSSP (Lombard 2015:11) and UNISA's research policy (UNISA 2016:17) the research data would be preserved for five years, before being destroyed.

1.7.3 Anonymity

Maintaining anonymity in research means that whilst participants will be able to identify themselves in the findings, the research team members and other readers will not (Grinyer 2009:4). This ensures that participants are protected from any form of harm or victimisation caused by their participation in the research process (Gibson 2013:4). The researcher planned to take care in presenting the information received from the participants and would be made known in the research report, that participants would not be recognised or identified from the findings presented (Ritchie & Lewis 2013:67).

1.7.4 Beneficence

Beneficence in qualitative research means that participants must be protected from harm, exploitation and discomfort during the research process and should experience some benefit from participating, even if only indirectly (Dalamo 2018:11). In other words, the research process should ultimately promote their welfare (Fouka & Mantzorou 2011:5). The benefits of participating in a study should always outweigh the risk to participants (Legewie & Nassauer 2018:1). Upholding the principle of beneficence in a study ensures that social justice is defended throughout the research process. Participants in this study would be reassured that they would not be expected to perform acts that would reduce their self-respect or shame them. They would also be reminded that permission had been granted by the Provincial Department of Health (DOH) to undertake the research and therefore that no one should expect to suffer any negative recourse from their participation. Interview questions would be carefully worded to prevent and minimise any distress or discomfort participants could experience during the interviews (Polit & Beck 2010:130). Participants would be informed about the types of questions they would be asked prior to being interviewed (see Addendum I) so that they would be able to prepare themselves for the questions rather than being caught off-guard. They would be reminded that the recommendations that emerged from the findings would be presented to the Provincial DoH to motivate for improved working conditions for social workers in the state hospitals in the Waterberg District and improve the utilisation of their services in the multi-disciplinary teams in which they worked. The researcher accepted that no matter what, he was ethically obliged to enlighten the hospital authorities about any socio-political issues that would be uncovered during the research process, especially those that violated the rights of the social workers in state hospitals in the Waterberg District. Participants would be informed at the outset that no one would benefit financially or occupationally as a result of involvement in the study.

1.7.5 Debriefing of participants

In the event of anyone being disturbed by his or her participation in the research process, it would be the researcher's ethical obligation to refer him/ or her for supportive counselling, referred to as debriefing (Mahlalela, Johnson & Mills 2011:35-36). Debriefing is a planned activity facilitated by an experienced professional that is conducted in a conducive environment (Reierson, Haukedal, Hedeman & Bjørk 2017:11) where he or she can reflect on, and work through the experience or experiences that contributed to his or her distress as a result of participation in the study (Mariani, Cantrell, Meakim, Prieto & Dreifuerst 2013:148). The researcher planned to engage an experienced social worker, employed by the Department of Social Development to provide this support and be available to debrief participants if necessary (see Addendum M).

1.7.6 Management of information

Data management is the most important phase in research as it ensures the reliability required to manage and protect the data (Krishnankutty et al 2012:1). In addition, Sutton and Austin (2015:229) view data management as the researcher's efforts to stay true to research participants to make sure that their voices and concerns are heard. Codes are used to refer to items or sources of data during the research project so that one makes sure that participants are heard, but without exposing them as individuals (Flick 2009:361).

The following data management techniques as suggested by Sutton and Austin (2015:230) were to be integrated during the research process:

- When reflecting on the experiences of participants, the researcher would remain true to them and edit his own experiences.
- The researcher would transcribe the digital recordings carefully by himself, capturing participants' responses verbatim. He would check the transcriptions against the audio recordings, making sure that he had not changed their wording. The transcriptions would be used to analyse the meanings participants ascribed to their experiences without altering their meanings.
- During the interviews and the focus group discussion the researcher would have to listen attentively to what participants were saying and take note of things they were not saying directly, by 'reading between the lines'.
- Common responses or similarities in the transcripts would be coded;

- The codes from the transcripts would be used to identify themes which would be used to interpret participants' experiences.

1.8 CLARIFICATION OF KEY CONCEPTS

The key concepts that follow are relevant to this research and are defined, explained and stated in terms of their application in the context of this study.

1.8.1 Multidisciplinary health team

A 'multidisciplinary health team' refers to a group of professional health workers who work as a team in the primary health sector (Xyrichis & Lowton 2008:147) to improve communication and service delivery (Murphy, Curtis & McCloughen 2015:45). This team consists of different disciplines who work together in a health setting, collaborating with each other (Chamberlane-Salaun, Mills & Usher 2013:66). The concept of multi-disciplinary health teams as used in this study, refers to a group of health service providers made up of members of different disciplines (including social workers), who work together to promote the physical and psychological care and welfare of the patient and to improve service delivery in state-based hospitals in the Waterberg District, Limpopo Province.

1.8.2 Hospital social workers

Beder (2009:486) states that 'hospital social workers' are social workers who are employed in hospitals as part of multi-disciplinary teams to manage the caseload of patients with psychosocial, mental and physical health needs. Hospital social workers promote the wellness of patients by providing education and interacting with professionals from other disciplines (Judd & Sheffield 2010:117). In addition, hospital social workers steer and promote patients' services in the hospital and the community at large (Limon 2018:1). For the purposes of this study, the concept hospital social work refers to the services hospital social workers render to promote the physical and psychological health of patients and improve service delivery in Waterberg state hospitals.

1.8.3 Occupational satisfaction

'Occupational satisfaction' refers to the sense of fulfilment employees experience in their work lives as a result of multiple factors that combine to create a healthy workplace environment for them and that support their profession (Munger, Gordon, Hartman, Vincent & Feehan 2013:282). Occupational satisfaction includes occupational prestige, a positive self-esteem and job satisfaction, all health promoting factors (Fujishiro, Xu & Gong 2010:2101). Simply stated, occupational satisfaction refers to the wellbeing of employees in the workplace (Gattino, Rollero & De Piccoll, 2015:3). Occupational satisfaction in this study refers to job satisfaction and the fulfilment social workers employed in the Waterberg District hospitals experience in their work lives.

1.8.4 Professional identity

'Professional identity' refers to how one views oneself as a professional person (Weaver, Peters, Koch & Wilson 2011:1221). Professional identify develops from what one conscientiously prioritises when executing one's work tasks, such as work practices, values, and interests which inform one's decision-making process (Weaver et al. 2011:1221; Trede 2012:163). As stated by Haynes (2011:39), professional identity denotes the development into stereotypes and a culture among a certain group of individuals in the workplace who are of the same profession. Professional identity in this study refers to how social workers within the hospital setting perceive themselves, their professional status, values and purpose.

1.8.5 State hospitals

'State hospitals' provide a form of specialised medical care for needy patients who cannot receive medical treatment from their homes (Beder 2009:486). They are non-profit health organisations funded by the state that aim to provide health care services to vulnerable community members who cannot afford private medical care (Rosenbaum, Byrnes & Rieke 2013:3). State hospitals are part of the public health system and are measured by their location, size, the services they provide and the standards of the services they offer (Packard & Jones 2015:154). The concept state hospitals, as used in the study refers to non-profit public hospitals in the Waterberg District that fall under the provincial DOH of Limpopo Province.

1.8.6 Health sector

The 'health sector' refers to a range of health care facilities either state owned, privately owned, or unlicensed which either sell or provide medication and medical treatment to needy patients (Mackintosh, Channon, Karan, Selvaraj, Cavagnero et al 2016:2). Adeleye and Ofili (2010:2) define the health sector as a broad institution that focuses on the physical mental, and social wellbeing of citizens. The health sector is responsible for ensuring services that promote the wellbeing of citizens (Peters, Paina & Schleimann 2013:885). Health sector in this study, refers to all hospitals and primary healthcare sites in the Waterberg District, private and governmental.

1.8.7 Experiences

'Experiences' refers to what a person feels and thinks when in contact with the environment or an event (Karjaluoto, Munnukka, & Kiuru 2016:4). Chang and Ramnanan (2015:1163) refer to experiences as self-reported feedback with an encounter, an object or subject. A person's experiences are a combination of the person's practical encounters and observations with and in the environment and the degree of feeling experienced during such an encounter, or observation of an event (Huta 2016:4). In this study experiences refer to the feedback, feelings and impressions social workers in Waterberg District hospitals in Limpopo Province encounter whilst working as medical social workers in state-based hospitals in the Waterberg District.

1.9 FORMAT OF THE DISSERTATION

The dissertation is divided into five chapters as listed in Table 1.3.

Table 1.3: Outline of the study.

Chapter 1 General introduction, problem formulation and orientation to the study	Chapter 1 informs the reader about what the study is and the research context. It presents the researcher's statement of purpose and the issues that sparked his curiosity to investigate the experiences, challenges and coping strategies of social workers based in multidisciplinary teams in state-based hospitals in the Waterberg District. It outlines the research questions, research objectives, research approach, design and research methods as planned at the outset of the study, as well as the data verification methods and

	practical integration of ethical principles throughout the study. It provides a summary of the key concepts as relevant to the study.
Chapter 2 Literature review	Chapter 2 offers a general overview of scholarly knowledge in the form of literature related to social work in health care settings, paying special attention to social work in multidisciplinary teams in hospital settings to strengthen the rationale for the study. The literature consulted assisted to position the study in terms of what is already known about the topic. The theoretical framework used, namely the systems theory and the ecological systems approach, is outlined in more depth, highlighting concepts that are relevant to this study. It explains how these theoretical concepts have informed the research processes followed for the study and how the theories helped to structure the research findings.
Chapter 3 Application of research methodology, approach and design	Chapter 3 offers insight into the researcher's application of the qualitative research approach. The methods and procedures and how they were applied to execute the study such as sampling, data collection, and data analysis are detailed, including field related issues that necessitated changes to the original research plan. The modifications to the original research plans are explained.
Chapter 4 Findings of the research study	Chapter 4 contains the findings of the interviews that were conducted with the social workers and the outcome of the focus group discussion. Verbatim examples of what they said are presented to illustrate each theme and subtheme identified in analysing the data. A literature control is woven throughout this chapter, to compare and contrast the findings with existing literature and vice versa.
Chapter 5 Summary, conclusions, limitations and recommendations	Chapter 5 summarises the research findings and concludes with a review of whether the research questions have been successfully answered. The findings inform the researcher's recommendations about how the occupational satisfaction and professional identity of social workers based in multidisciplinary teams in state-based hospitals in the Waterberg District can be improved. The limitations of the study are mentioned.

1.10 SUMMARY OF THE CHAPTER

This chapter served to outline the conceptualisation of the research topic which then developed into the problem statement, rationale for the study, theoretical framework, research questions, research goal and objectives, research methodology, research design, research methods for sampling and data collection, data analysis, data verification, adherence to ethical principles and clarification of key concepts.

It was noted that whilst social workers for many years have been recognised as offering a valuable contribution in multidisciplinary teams in hospital settings, they face challenges that affect their job satisfaction and professional identity. Several external factors that have impacted on social workers working in multidisciplinary teams in hospital settings were mentioned, namely the industrialisation of social work; the nature of South Africa's post-apartheid health care sector; escalation of the demand for hospital services from socio economically disadvantaged patients; the progress in establishing a specialisation in hospital social work and the soon to be legislated regulations for registration as a hospital social worker with the SACSSP; and finally the influences of the global pandemics of HIV/AIDS and COVID 19.

It was noted that empirical evidence of how social work practice in hospital settings had evolved to adjust to overcome internal and external challenges that impact on social work and health care services, was clearly lacking. More specifically, locally specific information about the experiences and challenges of social workers working in multidisciplinary teams in state hospitals in the Waterberg District, Limpopo Province was distinctly lacking. It was therefore concluded that a systemic approach was needed to examine and highlight the intersectionality of challenges that social workers face in their hospital working settings and appraise their recommendations of how their job satisfaction and professional identities as social workers in multidisciplinary teams in state hospitals in the Waterberg District could be enhanced.

The next chapter offers a review of literature relevant to social work in multidisciplinary teams in hospital settings and expands on the systems theory and the ecological systems approach, and their relevance for providing the conceptual framework for this study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The purpose of the study was to explore, describe and contextualise the experiences of social workers working in multidisciplinary teams in state hospitals in the Waterberg District. This chapter expands the discussion to offer additional information that the researcher sourced from different literature sources consulted after having interviewed the research participants. In this discussion of the literature, the focus is on the social workers in hospital settings, new realities affecting social workers in health care settings and the theoretical framework of the study, before presenting a summary of the chapter.

2.2 SOCIAL WORKERS IN HOSPITAL SETTINGS

This section discusses social work in a hospital setting. As a member of the multi-disciplinary team, a social worker working in a hospital setting works with patients and their families in need of psychosocial help. Based on the literature, the role of social workers in hospital settings is examined below; before dealing with multidisciplinary teams' benefits and their challenges for social workers.

2.2.1 Role of social workers in a hospital setting

Social workers are employed in hospital settings to augment patients' care, act as a link between patients and the medical resources, strengthen the communication between patients and the medical staff, and counsel patients and their families (Allen 2012:184). They render psychosocial support services to patients and families and advance holistic assessments of patients to develop effective treatment plans for them which is a specialised service. They also promote collaboration amongst the different professionals who work together in the multidisciplinary teams (Kitchen & Brook 2005:1; Hesjedal, Hetland & Iversen 2013:441; Supper, Catala, Lustman, Chemla, Bourgueil et al 2015:719; Dowdy, Furlong, Raines, Bovery, Kauffman et al 2014:183). The inclusion of social workers in multi-disciplinary task teams in hospital settings dates back to the early 1900s (Kirschbaum 2017:6). The integration of social workers in hospital settings was first initiated by the physician Richard Cabot in 1905 in the United States of America, when he employed a nurse who had completed social work training

at the Boston School for Social Workers (Pugh 2011:32). Cabot requested the nurse to assist him by addressing the patient's social issues which were interfering with his medical interventions (Pugh 2011:32). Subsequently, he noted the benefits of social workers, doctors and educators combining their professional expertise to improve patient care (Kirschbaum 2017:6). Subsequently, there has been a steady increase in social workers employed to work in hospitals.

Social workers are now recognised for enhancing the communication between health care team members, patients and their families (Kirschbaum 2017:6; Kitchen & Brook 2005:6). Driven by their commitment to human rights and social justice, social workers navigate and advocate for patients' services within the health sector and the community at large (Limon 2018:1). Some writers attribute the metamorphosis and transformation from a traditional model in health care to the collaborative patient-centred model to the change efforts social workers have made in hospital settings (Kitchen & Brook 2005; Limon 2018:1). The contribution of social workers of non-medical information to team members impacts positively on the multidisciplinary teams' problem solving, ensures that patients and their families access relevant community resources, receive genetic counselling, mental health treatment and post-operative rehabilitation (Brown, Drake, Gehlert, Wolf, DuBois et al 2016:1; Singels, Annandale, De Jager, Schulze, Inman-Bamber et al 2010:3). It is now common practice to place social workers in specialised hospital departments such as paediatrics, oncology, nephrology, organ transplants and emergency trauma (Estelle 2017:31). The role assigned to these social workers has advanced from only conducting basic social visits, to providing therapeutic counselling services, participating actively in the discharge planning of patients, delivering interdisciplinary care, preparing for patient aftercare treatment outside the hospital setting, and performing the functions of an integral team member of the trans-disciplinary care system (Spitzer & Davidson 2013:960; Pugh 2011:33). The latter point is expounded upon next.

Social work training prepares social workers to facilitate group interaction (Rine 2016:143) which explains their proficiency in promoting interprofessional collaboration within the hospital teams (Albrithen & Yalli 2016:129; Giles 2016:30; Kirschbaum 2017:8; Kitchen & Brook 2005:6; Robinson 2012:1). Additionally, social workers contribute vital information to their other team members such as patients' motivations for advance directives, patient rights, and 'do-not resuscitate' orders, which impact strongly on treatment decisions the medical team must make (Brown et al 2016:1; Kirschbaum 2017:6). Social workers have expanded the traditional medical approach to health care by raising awareness of contextual and relational factors that impact on patient wellbeing (Kirschbaum 2017:8; McAuliffe 2009:130-131). Social

work ethical principles and anti-oppressive values prepare social workers to challenge medical personnel to be more realistic about and responsive to patients' needs (McAuliffe 2009:130-131). Social work knowledge of community networks assists team members to locate relevant networks of services convenient to where patients stay to augment the support they require during their rehabilitation (Kirschbaum 2017:8; McAuliffe 2009:130-131). Because of the strong relationships social workers foster with patients, patients tend to generalise this trust and cooperation to other members of the multidisciplinary team (McAuliffe 2009:130-131).

Some of the roles that social workers perform extend beyond direct face-to-face interactions with patients. In some instances, social workers fulfil desk-based duties by collating and interpreting computerised data; performing management or administrative functions in the hospital; and or focusing on research (Estelle 2017:31; Hennessey 2010:2; Olckers 2013:17). Much of the research outputs of social workers in hospital settings aim to advance effective collaboration and cooperation within interdisciplinary teams (Gehlert & Brown 2012:1).

Social workers in health care, are more recently acknowledged for working closely with specific communities to review and transform health care policies, facilities and programmes, to make sure that they are accessible to those that need them most, are more responsive to their needs and are effective and efficient (Brown et al 2016:1).

2.2.2 Multidisciplinary teams in hospital settings

A broad definition of a multidisciplinary team provided by Finlay (cited by Albrithen & Yali 2016:131) is "a group of individuals with varying backgrounds, perspectives, skills and training who work together towards the common goal of delivering a health or social outcome." The definition suggests that the professional expertise of different health care providers, nurses, social workers, psychologists, pharmacists, physiotherapists and dieticians are combined to advance the holistic care of patients (Albrithen & Yalli 2016:129; Ambrose-Miller & Ashcroft 2016:101; McAuliffe 2009:126). Each professional discipline is recognised to have specialised information and interventions that, when combined with the knowledge and skills of other team members contribute to the holistic treatment of patients. In summary, no single specialisation has all the answers but when their knowledge and skills are combined and their members work collaboratively and cooperatively together, patients receive comprehensive care. One therefore expects all team members to be awarded equal status (Dale, cited by McAuliffe 2009:126). Other authors explain multidisciplinary teamwork as inter-and trans-disciplinary collaboration between allied professionals and medical officers (Brown, Drake et al 2012:1).

The benefits of multi-disciplinary teams in hospital settings and the challenges experienced by social workers who are based within them are also addressed in the literature.

2.2.2.1 The benefits of multi-disciplinary teams in hospital settings

Some of the benefits of multidisciplinary patient health care are briefly mentioned in Chapter 1 (section 1.1.1). A more in-depth description based on the literature on the topic follows.

An analysis of literature about the benefits of multi-disciplinary patient health care reported substantial benefits of using multidisciplinary teams in hospital settings, which included the following:

- Multidisciplinary teams improve organisational efficiency; enhance service delivery; extend expertise in patient care management; increase mutual support amongst team members; advance the maturation and cohesion within hospital settings; and promote respect and understanding amongst the different professions involved in patient management (Albrithen & Yalli 2016:131).
- Further advantages noted by Schofied and Amodeo as cited by Albrithen and Yalli (2016:131) include increasing patient access to health care; improving patient self-care; increasing work satisfaction amongst the hospital practitioners; reducing in-patient hospital stays and premature hospital admissions; making a broader range of treatment interventions available to patients; adjusting treatments to suit individual patients; reducing the burden of responsibility on individual team members; fostering greater support among team members when dealing with difficult patients; and being more objective when delivering healthcare services.
- The organisational benefits of hospital staff working in multidisciplinary teams include better containment of hospital expenditure; more effective co-ordination of patient care; and greater accountability (Kirschbaum 2017:7).
- By working in teams, it becomes easier for team members to connect with key role players in a patient's care, namely the patients themselves, their caregivers and the medical team. Team members with the help of the allied professionals, access a wider range of services for patients such as housing, social relief, child protection and other relevant community support services, provided by external organisations (Albrithen & Yalli 2016:129; Dobriková et al 2016:83).

Research has ear-marked guiding principles for multidisciplinary care teams (Leach, Wiese, Agnew & Thakkar 2018:116) which various researchers have expressed as follows:

- Team members need physical spaces that facilitate interaction among the team; a shared sense of purpose and goals; effective communication; a leadership structure that reassesses team goals and activities regularly (Leach et al 2018:116).
- According to Ambrose-Miller & Ashcroft (2016:101) the well-functioning of multidisciplinary teams in hospitals depends upon four factors, shared values and ethics that support inter professional practice; clearly defined inter-professional roles and responsibilities for individual team members; good inter-professional communication between team members; and on-going initiatives to ensure team members maintain collaborative engagement with one another. These practices are further endorsed by other scholarly sources (Kirschbaum 2017: 8; McAuliffe 2009:126; Dobriková et al 2016:83).
- Communication in multidisciplinary teams is key and can be improved by hosting weekly multidisciplinary meetings, providing continuous professional development (CPD) training sessions, arranging coordinated patient care review meetings, increasing access of all team members to the information in patients' files, scheduling regular face-to-face team meetings; and encouraging team members to interact with one another using electronic and telecommunication methods (Giles 2016:28).

Whilst the advantages of social workers being part of multidisciplinary teams have been expounded upon, many multi-disciplinary teams are fractious and include various challenges, especially for social workers.

2.2.2.2 Challenges experienced by social workers in multidisciplinary teams in hospital settings

Social workers must have sufficient medical knowledge to converse freely and confidently about a patient's medical condition with other team members and position themselves well within the multidisciplinary teams they are part of (Beytell 2014:177). They need to be well informed about existing hospital resources, medical terminology, health care, and hospital procedures. Apart from their professional training as social workers, they need to undergo a formal induction programme when appointed to work in a hospital setting (Beytell 2014:177).

As noted by O'Leary, Tsui and Ruch (2013:135), power imbalances, exclusion, discrimination, and exploitation are common challenges experienced by social workers working within

multidisciplinary teams. These challenges undermine the partnerships social workers should have with other team members and impact negatively on their general contentment in working in hospitals (Ambrose-Miller et al 2016:101; Kirschbaum 2017:10-11; Dobríková, et al 2016:87). Much of the discontent experienced by social workers working in multidisciplinary teams in hospitals, is associated with boundary issues (O'Leary, et al 2013:135). Lack of medical expertise and unfamiliarity with medical terminology and hospital functioning are reported as major barriers for student social workers doing their practical work in hospital settings. These gaps in knowledge impact negatively on the relationships they establish with the other medical team members (Beytell 2014:176). The student social workers struggle to follow the medical terminology used in patients' files and medical reports and this frustrates the other team members. The perceptions of social work participants in Healy's study (cited by Beytell 2014:176) were that social workers working in multidisciplinary teams were marginalised and undermined by the other multidisciplinary team members and that power struggles were common between the different disciplines and social workers. As concluded by Beytell (2014:176) knowledge of the biological basis of health and illness is highly valued in hospital settings and those who possess such knowledge are automatically awarded more power and respect within the multidisciplinary team.

The problems experienced by social workers in multidisciplinary teams in hospital settings are complex and affect student social workers and social workers equally, as is explained in Table 2.1. Part of the problem is that social workers are expected to align their social and community development perspectives with a medical model perspective to connect both medical personnel and patients. As can be seen inTable 2.1. the challenges experienced by social workers are plentiful.

Table 2.1: Challenges faced by social workers in medical settings according to different authors

CHALLENGE IDENTIFIED	EXPLANATION	AUTHOR/S
Professional rivalry and mistrust	Hospitals still have not developed the culture of collaboration. Collaboration takes time to be implemented in the health sector. Conflicts between medical personnel and other team members in the hospital are therefore, not uncommon. Medical personnel are reluctant to	Ambrose-Miller & Ashcroft (2016: 101-107) Beytell (2014:176) Hansson, Friberg, Segesten, Getta,

	relinquish their traditional leadership roles in hospital settings	and Mattsson (2008:6) Kirschbaum (2017:29) Ambrose-Miller et al (2016:101-109)
Domination and lack of support from medical professions	Team members with medical expertise have more power than social workers in hospital settings. Social workers fail to assert their professional identity and role within the multidisciplinary teams. They are easily coerced into side-lining their primary social work purpose, advocacy for client systems, to perform lesser skilled tasks such as home-finding. They feel unsupported by their medical counterparts. They feel marginalised and undermined by other team members. Power held by the medical personnel is reinforced by the inequity of salaries amongst multi-disciplinary team members.	Albrither and Yalli Ambrose-Miller & Ashcroft (2016:101-107) Beytell (2014:176) Fraser (2010:27) Dobrikova et al (2016:87) Kirschbaum (2017:11)
The philosophical assumptions covered in the training of team members differs and they view patients and patient care differently	Different professions have different priorities as determined by their professional roles and professional values. The medical model adopted by medical staff versus the psychosocial approach adopted by social worker's position patient care differently. For example, the medical profession values saving lives over quality of life; the medical profession is authoritarian rather than respectful of the self-determination of patients. The non-directive, self-determining and empowering approach used by social workers is contrary to the medical model which is prescriptive and places the practitioner as the expert.	Kirschbaum (2016;10) Murphy and McDonald cited by Fraser (2010:09)
The nature of the social work	The purpose of social work separates social workers from medical experts. Social workers	Carpenter and Platt (1997:337);

profession is specific and separates social workers from others in healthcare	advocate for patient rights, adopt a humanistic approach, uphold cultural sensitivity, endorse person centred communication and rely on social inclusion and empowerment interventions. These places social workers in conflict with their medical counterparts.	Kirshbaum (2017:22-24) Dobrikova et al (2016:87) Ambrose-Miller & Ashcroft(2016:101-109)
Lack of clarity regarding professional roles and boundaries	The roles that non-medical team members play in patient care and the hospital are frequently misunderstood in hospitals, particularly the role of social workers. Medical staff expect social workers to provide concrete services (transport, residential placements and financial support) instead of psychosocial counselling.	Albrithen and Yalli (2016:132) Frost, Robinson and Anning, and (2005:188) Kirschbaum (2017:10) Raniga and Kasiram (2010:263) Ambrose-Miller & Ashcroft (2016:101-109)
Role-blurring	The professional knowledge, boundaries and multi-disciplinary skills in multidisciplinary teams are blurred which affects a person's professional identity. Roles and responsibilities can be changed by hospital administration and create discomfort and anger between team members. Confidentiality issues are common.	Yalli (2016:132) Frost, Robinson and Anning (2005:188) Kirschbaum (2017 10) Raniga and Kasiram (2010:263) Ambrose-Miller & Ashcroft (2016:101-109)
Management structures	Medical staff members are better represented in the management teams of hospitals, while others, particularly social workers, are under-represented. Social workers often must report to the matron or nursing managers. Hospital funding is directed to medical patient care rather than social programmes. Hospital	Fraser (2010:27) Kirschbaum (2017:11) Dobrikova et al (2016:85, 91)

	management decides what is expected of social workers employed in hospitals and hospital statutory rules regulate the staffing of social work posts, basic conditions of employment for social workers, the scope of social work professional activities and social worker/patient ratios. Patient care is determined by hospital administrative demands and when funds are spent, budget cuts occur in hospital settings, social workers are expected to make arrangements to discharge patients early and shorten hospital patient stays.	
Social workers lack adequate training in medical terminology and knowledge	Without adequate understanding of the biological basis of health and illness and medical terminology, social workers struggle with interpreting and updating written patient records and conversing with medical practitioners.	Beytell (2014:176)
Regulations, reimbursement practices or organisational goals	Hospital employment regulations and human resource structures in health care grade the positions of different disciplines differently which results in different dispensations amongst team members.	Leach et al (2018:116)

In general terms, the literature consulted confirmed that there were gaps in the literature about the experiences of social workers working in multidisciplinary teams in state hospitals in the Waterberg District. There was little evidence about how the challenges affect social workers' ability to fulfil their professional mandate; impact on their professional morale and personal well-being; and the quality of care they provide to patients. Furthermore, locally specific insights about the conditions under which social workers work in multidisciplinary teams in state hospitals in the Waterberg District were lacking, especially regarding external conditions that affect social workers' roles and morale. Literature sourced focussed mainly on internal challenges within multidisciplinary teams in hospital settings and failed to present a more holistic ecological systems explanation. The researcher's professional experiences as a social worker made him wonder about the roles of external factors such as health and welfare

policies, socio structural realities that affect client systems which social workers have to deal with, the kind of professional training social workers receive, and if any of these external forces affect the occupational satisfaction and professional identity of social workers working in hospital settings. The researcher therefore resolved to conduct an exploratory, descriptive and contextual study to contribute an ecological systems perspective of social worker's experiences and challenges of working in multidisciplinary teams in state hospitals in the Waterberg District.

2.3 NEW REALITIES AFFECTING SOCIAL WORKERS IN HEALTH CARE SETTINGS

It remains unclear if social workers have been expected to adapt their roles in multidisciplinary health care settings in response to the 'new realities' of health and welfare services that have occurred, especially within South Africa. The researcher contemplated whether failure to adapt to their new circumstances could have negative consequences for social workers in hospital settings. Themes pertaining to changes that social workers working in hospital settings are affected by, were located and are briefly explained.

Some of the 'new realities' of social work in health care settings are of an international nature and others from a national nature. Some are generic to social work and others more specific to social workers in hospital settings. The topics identified in this regard are the industrialisation of social work; the changes in the health care and welfare systems in post-apartheid South Africa; the HIV/AIDS and COVID-19 pandemics; and the specialisation of social work in health care in South Africa.

2.3.1 Industrialisation of social work since the early 1990s.

To increase the reach of social work services, whilst curtailing service costs, social work has become more industrialised. This has significantly curtailed the autonomous decision making of social workers; regulated the nature of the services social workers offer; reduced specialized services; and called for a more generalist approach to service delivery from social workers (Carpenter & Platt 1997:341). According to Carpenter and Platt (1997: 342). This has led to social work services becoming fragmented. As noted by Kitchen and Brook (2005:3) the shift in social work services currently is towards briefer, more solution focused and case management models in hospital settings. The changes have made it difficult for social workers to respond effectively to the complex human issues they are expected to address, and social workers are sorely challenged to uphold social justice and the rights of their patients at all times (Strom as cited by Carpenter & Platt 1997: 341). This is a major blow for social workers

whose hallmark is their focus on social justice issues and the wellbeing of marginalised people (Carpenter & Platt 1997:338; Delobelle 2013:160). Beddoe (2011:24) postulates that to survive in multidisciplinary teams in hospital settings, social workers must be more assertive to protect and uphold the professional values that define them. This position is also presented by Raniga and Kasiram (2010). In the light of the changes in health care and social work services, it is more difficult for social workers to assert themselves where they have less power and status.

2.3.2 South African 'new realities' impacting on social work practice in hospital settings

Apart from the generic challenges social workers in hospital settings face as discussed in the previous section (see section 2.2.2.2 Challenges experienced by social workers in multidisciplinary teams in hospital settings), several other pressing challenges situated outside the multidisciplinary teams and hospitals have the potential to lower occupational satisfaction and lead to a poor job satisfaction and professional identity amongst social workers in hospital settings. Amongst the challenges impacting on social work practice in hospital settings in the form of new realities identified in the literature, are the changes in health care services in South Africa, changes in the South African welfare system, specialisation of social work in health care in South Africa, HIV/AIDS and the COVID-19 pandemics.

2.3.2.1 Changes in the South African health care system

For the purpose of this research it is important to reflect on health and social work services before and after the first democratically elected government came into power in South Africa in 1994.

Under the apartheid system both the welfare and the health systems were segregated according to race and whites received greater privileges than other races (Smith 2014:42). Racial discrimination was driven by the political and economic objectives of the ruling elite (Schmid 2016:72; Smith 2014:42). Therefore, the first agendas established by the first democratically elected South African government was to promote parity in services rendered by all government departments to South African people, particularly within the health sector. The majority of disadvantaged persons had suffered severely before 1994 as a result of the inadequate health care services they could access (Coovadia, Jewkes, Barron, Sanders & McIntyre 2009:825). The African National Congress (ANC) therefore resolved to correct two major challenges in health care, the urban-rural inequity of health services and the social

structural remnants of the apartheid regime (Coovadia et al 2009:825; Omotoso & Koch 2018:1). The expansion of health care services to reach those living in rural areas and uplift disadvantaged communities, placed great strain on healthcare services in South Africa and caused a rapid decline in the quality of services delivered (Coovadia et al; Delobelle 2013:159; Plaks & Butler 2012:138). Poor management, underfunding, shortages of qualified health care staff and deteriorating infrastructure are criticisms of the current healthcare system. These shortcomings are as a result of the policy shifts implemented to decentralise healthcare and expand primary health facilities and services care (Delobelle 2013:159; Plaks & Butler 2012:138).

Health care is meant to be a constitutional right in South Africa, but fragmentation, segregation and social injustice continue to wear the South African health system down (Maphumulo & Bhengu 2019:1). The pluralistic South African health care system remains and only a small minority of the population can afford medical insurance which secures them comprehensive medical services (Plaks & Butler 2012:138). The majority of South Africans depend on a public health system that is overburdened and cannot meet the demand for its services (Plaks & Butler 2012:138). A study conducted during 1996 in the KwaZulu-Natal Province confirmed that urban hospitals remain better staffed than the rural hospitals and that rural hospitals remain grossly understaffed (Burns 2011:105).

Unfortunately, the people who need health care services the most are the least likely to receive them (Plaks & Butler 2012:138). This is a matter of great concern. Socio structural factors deeply rooted in South Africa's history continue to predispose the most vulnerable communities to extreme disadvantage which inclines them to high levels of disease, such as HIV/AIDS (Human Immune Virus/ Acquired Immune Deficiency Syndrome), tuberculosis (TB), pre-transitional diseases, and non-communicable or non-infectious diseases (Bezuidenhout 2017:190; Delobelle 2013:159). Vulnerable communities live in under policed communities with high levels of violence in their neighbourhoods, creating a demand for trauma services, which places additional weight on the national health care system (Delobelle 2013:159).

2.3.2.2 Changes in the South African welfare system

The South African welfare system mirrors similar themes as those discussed in the previous discussion about the South African healthcare system. Racial differentiation, embedded discrimination among welfare recipients, violations of social justice and human rights and lack of equity in the access people have to resources and opportunities, seriously undermine the social support available to those previously disadvantaged on the basis of colour (Patel

2005:72). The ANC government resolved to dismantle unfair welfare policies and change social welfare services to fight poverty and the social problems that kept people trapped in disadvantage (Schmid 2016:87). The White Paper for Social Development (1979) as outlined by (Schmid 2016; 87) was adopted in 1997 in an effort to correct the inequities of the old welfare system and create a more efficient and effective one. The old apartheid welfare system was cumbersome because it was administered by 14 separate departments divided according to race and segregated homelands (White Paper for Social Development 1997). Welfare services were disjointed, duplicated, inefficient and ineffective (White Paper for Social Welfare 1997). Services were organised along specialist lines, into different fields of service, which was essentially contrary to holistic practice and were remedial in nature and dependent upon institutional care (White Paper for Social Welfare 1997). Community work, preventive and developmental, was not widely practiced by social workers in these settings (White Paper for Social Welfare 1997). The policy frame work (set out in the White Paper for Social Welfare, 1979) was then adopted with major objectives and the shift from a residual to a developmental approach to social welfare to deal with the current social problems such as the high rate of people living in poverty, fragmented families, high rate of abandoned children, substance abuse, gender based violence and other social ills (Qalinge 2022:76).

The proposed changes included cash transfers, social relief and capacity building in the form of developmental services for disadvantaged people to assist them out of their challenging situations caused by unemployment, ill-health, pregnancy, child-rearing, widowhood, disability and old age (Patel 2015:15; White Paper for Social Welfare 1997), accepting that they needed socio and economic relief. Their human resource capacity would be increased simultaneously to assist them to care for themselves and their family members and reduce their dependence upon social grants (Patel 2015:15; White Paper for Social Welfare 1997). Social workers therefore were expected to integrate both social and economic development (Lombard, 2011:231).

The White Paper for Welfare 1997 was reviewed in 2008, ten years after it was adopted. Lombard (2008b:155) noted that the White Paper for Welfare had positively impacted on reducing poverty, addressing hunger, increasing household access to piped water, promoting job searches and increasing school attendance. However, it failed to deliver in other respects (Lombard 2008b:159). Social workers found it difficult to incorporate social development as an approach into their practice; they struggled to find ways to integrate socio economic interventions into their programmes; and little had happened in South Africa to minimise the impact of structural causes of poverty and inequality. According to the researcher's professional experience and confirmed by Beddoe (2011:24), social workers in hospital

settings are currently still challenged to promote economic development of patients, firstly, by the medical teams' expectations of what they should be doing to help patients and the team, secondly, by a lack of training in the developmental approach, and finally, due to their long-term efforts to concentrate on the psychosocial aspects of social work.

A reduction in poverty was noted between 2004 and 2010 (a decrease of 13 per cent between 2004 and 2008) (Abdulkareem, Ehiane & Nnanezie 2011:69) in response to the introduction of the Child Support Grant (CSG) and other social security measures (Petty & Mabetoa 2022:10). However, the poverty reduction curve reversed significantly between 2011 and 2015 (World Bank Group 2020). In 2011 the poverty rate reached 18.4 million people and by 2020 it was stated that approximately 55.5 percent (30.3 million people) of the population was living in poverty at the national upper poverty line with a total of 13.8 million people (25 percent) suffering food poverty (World Bank Group 2020). Limpopo Province has the second highest poverty rate amongst the South African provinces, 11.5%, with the Eastern Cape leading with 12.5%. Patients living in poverty make up 7.8 % of hospital admissions in Limpopo Province and most referrals to social workers in the Waterberg hospitals require referral to shelter accommodation; assistance with accessing social grants; requests for donations and social relief; and a request for transport.

Even though measures were in place to address pre-apartheid shortcomings in social work systems in South Africa, Smith (2014:1) argues that the loopholes in the post-South African democracy remain and many South Africans still suffer from oppression, inequality, and poverty. Social workers are unfairly left with the responsibility of promoting transformation. Their role to advocate against social injustice, promote socio-economic interventions, oppose inequality and increase people's access to health care and welfare is more pressing than ever before (Mbecke 2016:3201). The South African democratically elected government has inherited an oppressive legacy that has been very difficult to correct. Health and welfare services remain seriously challenged. There is little clarity about social work services in hospitals. The professional status, roles and responsibilities assigned to the social workers who work in multidisciplinary teams have been adjusted in response to these changes. Little is known about the social workers' experiences of the goodness of fit between hospital management and multidisciplinary team expectations of them as multidisciplinary team members in view of the current health and welfare policies. As confirmed by Peterson and Pretorius (2022), strategic policies pertaining to the implementation of the social development approach in health care are distinctly lacking and social workers in health care need a framework for a social development approach in health care in South Africa, as well as further training in this approach.

2.3.2.3 Specialisation of social work in health care in South Africa

It is generally acknowledged that there are specific competencies required of social workers in hospitals and health care settings that are not characteristically included in the undergraduate training of all social workers. Despite this, there is only one accredited postgraduate course available in South Africa to prepare social workers to specialise in health care. The master's degree in Social Health Care MSW (Healthcare)), offered by the University of Pretoria is a postgraduate degree that aims to develop critical reflective practice amongst social work health care practitioners (Olckers 2013:12). The course consists of coursework modules, such as health policy, structures and primary health care, and social health care, as well as practical work training and a mini dissertation (Olckers 2013:12). The comprehensive curriculum reflects the broad knowledge base expected of social workers in the health care field. From the researcher's experience, few social workers employed in hospital settings have this qualification. This raises questions about whether those based in health care settings are suitably prepared to work there.

The SACSSP investigated the need to recognise social work in health care as a specialised area of social work. Interested persons were invited to submit written comments and recommendations on the matter. Subsequently, interest groups met with one another to prepare their submissions which were considered by the SACSSP. A final draft of Regulations Relating to the Requirements and Conditions for Registration of a Speciality in Social Work in Health Care was circulated for further comment in 2008. The draft regulations outlined applicable definitions: requirements for registration; scope of practice for the speciality of health care; conditions of practice for the speciality of health care in social work; application process to register for the speciality of health care in social work; and the use of the title social worker specialised in health care. After integrating the feedback related to the document, the proposed Regulations Relating to the Requirements and Conditions for Registration of a Speciality in Social Work in Health Care made in terms of the Social Service Professions Act, 1978 (Act No. 110 of 1978 as amended), were submitted to the Minister of Social Development. On 22 May 2020 the Minister invited interested persons to submit substantiated written comments or representations on the intended regulations, to her (Regulations relating to the registration of a speciality in social work in health care, 2020). It has yet to be promulgated.

Regarding the intended scope of practice for the speciality in social work in health care, social work in health care as a field of speciality in social work will provide social work services within the national health system, including, but not limited to, health establishments, rehabilitation

programmes, community-based programmes and private practice (Department of Health 2020:1)

In terms of the gazetted regulations the roles reserved for specialist social workers in health care will include -

- conducting bio-psychosocial assessment of the diverse client systems to identify and develop culturally and contextually suitable interventions to manage physical, psychological and social health challenges;
- promotion of health education and prevention of illnesses through capacitating client systems (individuals, families, groups and communities) to improve their own health outcomes by offering relevant information that enables them to make informed decisions;
- applying relevant models of intervention with client systems that are consistent with appropriate South African legislation, policies and procedures;
- participating in discharge planning by appraising the bio-psychosocial adjustment required by patients and offering or increasing their access to a continuum of care which includes community-based education, rehabilitation and after care;
- interfacing and networking with other stakeholders to develop sustainable resources for patients and making referrals to inter-sectorial partners when appropriate;
- advocating for policies, procedures and legislation that meet and protect patient interests and wellbeing; collaborating with health service providers and their significant others to maximise the bio-psychosocial functioning of client systems are pertinent to their health challenges; and
- strengthening interactions between health service providers and health service users by advocating for those with less power whose needs are not met, mediating conflicts, easing tensions, coordinating and increasing collaborations between service users and service providers (Regulations relating to the registration of a speciality in social work in health care, 2020).

Once the regulations have been promulgated, to qualify for registration as a specialist social worker in health care, one will have to be a social worker who has completed one or more of the following:

- a masters' degree in social work that is appropriate to social work in health care, plus two years' evidence based practical knowledge and experience relevant to working within the field of social work in health care; or

- a post graduate certificate or diploma relevant to social work in health care, with three years' relevant evidence and practical knowledge; or
- a bachelor's degree in social work and a completed accredited short course in social work in health care as acknowledged by the SACSSP, on recommendation of the Professional Board for Social Work, plus relevant experience and knowledge gathered by working as a social worker in health care; or
- a bachelor's degree in social work, with five years of relevant evidence based practical knowledge and experience within the scope of social work in health care (Regulations relating to the registration of a speciality in social work in health care, 2020).

2.3.2.4 HIV/AIDS and the Covid-19 pandemics

The Human Immune Virus/ Acquired Immune Deficiency Syndrome (HIV/AIDS) pandemic has over the years increased the South African mortality rate significantly, as well as the number of orphaned children (Patel 2015:148). HIV/AIDS has an intense social impact and several facets of contracting HIV/AIDS require intense social work support. Families struggle to disclose their status because of the associated stigma. The disease tends to deplete a family's financial resources because in lower socio-economic groups the family's income earning capacity is much reduced because when an infected person becomes too sick to work, the person loses his or her job and or those who have to care for the infected family member give up their jobs to care for the sick relative and assume responsibility for the household and child care duties (Bezuidenhout 2017:193). The health care system places the burden of caring for HIV/AIDS patients on families, expecting them to treat the HIV/AIDS infected member at home so that health care resources can be preserved. Greater access to Antiretroviral drugs (ARVs) in recent years has significantly lowered the number of orphaned children (Petty & Mabetoa 2022:13) and reduced mother-to-child transmission (Bezuidenhout 2017:191). These developments have escalated governmental expenditure for health care and health education services at a time when investment needs have increased, global financial resources are strained, and international organisations and donors who previously invested in HIV/AIDS treatment and education can no longer do so (Bezuidenhout 2017:193). This has resulted in imposed budget cuts for other health care services. Social workers therefore have an important role to play in offering counselling to help people to come to terms with their diagnosis, support the HIV/AIDS patients and their families in accessing social relief and grants, relationship counselling and in some situations, linking them to child welfare and child protection services.

Another issue of concern is the high tuberculosis (TB) and HIV co-infection rate that manifests as a multi-drug and drug resistant TB (Bezuidenhout 2017:190). The multi-drug resistance most typically occurs when TB management is poor, medications are improperly used and/or treatment regimens are incorrectly applied, and/or when patients do not complete their prescribed treatment course (Alexander & De 2007:289). The challenges of a TB and HIV co-infection are that the infection is more severe and causes a reactivation of latent TB; and the active TB creates an increased HIV viral load, that fast tracks the progression from HIV to AIDS, and ultimately death.

The impact of HIV/AIDS on the health system and South African nation has been compounded by the emergence of the COVID-19 pandemic. COVID-19, a flu-like or fever-like illness, that causes severe acute respiratory disease, is highly infectious and spreads through respiratory droplets and direct physical contact (Cai, Sun, Huang, Gamber, Wu & He. 2020a:1; Chughtai & Malik 2020:2). It is caused by the SARS-CoV-2 virus and is distinctly different from the other common viruses (Arabi, Murthy & Webb 2020:1; Murphy, Vallières, Bentall, Sheevlin, McBride et al 2020:1; Wang, Liu, Wu, Chen, Li et al 2020:1; Vilches, Sah, Moghadas, Shoukat, Fitzpatrick et al 2020:1; Xiao, Zhang, Kong, Li & Yang 2020:1; Cai et al 2020:1). Whilst most people infected with the virus experience mild to moderate symptoms and recover without special treatment, some become seriously ill and require intensive medical treatment. This, in a developing country such as South Africa, imposes intense strain on an already teetering health care system.

COVID-19 was first announced on the 31st of December 2019 in the city of Wuhan, Hubei Province in China. Because of COVID-19's rapid global spread, it was declared a global pandemic on 11th March 2020 by the World Health Organisation (WHO) (World Health Organisation 2019). In order for South Africa to protect its already burdened healthcare system, and the high number of vulnerable people with co-morbidities such as HIV, tuberculosis and diabetes, the government declared a national state of disaster on the 27 of March 2020 (Cai et al 2020a:1; Chughtai & Malik 2020:2). The plan was for the health care systems to focus on devising ways to flatten the curve of the pandemic and increase the healthcare system's capacity to manage the pandemic before the main wave of COVID-19 cases occurred.

South Africa has experienced four COVID-19 waves as explained by Bhoumily (2022). The first, the Alpha variant, presented between June and August 2020 and was recognised as the original SARS-CoV-2 variant. The second manifested between November 2020 and January

2021 and was identified as the Beta variant and the third occurred between May and September 2021 and was classified as the Delta variant. The fourth is the Omicrom variant which was found in November 2021 and is currently considered to be the most virulent of all the variants thus far. The Omicrom variant has presented more spike protein mutations than previous variants, which explains its transmissibility and its ability to evade vaccines.

By December 2021 South Africa reported that 44.3% of the adult South African population had been vaccinated and more than 50% of the population had been exposed to SARS-CoV-26. (Maslo, Friedland, Toubkin, Laubscher, Akaloo et al 2021).

The national lockdowns imposed several restrictions in accordance with the large number of confirmed positive COVID-19 cases at the time. This placed several restrictions on face-to-face contact between people as a means of mitigating the perilous risks of coronavirus transmission between people. South Africa reported a cumulative total number of 625 056 cases with 2 505 new cases identified by August 2020, a total number of 47 deaths were recorded which brought a total number of 14 028 deaths with 538 604 recoveries translated to a recovery rate of 86% (WHO- COVID-19 2020;1) leading to the Government enforcing severe movement and other personal restrictions.

Over time, matters improved to such an extent that the South African President, Mr Cyril Ramaphosa announced the easing of the restrictions by allowing the entire country to move down to alert level 2 lockdown on 18 August 2020 which allowed and permitted –

- opening of travel between provinces again,
- visiting of family and friends,
- opening of restaurants with the allowance to serve alcohol with a curfew from 10pm to 4am,
- opening of public places such as parks and social gatherings with other restrictions remaining in place such as all gatherings being limited to a maximum of 50 people,
- limited numbers of people to be allowed in a retail store, cinema or other public space,
- current restrictions on international travel to remain the same,
- the sale of alcohol from Monday to Thursday from 9am to 5 pm by licenced premises,
- the sale of tobacco products, and
- gyms and fitness centres to open with strict health and safety protocols in place, hotels and accommodation facilities being opened including leisure travels being opened

whilst the number of guests at any time remaining limited to prevent the spread of the virus (Intensive Care Unit 2021:2).

The lowering of the lockdown level was motivated by a decrease in number of new cases and hospital admissions to Intensive Care Unit (ICU) which was putting the pressure on hospitals which did not have enough beds for the patients at the time.

The COVID-19 prevention strategies discouraged direct face to face contacts which impacted significantly on the services social workers have rendered, particularly social workers in hospitals. Family visits and family counselling and support services were discouraged, which challenged social workers to fully execute their social work roles (Colaneri, Seminari, Piralla, Zuccaro, Filippo et al 2020:301; Willan, King, Jeffery & Bienz 2020:1). Family members were prohibited from visiting patients in hospital (Willan et al 2020:1). Whilst hospitalised positive COVID-19 patients were forced into quarantine, many died alone without their families being able to take leave of them. Family members of patients struggled to access information about patients' progress because family visits at the hospitals were restricted (Barber, Kogan, Riffenburg & Enguidanos 2015:3). Social workers in state hospitals in the Waterberg District were accosted by family members in the car parks and entrances to the hospital to find out about their family members who were hospitalised.

Self-isolation of health care workers, social distancing, lack of personal protective equipment (PPE) and the lockdown measures, affected social workers in hospital settings, creating emotional and mental frustration because they were amongst the front-line workers during the COVID-19 pandemic (Willan et al 2020:2; WHO Coronavirus disease 2019 (COVID-19) Situation Report 72:1; Greenstone and Nigam 2020:4; de Quervain, Aerni, Amini, Bentz, Coynel et al 2020:3).

From the discussion above, it is obvious that the COVID-19 (coronavirus) pandemic has negatively affected the normal day to day social work functions in hospitals and has created some uncertainty about the role social workers are expected to play in multi-disciplinary teams in South African hospitals. Face to face contacts between hospital social workers and the patients' families were restricted as part of the lock-down regulations. The State of Emergency was lifted on 14th April 22 (Presidency Republic of South Africa 2022). Face to face contacts have subsequently been resumed. It was difficult to make use social technology to execute social work duties, because Limpopo Province is predominantly rural and there is a scarcity of mobile network towers that impacts negatively on mobile users' connectivity.

2.4 THEORETICAL FRAMEWORK OF THE STUDY

To assist the researcher to organise the information gathered and add depth to the meanings and experiences that participants shared in the individual interviews and focus group discussion, a theoretical framework was developed for the research. A theoretical framework creates a lens through which the researcher can view events and phenomena (Maxwell 2013:49-53). It creates a schema of interconnected empirically demonstrable concepts that offers a frame of reference to focus and define one's observations, a structure that organises and categorises one's observations; terms to describe one's observations concisely; and to make reliable inferences about what behaviour one can expect (Gitterman 1996:472-473). For this reason, systems theory, more precisely Bronfenbrenner's bioecological approach and Gitterman and Germain's the life model approach (Gitterman & Heller 2010:204) were combined for the study. The motivations for choosing these approaches were presented in Chapter 1 (see section 1.2.3).

The theoretical framework developed for this research is described by outlining relevant concepts of the systems theory as related to the study, namely Bronfenbrenner's ecological systems approach, the definitions and tenets 'life model theory', advantages and disadvantages of using Bronfenbrenner's bioecological systems approach and Gitterman and Germain life model theory for the study. The defining concepts of the theoretical framework and their application to the study are sketched.

2.4.1 Systems theory

Systems theory as conceived by biologist Ludwig von Bertalanffy has been applied consistently within social work contexts since the 1940s (Lindsay 2013:123). The theory assumes that families, organisations and institutions are open systems that are in constant interaction with other systems (Lindsay 2013:123). Each system is made up of units or parts that function as a whole, and each separate unit or part influences the functioning of the system as a whole (Lindsay 2013:123: Teater 2010:18). The interactional processes and relationships between the different units are the focus of attention. According to Teater (2010:18) different elements of the system work together in an orderly, interrelated way to achieve the system's purpose or goal.

In this case, as outlined in Chapter 1 (see 1.3.2) the purpose of the study was to examine social workers in Waterberg state hospitals (a part or unit of the hospital) and study their relationships and functioning within the hospital (the system as a whole). The interactions and

functioning of social workers within the multidisciplinary teams and organisational structures of the hospitals where they were based are studied to obtain an understanding of their contribution to the attainment of the hospital's goal to provide effective and efficient health care to patients and their families. Cognisance is taken that invisible boundaries separate the different units of the system, differentiating each system from the others (Teater 2010:19). Occupational boundaries between the different disciplinary team members in hospitals working together in multidisciplinary teams are commonly decided by their unique professional training, the roles they are assigned, their job descriptions and the authority they are allocated to within the hospital organisation.

Systems theory assumes that material or information moves in and out and between the subsystems or different units and throughout the whole system. Systems try to maintain a state of equilibrium or balance to ensure that they will achieve their goal (Teater 2010:19). When events occur that prevent the growth and goal attainment of a system or part thereof, the system or subsystem is caught off guard and experiences disequilibrium (Teater 2010:20). In the context of this study an example of disequilibrium would be the resultant burnout of social workers caused by their boundaries not being respected, their inability to access the resources and opportunities they need to fulfil their professional role, or events they experience that compromise their personal and professional wellbeing.

The experiences of social workers in hospital settings potentially affect the services they deliver to hospital patients, patients' families and the community at large, as well as their functioning in multidisciplinary teams. Systems theory is a relevant theory to use in this research, because its theoretical constructs enabled the researcher to examine the experiences of social workers in a hospital context (the phenomenon being investigated), the quality of the dynamics within the hospital system (that is the quality of interactions between social workers, multidisciplinary teams, the hospital management and external forces such as policies and legislation regulating health services and social work practice prescribed by the Department of Health and the SACSSP). It would highlight internal and external factors that impacted on social workers in the hospital setting as a whole, the individuals, departments, management of the hospital, and broader macro system influences such as politics, economics and culture to determine what bearing these have on the ability of social workers to execute their professional mandate within the hospital (Barile et al 2016:654), their professional identity and their job satisfaction. This information would inform recommendations for practice for social workers working in multidisciplinary teams in state hospitals in the Waterberg District.

The advantages of adopting a systems approach in the study are presented in Chapter 1 (see section 1.2.2). So, it will not be repeated here.

2.4.2 Bronfenbrenner's bioecological systems approach

The bioecological systems theory, developed by Bronfenbrenner, proposes that individuals constantly grow or change, positively or negatively as a result of their direct or indirect interactions with the inter-related systems in which they are situated (Barile et al 2016:653; Duerden & Witt 2010:108; Shin & Steger 2017:20). The bioecological systems approach breaks the context in which an individual finds him or herself in into to five system levels, distinguished as the micro-; meso-; exo-, macrosystems, and the chronosystem that was only added by Bronfenbrenner later. Bronfenbrenner arranged these levels from the most intimate level to the most distant levels, in the order mentioned (Rosa & Tudge 2013:246-247).

The **microsystem** focusses on the individual's inner world of experience and incorporates intrapersonal factors such as the person's make-up, bio-psychological functioning, intelligence, personality and intergenerational factors that are vertically transmitted (Feit & Holosko 2013:10). When applied within an organisational context the microsystem incorporates the individual employees' experiences and perceptions of the organisation's demands and their sense of wellness associated with working within the organisation (Barile et al 2016:658). This study needed information about the experiences and perceptions of individual social workers operating as professionals within multidisciplinary teams in state based-hospitals in the Waterberg District. Exploration and description were needed about the daily challenges and coping mechanisms social workers used to fulfil their role in a hospital setting. Information about social workers' perceptions of self-identity, role clarity, knowledge and expertise and professional values were needed to advance an understanding of the experiences of social workers in that context (Kirschbaum 2017:8-10). Any positive or negative attributes that enabled social workers to operate successfully within the hospital setting located in literature were used to compare the participants' experiences against. Some examples of positive factors situated within the microsystem as mentioned in the literature include being willing to adopt a collaborative approach with other disciplines (Ashcroft et al 2018:48); establishing role clarity about what is expected of them as social workers in a hospital setting (Vungkhanching et al, cited in Kitching 2013:20); being motivated to acquire adequate information about chronic illnesses, psychotropic medications, cultural competence and psycho-education; and developing competence in advance end of life directives and decision making (Summer et al, as mentioned by Kirschbaum 2017:21).

The **meso level** refers to the daily interactions the individual encounters with significant others situated within the immediate work setting (Holosko & Feit 2013:10). The individual's relationships with these significant others are interconnected and a source of support and assistance for them (Hu, Liao, Dai-Hong, Liu, Wang et al 2010:59). Team members in a hospital setting are expected to respect that the members of other disciplines have different conceptualisations of patient care and that the combination of these different perspectives leads to a broader, more holistic conceptualisation of the patient and patient care. Good collaboration amongst team members, positive inter-communication and positive conflict management skills within the team are therefore expected (Kirschbaum 2017:20-21). In terms of this study the researcher needed information about the working relationships that exist between social workers, their supervisors/managers in the Social Work Department and other multidisciplinary team members in the hospital, such as doctors, nurses and members of the allied professions which include physiotherapists, occupational therapists, dieticians, pharmacists, psychologists, optometrists and administrative personnel. To fulfil the research goal of the study, the researcher needed to describe the interactions social workers have with the team members and identify the factors that enhanced or disabled the pivotal relationships they have within inter-disciplinary teams.

The **exo level**, on the other hand, refers to the context in which the individual operates (Krishnan 2010:8). Ideally a healthy context provides individuals with resources and opportunities to promote their wellbeing and enable them to fulfil their professional obligations and duties (Liao, Hong & Rao 2010:59). The exo level system is responsible for creating the culture of the organisation and is reflected in the language adopted in the organisation and the relations and structures that accelerate or inhibit creativity and development therein. Information was needed about how resources and finances in state hospitals in the Waterberg are distributed to different disciplines, the policies that regulate their distribution, the management of multidisciplinary task teams, and the existing hospital culture and how it affects social workers' ability to fulfil their professional mandate.

The **macro level** system refers to broader influences that impact on the organisation or individual, such as culture; religion; socio economic issues; social values; policies; and the educational, health and legal systems (Rosa &Tudge 2013:247). As noted by Liao et al (2010:59) this refers to the structural factors that regulate the individual's social standing and the roles expected of them. In many instances, structural factors are formalised into policies drafted by businesses or the Government to reflect current ideas or values about mechanisms that must be in place to manage risks and rewards, and regulate governance so that service networks can be changed in accordance with contextual realities. Imaginative social policies

and interventions are required for organisational growth and development (Coovadia et al 2009:832). Examples of macrosystem level factors that negatively affect social workers in hospital settings, include issues such as the poor representation of social workers in formal health care leadership roles and the hierarchical culture that favours and awards more power to medical personnel (Kirschbaum 2017:20). Practical examples of external structural forces of interest in this study are the SACSSP, DoH Service Operating Procedures, and PMDS (performance management development systems).

Chronosystem level refers to factors that occur across time which impact on individuals and the hospital system. The chronosystem factors may be of an historical nature, in some cases even present over several generations. An example in this study is the apartheid system which was responsible for the unequal distribution of services among different South African population groups, which, 25 years later, still oppresses and disadvantages people previously marginalised is advantaged (Cottrell 2016:199).

The four components that are central to Bronfenbrenner's bioecological systems approach that impact on individuals, namely the process; person; context; and time (Rosa & Tudge 2013:251-254; Evans & Wachs 2010:80) respectively entail the following:

- *Process* refers to the interactions persons have with their immediate surroundings. The interactions may be proximal (face to face) or distal (indirect) (Petty & Mabetoa 2021:59). The interactions impact either positively or negatively on the individual. The proximal interactions that offer positive benefits for the individual include a sense of intimacy, emotional support, nurturing that promotes the individual's self-esteem and wellbeing. Proximal relationships occur at micro- and messo levels. Distil interactions are those that provide resources, opportunities, social inclusion, rights and cultural identity. They occur at exo-, and macro levels.
- *Person* refers to the personal characteristics of an individual that influence how others relate to them. It encompasses the individual's interactional styles with others, inner resources, attractiveness, ability, knowledge and skills (Petty & Mabetoa 2021:59).
- *Context* refers to the five system levels as discussed, namely the micro-, meso-, exo-, macro- and chronosystems. The systems present both protective forces and risk factors for the individuals that impact on their wellbeing. The different systems interact with one another. Each system level has potential to offer the individual protective resources or generate stress (Rosa & Tudge 2013:246).

- *Time* refers to the chronosystem which as indicated earlier, acknowledges that events and developmental changes occur as a person moves through time, affect his or her well-being. Socio-historic events can affect later generations.

Bronfenbrenner's bioecological systems theory was chosen to structure the information gathered about social workers' experiences of working in multidisciplinary teams in state hospitals in the Waterberg District. A contextual perspective was needed to provide insight about the bi-directional interactions social workers have with the different systems that surround them concentrically, in the form of multidisciplinary teams; hospital management; health and welfare governmental departments; broader cultural and occupational influences; and the quality of those relationships. Information about the proximal (direct interactions, person to person) and distil (indirect interactions with larger systems) social workers experienced within the organisation structure of the state hospitals and external influences that impacted on them, assisted to answer the research question. The researcher was curious to discover what protective and risk factors were located in each of the ecological systems that impacted on social workers so that the information could be used to inform social work practice in multidisciplinary teams in state hospitals in the Waterberg District.

2.4.3 The definitions and tenets of 'the life model theory'

An off-shoot of the bioecological systems theory, 'the life model theory as developed by Gitterman and Germain was selected to augment the bioecological systems approach in this research. The life model theory, like Bronfenbrenner's bioecological systems theory, highlights the person-in-environment and the connections, interactions and communications that occur between the person, his or her family, groups and communities and the broader systemic environments wherein he or she is situated (Corey, Corey, Callanan & Russell 2014:398; Duerden & Witt 2010:110); Teater 2010:19, 24. The life model theory encourages one to be curious about, ''What is going on?'' rather than ''Why is it going on?''. With more information and understanding one can concentrate on 'what' needs to be changed' rather than 'who' should be changed. (Gitterman & Germain 2008:54).

The life model theory does not focus on the individual's development as does Bronfenbrenner's bioecological systems theory. It rather explains the person's experiences of trying to fit into the complex environment in which he or she is situated, hence referring to the 'person-in-environment' concept (Gitterman & Germain 2008:51). Instead of separating the context wherein the individual operates into five categories, the life model theory concentrates

on only three categories, namely the physical, social and cultural categories (Gitterman 2009; Teater 2010:24; Teater 2014). Teater (2014) explains the *physical environment* as the context that represents the natural world in which the individual lives which includes the man-made buildings and infrastructures that people need. *Social environments* represent the person's relationships and interactions with his or her friends, family and social and community links. Individuals may be linked to or be a member of different organisations. Societal structures control people. They regulate how they are organised politically, legally and economically (Gitternan 2009). The *cultural dimension* of the ecological system refers to the norms, values beliefs and language that shape a persons' outlook, perspectives and expectations (Gitterman 2009). There are many factors and dynamics situated in these three different contexts that affect the person positively or negatively. The intention of the life model theory is to enable social workers to assess and intervene when the interactions between individuals and their contexts are stressful (Gitterman & Heller 2010:205).

Several person-in-environment concepts coined by Germaine and Gitterman (1976:605) and Teater (2010) are pertinent to this study, including person-in-environment fit, adaptations, stressors, coping measures, relatedness, self-esteem, autonomy, and coercive power. Clarity about these concepts is needed to deepen the interpretations of participants' meanings of working in multidisciplinary teams in the state hospitals in the Waterberg District (Gitterman & Heller 2010:205).

Person-in-environment fit: A person or a collective group's perceptions of how their physical, intellectual, emotional and motivational strengths and limitations, environmental resources (family, social networks, organisations and physical space) help them to manage their life tasks and or challenge(s) are indicative of their 'person-environment fit' (Gitterman & Heller 2010:205; Teater 2014). When a person is allocated roles or activities they perceive to 'fit' with their true selves, he or she experiences a good person-environment fit (Duerden & Witt 2010:108). A person's requirements, rights, purposes and capacities must be compatible with his or her physical and social contexts (which include culture and history) for him or her to experience a good person-environment fit (Teater 2010:26). A person will experience his or her daily life stress according to his or her perceptions of the level of fit between him or herself and the personal and environmental resources available to him or her (Gitterman & Heller 2010:205). When the person perceives that he or she and his or her environment are compatible, the person's potential for personal growth and mastery is freed (Gitterman & Heller 2010:205; Gitterman & Germain 1976:605). If the person's perceptions of the availability of personal and environmental resources are negative, the person experiences stress (Gitterman

& Heller 2010:205; Teater 2010:26). The person's 'person-in-environment fit' is rated on a continuum of 'favourable', 'minimally sufficient', or 'unfavourable'.

Adaptedness: All persons from time to time encounter unpredictable, unsettling changes within the different contextual layers they find themselves in. In order to survive they must adapt in to restore their balance/equilibrium (Gitterman & Germain 1976:602; Pike et al 2010:117). 'Adaptedness' refers to the on-going, change-oriented thoughts, sensory-perceptual and behavioural efforts a person requires to maintain or improve the goodness of fit between him or herself and his or her environment (Teater 2010:26). When persons believe they can rely on their environment to provide them with the essential resources they require for their needs to be met, and/or they have inherent strength within themselves to adapt to the changes, they develop, grow, adjust and feel satisfied (Gitterman & Germain 1976:605; Teater 2014). Unfortunately, when they experience their environmental resources to be lacking, and/or that they lack the necessary personal strengths to adapt, they experience stress. Stress is an indicator of a poor level of adaptive fit (Gitterman & Germain 1976:602; Teater 2014) that may result in a person having to receive help (Teater 2014). Three levels of intervention are indicated during times of stress, namely changing the individual's perceptions and behaviours; changing the response from the environment; or trying to improve the quality of exchange between the individual and his or her environment (Gitterman, 2009). Individuals and all elements of their environments evolve and adapt through their interactions with one another over time (Gitterman & Germain 1976:602).

Stressors: When people find that the life issues that they have to manage require more personal or environmental resources than they have at their disposal, they experience threat, loss and/or a sense of being off balance, which is referred to as stress (Teater 2010:26; Teater 2014). The degree of stress they experience firstly depends on individual factors such as how they view their physical wellbeing, level of motivation, attitude, coping skills and the meanings they ascribe to their negative situation (Gitterman & Heller 2010:206). Secondly, the degree of their stress is influenced by their perspective of organisational resources that are available to them in relation to the questions of: "What kinds of resources are available?"; "How accessible are the resources they need?"; "What social support networks do they have at their disposal?"; "What material or financial resources can they get from external sources?"; and "How their physical domain will ease or remedy the stressors?" (Gitterman & Heller 2010:206). Stressors can be minimised once dysfunctional transactions between the person and his or her environment are assessed and then by finding ways to alter the dysfunctional transactions (Gitterman & Heller 2010:205).

Coping measures: refer to the efforts people make to manage or deal with the extra demands caused by stressors and it usually involves engaging a combination of external and personal resources that enable them to adapt (Teater 2010 26). As noted by Barile et al (2016:653) the coping measures people mostly require in organisations include material, energy, information, money, interpersonal relationships and collaborative relationships between different disciplines.

Relatedness: Refers to connections, friendships, bonds and social ties that provide a person with a sense of belonging to a social network (Teater 2010:26). Lipsky (cited by Tummers 2012:05), explains that the opposite of relatedness is work alienation which makes people feel overwhelmed by the scope of practice and powerlessness they experience during the multidisciplinary team decision-making process. These perceptions generate a sense of meaninglessness in the work environment.

Self-esteem: Refers to a person's sense of being respected and viewed as a competent and worthy member of the system (Teater 2010:26). Usually, people who operate in systems that provide them with social support experience higher levels of self-esteem (Shin & Steger 2017:20).

Autonomy: People do better when they feel they have some control over their lives, are responsible for making decisions and are accountable for their personal and professional actions (Teater 2010:26). This should be evident by offering employees opportunities to be involved in making decisions about the projects they are involved in and having some input into the formulation of their job descriptions in their organisations (Duerdan & Witt 2010:115). Duerdan and Witt 2010:108 note that when a work system respects the autonomy of employees, the employees' sense of relatedness and their competence are promoted, which benefits the organisation as a whole.

Coercive power: This term refers to situations where people withhold power from vulnerable groups based on their personal or cultural characteristics (in the instance of this study it may include professional characteristics) which are oppressive and lead to their marginalisation (Teater 2010:26; Teater 2014). Social workers are generally marginalised in secondary settings such as hospitals by being criticised and undervalued (Raniga & Kasiram 2010:263).

2.4.4 Advantages and disadvantages of using Bronfenbrenner's bioecological systems approach for the study

Having clarified bioecological systems theory concepts that are useful for understanding the position and interactions of social workers within the Waterberg state hospitals, the advantages and disadvantages of using the bioecological systems theory for this study are explained.

The advantages of applying Bronfenbrenner's bioecological systems approach are as follows:

- The bioecological systems approach is well indicated and described in research that requires exploration.
- It provides a specific lens for the researcher to identify the different systems that challenge social workers, undermine their job satisfaction and erode their professional identity so that recommendations can be made about how the challenges could be addressed (Coovadia et al 2009:832). The five systems levels help to structure the data gathered so that the experiences of social workers in the study could be described and contextualised. One can pinpoint the different socio-cultural and organisational factors that affect social workers and multidisciplinary teams and the healthcare system at large. One may recognise opportunities and constraints created in each specific system level such as individuals, teams and the institution as a whole, and track how they impact on one another (Kirschbaum 2017:13).
- A review of the opportunities and constraints within the five systems levels of micro-, meso-, exo-, macro- and chromo levels could contribute significantly to the development of a holistic plan to improve the work environment of social workers and enhance the bidirectional interactions between social workers and the different actors positioned in different system levels.

The following disadvantages of using Bronfenbrenner's bioecological system approach for the study are acknowledged:

- Whilst one may identify what changes need to happen to improve the experiences of social workers working in multidisciplinary teams in state hospitals, the changes can

usually only be effected if there is excellent leadership to drive the change (Coovadia et al 2009:832).

- Initiating change within hospitals is challenging because a unitary vision is difficult to create across different sectors in the hospital setting, because the different units in the hospital are made up of people of diverse cultures and professional orientations implying that their priorities will differ (Coovadia et al 2009: 832).
- Bronfenbrenner's bioecological systems approach is not in itself action orientated, which is why the life model theory was chosen to augment it.

2.4.5 Advantages and disadvantages of using the life model theory

The following advantages for including the life model theory are noted:

- The life model theory keeps the focus of the study on ''What is going on?'' rather than ''Why it is happening?''. With more information and understanding the researcher would reach more possibilities of 'what' could be changed' instead of 'who' should be changed (Gitterman & Germain 2008:54).
- The concepts outlined in section 2.1.1 (person-in-environment fit, adaptations, stressors, coping measures, relatedness, self-esteem, autonomy and coercive power) are useful for deepening the meanings participants ascribed to working in multidisciplinary teams in the state hospitals in the Waterberg District (Gitterman & Heller 2010:205).The life model concepts offer more detail to the broader ecological system concepts such as challenges and opportunities, and bidirectional interactions as outlined in Bronfenbrenner's bioecological systems approach. In applying this theory, more descriptions of what it is like to work as a social worker in multidisciplinary teams in state hospitals in the Waterberg District were available.
- The life model theory is more action orientated than Bronfenbrenner's bioecological systems approach. The life model theory offered the researcher "a vision, a map, and a guide for practice" (Gitterman & Heller 2010:206). Recommendations could effect change at two levels (Gitterman & Heller 2010:205). The first level would be to focus on helping social workers to develop more adaptive behaviours as outlined under the concept 'adaptiveness'. The second level would be to decide how different sectors in the hospital environment such as other multidisciplinary team members, social workers in the DoH and management teams in state hospitals in the Waterberg District could be more responsive to the social workers' needs (Gitterman & Germain 1976: 203).

2.5 SUMMARY OF THE CHAPTER

The literature review was broken up into two parts. The first part addressed the following: hospital social work and why it is important, hospital social work in South African history-the different phase's pre apartheid and post-apartheid, different ways social workers are integrated into the hospitals, the roles social workers perform in hospitals settings, social work services in hospitals, a systemic presentation of social work in a hospital setting; coping strategies social workers use to survive in hospitals, and way forward in medical social work. The second part focused on the theoretical framework that was used for the study. It reflected on the relevance of using systems theory, more specifically Bronfenbrenner's bioecological systems approach and Gitterman and Germain's life model theory. The justification for combing the two approaches was shared by exploring the advantages and limitations of each of the theories, so that the value of each augmenting the other could be recognised.

The research methodology follows in the next chapter (chapter three). It explains how the research methodology and methods were used to enable the researcher to answer the research question and fulfil the research objectives (Kastner, Anthony, Sobian, Strauss & Tricco 2016:46).

CHAPTER 3

APPLICATION OF RESEARCH METHODOLOGY, APPROACH AND DESIGN

3.1 INTRODUCTION

This chapter offers a detailed report of the application of the qualitative research method and design in the study. This detail is important because the reader must understand the research actions that were taken to collect the data and uncover the underlying meanings of the information gathered so that the research question and sub questions could be answered and the research objectives could be achieved. The purpose of the chapter is to offer details about how the research plan depicted in Table 3.1 was applied to achieve a systemic understanding of the experiences of social workers in multidisciplinary teams in state hospitals in the Waterberg District, Limpopo Province. It offers insight into the researcher's actions and experiences once the study commenced and explains what modifications to the research plan were necessary in response to research realities that were encountered in the field (Creswell & Poth 2018:239).

In describing the application of the research methodology, approach and design the contents of the chapter are arranged in the following order and as listed in Table 3.1: this introduction, research approach, research design, research population, sampling, data collection methods, ethical considerations and summary of the chapter, as portrayed in Table 3.1.

Table 3.1 Application of research methodology, approach and design

INTRODUCTION	
RESEARCH APPROACH	Qualitative approach
RESEARCH DESIGN	• Phenomenological research design • Integrating exploratory, descriptive and contextual research designs
RESEARCH POPULATION	
SAMPLING	• Sampling strategy • Size of the sample
DATA COLLECTION METHODS AND PROCEDURES	• Locating the site and sample for the study • Gaining access to the setting • Rapport building • Collecting the data

	○ Interviewing as the primary data collecting tool ○ The qualitative interview guide ○ The pilot test ○ The focus group discussion ○ Secondary forms of data collection • Record keeping and interview protocol • Data analysis • Data verification ○ Credibility ○ Transferability ○ Dependability ○ Confirmability
ETHICAL CONSIDERATIONS	• Informed consent • Privacy • Confidentiality • Anonymity • Beneficence • Debriefing of participants • Management of information
SUMMARY	

3.2 APPLICATION OF THE QUALITATIVE RESEARCH APPROACH

A qualitative research approach was selected to explore, describe and contextualise the experiences of social workers in multi-disciplinary teams in state hospitals in the Waterberg District. The qualitative approach advocates intensive interaction between the researcher and participants, which in this study occurred during semi structured interviews and a focus group discussion. The qualitative approach is interpretive in its nature and requires the researcher to pay attention to the political, social and cultural context of the study (Creswell & Creswell 2018:181). Because the researcher collaborated closely with research participants to discover the meanings of their experiences, the researchers' presence and reflexivity were important throughout the research process (Creswell & Poth 2018:43).

Several distinctive characteristics of the qualitative approach outlined by Creswell and Poth (2018:43-44) and Creswell and Creswell (2018:181-182) were evident throughout the research process. Taking the characteristics of the qualitative approach into consideration

whilst conducting the research enabled the researcher to achieve a holistic understanding of the participants' experiences of working in multidisciplinary teams in state hospitals in the Waterberg District:

- The researcher collected the data at the site where the social work participants experienced the phenomenon of working in multidisciplinary teams in state hospitals in the Waterberg District. The participants were in most instances interviewed in the hospitals where they worked. The researcher chose to interact with participants face to face, so that he could observe their behaviour and actions in their workplace. He opted to do this for a prolonged period of time (from 26 August 2020 to 28 January 2021).
- The researcher collected the information personally. He interviewed participants and observed their behaviour when preparing for and executing the interviews, reviewed existing hospital documents about hospital policies for social workers and reviewed literature of social work in hospital settings. These combined measures enabled him to develop a first-hand account of the experiences, challenges and coping strategies of the participants working in multidisciplinary teams in state hospitals in the Waterberg District (presented in Chapter 4).
- The data were collected by means of conducting individual semi-structured interviews assisted by an interview guide with open-ended questions, which allowed participants to share their experiences as social workers spontaneously, as well as by conducting a virtual online discussion forum to replace the focus group meeting. The researcher's observations about participants' behaviour and actions during the interviews were captured in his research journal and were integrated in the data gathered.
- Information extracted from the verbatim transcripts of the interviews conducted between the researcher and participants were carefully scrutinised to identify the emergent patterns, then sorted into different categories and eventually into themes. Together, the researcher and independent coder revisited the themes to establish if additional information was needed and some of the themes could be collapsed. This process involved inductive and deductive logic.
- The meanings the social workers ascribed to working in multidisciplinary teams in state hospitals in the Waterberg District remained the focus of the study throughout the research process. They were also highlighted in the researcher's research journal. Ten social workers, with different years of work experience, placed in eight different state hospitals within the Waterberg District were interviewed. This meant that the research data consisted of multiple diverse perspectives on the experiences

of social workers in multidisciplinary teams in state hospitals in Waterberg District. The researcher stayed as true to participants' experiences as he could by bracketing his personal, professional and existing theoretical perspective on the topic.

- The contextual realities of social work participants working in multidisciplinary teams in state hospitals in the Waterberg District were closely examined based on the assumption that contextual realities affect participants' experiences. Having an understanding of the contextual realities of participants, assisted in and was useful for understanding the nature and complexity of the participants' experiences.
- Several aspects of the research plan as designed at the start of the study had to be changed in response to feedback that the researcher received when he started with the research. For example, some questions in the interview guide were changed during the pilot test, once the trial run took place with the two social workers who were excluded from the study because they were based in the same hospital as the social worker. Several research methods were modified to accommodate unexpected contextual developments such as the COVID-19 pandemic, for example interviews with research participants were delayed till the government-imposed lock-down measures were lifted, and the focus group discussion was replaced with a virtual online discussion forum.
- As mentioned in the introductory chapter, the researcher had to position himself, personally and professionally as a senior social worker working in a multidisciplinary team in a state hospital in the Waterberg District so that readers could gauge the extent to which his personal and professional experiences informed his interpretation of the findings.
- A comprehensive account of the experiences of social workers in multidisciplinary teams in state hospitals in the Waterberg District was definitely achieved because the researcher obtained multiple perspectives from ten different participants employed in nine different hospitals as presented in the research findings (Chapter 4).

There were advantages of using the qualitative approach for the study. The qualitative approach was consistent with the theoretical framework the researcher had developed for the study, that is the systems theory the bioecological systems approach and the life model theory as described in the literature review (see Chapter 2). This meant that rich detailed contextual information was gathered about the experiences of the social workers and could be quoted verbatim (see Chapter 4). The research approach drew attention to the personal resilience and commitment of research participants and highlighted their personal agency. It revealed that despite the multiple challenges the participants faced working as social workers in

multidisciplinary teams in state hospitals in the Waterberg District, they tried to address the needs of their service users to the best of their ability (Masten 2013:57). The qualitative approach included an empowering element to the research process because the participants realised that their first-hand experiences would be combined to inform recommendations for improved working conditions for social workers in multidisciplinary teams in state-based hospitals in the Waterberg District. These augers well for the image of social workers and as described by Zepeda (2012:19) because the research created knowledge for use.

How the research design was applied during the operationalization of the study is discussed next.

3.3 APPLICATION OF THE RESEARCH DESIGN

As noted in the presentation of the theoretical framework (Chapter 1 section 1.3 theoretical framework), the research design guides the researcher in the early stages of a study, shapes the plans he or she makes and creates a structure for the research process (Lune & Berg 2017:22). The choices made in terms of the research design are discussed in describing the theoretical framework (see section 1.3 theoretical frame work). The researcher was satisfied that the structure imposed by the research design (a phenomenological design that integrated exploratory, descriptive and contextual research designs) was relevant for the study. The research designs that were integrated contributed significantly to shaping the kinds of questions that the researcher asked in this study; influenced the choice of research techniques selected to collect the research data; guided the researcher in his decisions about the sampling strategies that were best needed to select the research sample; and spatialized and ordered the research steps that had to be followed to complete the analysis of the data (Thyer 2012:115; Bloomfield & Fisher 2019:28).

The applied description of how the phenomenological research design as augmented by the exploratory, descriptive and contextual research designs is presented next.

3.3.1 Phenomenological research design

Phenomenology is used to describe a social occurrence, or the way things are perceived to be by some, as their lived experiences Guba (in de Villiers & van der Wal 2008:147). The characteristics of phenomenological studies as presented by Creswell and Poth (2018: 76-77) are discussed and a motivation is given about why this design was relevant for structuring the research process. Applying a phenomenological research design was ideal for this study

because the purpose of the study was to understand the experiences, actions, ideas and images of social workers working in multidisciplinary hospitals in the Waterberg District and comprehend the events that affected them. The plan was to make the individualised meanings of the social workers explicit (Chaplin et al 2015:150) and reconstruct their meanings into knowledge, grounded on a firmer footing, for the benefit others (Pilock 2012:45).

The focus of the study was on a single concept throughout the research process, the 'experiences of social workers working in multidisciplinary teams in state hospitals in the Waterberg District'. A group of ten social workers, employed to work in multidisciplinary teams in state hospitals in the Waterberg District were studied, which was the homogenous factor of the study. The sample size of ten participants, fell within the recommended range of samples for phenomenological studies, three to fifteen participants (Creswell & Poth 2018:66-67). The sample was heterogeneous in terms of gender (there were nine women and one man that participated); the ages of participants ranged from 31 to 51; the ethnicity of participants differed although most were Sepedi and Tsonga speaking; and their years of experience of working in the state hospitals in the Waterberg District ranged from five to 30 years. The researcher concluded that information of a multitude of realties experienced by social workers working in multi-disciplinary teams in state hospitals in the Waterberg District were gathered during the study and provided adequate details of the participants' diverse experiences, challenges and coping strategies of working in the state hospitals. Because of its size and diversity, the sample was adequate and produced rich subjective data of the participants' views and experiences which allowed the researcher to create a comprehensive, contextualised 'insider' perspective typically associated with the phenomenological research design (Guba in de Villiers & van der Wal 2008:12). The participants' verbal expressions were extracted from the transcriptions of individual interviews to reveal the personal meanings they ascribed to their situations. The researcher and participants collaborated to construct the participants' meanings during the interviews, member checks and the online virtual discussion forum. The researcher had to maintain a reflexive stance throughout the study and also relied on the note-taking in the research journal where his observations and reactions were recorded. These notes were discussed with the supervisor during the supervision sessions, to make sure that the researcher would bracket himself out of the study as much as possible and stay true to the participants' experiences (Yüksel & Yildirim 2015:5). The essence of participants' experiences was identified as presented in Chapters 4 and 5, respectively about the research findings and the recommendations based on the findings.

The research process was structured as follows according to the procedures of the phenomenological research design (Creswell & Poth 2018:78-80; Guba in de Villiers & van der Wal 2008:148):

- The researcher made sure that the phenomenological approach would benefit this study. He was certain that a better understanding of a sample of social workers' shared experiences of working in a multidisciplinary team in state hospitals in the Waterberg District would create a holistic account of the social workers' experiences and that the deeper understanding of them would contribute significantly to establishing better working policies and practices for social workers in the state hospitals in that district.
- The phenomenon of interest was identified for study and described in the statement of the research problem (see section 1.1.4)
- The researcher familiarised himself with the broad philosophical assumptions of phenomenology and checked to see that all plans for the study were well aligned with the characteristics of the phenomenological approach as discussed in the previous section.
- Data were collected data from individual participants who worked as social workers in multidisciplinary teams in state hospitals in the Waterberg District. Individual semi structured interviews facilitated by an interview guide and a focus group discussion were used to gather data from multiple sources. The researcher immersed himself in the participants' descriptions of their experiences. He stayed closely to the meanings they ascribed to factors such as occupational satisfaction and professional identity and the challenges they experienced and the coping strategies they employed when executing their daily tasks in the hospitals where they worked. He made sure that he captured the participants' descriptions of these experiences accurately and relied on their own words in writing up the research report.
- Once the data collected were analysed, and meaningful insights were extracted relating to the social workers' experiences, challenges and coping strategies as social workers in multi-disciplinary teams in state hospitals in the Waterberg District, the researcher used these to generate themes (as expounded upon in section 4.3.2). The significant statements and themes extracted from the interviews and virtual online discussion forum were used to present participants' descriptions of several contextual factors that influenced their experiences (to create a structural description). Possible relationships and connections with other phenomena were identified as summarized in in the recommendations from findings (Chapter 5).

- This research report serves to present the essential ‘essence’ of the participants’ experiences and make their most common experiences explicit.
- The research findings and the recommendations deduced from the findings present the social work participants’ experiences in a structured written form (Chapters 4 and 5, respectively).

Cognisance was taken about the following drawbacks of using a phenomenological design for the study, which were not too serious:

- The research process took longer than anticipated, because true to the nature of phenomenological research, before the participants were willing to share their lived experiences, they had to be put at ease, connect with and establish a trusting relationship with the researcher (Lodico et al 2010:40). This took longer than the researcher expected for two reasons. Because the participants were known to the researcher before the study commenced, they had to be helped to see that their researcher-participant relationship was different to the working relationship participants had with the researcher before the study commenced. It took participants longer to open up and share their experiences freely and with honesty. Therefore, the one and a half hours planned for each interview was not sufficient. Second appointments had to be scheduled with all participants to gather the detailed information needed once participants were more comfortable about discussing the true nature of their work experiences.
- It is always challenging for researchers to put their own experiences aside and focus on participants’ lived experiences (Yüksel & Yildirim 2015:5). The researcher struggled somewhat with the role of researcher at the outset of the study and was coached during supervision to maintain neutrality. The use of the research journal and the notes he kept in it of his observations and personal experiences during the interviews, helped to improve his neutrality and to remain neutral during the interviews. The researcher monitored his own thoughts, feelings, attitudes and reactions to make sure that his personal biases and professional experiences did not interfere with the research process in any way (Ritchie & Lewis 2003:20).

The inclusion of the exploratory, descriptive and contextual research designs is discussed next.

3.3.2 Exploratory research design

The exploratory research design was chosen to explain the experiences of social workers working in multidisciplinary teams in state hospitals in the Waterberg District in great detail (Terrell 2016:162). The detail was needed to reach a deeper understanding of their challenges, coping strategies and identify their recommendations of how the prohibitive factors that undermined their occupational satisfaction and professional identity in multidisciplinary teams in state hospitals in the Waterberg District, should be addressed (Thomas & Pierson 2010:440). Employing an exploratory research design was necessary because little locally specific information was known about how social workers working in multidisciplinary teams in state hospitals in the Waterberg District experienced their work space (Hesse-Biber & Leavy 2011:10; Creswell 2014:29). The lack of existing knowledge meant that the 'what' questions had to be asked, such as, "What challenges did the social workers in multidisciplinary teams have to contend with as they went about their daily routines in the state hospitals in the Waterberg District?"; "What protective factors enabled them to fulfil the social work mandate in state hospitals in the Waterberg District?"; and "What was needed to help social workers meet the social work mandate in state hospitals, and increase their occupational satisfaction and improve their professional identity in the multidisciplinary teams where they worked?"

The benefit of integrating the exploratory research design was the potential it offered for gathering locally specific information about the experiences of social workers. It helped to make the locally specific information about social work in multidisciplinary teams more explicit and uncovered relationships between different variables that affected the occupational satisfaction and professional identity of social workers in the multidisciplinary teams in state hospitals in the Waterberg District (Creswell 2014:29; Strydom 2013:151; Thyer 2012:115; Bloomfield & Fisher 2019:28). Several questions needed to be answered to advance an understanding of the factors that contributed to the positive and negative experiences, challenges and coping strategies of social workers employed in state hospitals in the Waterberg. No empirical evidence was available about what factors were responsible for the work stress that social workers in these hospitals experienced, nor about the nature of their experiences of working there, and how the workspace impacted upon their professional identity as social workers. The application of the exploratory research design meant that the researcher explored and discovered these topics directly with social workers and developed an understanding about what this social reality was all about. Textual data were collected and analysed relying on non-statistical methods of analysis consistent with exploratory research designs (Creswell 2014:34; Neuman 2014:48. The insights gathered could be more thoroughly researched later in a larger study.

The next section offers a review of the application of the descriptive research design.

3.3.3 Descriptive research design

The goal of using a descriptive research design was to gather detailed information to develop and present a comprehensive picture of social work in multidisciplinary teams in state hospitals in the Waterberg District (Hesse-Biber & Leavy 2011:10; Rosa & Tudge 2013:247) without dwelling too much on the causes of the problem (Strydom 2013:153). The 'how' and 'who' questions, such as "How often does it happen?" and "Who is involved?" had to be asked in the interviews with participants (Neuman 2014:48). The answers to these questions were helped to uncover relevant elements of the phenomenon (Hesse-Biber & Leavy 2011:10). An interview guide was used and after pilot testing it, the researcher adjusted a few questions in response to cues and leads provided by the participants in the pilot test, so that more descriptive questions were asked. Participants were for example asked the following on cue: "How were you affected working in a multidisciplinary team in state hospitals in the Waterberg district?"; "How had the social milieu in the state hospitals in the Waterberg District impacted on your professional identity as a social worker?"; "Who contributed to your occupational stress"; "How do you manage your occupational tension?"; "How have you been able to fulfil your role as a social worker in the multidisciplinary team and your professional mandate simultaneously?" (See addendum I Interview guide). The comprehensive detail obtained led to patterns, themes and relationships between the different variables that were discovered (Polit & Beck 2010:51) (see Chapter 4 about the research findings). These descriptions enabled the researcher to answer the research question and sub questions (Neuman 2014:49) (See Chapter 2).

To conclude the discussion of the application of the research designs in the study, the contextual research design and its application are described.

3.3.4 Contextual research design

The contextual research design provided an invaluable dimension to the study because it augmented the phenomenological research design and was consistent with the theoretical framework developed for the study, namely systems theory and the bioecological systems approach (see Chapter 2). The contextual design factored in details about the context or environment in which the phenomenon of social work in state hospitals in the Waterberg District occurred. This information was used to explain why the events observed happened to

some and not to others (Babbie & Benaquisto 2010:82). Applying a contextual research design helped the researcher to develop a contextual understanding of the realities experienced by participants that pinpointed how they were affected by different ecological systems connected to the phenomenon under investigation (Creswell 2014:47).

The researcher was able to track down how social workers working in state hospitals in the Waterberg District perceived the bi-directional transactions that transpired within each level of the ecological system. This contributed explanation of how external factors of interpersonal, professional, cultural and contextual factors were responsible for their experiences, challenges and the coping strategies they used to adapt to working in the state-based hospitals. This provided insight about the occupational satisfaction and their professional identity of the social workers based within the state hospitals in the Waterberg District.

This concludes the discussion related to the researcher's selection and motivation for adopting a phenomenological research design which integrated exploratory, descriptive and contextual research designs. The research methods the researcher used for this study will follow.

3. 4 RESEARCH POPULATION

The population of a study refers to the total group of participants that the researcher is interested in collecting data from (Rubin & Babbie 2016:626). Because one cannot study a population completely, a sample is usually selected from the population to ensure that the research statements made at the end of the research process are representative to the wider population (Carey 2012:247; Flick 2014: 168). The population in this study was small enough for the researcher to involve almost the whole population. Thirteen social workers were employed in the nine state hospitals in the Waterberg District, Limpopo Province, all of whom worked in multidisciplinary teams. The researcher stuck to the original plan to interview all the participants who agreed to participate in the study and had signed the voluntary consent form. However, in an effort to uphold the trustworthiness of the data and research ethics, he excluded himself and the two social workers who worked in the same hospital where he was based, from participating because of a potential conflict of interest that this may have caused. The latter two social workers nevertheless assisted in adjusting the interview guide in its pilot testing. The participants represented the units of analysis for the study about the phenomenon of interest (Neuman 2014:69). Their experiences, challenges and coping strategies working in state hospitals were studied and analysed and led to conclusions (Mason 2018:64) as presented in Chapter 5. The researcher was satisfied that this group shared the

phenomenological experience of working as social workers in multidisciplinary teams in state hospitals in the Waterberg District, Limpopo Province (Creswell & Poth 2018:104; Mason 2018:64) and that their experiences were meaningful. for this research. The social workers were all members of the Waterberg District Forum, a forum for social workers based in state hospitals in the Waterberg district. As this was a phenomenological study it was advantageous to recruit participants who were members of the Forum because the Forum represented a significant existing network (Robinson 2012:21; Ritchie & Lewis 2013:88).

3.5 SAMPLING

Even though almost the whole population of eligible participants were included in the study, namely 10 of the 13 social workers, a discussion of sampling strategies and an outline of the sample that was chosen for the study are relevant for this discussion.

There are two types of sampling, purposive and non purposive sampling in research (Carey 2012:38). Qualitative research is purposive in nature and is usually used in qualitative research (Creswell & Poth 2018:158; Terrell 2016:177). Therefore, the researcher purposefully selected participants who, according to his judgement, had meaningful data to offer to this research (Bouma et al 2012:140; Carey 2012:39; Creswell & Creswell 2018:249) without compromising their wellbeing and the ethical principles required in qualitative research. The social workers all had first-hand knowledge of what it was like to work as social worker in a state hospital in the Waterberg District and could provide the primary data needed for the study. Additionally, it was foreseen that their experiences about it, would advance the understanding of this social reality in the research (Bouma et al 2012:140).

As stated by Creswell and Poth (2018:157) the three things that were considered when choosing the purposive sampling technique were who would be selected as participants; what sampling strategy would be applied; and how big the sample needed to be, which (entailed the following:

3.5.1 Selecting participants for the study

The researcher reasoned that participants had to be social workers employed in state hospitals in the Waterberg District, Limpopo Province that worked in multidisciplinary teams in these hospitals at the time of the study. The participants were easy to identify (Babbie 2014:179). Morse's criteria (cited in Flick 2014:176) were used to confirm that selected participants were best suited for the study. Hence it was ensured that the social workers had the necessary

knowledge and experience of working as social workers in state hospitals in the Waterberg District and could answer the interview questions; were all capable of reflecting on and expressing their experiences; and were available and willing to participate in the study. The researcher concluded that their first-hand experiences of practising social work in the locally specific hospitals would yield information rich data. The researcher knew exactly who the members of the population were and from whom the data had to be collected (Creswell & Poth 2018:158; Terrell 2016:177). The researcher was satisfied that the ten social workers none of whom worked in the same hospital as himself, had information rich data based on their personal experiences, that could be used to answer the research question (Carey 2012:39) The selected participants were all social workers registered with the SACSSP and from the researcher's experience of their participation in the Waterberg District Forum meetings could reflect on and articulate their experiences (Creswell & Poth 2018:153).

3.5.2 Sampling strategy

Different sampling strategies can be applied when selecting participants for qualitative studies (Creswell & Poth 2018:150). However, only a few purposive sampling strategies are applicable to phenomenological studies (Creswell & Poth 2018:158). The sampling strategies that resonated positively for this study were typical case sampling and criterion sampling (see 1.6.4 Sampling).

The *typical case sampling* strategy was needed to ensure that the researcher gathered the perspectives of 'typical' or 'average' representatives of the affected population (Thought Co 2019:23). In this study, the participants were average representatives who worked as social workers in multidisciplinary teams in state hospitals in Waterberg District Limpopo Province for longer than a year. Hence, they were participants who could share and describe the contextual realities of practising social work in state hospitals in the Waterberg District.

Criterion sampling allowed the researcher to have a list of predetermined criteria so that the most suitable participants for the study were included which had a positive impact on the quality of data that was collected (Creswell & Poth 2018:159). The criteria usually contain both inclusion and exclusion elements.

The inclusion criteria developed for the selection of participants for this study were developed when the research proposal was reviewed by the Department of Social Work Scientific Review Committee at Unisa. Nothing needed to be changed from the original plan and all the included participants satisfied the following inclusion criteria:

- They were social workers with a minimum qualification of a Bachelor of Social Work degree.
- They were registered as social workers with the SACSSP.
- They were permanent employees in state hospitals in the Waterberg District, where they worked in multidisciplinary teams.
- They were employed in the state hospitals in the Waterberg District for longer than twelve months.
- They gave their voluntary consent (confirmed in writing) to participate in one or two interviews that were conducted at the hospitals where they worked at a time and place convenient to them and their work schedules.
- They agreed to avail themselves to participate in a follow-up focus group discussion after the data gathered from the interviews were processed and analysed.

The criteria for exclusion were that the researcher and the two social workers who worked with him in the same hospital were excluded from participating in the research, because of a potential conflict of interest and to prevent jeopardising the research through their involvement. In terms of the inclusion and exclusion criteria, they were the only participants who were excluded from participating in the research.

As prescribed by Mason (2002:128) the inclusion and exclusion criteria enabled the researcher to select a fairly uniform and meaningful sample of social workers who had sufficient first-hand experience of the research topic. The sample enabled the researcher to obtain insight into the meaning the participants ascribed to their work environment in rich, descriptive, contextual detail. The participants shared their experiences by providing particulars about their relations and attitudes that they associated with working as social workers in multidisciplinary teams in the geographically specific context of the Waterberg District which were sufficient for the researcher to answer the research questions (Carey 2012:32).

3.5.3 Size of the sample

The sample size in qualitative phenomenological studies is determined by two factors, the depth of information needed for a study and the absence of any statistical analysis which enables the researcher to focus on smaller samples where depth of information is more valuable than quantity of responses (Hesse-Biber & Leavy 2011:45; Bouma et al 2012:149). The sample size in this study was small enough for the researcher to collect detailed

information about the social workers' experiences of working in state- based hospitals within a relatively short time frame and relying on limited resources to do so. The population studied was small, consisting of only thirteen social workers (three of whom were excluded as explained previously) (Hesse-Biber & Leavy 2011:45; Bouma et al 2012:149). The sample size of phenomenological studies according to Creswell and Creswell (2018:186) usually consists of between three and ten participants, whilst Bouma et al (2012:151) indicate between three and fifteen. Typically, the size of qualitative samples is determined by the principle of data saturation which refers to the point that the study reaches when the information or data presented become repetitive or saturated. When the point of saturation is reached and the data collected become repetitious, this confirms that the sample is big enough and there is little point in interviewing more participants (Carey 2012:136; Creswell 2014:239; Mason 2018:70). The research population of this research was small enough for all its members (with the exception of the three social workers referred to) to be involved in this research. Therefore, data saturation played a secondary role in determining the size of the sample, with some research participants repeating information that had been shared by others towards the end of the interviews. The reason for this was that the researcher wanted to make sure that information was collected from social workers in each of the state hospitals, apart from the one he was based at, in case the experiences of social workers differed according to the hospitals they were based at. Data saturation therefore was less important in this case as motivated.

3.6 APPLICATION OF DATA COLLECTION METHODS AND PROCEDURES

As stated in Chapter 1, the generation of data is the main building block of a research study (Carey 2012:246). Executing the interrelated activities planned to gather the information to answer the research question was operationalized, with a few modifications to the original plan as explained in this section. A circle of data collection activities as referred to by Creswell and Poth (2018:149) was used to structure the data collection and the execution of data collection activities by locating the site and sample; gaining access and developing rapport with research participants; collecting data; recording information; determining an interview protocol, data analysis and data verification.

3.6.1 Locating the site and sample for the study

Participants and sites are purposively chosen in phenomenological qualitative studies (Creswell & Creswell 2018:185). Miles and Huberman (as cited by Creswell & Creswell 2018:186) recommend that information about the research context (where the research takes

place); the actors (participants observed and interviewed); the events (actions performed by the actors) and a description of the events that the actors within the setting undertake, should be discussed to provide an understanding of the site and the sample.

The research context or place of the study was the nine state hospitals in the Waterberg District that employed a total of 13 permanent full-time social workers. Each of the hospitals employs between one and three social workers, all working in multidisciplinary teams. The hospitals are situated as follows in the following towns:

- Modimolle - FH Odendaal hospital, a general hospital also assisting with eye speciality, and MDR TB Hospital rendering specialising services to patients with TB and COVID-19.
- Bela-Bela - Warmbath hospital, a general hospital.
- Mokopane - Voortrekker hospital, a general hospital, Mokopane hospital in the Mahwelereng township, a specialised hospital and a senior hospital for the Waterberg hospitals, and George Masebe hospital situated next to Leyden village, also a general hospital.
- Lephapale - Elisras hospital, a general hospital.
- Thabazimbi - Thabazimbi hospital, a general hospital.

Ten social workers based in eight of the nine hospitals were studied. As justified in the section on sampling (1.6.4 sampling), a purposive sample was applied. The purposively selected typical and criterion sampling techniques were applied to ensure that the actors studied could inform the researcher about their experiences, challenges and coping strategies as social workers working in multidisciplinary teams in the Waterberg District hospitals (Creswell & Poth 2018:148; Flick 2014:1) The actors selected were willing to provide descriptions of their experiences to close the gap in locally specific knowledge about the lived experiences of social workers in multidisciplinary teams in the state hospitals in the Waterberg District.

Each actor participated in two one on one interviews that lasted between an hour and an hour and a half each and a virtual online discussion forum once the analysis of the information gathered in the interviews was concluded. The actors knew beforehand what questions they would be expected to answer. The actions that were needed to interface with the participants are discussed in detail below (see section 3.6.4.4 the focus group discussion onwards).

3.6.2 Gaining access to the setting

Before starting any form of data collection, researchers must execute specific steps of gaining admittance to the setting and obtaining the go-ahead from the gatekeepers (Singh & Wassenaar 2016:42). The researcher must secure participants' voluntary consent to participate in the study once the researcher has explained to them how their interests will be protected; what will be expected of them; and how their interests and privacy would be safeguarded. The participants deserve to receive information about the type of research study they will be getting involved in (Daymon & Holloway 2011:60–65).

The letter confirming that UNISA's Department of Social Work's Research Ethics Committee, had approved the research proposal was received on 6 July 2020 (see Addendum R). It was delayed by the national lockdown imposed in response to the COVID-19 pandemic. Once the letter was received the researcher approached the hospital-based research review committee at the Limpopo provincial Department of Health's office to establish what process he had to follow to gain permission to conduct the study in the Waterberg District hospitals. The researcher was directed to the Coordinator of the Limpopo Department of Health Research Ethics Committee who requested the researcher send his request to him in writing. The request letter (Addendum J) was submitted with the Ethical Clearance Certificate from UNISA and a copy of the research proposal. The researcher was granted permission to proceed from the DoH, Limpopo Province with the study on 1 July 2020 (Addendum Q).

Recognising the fact that research can disrupt and disturb institutional routines without offering them and their members, immediate pay-offs (Flick 2014:160), the researcher was motivated to seek the hospitals' cooperation before he commenced with the gathering of data. Therefore, the researcher chose to address the social workers at one of the Waterberg District Forum meetings beforehand to seek their cooperation as participants and alert them about how they and other hospital staff would be affected by the research process (Creswell & Poth 2018:156; Flick 2014:158). Using the pointers outlined by Creswell and Poth (2018:156), the social workers and their superiors were informed about -

- what the researcher would do at each of the research sites and how much time he would spend there (see section 3.4.6 about the interview protocol);
- what processes the researcher had in place to minimise disruptions in the social work operations at the hospitals;
- how the research results would be reported and;

- what the benefits of participation would be for research participants, the hospitals and the social work profession

During this meeting the researcher called for the colleagues' voluntary participation in the research and explained that he would interview each social worker based at eight of the nine district hospitals in the Waterberg District who wished to participate. They were also informed that the interviews would take between an hour and an hour and a half, and that arrangements would be made with the participants to be interviewed at a time and venue that were convenient to them so that their involvement in the study would not disrupt their work operations. They were assured that the COVID-19 safety protocols as regulated by the DoH Limpopo hospitals and as prescribed by UNISA, would be followed when the interviews were conducted. It was mentioned that should lockdown rules forbid face-to-face interviews, or if participants were uncomfortable meeting with the researcher face-to-face, the interviews could take place online. At the meeting the researcher explained that once the interviews were concluded the information would be analysed by the researcher and an independent coder, and the preliminary findings would be verified at a focus group discussion that would be conducted at Pietersburg provincial hospital where the provincial meetings were conducted. However, due to COVID-19 regulations the focus group discussion was eventually conducted as a virtual online discussion forum via Microsoft Teams on 30 September 2021. They were informed that during the focus group discussion a few open-ended questions would be posed to the group to facilitate group dialogue amongst the social workers about what positive changes were needed in state hospitals in the Waterberg District to improve the occupational status and professional identity of social workers employed there.

The social workers who satisfied the criteria for participation were approached telephonically. An individual, pre-interview telephonic interview was arranged with each prospective participant during which the researcher explained how the study could affect participants positively or negatively and what their rights as research participants were. It was noted that this information was consolidated in the information sheet for participants that included the consent form (Addendum C) that the researcher had emailed to them. They were asked to sign the consent form and submit it to the researcher at the start of their first interview. The researcher explained the meaning of voluntary consent with them again. The consent form also reflected each participant's consent for their interviews and focus group discussion to be audio recorded (see Addenda C, D and E). Cognizance was taken that written voluntary consent is especially important in phenomenological studies (Creswell & Poth 2018:156). Participants were provided an opportunity to ask questions about the research process. The specifics of obtaining participants' voluntary consent to participate in the research process are

further expanded upon in the discussion about the application of the ethical procedures of the study (see section 1.7 ethical considerations). The researcher checked that all participants who volunteered to participate (ten in total) met the criteria for inclusion and finalised the arrangements for conducting their first interviews.

3.6.3 Rapport building

Researchers are usually expected to build rapport with research participants before commencing with the interviews, but this was not applicable in this instance. The reason being that the researcher already was familiar with both the research context and research participants and they with him. He had regularly engaged with each participant professionally and interacted with them at the Waterberg District Forum meetings. He has an understanding of the cultural, professional, religious and gender issues experienced within the Waterberg District hospitals, understands the hospital structures and protocols that had to be respected, and has first-hand experience of how the healthcare system in Limpopo Province functions. What the researcher had underestimated though, was that research participants would continue to regard him as a colleague rather than a researcher. He therefore had to dedicate time before each interview to work through this issue with them, discuss potential clashes of interests, and encourage participants to share their stories as if he was someone who had no experience of working as a social worker in a multidisciplinary team in a state hospital. When participants made remarks such as, “well you know how it is…”, or “I don’t have to explain to you because you know what I am talking about,” he would remind them that as the researcher he had to bracket his personal experiences and understandings out of the study because his role was to capture the individual meanings they as participants ascribed to working in the multidisciplinary teams in the state hospitals in the Waterberg District.

Qualitative phenomenological research designs rely mainly on text-based observations or face-to-face interviews to collect data (Ritchie & Lewis 2013:56; Terrell 2016:76). In the case of this study, face-to-face interviews were chosen to gather detailed descriptions of participants’ experiences of the phenomenon being researched. The face-to-face semi-structured interviews were facilitated by an interview guide. At a later stage, a virtual online discussion forum was conducted to generate accurate reflections of the social workers’ perspectives and experiences of working in state-based hospitals in the Waterberg District (Robinson 2012:22). Some secondary sources were used such as hospital and SACSSP documents, and the researcher’s notes of his observations as captured in his field work journal (Creswell & Poth 2018:105; Terrell 2016:179).

3.6.4 Collecting the data

Collecting the data for this research is explicated by focusing on the application of interviewing as the primary data collecting tool, the qualitative interview guide, the pilot test, the virtual online discussion forum and secondary forms of data collection.

3.6.4.1 Interviewing as the primary data collecting tool

Ten social workers participated and in-depth, semi-structured interviews were conducted individually and face-to-face with each participant (Mason 2018:109). The interviews took place from 26 August 2020 to 28 January 2021. The researcher made sure that the interviews remained true to the characteristics of qualitative interviews as outlined by Mason (2018:109-110). The characteristics that were emanated during the study ensured that the interviews were:

- interactional in nature, with direct verbal exchanges between the researcher and individual participants;
- informal without being so informal that the purpose of the interviews was lost (Burgess cited in Mason (2018:110);
- regulated by ethical principles of research, one being the researcher's reflexivity which was important to uphold the integrity of the study by making sure he remained neutral during all the interviews;
- facilitated by an interview guide so that important questions were covered, but still allowed participants to share their experiences in a spontaneous way and provide participants a space to say what they wanted to say that was of importance to them (benefitting the research process because some unexpected themes were uncovered); and
- brought situated and contextual factors to the fore by allowing the researcher to probe in response to participants' cues that they had something more to share.

The recommendations of Moustakas for data collection (as cited in Creswell & Poth 2018:79) were closely observed by the researcher starting the interviews with asking the following broad questions:

- "What are your experiences of practising social work in a multi-disciplinary team in the state hospital where you are employed?"

- "What internal or external contextual factors or circumstances positively or negatively influence your performance as a hospital social worker in your work setting?"
- "What coping strategies enable you to fulfil your professional social work responsibilities as a hospital social worker to mitigate against the situational or contextual factors you experience working there?"

Additional open-ended questions were asked to gather detailed textural and structured descriptions of the experiences of social workers based in state hospitals in the Waterberg District (Creswell & Creswell 2018:187; Mason 2018:119) (see Addendum I).

The questions included in the interview guide were amended a few times before the study commenced. Some amendments were in response to recommendations made by the Scientific Research Committee of the UNISA Department of Social Work and others after the interview guide was pilot tested. Some of the topical questions were a bit vague and difficult for the pilot test participants to answer. In response to the pilot test the questions were simplified. Therefore, they were adapted and reformulated.

The benefits of using the interview as the primary data collecting tool for the study were confirmed by the following:

- The researcher gathered rich and complex detail of social workers' experiences of working in multidisciplinary teams in state hospitals in the Waterberg District (Carey 2012:109; Cavan, cited in Khan 2014:306; Creswell & Creswell 2018:187).
- The process of conducting the interviews was affordable, expedient and relatively uncomplicated. A large amount of information was collected within the timeframe allocated for the researcher's post graduate study (Carey 2012:109).
- The researcher stayed attuned to participants' verbal and non-verbal cues and probed to elicit deeper insights about their experiences. He adapted the sequence and wording of research questions in accordance with participants' preferences and understanding of them (Carey 2012:110; Chan, Fung & Chien 2013:5). Participants expressed themselves more freely in response to this relaxed interview structure which ignited their spontaneity and enthusiasm to share more (Chan et al 2013:5).
- The power between the researcher and participants was equitably distributed because the participants were positioned as the experts of their experiences and the researcher merely as the facilitator of the research process whose role was to track the participants' experiences (Carey2012:110).

3.6.4.2 The qualitative interview guide

Using a qualitative research interview guide ensured that the researcher asked relevant questions so that the participants' situation of working in multidisciplinary state hospitals in the Waterberg District could be better understood (Castillo-Montoya 2011:813). The following advantages of conducting interviews and using the interview guide were consistent with the literature consulted during the planning phase of the study:

- It delivered a collaborative account of the participants' and researcher's perspectives as a result of the interactions between them during each interview (Daymon & Holloway 2011:225).
- The researcher remained 'in step' with participants when they answered the open-ended questions, or when they raised new themes that they considered important. The researcher relied on probing to encourage participants to deepen their answers. During the interviews, the researcher stayed as close to participants' trains of thoughts as he could (Qu & Dumay 2011: 238; Edwards & Holland 2013:29)
- The interviews had enough structure to ensure that conversation stayed purposeful and that the focus remained on themes that were related to the study (Govender & Sivakumar 2019:45).

  The interview guide (Addendum I) contained the following topical questions that were asked and discussed:

Topical questions

1. What are your experiences of practising social work in the state hospital where you are employed?
2. What internal or external factors or circumstances positively or negatively influence your performance as a hospital social worker in your work setting presently?
3. What coping strategies enable you to fulfil your professional social work responsibilities as a hospital social worker given the current situational and contextual realities of working in a state hospital now?
4. What activities are you expected to perform as a social worker by other multi-disciplinary team members in the hospital where you work?
5. What are your thoughts regarding authority and decision-making processes within the multi-disciplinary team that you are part of in your hospital?
6. How does the hospital management facilitate or compromise your ability to fulfil your social work professional obligations to patients?
7. Please explain whether your voice as a social worker is heard or not in your work context?
8. What are the challenges that you are faced with as a social worker in the hospital where you are based?
9. What recommendations do you have for improving the occupational satisfaction of social workers in state-based hospitals in the Waterberg region?
10. How does the hospital where you work respect your professional identity as a social worker?
11. How do you rate your occupational satisfaction working as a social worker in a state-based hospital presently? Please explain your answer.
12. Explain whether your social work role in the hospital is consistent with the developmental approach to social work.

A few additional demographic questions were asked to develop a profile of the research sample such as participants' genders, ages, ethnicities, professional qualifications, years of work experience in a multidisciplinary team in a state hospital in the Waterberg District Following Moustakas' recommendation (cited in Creswell & Poth 2018:79), (see Addendum I Interview guide). This profile is presented in detail in Chapter 4.

It became a challenge to arrange the interviews according to the proposed interview plan because of the outbreak of COVID-19. Instead of the interviews being conducted during the period 5 May 2020 to 30 October 2020 as originally planned, the rescheduled interviews were

conducted from 26 August 2020 to 28 January 2021, once the state lockdown measures had eased. At that time the hospital social workers in the state hospitals in the Waterberg District were working on a rotational basis to uphold protective social distancing as regulated by the DoH, Limpopo Province, which protracted the interviewing phase even further. COVID-19 protocols were strictly followed during the interviews, by maintaining a social distance of 1.5 meters between the researcher and participants throughout the interviews, the researcher seeing to it that hand sanitizers were available to participants and that the office furniture in the dedicated interview offices at the hospitals were properly sanitized before the interviews commenced. As prescribed, the researcher and participants also wore face masks when they met. The participants and researcher adhered to the hospital screening protocols and completed the Waterberg District's state hospital COVID-19 screening test each time they entered the hospital premises where their temperatures were taken and the standard questions were asked such as if they had a cough, fever, contact with a COVID-19 patient and details about their travel history. The interviews were conducted individually and face-to-face as planned.

The research participants were interviewed in their offices at the hospitals where they were based. This was convenient for them and safeguarded their privacy. It is normal practice for social workers from different state hospitals in the Waterberg District to meet at one another's offices for business purposes. At the request of some participants one interview was conducted at the researcher's office, one at a quiet place at a mall because the participant was on leave at the time and the rest of the interviews were conducted at the participant's offices. Specific times were set for each interview so that participants could ensure that they would not be disturbed during their interviews at their workplaces.

The interviews took approximately 15 minutes for preparations and between 45 and 75 minutes to conduct. In response to the questions in the interview guide, the participants shared details of their experiences of working in multidisciplinary teams in state hospitals, discussed the challenges they faced working in that context and identified some of the coping strategies they used to get by in their work setting. Information about their job satisfaction and lack of professional identity in the multidisciplinary teams in state hospitals became better known.

The interviewing skills were applied as planned and discussed (see 1.8.4). Asking and discussing open ended questions and probes enabled the researcher to explore participants' experiences of working in multidisciplinary teams in state hospitals in the Waterberg District, encouraged the participants to describe their experiences in detail and contextualise their experiences (Polit & Beck 2010:341). Clarifying and paraphrasing improved the accuracy of

the information that was collected (Edwards & Holland 2013:29) and confirmed that the researcher had listened to participants carefully (Polit & Beck 2010:341). The combination of interviewing skills made participants feel that the researcher was interested and alert during the interview, and had been absorbed by what they had shared (Chan et al 2013:5; Edwards & Holland 2013:71). After a preliminary analysis of interview transcriptions completed by the researcher personally, it was concluded that in each of the interviews he had missed some comments participants had made that he could have followed up on which could have led to the uncovering of more themes (Edwards & Holland 2013:29). A decision was taken to set up a second interview with each participant to create an opportunity for the researcher to verify the information that was gathered and probe more thoroughly the areas he had missed in the initial interviews. The transcripts were reread to identify sections of the interviews where more probing was needed. Follow up Interviews were arranged and conducted with nine participants. The tenth participant declined the second interview because she had contracted COVID-19 and was booked off work for several weeks. To minimise the inconvenience of a second interview, participants were given the choice of meeting with the researcher face-to-face, being interviewed online, or interviewed telephonically. All the participants opted for the follow-up interviews to be done face–to-face.

The second interviews generated more information and removed some ambiguities which increased the accuracy of the gathered information (Edwards & Holland 2013:71). When the researcher transcribed the second round of interviews, he was satisfied that authentic information had been gathered about the experiences of social workers in multidisciplinary teams in state hospitals in the Waterberg District. Additional Information was obtained about how the challenges affected their occupational satisfaction and their professional identity in the multidisciplinary teams in the state hospitals in which they worked. The researcher could document the coping strategies the social workers used to mitigate against the challenges they faced working in multidisciplinary teams in the state hospitals in the Waterberg District.

3.6.4.3 Pilot test

As mentioned in the discussion of the sampling strategy applied in the study (see section 3.3.2) two social workers were excluded from the study because they worked in the same workplace as the researcher. These social workers were invited to pre-test the interview guide and research protocol. A pre-test is a common research practice in qualitative studies (Dikko 2016:522). Before interviewing the research participants, the two social workers were interviewed individually by the researcher by using the interview guide that had been developed for the study. Once they had answered all the questions, they shared their views

about the questions they had found to be ambiguous and/or difficult to answer. An example is question number 10 which asked whether the role of social workers was respected in the hospital. It was suggested by the pilot test participants that the question should be escalated, as people may have difference expectations of hospital social worker's by not knowing their role. It was suggested that the question should rather be whether the roles are known to or by anyone in the hospital. The question was then rephrased as "How do you rate your occupational satisfaction working as a social worker in a state-based hospital presently? Please explain your answer" (Addendum I, topical question number 11) (Creswell 2014:162; Dikko 2016:522). The researcher analysed the data he had collected and then checked to see if it would answer the research questions. The researcher was satisfied that they would. In finalising the pilot testing, the researcher and the two social workers met together to reword the ambiguous or difficult questions. Once that was accomplished the researcher finalised the interview guide and prepared for conducting the individual interviews (Addendum I).

3.6.4.4 Focus group discussion

The data obtained from the semi-structured interviews were meant to be supported by information collected from a second data gathering phase, the focus group discussion. The purpose of the focus group discussion was to create a platform for research participants to verify and further contextualise the research findings (Flick 2014:537). The ten participants who had participated in the individual interviews were invited to partake in a facilitated dialogue about their mutual experiences of working in multidisciplinary teams in state hospitals in the Waterberg District (Bouma et al 2012:282; Carey 2012:127, 246). Nine participants accepted the invitation to participate. This was an acceptable number of participants for a focus group discussion because the recommended size is usually between four and fourteen members (Bouma et al 2012: 282; Carey 2012:130).

The researcher arranged and confirmed that the independent social worker, who had experience of working as a social worker in a multidisciplinary team in another province, would facilitate the focus group discussion (Bouma et al 2012:282; Carey 2012:127) (See Addenda G and H). The facilitator agreed to moderate the discussion; offer participants support; prompt them to share their views; steer the debate; and curtail the behaviour of overbearing participants (Carey 2012:130-131; Flick 2014:250). This arrangement would have freed the researcher to present the preliminary findings of the individual interviews for participants to verify and capture research participants' responses to the three open ended questions as planned for the discussion (Flick 2014:243).

The researcher booked the venue where the Polokwane DoH district and provincial meetings were hosted, because it was accessible to participants and well equipped with resources such as flip charts, a data projector and seating. Unfortunately, the face-to-face focus group meeting had to be cancelled because South Africa experienced the second wave of COVID-19 just at the time the discussion was scheduled. A state-imposed level four lockdown was announced that forbade the hosting of meetings. Fortunately, due to the rapid growth of computer mediated communication, the researcher could use other recognised qualitative interview techniques to virtually gather the research participants' descriptions of working in multidisciplinary teams in the state-based hospitals in the Waterberg District (Opdenakker 2006). A virtual online focus discussion appeared to offer the best solution.

Online focus groups are focus groups that recruit participants into a virtual online forum by means of a Zoom or Microsoft Teams video conference facility software (Carrol 2021). There were several motivating factors that directed the researcher to choose this option. It was a cheaper, safer and a convenient alternative to the in-person focus group the researcher had planned; reduced the risk of exposure to COVID-19; and was a practical option for participants because they could participate from their personal physical locations without any risk (Carrol 2021; Iyiola & Keen 2021; Kamarudin 2015).

The research participants indicated that they were most familiar with Micro Soft Teams and so this was the platform the researcher chose to use for the virtual focus group discussion. There were some risks that had to be weighed up against the benefits. The researcher could end up with fewer participants because those without a home computer, internet connection, or a smartphone would not be able to participate. As noted by Iyiola and Keen (2021) this would affect the generalizability of the findings (not a major concern for this exploratory, descriptive and contextual study). Secondly, the change necessitated additional preparations. The researcher had to contact each participant individually to find out what online platform they were most familiar with and preferred to use (Carrol 2021). The Power Point presentation that had been prepared for the meeting had to be modified to make the slides more legible for those who would only have small mobile screens on which to follow the virtual online forum discussion (Iyiola & Keen 2021). Participants were prepared telephonically about the logistics of the virtual online forum discussion, the software they would be using, the link to join the meeting, and they had to be clear about how to join the group, activate their video and audio functions and know-how to raise their hand and use the chat function (Carrol 2021; Iyiola & Keen 2021). An electronic invitation was sent to each participant to confirm the date and time; purpose of the discussion; and the virtual online discussion forum link. Those who lacked confidence of how to use the MicroSoft Teams software were given a preliminary

demonstration of how it worked. Participants were reminded about the importance of arranging a quiet place for the whole duration of the discussion (Carrol 2021).

The phases of the virtual online discussion forum were not dissimilar to the phases of the face-to-face focus group discussion.

The *first phase* involved deciding what questions would be discussed (Carey 2012:130-131; Flick 2014:250). The researcher and facilitator had settled on three questions for the focus group discussion which Bouma et al (2012:282) indicate are adequate for a focus group interview guide. The questions were:

- "What are your experiences of social workers practising in multi-disciplinary teams in the Waterberg State hospitals?"
- "What existing internal factors or circumstances related to working in multi-disciplinary teams in these hospitals positively or negatively influence the performance of the hospital social workers?"
- "What coping strategies do hospital social workers use to mitigate against situational or contextual factors they experience working in multi-disciplinary teams in the Waterberg State hospitals?

The questions were appropriate for the purpose of the session; they elicited lively debate amongst participants; and prompted participants to share their beliefs and attitudes related to the topic (Carey 2012:130-131; Flick 2014:250).

The *second phase* involved giving each participant an opportunity to introduce themselves and mention their expectations of the session. The ground rules for the session were set which included using the 'raising the hand' icon to indicate their need to speak; muting their speakers unless it was their turn to share their perspectives; and assenting to the application of ethical matters such as maintaining confidentiality, respecting participants' views, and agreeing to disagree (Carey 2012:130-131; Carrol 2021; Flick 2014:250).

During the *third phase* the researcher presented the findings of the one-on-one interviews (see section 4.3.2 for the list of themes that were discussed). There were two reasons for doing this, to find a way to make participants feel relaxed about sharing their views about working in multidisciplinary teams in state hospitals in the Waterberg District in the group context, and to verify the findings of the one-on-one interviews. The researcher concluded that participants understood the reasons for hosting the virtual online discussion forum (Carroll 2021).

The three focus group questions were posed to online participants in the *fourth phase* (Carey 2012:130-131; Flick 2014:250). By that time participants were familiar with the group and more transparent and comfortable with this research method (Carrol 2021). However, their responses were repetitive, failed to contribute anything new, and simply confirmed that the point of saturation had been reached (Carey 2012:136; Mason 2018:70).

During the *fifth and final phase*, the researcher summarised the proceedings and thanked participants for their involvement (Carey 2012:130-131; Flick 2014:250). Participants were asked if they had any final thoughts or comments about the topic (Carrol 2021). The consensus was that those present had verbalised their most pressing concerns and that they felt good about having an opportunity to do so.

Despite the effort invested in thoroughly planning the virtual online discussion forum, the following hiccups were experienced that significantly affected the outcome:

- The Internet connection for some participants was not stable. Their connections were intermittent or created a time-delayed response between the researcher and participants (an issue also reported by Kamarudin 2015). The biggest Internet connection problem was that the facilitator and three participants could not connect at all and missed the entire focus group discussion, while three other participants were in hospital meetings and forwarded their apologies via WhatsApp for not attending the virtual online discussion forum. Online discussion groups are known to be complicated by limited bandwidth and technical challenges (Kamarudin 2015). Unpredictable internet connection is the biggest barrier in such group discussions (Iyiola & Keen 2021; Kamarudin 2015).
- The researcher had to wear multiple hats on the day. He stepped into the role as facilitator, managed the Microsoft Teams platform, and monitored participants' participation. Several participants requested his support to manage the technical issues they struggled with, such as having been unable to activate their audio, mute their audio, log out and log back in (Iyiola & Keen 2021). It was a struggle to do all this whilst managing the discussion process and group dynamics (Flick 2014:248). On reflection, the researcher realised that he had become task focussed at the expense of paying attention to the group process, which may have affected the group members' participation.
- Some participants did not position themselves properly in front of the camera and only a part of their faces was visible which made it difficult for the researcher to

monitor their non-verbal expressions (Kamarudin 2015). One of the drawbacks of online focus group discussions is that nonverbal cues and communications can be easily overlooked (Carrol 2021; Opdenakker 2006). It was very challenging to create an intimate atmosphere and it is possible that this may have affected the participants' self-expression, sharing of opinions and feedback (Carrol 2021).

- It was impossible for the researcher to record any observations and make notes about individual participants exact responses, which made analysing the data difficult. The researcher only had the Microsoft Team audio recording of the event to use to type a transcription of the group discussion. Listening to the multiple voices on the recording was difficult and time-consuming because the researcher struggled to distinguish who had said what (Carey 2012:133).

Despite the challenges, the virtual online discussion forum confirmed that the views of the participants were consistent (Flick 2014:243). The online event supported the findings of the one-on-one interviews (Flick 2014:253). This was very important because when the researcher is an employee of the organisation that is being studied, some form of triangulation is needed (Creswell & Poth 2018:156).

3.6.4.5 Secondary forms of data collection

Consulting organisational documents, such as hospital human resource policies that focus on topics such as work conditions, job descriptions and staff development, offered an additional source of information relevant to the research topic (Creswell & Poth 2018:163). The sources of information that were used from the DoH were hospital policies or guidelines that regulated the role of social workers in state hospitals in the Limpopo Province. Additional information was sourced from the SACSSP, namely draft proposals regarding requirements for the registration of social workers in medical settings as a specialized area of social work practice (van Breda & Addinall 2021; Carter 2013; Vergottini 2019).

3.6.5 Record keeping and interview protocol

The recording methods for reporting the research data were important for a positive outcome for the study. Two kinds of recordings were used, digital audio recordings of the interviews and the researcher's field note entries in his research journal.

The audio recordings of the interviews worked well. Once the interview had been recorded, the researcher replayed the recording several times to make sure that he had really 'heard' what the participant had implied during the interview and could discern what information had been important for him or her (Bouma et al 2012:228). The multiple replays of the audio recordings allowed the researcher to double check verbatim interview transcriptions he had typed up for accuracy which was critical to ensure the trustworthiness of the research findings (Bouma et al 2012:228). Listening to each interview and then typing it made the researcher immerse himself fully in the data, which helped him to develop insight into the personal experiences of every research participant (Englander 2012:15). The researcher made field notes of every interview in a research journal to reduce the risk of losing information because of the digital device malfunctioning (Carey 2012:117; Creswell & Creswell 2018:190; Mason 2018:134). An added benefit of maintaining the research journal was that it forced the researcher to remain conscious of his observations, interpretations, experiences and judgements. This is an essential research practice that enabled the researcher to bracket himself out of the study and remain neutral throughout the research process (Bouma et al 2012:228; Mason 2018:133-134). The same recording processes were intended for the focus group discussion but were applied slightly differently. Unfortunately, because the focus group was changed to a virtual online event and the researcher having had to facilitate the virtual discussion, because the person whose services had been obtained to facilitate the discussion, had connectivity problems. The researcher therefore had to rely solely on the Microsoft Teams digital audio recording of the event to transcribe the proceedings. In addition, the recording was indistinct in places because of Internet connectivity issues. The only field notes he made were reflective comments that he made once the event had ended. It was therefore more challenging to verify the accuracy of the virtual online discussion forum transcription (Bouma et al 2012:233).

The interview protocol described in Chapter 1 (see section 1.6.5.1 Developing an interview protocol) was developed at the outset of the data collection phase to standardise the process for asking questions, record the answers and capture hand-written field notes (Creswell & Creswell's 2018:190). The motivation was to ensure that the research data were captured accurately and transparently so that the research processes could be endorsed by others and the findings would be considered trustworthy (Ritchie & Lewis 2013:10). The language and interviewing procedures were regulated to make sure all participants received the same cues (Ritchie & Lewis 2013:10). The interview protocol outlined how the researcher had to introduce himself to the research participants, induct them in terms of the research process that would be followed, ask the research questions, and bring the interview to a close (Creswell & Creswell 2018: 165; Mason 2018:121).

An applied description of how data analysis was managed in this study is presented in the next section.

3.6.6 Data analysis

As directed, once the data had been collected and transcribed, the researcher had to 'make sense of it' and report 'what is going on', to advance an informed understanding of the experiences of social workers in state hospitals, offering first-hand knowledge of 'what it was like' to be there with the research participants (Bouma et al 2012:236-239). Data analysis is that part of the research process where the researcher looks out for leading themes, recurring language and beliefs situated in the participants' stories, by closely examining what they shared about their situation (Anfara et al 2015:30). The researcher divided the data up, took it apart and put it back together again (Creswell & Creswell 2018:190).

In analysing the data, the researcher followed the following steps recommended for data analysis offered by Creswell and Creswell (2018:192):

- **Step 1**: The researcher arranged and prepared the data for analysis. The recordings of all the interviews and the virtual online discussion forum were transcribed and the field notes typed. The data were safely stored in a locked-filing cabinet.
- **Step 2**: The data were read and re-read to get an overall idea of what participants had said and what the tone of their ideas were. Notes were made when reading through the transcripts and field notes. Essentially, the researcher required a deeper understanding of what social workers observed and heard, how they felt, reacted and behaved as they tackled their daily duties as social workers in the state hospitals in the Waterberg District (Bouma et al 2012:239). The researcher made notes in the margin of each transcription and scanned his field notes and researched journal entries to see whether they concurred with ideas that started to emerge (Creswell & Poth 2018:186). This is a preliminary step that led to the development of codes.
- **Step 3**: The preceding step is the foundation for coding the data. Participants' sentences were segmented into chunks of data that appeared to be significant statements associated with the contextual realities of working as a social worker in a state hospital in the Waterberg District. Creswell and Poth (2018:199) refer to this as descriptions of the essence of the phenomenon. Each chunk of data represented a separate category that was labelled, using a word, or term, that participant/s had used. The researcher kept a list of the code categories and descriptions. Each interview was

read and the developed codes were assigned to relevant sections of the transcribed text.

- **Step 4**: These categories were grouped into five themes (usually about seven themes for a research study). All themes represented different concepts identified from the interviews and became the headings for the findings section. The themes comprised of significant statements or units of meaning about the phenomenon of working in state-based hospitals in the Waterberg District.
- **Step 5**: The researcher identified subthemes related to each theme from reworking the interview transcriptions so that a list of descriptions associated with each theme was developed.
- **Step 6**: The findings were represented and visualised. Excerpts from the transcriptions were chosen to illustrate each theme and subtheme to build a contextual understanding of the phenomenon. The researcher developed an interpretation of the data using the theoretical framework he had developed for the study.

The researcher displayed and reported the data, which represented an empirical perspective of the experiences, challenges and coping strategies of social workers in state hospitals in the Waterberg District. The report provides the reader with a textual description of what happened, how the social phenomenon was experienced and conveys to the reader a sense of understanding of the 'essence' of what it is like to be a social worker in a state-based hospital in the Waterberg District. The intention was to collect data and analyse it concurrently. Once a preliminary understanding of the themes and subthemes was achieved, a social work researcher was engaged as an independent coder to code the data. The researcher and his supervisor arranged a consultation session with the independent coder to finalise the codes and themes for the data analysis phase. The value of doing this contributed to the verification of the findings.

3.6 7 Data verification

As indicated in Chapter 1 (see section 1.10) it is of imperative importance for qualitative research results to be trustworthy. To ensure this trustworthiness the researcher adhered to Guba and Lincoln's (1981) classic model of trustworthiness and followed the criteria as discussed in Lietz and Zayas (2010:443) and Krefting (1991:216-217). The researcher adhered to the four elements of trustworthiness which are: the truth value of the findings (credibility); its applicability (transferability); its consistency (dependability); and its neutrality (confirmability). Adhering to the four elements of trustworthiness assisted the researcher to

achieve the overall purpose of the study which was to explore the experiences of social workers working in multidisciplinary teams in state hospitals in the Waterberg District in Limpopo Province (Koonin 2014:258).

3.6.7.1 Credibility

Credibility in research, as described by Creswell and Poth (2018:259–261); Nieuwenhuis (2016:123); Shelton, Smith and Mort (2014:271) refers to the degree of confidence about the honesty and accuracy of the research findings of the study conducted, which according to Padgett (2017:210) is in line with the researcher's views of the findings in relation participant's interpretations. The credibility of this research was ensured as follows:

- The researcher constantly communicated with the participants through phone calls for preparation of data collection process arrangements. Various research and data collection methods were applied during this triangulation process. A qualitative research method, that combined a phenomenological research design which integrated exploratory, descriptive and contextual research was chosen to guide the research decision making process (Guest et al 2011:2) as discussed in Chapter 1 (see section 1.4). As defined by Babbie (2014:121); Maxwell (2013:128); and Noble and Heale (2019:1) triangulation refers to the process of applying various data collection and research methods in a qualitative study to increase the creditability of research findings. Triangulation is divided into four types, namely data triangulation which focuses on periods of time, space and people; triangulation of investigation which uses various researchers in the research project; triangulation of theory which focuses on various theoretical approaches to explain phenomena; and methodological triangulation which consists of various data collection methods such as interviews and observations which were applied in this study (Noble & Heale 2019:1).
- To ensure credibility of the study the researcher excluded two colleagues who work with him in the same hospital by only using their input during the pilot test.
- The researcher used purposive sampling in this study (Creswell & Poth 2018:158; Terrell 2016:177) (see section 3.3). He purposefully selected participants who, according to his judgement, would offer meaningful data required for the study, as asserted by Wilkinson et al (2012:140); Carey (2012:39); and Creswell and Creswell (2018:249), without compromising their wellbeing and the ethical principles applicable in qualitative research.

- The researcher conducted an interview of 45 to 75 minutes with each participant to collect data that were consistent with the context, experiences and unique coping skills of each research participant.
- A virtual online discussion forum via Microsoft Teams which took about an hour, was conducted instead of the initial planned approximate three-hour focus group discussion, due to COVID-19 regulations which did not allow face-to-face interactions.
- Data were audio recorded as planned during the data collection process of interviewing participants and the researcher's journal was always available to record any information or data that he regarded as being beneficial to the findings of the study, which could not be audio recorded.
- An independent facilitator was invited to facilitate the focus group session, however due to network issues during the Microsoft Teams meeting, he could not log in to the session which led to the researcher having to take over the role of facilitator to complete the facilitation process.
- The researcher presented the themes, subthemes and recommendations to the research participates to confirm they were consistent with the participants' frames of reference. All participants approved the presented themes, subthemes and recommendations to be a true reflection of what they had shared during the data collection process (see section 4.3 themes and subthemes and Table 4.1. Summary of themes and subthemes identified during data analysis)
- The researcher constantly engaged with his supervisor, and the coder to ensure that the descriptions were complete and devoid of his personal perceptions and valuing systems regarding social work in state hospitals in the Waterberg District. As asserted by Creswell and Poth (2018:271) the researcher and the supervisor scheduled regular debriefing sessions to identify his possible blind spots and biased interpretations of research findings so that he remained close to the participants' actual experiences rather than his own perceptions (Houghton, Casey, Shaw & Murphy 2013:14).
- To ensure appropriateness of the terms of reference and their interpretations and assessment thereof, an independent coder was engaged to verify the codes and themes that were identified in the raw data to confirm that the insights presented were more than the taken for granted assumptions. To deal with this, the codes where shared between the researcher and the supervisor to ensure consistent interpretations would be used during their discussions.

- Member checks to validate the accuracy of transcripts were conducted by the researcher telephonically contacting each research participant and sharing the transcripts with them to validate the interpretations (Creswell 2014:259; Anney 2014:276). The transcripts and themes of all research participants were later discussed during the virtual online discussion forum meeting on 30 September 2021 held by means of Microsoft Teams due to the level of lockdown regulations at the time.
- The researcher consciously bracketed himself and relied on the supervisor and independent coder to make him conscious of and point out any failure on his part during the research process. (Bracketing refers to the researcher setting aside his pre-understanding of a matter and applying non-judgemental attitudes (Sorsa, Kiikkala & Astedt-Kurki 2015:1).

3.6.7.2 Transferability

Transferability in qualitative research refers to the degree to which the research findings can be applied to similar contexts and settings or to other groups of individuals (Anney 2014:277; Creswell & Poth 2018:495-496). The transferability of the research was achieved as follows:

- The researcher presented a clear description of the purposive sample of social workers required and selected for the study that consisted of ten social workers (see section 3.3).
- Details are provided of all the actions taken during the research process of the study, from the preparations for the research, to the point of sampling, data collection, data analysis and the production of the final research report. Clear explanations were offered throughout the process so that others interested in the study could replicate it if they wanted to.
- A thick description of the context and nature of state-based hospital social work services in the Waterberg District is presented throughout this research report.

3.6.7.3 Dependability

Dependability in qualitative research ensures that the research is conducted in a constant and reliable manner (Daymon & Holloway 2011:86; Korstjens & Moser 2017:435).

Every step of the study was detailed in the research report (see section 1.6.5.7 Data verification and maintaining the trustworthiness of the study), to explain how the research instrument was developed and amended after the pilot test and in response to research realities encountered during the study (Creswell & Creswell 2018:201; Creswell & Poth 2018:488). This entailed the following:

- Completed transcriptions were checked against the audio recordings and members were asked to verify that the transcriptions were an accurate account of what they said during the individual interviews (Creswell & Creswell 2018:201).
- The research protocol compiled (see section 1.8.6) was finalised after appraisal during the pilot interviews (Creswell & Creswell 2018:202).
- For the purpose of a procedural dependability audit, all raw data collected and recorded are stored securely in a locked cabinet (see section 1.11.), as are the summaries, theoretical notes, memos and field notes that were saved for cross-checking purposes. All computerised material is secured in a password encrypted file on the researcher's computer. After the prescribed period of five years all the data will be destroyed (Lombard 2015:11; UNISA 2016:17).
- The consolidated findings of the research were presented at a virtual online discussion forum to ensure the participants' verified perspectives informed the recommendations of this study (Daymon & Holloway 2011:86) (see section 4.3.5 theme 5).

3.6.7.4 Confirmability

The neutrality of findings is of paramount importance (Gunawan 2015:4) and the research findings must be reliable before they are presented to the public (Connelly 2016: 435). Lincoln and Guba (in Nieuwenhuis, 2016:125) concur that confirmability refers to the degree in which research participants confirms the interpretation of the findings and not the researcher's biases. Confirmability was obtained as follows in this research:

- Bracketing was applied to filter the researcher's beliefs, values knowledge and experiences to avoid any contamination on the part of the researcher and to refrain from the researcher being biased (Chan et al 2013:2).
- A record was kept of the researcher's thoughts, ideas, feelings and observations throughout the study to make sure that participants' perceptions and experiences were not distorted.

- Supervision was used as a safety-net to remove any possible bias during the research process. The role of the supervisor was to hold the researcher accountable for capturing uncontaminated data and developing the analysis of findings with neutrality. This was done through constant supervision and debriefing sessions conducted during the process of the study
- The use of an independent coder contributed significantly to the neutrality of the research findings.
- Care was taken to focus on what the participants said when recording information, transcribing and reporting participants' responses in their own words. The commitment was to only report information that was genuinely presented.
- It is demonstrated consistently throughout the research report how the interpretations of the findings originated (Mason 2018:240).
- Consistent transparency about methods and methodology was strengthened in the researchers' conclusions and recommendations of the study.

3.7 ETHICAL CONSIDERATIONS

In this section the actions taken to uphold the principles of research ethics throughout the study are articulated. Ethical considerations in qualitative research refer to the moral behaviour of the researcher whilst conducting the research (Resnik & Finn 2011:1; Wilese et al 2013:4). Hesse-Biber and Leavy (2011:58) concur that the moral integrity of the researcher is a critically important aspect that determines whether the research process and research findings are trustworthy and valid. According to Creswell (2014:131) research ethics imply protecting the research participants from harm that might occur during the research process, securing participants' trust, promoting the integrity of the research and guarding against misconduct and impropriety that might reflect negatively on the institutions involved in the study. Typically, the ethical principles of research are confidentiality, informed consent and anonymity (Wilese et al 2013:4; Resnik & Finn 2011:1). The researcher understands ethical considerations to mean the moral good practices that should underlay all his research plans and their operationalization, to protect the participants and the integrity of his research.

The researcher applied the ethical principles of research as presented by Polit and Beck (2010:121-125) and the code of conduct for research as outlined by the SACSSP (Londt, 2018:129). Hence, he focussed his discussion on applying the ethical principles on informed consent, confidentiality, anonymity, beneficence, debriefing of participants and management of information.

3.7.1. Informed consent

The voluntary participation of participants is a central ethical principle. Informed consent aims to ensure that every subject's participation is fully intentional (Wiles et al 2013:3). There are three research actions that contribute to participants' voluntary consent (Polit & Beck 2010:127), that is that participants need to be properly informed about the research process that will be followed, reassured that their participation is voluntary and that they have the right to withdraw at any time, and that they should only be included in a study if they have information to share that is relevant to the study (Polit & Beck 2010:127). The way the researcher applied these three prerequisites are explained next.

In applying these three prerequisites a consent form (Addendum C) was given to participants prior to their interviews to allow them sufficient time to read through it and think about it. The form informed them of how their confidentiality would be respected. They were also given the opportunity to ask questions regarding the study (Benson, Brand & Gibson 2012:7) and were informed about what the study was about, what its risks and benefits were and how the results would be used (Hesse-Biber & Leavy 2011:64). Ritchie and Lewis (2013:66) expand on this by saying that participants should receive information about the purpose of the study, what subject it will address, how long it will take to complete the study, who the funder and the research team are and how data will be used. In addition to doing this, the researcher reassured participants throughout the research process that their participation was voluntary and that they could withdraw from the process at any time (Hesse-Biber & Leavy 2011:64; Ritchie and Lewis 2013:66). The researcher refrained from using any form of coercion to secure their participation (Polit & Beck 2010:127). This was important in the present study because participants were acquainted with the researcher and might have felt uncomfortable declining his invitation to participate. He had to reassure them that there would be no relational nor occupational repercussions should they choose not to participate or decide to withdraw during the study.

Individual meetings were arranged with potential participants to make them feel comfortable about asking questions and share any misgivings they might have had about participating. The concept of informed consent was explained at these individual meetings. In addition, a letter was issued to each social worker who was interviewed, outlining this (see Addendum C). The research interview proceeded only when participant had signed a written consent form which attested to their voluntary agreement to participate in the study and consented to allow the researcher to record their interview/s digitally (see Addenda D and E). The same informed

consent form was subsequently used again for participants who chose to be part of the virtual online discussion forum.

3.7.2. Privacy

As indicated by Creswell and Creswell (2018:95) every researcher must respect the privacy of participants and this is achieved by protecting the anonymity of participants, their roles in the study and their involvement in any incidents during the research process. It is important that they are protected from being publicly scrutinised because they have shared their opinions, actions or attitudes during the study (Carey 2012:102). Therefore, measures were taken to demonstrate this as further outlined under the ethical considerations confidentiality and anonymity which follow.

3.7.3. Confidentiality

The researcher has an obligation to safeguard each participant's identity, location and research location (Polit & Beck 2010:129). This was particularly important in this case, where participants might have felt at risk of disclosing experiences related to working in the state hospitals in the Waterberg District. A coding system was developed so that participants' names and details did not appear on the field notes, printed transcripts or labels of the digital recordings. The codes assigned to each participant were secured in a password encrypted file on the researcher's computer. Careful attention was paid when presenting the findings so that no one would be able to identify and link any information as coming from any specific participant or relating to any specific hospital where the participants were based (Creswell & Creswell 2018:95). It had to be stated that the research took place in the Waterberg state-based hospitals in the Limpopo Province, and due to the small research population the researcher had to be extra cautious to safeguard the confidentiality of the participants and to ensure that no information received could be linked to any individual participant. All printed transcripts and research documents were locked in a cabinet at the researcher's home. The research participants and the researcher, the independent coder, focus group facilitator and debriefer all completed the same confidentiality agreement form (Addendum S). The researcher, focus group facilitator, debriefer undertook not to discuss any information received from participant(s) with others. In accordance with the prescribed five-year rule set by the SACSSP (2015:11) and UNISA'S research policy (UNISA 2016:17) the research data will be preserved for five years after completion of the research before being destroyed.

3.7.4. Anonymity

Anonymity in research means that the participants will be able to identify themselves in the findings, but the researcher and other readers will not (Grinyer 2009:50). In qualitative research, anonymity means invisibility of participants. It is the researcher's responsibility to ensure that all participants are protected from any form of harm or victimisation caused by their participation in the research process (Benson et al 2012:4). As required, the researcher ensured that none of the participants would be recognised or identified from the findings presented (Ritchie et al 2013:67).

3.7.5. Beneficence

Beneficence in qualitative research means that participants will be protected from harm, exploitation and discomfort during the research process and should essentially benefit from participating in the study, even if it is indirectly (Dalamo 2018:11). In other words, the research process should ultimately promote their welfare (West 2011:5). As mentioned by Polit and Beck (2010:121) the purpose of practising beneficence is to ensure that social justice is upheld during the research. The benefits of a study should always outweigh the risk to participants (Legewie & Nassauer 2018:1). Participants were reassured that they would not be expected to perform acts that would reduce their self-respect or shame them and were reminded that the study was authorised by the Provincial DoH and that therefore no one should suffer any negative recourse as a result of their participation. The interview questions were worded carefully, so as not to cause participants any distress or discomfort (Polit & Beck 2010:130). Participants were alerted to the types of questions they would be asked prior to being interviewed (see Addendum I) to allow them to prepare themselves for the interviews. Participants were reminded that the recommendations that emerged from the findings would be presented to the Provincial DoH to motivate for improved working conditions for social workers in the state hospitals in the Waterberg District. The researcher was ethically obliged to enlighten the hospital authorities about any socio-political issues he identified during the research process that violated the rights of the social workers in hospitals. It was made clear at the outset that no one would benefit financially or occupationally as a result of having taken part in the study.

3.7.6. Debriefing of participants

Concomitant to doing no harm, plans were made to debrief any participant who might have been distressed by their participation in this study. The researcher had an ethical obligation to refer any participants who had been disturbed by their participation in the research process for supportive counselling, which is referred to as debriefing (Dey, Thorpe, Tilley & Williams 2011:35-36). Debriefing is a planned activity facilitated by experienced professionals conducted in a conducive environment (Haukendal, Hedeman, Reierson & Terunn 2017:11). A safe context is created for the disturbed participant to reflect on and work through the experiences that contributed to his or her distress after engagement in the research (Mariani et al 2013:148). The researcher approached and arranged for an experienced social worker employed by the Department of Social Development to provide this support. This request was made in writing and the debriefer's acceptance and curriculum vitae are included (see Addenda M). No one made use of this opportunity in this research.

3.7.7. Management of information

Data management in research refers to the process of controlling information obtained during a research study and the outcome of the study depends on the quality of the collected data (Krishnankutty, Bellary, Kumar & Moodahadu 2012). As prescribed, in managing the data and information received, the researcher used codes to refer to items or sources of data during the research project (Flick 2009:361). Sutton and Austin (2015:229) view data management as the researcher's efforts to stay true to research participants to make sure that their voices and concerns are heard.

The following data management techniques suggested by Sutton and Austin (2015: 230) were followed in this research:

- Interpretation of data - The researcher reflected on the experiences of participants and tried to edit his own.
- Transcribing and checking - The researcher transcribed digital recordings carefully, capturing participants' responses verbatim. The transcriptions were used to analyse the meanings of participants to ascribe to their experiences without the researcher changing any wording.
- Reading between the lines - During the interviews and virtual online discussion from the researcher listened attentively to what participants were saying and noted the things they were not saying directly, but hinted at.

- Coding – The researcher identified common responses or similarities in the transcripts.
- Theming – The researcher developed codes from the transcripts used to interpret participants' experiences.

In managing the information, all hard copies containing data and information are stored securely in a locked cabinet and all computerised material are secured in a password encrypted file on the researcher's computer. After the prescribed period of five years all the data will be destroyed (SACSSP 2015:11; UNISA 2016:17).

3.8 SUMMARY OF THE CHAPTER

The researcher in the chapter outlined the research paradigm, approach and methodology that were adopted to achieve the goals and objectives of the research. The researcher reported on the application of the research design, sampling methods, data collection methods, data analysis and verification methods, and ethical principles that were applied in the study.

The researcher was satisfied that the qualitative research approach, phenomenological research design that integrated an exploratory, descriptive and contextual research designs contributed favourably to the development of a comprehensive understanding of the experiences of social workers working in multidisciplinary teams in the Waterberg District in Limpopo Province. The purposive sample of ten social workers based in state hospitals in the Waterberg District provided relevant information that helped the researcher to answer the researcher questions. The data that was gathered was collected from face-to face interviews using semi-structured interviews facilitated by an interview guide. The direct and prolonged contact the research had with participants produced detailed contextualised information. The analysis of the data was achieved using Tesch's method as outlined by Creswell and Creswell (2018:192). The data collected were supported by a virtual online discussion forum which helped to strengthen the trustworthiness of the findings. Principles of credibility, transferability, dependability and neutrality, as presented by Koonin (2014:253) were used to verify the data. Ethical principles of informed consent, confidentiality and anonymity, beneficence and careful management of data were applied to uphold the ethical integrity of study and the safety of research participants.

Chapter 4 offers a detailed description of the positive and negative experiences of social workers working in multidisciplinary teams in state hospitals in the Waterberg District. It

highlights the challenges they experienced in the multidisciplinary teams, hospital structure and management, and the external factors that impacted on their ability to fulfil their professional mandate. The coping strategies that the social workers used to adapt to the challenges are explained as well as their recommendations about what must happen to improve the occupational satisfaction of hospital social workers in multidisciplinary teams in state hospitals in the Waterberg District.

CHAPTER 4

FINDINGS OF THE RESEARCH STUDY

4.1 INTRODUCTION

In the preceding chapter, the research methodology and methods applied during the study to answer the following research question are discussed: **What are the experiences and challenges of social workers working in multidisciplinary teams in state-based hospitals in Waterberg District, Limpopo Province?** The intention was to satisfy the research, goal which was to - **obtain an in depth understanding of the experiences and challenges of social workers working there.** The purpose of the current chapter is to present the processed data as collected from the social work participants to see whether the overarching research question can be answered. The chapter is sub-divided into the biographical profile of participants and the different themes and subthemes identified during data analysis.

Data were collected directly from participants in two phases. Information was gathered directly from research participants during individual interviews in phase one and in phase two, by means of a virtual online forum discussion with participants who had participated in phase one. Participants were given these two opportunities to explore, describe and contextualize the experiences of working in multidisciplinary teams in state hospitals in the Waterberg District.

This chapter addresses the following five themes identified once the raw data were analysed:

- Participants experiences of job satisfaction working in multidisciplinary teams in state hospitals in the Waterberg District.
- Participants' experiences of hospital organisation and management in state hospitals in the Waterberg District.
- Participants' challenges.
- Participants' coping strategies.
- Participants' recommendations to improve the occupational satisfaction of social workers in multidisciplinary teams in state hospitals in the Waterberg District.

Verbatim extracts taken from the transcriptions of participants' interviews are used to illustrate the themes and offer descriptions of what participants felt and said, how they reacted and behaved (Bouma et al 2012:239). As stated by Creswell and Creswell (2018:209) the use of

narrative text is the most popular way of displaying findings in qualitative research because it generates a holistic picture of participants' experiences. This will enable readers to experience the challenges and coping strategies according to the subjective experiences of the research participants (Creswell & Creswell 2018:209). The five themes are subdivided into subthemes.

The chapter commences with an overview of the biographical details of research participants. As asserted by Schubring, Mayer and Thiel (2018:19) it is crucial to introduce the biographical information of research participants as it provides an overview of the context and insight of the study. In a qualitative study, pseudonyms are usually assigned to each participant to protect their identities and privacy (Goodwin, Mays & Pope 2020:22). In this study, a decision was taken to represent each research participant by using the acronym RP (research participant) and allocating a number to each one (Benson, 2013:19). Due to the relatively small research population, participants' biographical details are not presented in a table, to ensure the anonymity of participants. In addition, the gender-neutral pronouns 'the participant', 'they', 'them' and 'their' are used to advance anonymity.

4.2 BIOGRAPHICAL INFORMATION ABOUT RESEARCH PARTICIPANTS

Before the themes are discussed, a biographical profile of the participants is presented, reflecting the determinants that were used for the inclusion of participants who fitted the purpose of the research study (Deurden & Witt 2010:2; Johnson 2019:89; Tan 2017:3). It is pointed out that information about participants' personal, professional and academic background and their biographical information offers some context and meaning to a study (Johnson 2019:89; Deurden & Witt 2010:2).

The participants in the study were between the ages of 31 to 51 years old. The two youngest participants were 31 and 32 years of age and the remaining eight participants were older than 41 years. Four of them were 41 to 45 years of age; two were 46 years of age and two were 50 and 51 years of age respectively. The significance of age in this study is to reflect participants' maturity, which could have affected their professional and personal experiences when answering the research questions. Most participants were in middle adulthood according to Erikson's well-known model of life stage development (Horner, Paterson, Walker, Perry & Jacksons 2020:44). Middle adulthood represents the life stage of generativity versus stagnation, a time in the life span when one expects a person's career to be developed, their relationships to be strong and for them to feel that they contribute positively to society (Horner et al 2020:44). Sacco (2013:40) asserts that maturity and intimacy are the two most important developmental tasks associated with middle adulthood. In a longitudinal study conducted by

Golovey, Manukyan and Sttrizhitskaya (2015:113) participants in the middle adulthood age 38 to 45 years of age, demonstrated higher levels of psychological maturity, self-control and responsibility. Similarly, findings in Zimmerman and Iwanski's study (2014:1) indicated that women in middle adulthood were more likely to present characteristics of emotional stability, and increased self-control than other age groups.

There were nine female participants in the study and only one male. The Waterberg District state hospitals have only two male social workers working in multidisciplinary teams. The sampling procedures were therefore not responsible for selecting more females than men to participate in the study. Over representation of female social workers and health care workers in studies is not uncommon because the historic characteristic of assigning women to helping and caring tasks still lives on in the current time (Gutierrez, Pinheiro, Silva & Tambasco 2017: 143). This historical practice may contribute to an identity threat amongst male social workers since they are in minority in the profession (López, Mayén & Berges 2015:104; Dedotsi & Paraskevopulou-Kollia 2015:119; van Veelen, Derks & Endedijk 2019:7).

The highest level of qualification held amongst the participants in the study was the Bachelor of Social Work (BSW) degree. This is consistent with the findings of an exploratory study conducted in the Limpopo Province that noted the ambitions of social workers to extend their studies beyond their bachelor's degree qualifications which were undermined by obstacles such as lack of motivation, poor image of the social work profession, heavy workloads, family obligations, financial constraints, and the poor academic practices they had been exposed to (Sithole & Mmadi 2019a).

Seven of the participants had worked in the state hospitals in the Waterberg District for 11 years and longer (two for 11 years; one for 14 years, one for 16 years, one for 17 years, one of 26 years and one for 30 years). The remaining participants had worked in the state hospitals in the Waterberg District for five years (two participants) and six years (one participant). Cumulatively, the ten participants had 141 years work experience in a hospital setting in the Waterberg District. It was therefore assumed that they would offer rich descriptions of what it was like to work in multidisciplinary teams in the state hospitals in their district. The protracted work service of the research participants contradicts the South African and international trend, of the retention of social workers being a major challenge (Calitz et al 2014:153; Skhosana 2020:109).

The researcher anticipated that the levels of experience and authority amongst participants could influence participants' personal and professional responses to the research questions.

The grades held by participants varied from grade one to grade 10, suggesting that there was adequate diversity of job grade levels represented in the study. There were two supervisors and one chief social worker amongst the ten participants. The small number of social workers in senior social work positions in the state hospitals in the Waterberg District suggests that there were limited opportunities for career advancement and salary progression for social workers in state hospitals in that district. Scholarly sources confirm that the hospital hierarchy offers limited opportunities for work progression for social workers based in multidisciplinary teams in hospital settings (Lee, Kim, Park & Cho 2012:88). It is noted that the job satisfaction of quite a number of social workers in multidisciplinary teams in health settings apparently tends to be low (58.2% of the social workers in the study of Lee et al 2012:88) because of the social workers' being dissatisfied with their conditions of employment. Their job grades and the remuneration and salary they receive, play a big role in their job satisfaction (Calitz et al 2014:60). The lower the salary scale the lower the satisfaction in the workplace (Calitz et al 2014:60). Remuneration in hospital settings can only be determined by the level of seniority a social worker occupies.

This concludes the discussion of the biological profile of research participants. The sections that follow present the themes that emerged during the data analysis.

4.3 THEMES AND SUBTHEMES

A theme is defined as a meaning gathered from research participants that guides the researcher on how to answer the research question (Kiger & Varpio 2020:3). Themes reflect the perceptions and experiences of research participants, based on their personal frames of reference during the data collection process, which are significant to the research question (University of Huddersfield 2022:1; Squire, Ryan & Bernard 2020:1).

After collecting the data from the individual participants and processing and analysing it, the researcher conducted a virtual online discussion forum session with participants to discuss and confirm the themes that emerged during the data collection process. Participants were satisfied with the presented themes. In analysing the data, different themes and subthemes as determined by the independent coder and confirmed by participants were listed. The following themes tabulated in Table 4.1 with their subthemes, are subsequently discussed individually with their subthemes:

- Participants' experiences of job satisfaction working in multidisciplinary teams in state hospitals in the Waterberg District.

- Participants' experiences of hospital organisation and management in state hospitals in the Waterberg District.
- Participants' challenges.
- Participants' coping strategies.
- Participants' recommendations to improve the occupational satisfaction of social workers in multidisciplinary teams in state hospitals in the Waterberg District.

Table 4.1. Summary of themes and subthemes identified during data analysis

THEMES		**SUBTHEMES**	
1	Participants' experiences of job satisfaction working in multidisciplinary teams in state hospitals in the Waterberg District	1.1	Participants' positive experiences of job satisfaction
		1.2	Participants' negative experiences of job satisfaction
2	Participants' experiences of hospital organisation and management in state hospitals in the Waterberg District	2.1	Social workers' perceptions of being disrespected and unsupported
		2.2	Lack of resources for social work departments
		2.3	Multidisciplinary team members' poor understanding of the role of social workers
		2.4	Poor relationships between social workers and hospital management
3	Participants' Challenges	3.1	Individual; challenges
		3.2	Internal challenges within the multidisciplinary team, hospital organisation and management
		3.3	External challenges
4	Participants' Coping strategies	4.1	Individual coping strategies
		4.2	Supervision
		4.3	Education and training
		4.4	Adhering to district and provincial DoH policies
		4.5	Not coping
5	Participants' recommendations to improve the occupational satisfaction of social workers in multidisciplinary teams in state hospitals in the Waterberg District	5.1	Improving the work conditions of social workers in the workplace
		5.2	Training and professional development
		5.3	Employee wellness programmes and debriefing sessions

The different themes and subthemes determined in analysing the data as listed in Table 4.1, are discussed, supported by quotations from what participants said and literature linked to the participants' responses about their experiences and challenges in working as social workers in multidisciplinary teams in state-based hospitals in the Waterberg District. Their perspectives

are integrated and linked by confirming or contrasting them with the literature by means of a literature control throughout the discussion.

The discussion of the themes commences with theme 1, the meanings participants ascribed to job satisfaction working in multidisciplinary teams in state hospitals in the Waterberg District.

4.3.1 THEME 1: PARTICIPANTS EXPERIENCES OF JOB SATISFACTION WORKING IN MULTIDISCIPLINARY TEAMS IN STATE HOSPITALS IN THE WATERBERG DISTRICT

Employment is an important factor in a person's life because when a person feels productive and useful, the person's levels of satisfaction and happiness increase (Altuntas 2014:513; Moro, Ramos & Rita 2020: 5; Ram 2013:16). Job satisfaction affects the productivity of employees because when they enjoy their work, they do it well (Moro et al 2020: 5; Ram 2013:16). Job satisfaction can be defined as how a person feels about his or her job and the different aspects related to it. Job satisfaction may be positive, for example, when people like the work they do, or it may be negative, such as when the persons are dissatisfied about what they have to do and they disapprove of the conditions under which they must perform their job-related tasks (Spector cited by Calitz et al 2014:156). Job satisfaction is high when an employee experiences a pleasant feeling once having completed the work-related tasks (Zhu 2012:294). When job satisfaction is high, employees tend to stay in their jobs. The factors commonly linked to long-term tenure in the social work field include being valued, feeling safe and being treated fairly (Calitz et al 2014: 157).

The theme about participants' experiences of job satisfaction in multidisciplinary teams in state hospitals in the Waterberg District is sub-divided into two subthemes, namely participants who experienced job satisfaction and those who did not.

4.3.1.1 SUBTHEME 1.1: Participants' positive experiences of job satisfaction

Individuals who experience positive emotions in their workplace are more likely to express job satisfaction (Fiori, Bollmann & Rossier 2015:9). Employees who feel appreciated in their work environment are more prone to experience high job satisfaction (Pfister, Jacobshagen, Kälin, & Semmer 2020:465).

The responses of the participants in this research regarding their positive experiences of job satisfaction are discussed in terms of their personal satisfaction of being a social worker, the

benefits of the specialised training and orientation they received from the hospital, being acknowledged by hospital management and other multidisciplinary team members; and working in a multidisciplinary team.

- ***Personal satisfaction of being a social worker***

Participants verbalised their personal satisfaction of being a social worker as follows:

Participant	Excerpts from interviews
RP4	*"Nothing is perfect but I'm enjoying working. Maybe is because I have been here for long time. So that's what motivates me, seeing people getting help.*"
RP6	**"***I… I… I enjoy my job. I chose to be a social worker when I was still in high school. So, beside all challenges, I still feel motivated because I…I keep on doing what I like. I see lot of people appreciate it.*"
RP8	"*I love the profession. I love helping my clients and that is what I'm trained to do. Even when I'm frustrated, I know that there are clients out there who need my services. And…if I don't provide the services… what will become of them*? *When I serve my clients, I do it with passion. That's what I do on a daily basis.*"

Participants mentioned the personal satisfaction they gained from performing their social work tasks in the state hospitals where they worked. The positive factors they mentioned included helping people and being appreciated for doing so, the inherent passion they had within themselves to be a social worker and realising that social workers fulfil a function that no one else in the hospital fulfils.

RP4 shared the view about the job satisfaction of working in the hospital as follows: *"Nothing is perfect, but I'm enjoying working. Maybe is because I have been here for long time."* The participant expanded as follows it: ***"****So what motivates me, is seeing people getting help.*"

RPS6 too, felt motivated and satisfied in fulfilling the calling of becoming and being a social worker, in realising that many of the people helped appreciated it. The participant explained it as follows: **"***I… I… I enjoy my job. I chose to be a social worker when I was still in high school. So, beside all challenges, I still feel motivated because I… I keep on doing what I like. I see lot of people appreciate it.*"

RP8's job satisfaction expressed as follows, was also closely related to the participant's love for the profession: "*I love the profession. I love helping my clients and that is what I'm trained to do. Even when I'm frustrated, I know that there are clients out there who need my services. And…if I don't provide the services…. what will become of them*? *When I serve my clients, I do it with passion. That's what I do on a daily basis.*"

The point about making a difference in people's lives was raised by **RP4** as follows: *"So I think I'm satisfied that I'm able to be given this opportunity to give into the community, to get into the hospital to make somebody's life to be a little bit easier here and there…"*

The participants' responses concur with the definition of positive job satisfaction, namely the pleasant feeling an employee experiences once they have completed their work task (Zhu 2012:294). Participants presented themselves as social workers in a hospital setting who were committed to the social work profession. They were satisfied working in the hospital setting because their altruistic need for assisting people was satisfied (Alegre, Mas-Machuca & Berbegal-Mirabent 2016:1392). Wiles (2013:858) refers to this as an altruistic commitment to service that social workers experience.

- ***Specialised training and orientation offered by the hospital***

A participant had the following to say about the specialised training and orientation offered by the hospital:

Participant	Excerpt from interview
RP1	"*So, fortunately, when I arrived, there was a social worker who came here to help me. "She was working in another hospital, but she came here to take me through what was expected of me."*

Associated with positive job satisfaction of social workers who work in hospital and health care settings are guidance received from other social workers; in service training for allied clinical staff; a proper induction of allied clinical workers; acquisition of specialised knowledge to enable social workers to operate in a specialised setting; and multidisciplinary training of allied clinical workers where team members interpret their professional role and scope of interventions accurately (Wamsley, Satterfield Curtis, Lundgren & Satre 2018:267; Cwikel & Friedmann 2019:1; Ward-Lasher, Messing & Hart 2017:211). It was evident that being properly orientated and receiving additional training impacted positively on the job satisfaction of the participant who had received this.

In this regard, **RP1** mentioned the benefits of having been orientated by a social worker who worked at another district hospital, by stating that - *"So, fortunately, when I arrived, there was a social worker who came here to help me. She was working in another hospital, but she came here to take me through what was expected of me"*.

Internal hospital training for allied clinical staff was also mentioned as follows by RP1, as playing an important role in making participants aware of specialised services that are available to patients*: "I attended training when I started here. Training was arranged the first*

month I started here. That helped because it was training for allied clinical staff. So, relevant information was shared. I think that helped a lot, in terms of knowing what type of patients we work with. So, it really made my life very easy in that when I had to see patients, I understood what was needed, or what was expected of me."

Acquiring specialised knowledge was an additional factor that affected job satisfaction positively. In this regard, **RP1** explained*: "So, so far I think I have learned a lot. It is very interesting…because I have learned things that I think if I were in other hospital I wouldn't have known. So, since this is a specialised hospital. There is a vast amount of information that is available".*

RP1's job satisfaction was clearly linked to the orientation and training she received in the state district hospital where she was based. The link between job satisfaction and professional competence is highlighted by Malmberg-Heimonen, Natland, Tøge and Hansen, 2016:1355. The authors point out that professional competences are developed through both formal education and workplace experience (Malmberg-Heimonen et al 2016:1355). Having received on the job training from a more experienced social worker, attending a proper induction by allied clinical professionals, and acquiring specialised knowledge about working within a specialised hospital, empowered and stimulated **RP1** to perform her tasks as a medical social worker. Generalist social work training is not regarded as being sufficient for preparing medical social workers to be competent to work in multidisciplinary teams (Mathews 2019). This will become more evident in the presentation of participants' dissatisfaction working in state hospitals in the Waterberg District.

- ***Being acknowledged by hospital management and other multidisciplinary team members***

For two participants, receiving recognition from hospital management and other allied professionals contributed positively to their work satisfaction. The participants shared as follows that they valued being acknowledged and assisted by hospital management and multidisciplinary team members because this made them feel more secure in the workplace:

Participant	Excerpts from interviews
RP4	*"There I think we are being acknowledged, hence I mentioned that they even expect us to perform miracles. So they do acknowledge us…err…as I said that they expect us to do miracles…err… whenever they refer a case to us even if is not for us they know that we will not return the case to them but it will be sorted…is…is like they know that once you refer to social work then is done…so…they know that we are important when they are stuck."*
RP1	*"Eerh … Hospital will always look into it and try to find a solution and see if whatever solution you are coming with its viable or it can it can be implemented, so they will not just say ok social worker*

	*speaking no hay we will not do that they will always take whatever you are saying to check further if it can be implemented***. "***Hospital XY is not so bad eerh staff most of the staff the colleagues they are very supportive, and ya, so I think the support from other colleagues and the multidisciplinary team as a whole it does contribute positively to my performance."*

RP4, in response to the question about whether they experienced job satisfaction working in a multidisciplinary team in a state hospital, highlighted as follows that social workers received positive acknowledgement from management and multidisciplinary team members: *"I think we are acknowledged. They even expect us to perform miracles…It is like they know that once you refer to a social worker, then the job will be done…so…they know that we are important and they use us when they are stuck."* Whilst **RP4** interpreted the faith that other team members had in social workers as a form of acknowledgement, scholarly sources note that it is not uncommon for social workers to receive inappropriate referrals because they are reliable and willing to help (Monterio, Arnold, Locke, Steinhorn & Shanske 2015:182; Beder 2009:8).

It appeared that **RP1** perceived that management deals respectfully with employees' requests. This made the participant feel acknowledged. The participant gave the following example: *"The hospital management will always look into it* [referring to when a problem is referred to hospital seniors] *and try to find a solution. They will see whether the solution you proposed is viable and can be implemented. …they will always take whatever you say seriously and then check further to see if it can be implemented*."

Collegial relationships with other multidisciplinary team members in the hospital is another contributing factor to **RP1**'s positive job satisfaction: "*Most of the colleagues, are very supportive, and ya, so I think the support from other colleagues and the multidisciplinary team as a whole does contribute positively to my performance."* However, **RP1** suggested that they too contributed to the collegiality within the hospital team by being open and transparent about their roles as a social worker: *"I make sure that people are aware of who I am, I respect my profession first and because I do that, I think the hospital recognises me as a social worker and they know what is expected of me. I think they do respect my profession*. Calitz et al (2014:159) add to this that employees who are involved in decision-making feel more engaged, which promotes their job satisfaction.

It is pointed out that the job satisfaction of social workers working in multidisciplinary teams depends upon the recognition and acknowledgement social workers receive from the leaders and the multidisciplinary members (Scanlan, Devine & Watkins 2019:81). The quality of communication between hospital management and multidisciplinary teams in hospital settings must be frequent, timely, accurate and address problems directly (Hartgerink, Cramm, Bakker,

van Eijsden, Mackenbach et al 2013). When these characteristics are present, Hartgerink et al (2013) note that the quality of relationships improve considerably which results in shared goals, shared knowledge and mutual respect. The need for social workers to be more self-assured and assertive is also acknowledged as a means of improving relationships with hospital management and within multidisciplinary teams (Mancini, Bouttura & Rossi 2019; Hamilton, Roda, Hwang, Abraham, Baumlin et al 2015:852; Beder 2009:11).

- ***Multi-disciplinary team collaboration***

Participants expressed themselves as follows about the issue of multi-disciplinary team collaboration and its benefits:

Participant	Excerpts from interviews
RP9	"*Yes, it is very good because we* [referring to the multidisciplinary team] *follow up on the progress. You must follow up so that you can report back to the team. As a social worker I will do a home visit or make a call as agreed on, and I do not want to be the one to delay the process."*
RP5	*"Like if they* [referring to other allied professional team members] *have…or rather their patents have…err...err... social work related problems then that's where I come in. I assist them to alleviate the patient's social problems. A social problem may block the team from doing what they need to do. They can't make progress or continue because they need this sorted out. We work as a team. Where I'm needed then I help…I feel I fit in".* "*So…but they can't dictate to me what duties I must do… do this, do that…you must do what you have to do."*
RP10	***"****When I realise that actually what the client expects from me is not in my line of expertise, I can just refer to a psychiatrist or occupational therapist, and they are here at the hospital. The client can be seen the same day. This is unlike when I worked in the community… where you had to go through a long process to refer a client..."* "*If I can put it like this…. Since I worked in another environment before coming to work here…and also, when I did my practical work whilst I was studying social work… I can say being a social worker in a hospital allows you to actually have a smaller number of patients, unlike working in the location or in the community where you have loads and loads of cases. So here I can really focus on my clients which is much more doable.*"

Several participants acknowledged that some of their interactions with other professionals in the multidisciplinary teams in the state hospitals contributed positively to their job satisfaction. Feeling needed and trusted by other multidisciplinary team members positively impacts on the occupational satisfaction of social workers which in turn enhances service delivery (Hartgerink et al 2013:211).

The benefits participants mentioned in this regard included, sharing the responsibility of patient management; being able to offer unique perspective and intervention about patient management; having different options available to refer patients to; and being better off than

social workers in welfare organisations who must deal with large caseloads and are unable to give in-depth focus to their clients.

Patient management requires accountability and the coordinated interventions of different multidisciplinary team members. For some participants this was a positive factor because they did not want to let other team members down. **RP9** for example explained it as follows: "*Yes, it is very good because we* [referring to the multidisciplinary team] *follow up on the progress. You must follow up so that you can report back to the team. As a social worker I will do a home visit or make a call as agreed on, and I do not want to be the one to delay the process."* This is likely to achieve better outcomes for patients which in turn makes the team feel positive about what they are doing and increases their job satisfaction (Beder 2009:9).

RP5 shared that as social workers, they had a unique role to play in patient care that benefitted not only the patient but also the other multidisciplinary team members: *"Like, if they* [referring to other allied professional team members] *have…or rather their patents have…err...err... social work-related problems then that's where I come in. I assist them to alleviate the patient's social problems. A social problem may block the team from doing what they need to do. They can't make progress or continue because they need this sorted out. We work as a team. Where I'm needed then I help…I feel I fit in".* **RP5** made it clear though that the other team members could not give social workers directives that were inconsistent with their professional roles, by stating: "*So…but they can't dictate to me what duties I must do… do this, do that…you must do what you have to do."* It is noted that when the role of social workers is clarified within a multidisciplinary context, the team functions better and job satisfaction increases (Zerden, Lombard & Jones 2019:144; Alegre et al 2016:1392).

Working in a multidisciplinary team context offered a benefit for **RP10** that others did not raise. **RP10** recognised the availability of a range of other professionals to whom patients could be referred to when the social worker was unable to assist them, by stating it as follows: ***"****When I realise that actually what the client expects from me is not in my line of expertise, I can just refer to a psychiatrist or occupational therapist, and they are here at the hospital. The client can be seen the same day. This is unlike when I worked in the community… where you had to go through a long process to refer a client."*

This discussion led **RP10** to identify another reason for being satisfied in the workplace: "*If I can put it like this…. Since I worked in another environment before coming to work here…and also, when I did my practical work whilst I was studying social work… I can say being a social worker in a hospital allows you to actually have a smaller number of patients, unlike working*

in the location or in the community where you have loads and loads of cases. So here I can really focus on my clients which is much more doable" [benefits of social workers working in a hospital setting is that they work with a multi-disciplinary team, they receive support and services from other team members, they have direct access to patients, referral sources are more accessible, and they deal with a smaller caseload].

Social workers in hospitals find comfort in collaborating with other professionals in multidisciplinary teams when managing patients. Job satisfaction of social workers working in multidisciplinary teams depends on the recognition and acknowledgement social workers receive from the leaders and other multidisciplinary team members (Scanlan et al 2019:81). Fleury, Greenier and Bamvita (2017:7). Bacter and Marc (2017:69) assert that job satisfaction in multidisciplinary teams is dependent upon knowledge sharing and a strong commitment to team tasks. Job satisfaction has a positive outcome on employee's job performance which enhances the organisation's delivery of services (Imayavan 2021:1424). Therefore, happy employees are productive employees (Reddy 2019:17).

It is therefore acknowledged that job satisfaction has much to do with the psychosocial factors of employees (Tambasco et al 2017: 141). Researchers found the following in this regard that confirms the views expressed by the participants about their job satisfaction:

- The development of a collaborative culture driven by hospital management contributes to the support and security of social workers in multidisciplinary teams in state hospitals (Leach et al 2017:120).
- Being made to feel that they are successful in the execution of their functions and are trusted enough to manage difficult cases that others cannot manage, increased the participants' self- esteem, confidence and general well-being in the hospital settings that they work in (Shier & Graham 2013:99).
- When significant people in the workplace make social workers feel they are doing good work, the wellbeing of social workers is promoted (Shier & Graham 2013:100).
- It can be concluded that job satisfaction is an emotional, personal, dynamic and changing condition that involves deeply rooted subjective experiences and external factors which are situated in the workplace (Gitterman & Germain 2008:55).
- Creating a collegial work environment is important because job satisfaction is linked to better outcomes, lower absenteeism and staff turnover, the wellbeing of social workers, and work productivity and work effort (Calitz et al 2014:156).

The focus now falls on the participants' feedback about the negative experiences that impacted on their job satisfaction.

4.3.1.2 SUBTHEME 1.2: Participants' negative experiences of job satisfaction

Participants were more expressive about the negative experiences that impacted on their job satisfaction than the positive ones. Negative factors that lower job satisfaction lead to burnout, and as reported by Limon (2018:iii) typically include organisational challenges, multidisciplinary team collaboration challenges, working within a medical setting, and lack of resources.

The discussion of the factors participants described which affected their job satisfaction negatively is mostly consistent with the findings of Limon (2018: iii) and is presented according to individual factors, supervisory support and collaboration, and hospital organisational, management and employment policies as raised by participants.

- ***Individual factors***

According to Bronfenbrenner's (2001) bioecological systems approach individual factors are those factors that are situated at the micro level. They represent the individual's inner world of experience. In the context of this study the microsystem incorporates the individual employees' experiences and perceptions of the organisation's demands and how they affect their sense of wellness (Barile et al 2016:658). Research participants said the following in this regard:

Participant	Excerpts from interviews
RP5	"you *are doing what to make sure gore (that) I'm ok functionally upstairs, for me to be able to assist somebody else, for me to be able run around the whole hospital because they will call you in that ward…in that ward….in that ward…especially if you are alone, you will feel like you are going crazy on a busy day. No, I don't think……I don't think I'm acknowledged. Errr… people just see you doing your work. Nje… (like that) but to acknowledge you that like you are doing a good job you are doing this and that, I don't think people see you. No Ya, you know there are the times where you feel like errrr…say there is tragedy somewhere that happened and then people think counselling they think social worker. Is like they will remember you in that sense but, they will never remember you to say our social workers are doing a good job, they are doing this, haahhh they don't acknowledge you**...*Ahhhmmm…. sometimes you feel that you are over worked and then you become emotionally drained but you are expected that when that person who just emotionally drained you who is out, somebody must come in."*
RP2	*"Really neh to work in a hospital setting is like you are working in a……in a cage if not in a prison, you are a prisoner most of the things you do them in here."*
RP9	"- *"It becomes emotionally draining when you are expected to arrange for a patient discharge without doing a proper family intervention. Where do you place that patient if the patient cannot speak any of our languages? How will you know if he is going to be cared for and given medication? It is just not fair leaving us to sort this out."*

RP8	"*My level of job satisfaction is low. Very, low. Very…very low. Personally, there are times when I considered packing and just leaving, and I don't see myself working until my year of retirement. Honestly."*

When asked about their job satisfaction, a few participants said that their job satisfaction was low. In being disillusioned with it, **RP8** contemplated leaving the employer: "*My level of job satisfaction is low. Very, low. Very…very low. Personally, there are times when I considered packing and just leaving, and I don't see myself working until my year of retirement. Honestly."* **RP5** shared that because job satisfaction was low working in the state hospitals in the Waterberg District, social workers were depressed: **"***So we all just get depressed.*" **RP2** explained they felt stuck their jobs: *Really neh to work in a hospital setting is like you are working in a……in a cage if not in a prison, you are a prisoner most of the things you do them in here."*

There clearly were several factors that made participants feel that negative work issues affected their wellbeing. With reference to employees' negative feelings in this regard, Gitterman and Germain (2008:64) point out that social workers' perspectives of organisational resources that are available or unavailable to them, relate to questions such as:

- "What kinds of resources do we have available?"
- "How accessible are the resources we need?"
- "What social support networks are available to us?"
- "What material or financial resources can we source from outside the hospital?"

The nature of social work is emotionally taxing. As noted by Shier and Graham and (2013:102) social workers carry the emotional burden of making hard, life-altering decisions that necessitate strength of character that many other professionals do not need to demonstrate. The following extract from **RP2**'s interview highlights this: "*Because the case, I mean the patients themselves have different kinds of problems, you end up being like emotionally involved with their …. eeerh…. problems. Some are psychiatric cases; some have intellectual disabilities. I don't know how to say it, but the number of difficult cases we dealing with, make you at the end of the day … become emotionally affected. Sometimes you do not know what to do with these cases. That's a problem.*" **RP9** too, highlights feeling emotionally drained when tasked with discharge planning because of the many factors over which they had little control, by stating that - "*It becomes emotionally draining when you are expected to arrange for a patient discharge without doing a proper family intervention. Where do you place that patient if the patient cannot speak any of our languages? How will you know if he is going to be cared for and given medication? It is just not fair leaving us to sort this out."*

This is confirmed by social workers having been reported to experience frustration and despair when they are unable to address their clients' needs, especially when clients present with problems that have no solution (Shier & Graham 2013:99). In addition, when social workers over-identify with their clients, this adds to their emotional overload that is a contributing factor to social worker 'burnout' (Travis, Lizano & Mor Barak 2015:1079; Sánchez-Moreno, Roldán & Gallardo-Peralta 2014:2371; Shinan-Altman, Werner & Cohen 2016:359). In these situations, social workers must learn to adapt their expectations to be able to maintain a positive outlook which is difficult to do (Shier & Graham 2013:99).

A heavy workload was described by **RP5** as follows, as another contributing factor to low job satisfaction: ***"****Ahhhmmm… sometimes you feel you are over worked. And then you become emotionally drained…But they expect you to continue to render services even though you are emotionally drained. You have got to carry on, do outreach programmes and work in the office as well."*

RP5 further mentioned that: *"you are doing what to make sure gore (that) I'm ok functionally upstairs, for me to be able to assist somebody else, for me to be able run around the whole hospital because they will call you in that ward…in that ward….in that ward…especially if you are alone, you will feel like you are going crazy on a busy day. No, I don't think……I don't think I'm acknowledged. Errr… people just see you doing your work. Nje… (like that) but to acknowledge you that like you are doing a good job you are doing this and that, I don't think people see you. No Ya, you know there are the times where you feel like errrr…say there is tragedy somewhere that happened and then people think counselling they think social worker. Is like they will remember you in that sense but, they will never remember you to say our social workers are doing a good job, they are doing this, haahhh they don't acknowledge you…Ahhhmmm…. sometimes you feel that you are over worked and then you become emotionally drained, but you are expected that when that person who just emotionally drained you who is out, somebody must come in."*

In addition, it seemed as though being an only social worker in a hospital with no relief social worker available, exacerbated the social workers' feelings of being emotionally drained. **RP1** elaborated as follows on this negative work factor: *"And then, also eeehhhh*… '*ke reng'* [what should I say] 'gore' [that] *being the only social worker, even though you get assistance from external social workers* [referring to social workers based in welfare organisations], *they are not always available. And if I'm on leave, when I come back, whatever needed to be done whilst I was away will be waiting for me when I get back. Wabona* [you see]?"

Some found it difficult to maintain their sanity in the hospital, because they were so busy trying to service different hospital wards simultaneously. In some instances, participants indicated it affected their sanity and two participants expressed themselves as follows in this regard:

RP5 explained how difficult it was to remain psychologically balanced by stating that - "Y*ou have to try to make sure that you're functionally well upstairs* [referring to being psychologically well]*, so that you are well enough to assist your patients. Meanwhile, you have to deal with all the demands… You have to run around the whole hospital because they will call you in that ward…in that ward….in that ward…This is especially hard if you work alone. You feel like you are going crazy on a busy day."*

RP8 provided the example of having been instructed by a hospital manager to persuade a farmer who had employed a husband and wife as day labourers, whose child had died, to advance their wages to enable them to pay for their child's body to be removed from the hospital mortuary. The child died during the first wave of COVID-19 when South Africa was at level five lock-down and under the regulations at that time, the parents were unable to work, which meant they did not receive any wages for that period. **RP8** suspected that because the couple were Zimbabweans, the hospital manager did not want to approve the couple's application for a pauper's funeral so that the parents could bury the child. The child's body remained in the hospital mortuary for several months. To appease the hospital manager, **RP8**, explained the visit to the farmer, who would not assist in this regard as follows: "*He is the employer. He can only pay a person at month end. It's the same for me where I work. I only get paid month end. When your cousin dies do you think the Department will give you money to bury your cousin? Naa! I wrote a report for the couple about the problems they had had with the COVID-19 restrictions and gave the reasons why they were not able to work so that they could be granted a pauper's funeral to bury their child. They didn't have the money. They were not being paid for all the time that the COVID regulations forced to stay at home."*

The next negative factor raised as being responsible for low job satisfaction are issues related to the availability of supervision and support for social workers in the hospital context.

- ***Lack of supervision, support and collaboration***

Participants explained that the lack of supervision, support and collaboration were responsible for their low job satisfaction within the immediate work place. Supervisory and support factors are situated at the meso level of Bronfenbrenner's bioecological systems approach (Holosko & Feit 2013:10). In the context of the study, the meso level represents the daily interactions a

person has with significant others within the immediate work setting they operate (Holosko & Feit 2013:10). The literature confirms that when the person experiences these relationships as interconnected, supportive and providing a source of assistance, job satisfaction is positively affected, but when the opposite is true, a person's level of stress increases and their job satisfaction declines (Liao et al 2010:59). Social workers' experiences in working with the other health care professionals is one of the most important factors that impacts on their daily work practices (Albrithen & Yalli 2016:134). As noted by Calitz et al (2014:159) supervisory and support factors are frequently responsible for the turnover of social workers who value and expect adequate guidance and support in the workplace. Participants expressed frustrations of having to report to clinical managers who were not social workers. This was due to factors such as experiencing lack of support insufficient guidance and support for inexperienced social workers as mentioned by research participants (Albrithen & Yalli 2016:134), feeling overlooked and disrespected by other multidisciplinary team members, and poor role clarity within the multidisciplinary teams. They expressed themselves as follows about it:

Participant	Excerpts from interviews
RP8	*"Every profession is specific. So social workers need supervisors who understand what social work entails, and what social workers need to render services effectively."*
RP5	*There are no formalised meetings, I know there are errhhh…meetings once quarterly, but there you just share the professions specific issues…. But when you have issues that frustrate you, some do not know who to turn to for help. Ah…I usually make a call to social workers that I know, that are within reach, just to discuss the frustrations that I have."*
RP3	*"It…it is frustrating… It is frustrating because the hospital environment is not supportive towards social workers. For instance, I work alone."*
RP4	"*There are those…who are just negligent. I think they don't have interest in finding out what social workers are meant to do… If they come across a stumbling block, they just refer to the social worker, no matter what it is. Ya, social workers…Master of All Challenges, Ya."*
RP7	***:*** *"My experience of working in the hospital as a social worker is that anything that anybody else does not want to deal with, comes to the social worker. So, I think we are like a wastepaper bin for the institution."* ***"****My experience of working in the hospital as a social worker is that anything that anybody else does not want to deal with, comes to the social worker. So, I think we are like a wastepaper bin for the institution."*
RP8	"*I don't have a social work manager. I'm level three, which is a supervisor post, but I'm not supervising anyone. Except when I'm allocated students who do their placements in the hospital. I report to a clinical manager who has no clue about what my profession is all about. Wa e bona taba"* [can you see my point]*?"* *"Every profession is specific. So social workers need supervisors who understand what social work entails, and what social workers need to render services effectively."* *"But for a new social worker it is frustrating because they still need supervision. If you don't know what you are supposed to do, who do you consult within the hospitals? It is really a difficult situation for our social workers in the health sector."* *"The situation is just…is so bad and for social workers who are new. They have to call other social workers who have been in these hospitals for a long time….You end up supervising another social worker from another hospital…And if you are supervising another social worker from another*

	hospital, the issue depends on how the management of that hospital views things [meaning that one's advice may not be consistent with the hospital based allied clinical managers]."

RP8, who filled the post of a senior social worker, had much to say about the lack of supervision in the state hospitals. Even though graded as a supervisor, this participant did not supervise social workers based in the state hospitals in the Waterberg District and said the following in this regard: "*I don't have a social work manager. I'm level three, which is a supervisor post, but I'm not supervising anyone. Except when I'm allocated students who do their placements in the hospital. I report to a clinical manager who has no clue about what my profession is all about. Wa e bona taba"* [can you see my point]*?"* The point that **RP8** made was that allied clinical managers do not have the professional insight needed to supervise social workers in a hospital setting and added that - *"Every profession is specific. So social workers need supervisors who understand what social work entails, and what social workers need to render services effectively."*

This is confirmed by the following definition of 'supervision' given in the *Supervision Framework for the Social Work Profession in South Africa* (Lombard 2015:8):
"Supervision is a formal arrangement through which supervisees review and reflect on their work. It is related to ongoing learning and performance. Social work supervision is an interactive process in a positive non-discriminatory relationship, based on distinct theories, models and perspectives of supervision. It entails educational, supportive and administrative functions that promote efficient and professional social work services."

The definition reflects supervision as an important social work professional activity which is informed by social work theories for the purposes of advancing the supervisee's knowledge, offering him or her support and fulfilling the administrative requirements necessary to deliver efficient and professional social work services. Supervision of social workers by social workers is mandatory in South Africa as prescribed in several official social work regulating documents including the Social Service Professions (Act 110 of 1978); the Code of Ethics of the Social Work Profession and the Children's Act 38 of 2005 (Engelbrecht 2014:125; Supervision Framework for the Social Work Profession in South Africa (Lombard 2015:8; Bhuda, Shirindi & Botha 2019:51). This confirms and explains participant **RP8's** perception of the lack of supervision as a serious issue that impacted negatively on the job satisfaction of the social workers in the state hospitals.

The implications of the lack of supervision and support for inexperienced social workers were even more serious. **RP8** explained: *"But for a new social worker it is frustrating because they*

still need supervision. If you don't know what you are supposed to do, who do you consult within the hospitals? It is really a difficult situation for our social workers in the health sector."

RP8 raised the matter again, later in the interview: *"The situation is just…is so bad and for social workers who are new. They have to call other social workers who have been in these hospitals for a long time…. You end up supervising another social worker from another hospital…And if you are supervising another social worker from another hospital, the issue depends on how the management of that hospital views things* [meaning that one's advice may not be consistent with the hospital based allied clinical managers]."

Several scholarly sources concur that it is important to have someone in the social work profession who offers direction to social workers in hospital settings so that the professional identity of the social work profession will be upheld (Steils, Moriarty & Manthorpe 2021:271; Lèvesque, Negura, Gaucher & Molgat 2019:2249). It is hard for social workers to maintain and develop their professional identity without having a social work role model immediately on hand, especially for newly qualified social workers who have not yet properly integrated the aims and values of social work into their daily practice (Scholar, McLaughlin, McCaughan & Coleman 2014:10). With organisational support employees become more engaged with their job and organisation which increases their job satisfaction. Supportive supervision for social workers in the state Waterberg District hospitals could increase the job satisfaction of the social workers who were based there (Scholar et al 2014:5).

The lack of supervision was not the only factor that minimised the participants' job satisfaction. Some indicated as follows that they missed opportunities for social workers to come together to offer support and exchange ideas. This was regarded it as a negative factor because they had to rely on their own initiatives to find support:

RP5 shared that - "*There are no formalised meetings, I know there are errhhh…meetings once quarterly, but there you just share the professions specific issues…. But when you have issues that frustrate you, some do not know who to turn to for help. Ah…I usually make a call to social workers that I know, that are within reach, just to discuss the frustrations that I have."*

RP3 expressed the loneliness felt as a social worker working in the hospital by stating that - "*It…it is frustrating… It is frustrating because the hospital environment is not supportive towards social workers. For instance, I work alone."*

In dealing with the matter, studies strongly indicate that by mobilising social support from colleagues and supervisors, employees' work engagement increases which positively affects their job satisfaction (Leiter & Bakker 2010:185).

The lack of appreciation of the role of social workers in a hospital setting was an additional factor that lowered the job satisfaction of some participants. As noted by Shier and Graham (2013:103) in multidisciplinary settings, other professions have limited insight into the role and functioning of social workers and sometimes expect more of social workers than they can deliver. This places social workers under pressure because they do not want to be left with the consequences of making wrong decisions when managing difficult cases referred to them (Shier & Graham 2013:103). *"It…it is frustrating…. It is frustrating because the hospital environment is not so much supportive for social workers, for instance, I'm working alone…. Honestly they don't know what they expect from you, for me is better because I have long been in the service, I have learnt. I know who to consult when I get some frustrations…But for a new social worker it is frustrating because you still need supervision, if you don't know what you are supposed to do, who are you going to consult within the hospitals, it is really a difficult situation for our social worker's in the health sector."*

Some participants described the quality of inter relationships between themselves and other multidisciplinary team members as poor. A general sentiment was that in many instances social workers felt overlooked and disrespected in the multidisciplinary teams to which they were assigned. For example, **RP5** responded as follows: *"No, I don't think……I don't think I'm acknowledged. Errr…. people just see you doing your work. But no one acknowledges you for doing a good job. I don't think people see you. No, but when there is a crisis somewhere, when something goes wrong, then people think of involving the social worker… Then they remember you. But they will never remember you and say, 'our social workers are doing a good job."*

Even though **RP3** perceived as follows that having adopted a self-sacrificing attitude at work so that the job could be done, others apparently did not notice it: "*It demoralises me every day. It doesn't give me peace. Really sometimes you go beyond your…your…your…your scope of duty…you knockoff very late so that you finish the cases of the day. So, you knock off very, very, late which compromises your personal agenda. Sometimes you use your own resources, you use your car, your own…your own things…to do your job. I mean this is very… very… risky because you are not covered at all* (referring to being insured). *So being under paid to me is… is… a is a big thorn in my flesh."*

One participant shared the opinion that social workers were mostly invisible in the hospitals unless there was a political agenda such as a visit from a political figure: **RP2** *"We get on a do what we are meant to do…. because we know our work our duties. They only come to us when politicians come to visit the hospital. Like when the MEC* [Member of the Executive Committee] *is going to be around."*

A significant factor that was expressed by several participants was that for many the multidisciplinary team had a very poor comprehension of the role and tasks of social workers, which added to their frustrations and undermined their job satisfaction, **RP3** *"It…it is frustrating… It is frustrating because the hospital environment is not supportive towards social workers. For instance, I work alone.* "This is confirmed by Shier and Graham (2013:95) stating that when role expectations in the workplace are not clearly delineated, it decreases work satisfaction and contributes to worker stress and strain, particularly when stakeholders in the workplace have different expectations of the social work profession than social workers have.

Another factor contributing to low job satisfaction experienced by participants, was the frustration of not having a clearly defined job description. **RP9** said the following in this regard: "*I need to know what I should do and what I should not do. But now I have been allocated other duties which are not in line with my grade. I'm the only social worker here. I see patients, I attend meetings and compile monthly statistics and reports which are meant to be the responsibilities of those with more senior* grades."

Some participants experienced that the lack of role clarity amongst other professional team members about the tasks and role of a social worker, led to social workers becoming the 'dumping ground' of certain patients. In several instances allied clinical team members referred cases to social workers when they did not know what to do for those cases. An extract from **RP8**'s interview illustrates this experience: *"They see a social worker as jack of all trades. When they are frustrated, or when they are unable to deliver or to render services to their patients, they just refer to the social worker. They hope that you will sort out the problems even though they are not social work related."*

RP4's perspective was much the same when saying that - "*There are those…who are just negligent. I think they don't have interest in finding out what social workers are meant to do… If they come across a stumbling block, they just refer to the social worker, no matter what it is. Ya, social workers…Master of All Challenges, Ya."* **RP7**'s experience was very similar: ***"****My experience of working in the hospital as a social worker is that anything that anybody else*

does not want to deal with, comes to the social worker. So, I think we are like a wastepaper bin for the institution."

The above experiences are confirmed by researchers who report that medical staff expect social workers to provide concrete services (like transport, residential placements and financial support), instead of psychosocial counselling (Albrithen & Yalli 2016:132; Frost, Robinson & Anning 2005:188: Kirshbaum 2017:10; Raniga & Kasiram 2010:263; Wayne & Rachelle 2016:101-109). In addition, one of the roles assigned to social workers in multidisciplinary teams is that of a 'janitor'. In this regard, Craig and Muskat (2013:100-101) explain that social workers are left to deal with "the unpleasant things, less clean, less clinical, left-over problems." It is concluded that other professionals in the hospital perceive these roles as having little status and as secondary level services. Hence they do not want to deal with them, which is why they refer these matters to social workers. Sadly, social workers find the role of 'janitor' very demeaning.

The impression is gained that the quality of the interpersonal interactions that some social workers had with multidisciplinary teammates in the Waterberg District state hospitals, were instrumental in the poor job satisfaction they experienced due to the different role expectations other team members had of social workers. The different role expectations are confirmed by researchers. It is reported that in these instances, role-related expectations of social work held by hospital members are not aligned to those of hospital social workers (Shier & Graham 2013:102). In addition, Albrithen and Yalli (2016:130) noted that medical practitioners and nursing staff expect social workers to work with family members and address the patient's environmental challenges, rather than render therapeutic interventions.

The last factor participants associated with low job satisfaction in terms of supervision, support and collaboration was the poor collaboration and coordination within the multidisciplinary hospital teams. **RP8** pointed out that - *"There is no co-ordination of services even in the hospital. We no longer work as a team."* The participant went on to say that there is a need for continuous multidisciplinary team meetings to ensure the effectiveness and sustainability of the team, as advised by Housely (2017:126).

As confirmed by other research, the experiences participants faced required personal and or environmental resources they could not access, which led to them being stressed and their job satisfaction being decreased due to their poor person-in-environment situations (Teater 2010:26; Teater 2014). As explained, the concept of relatedness in terms of the tenet of the

life model theory refers to connections, friendships, bonds and social ties that people need to experience a sense of belonging within their social network (Teater 2010:26) (see section 2.4.1.2). In the context of this study, participants' experiences of close connections and support were the opposite. They experienced work alienation, which made them feel invisible and powerless (Lipsky cited by Tummers 2012:5). The relationships that participants in the current research described in the hospitals in which they worked, however reflect a lack of respect, poor collaboration and negative inter-communication which made them feel alienated and unsupported as indicated by Kirschbaum (2017:20-21).

- ***Poor hospital organisation, management and employment policies***

Organisational structure is largely responsible for multidisciplinary collaborations, as it creates the clinical and administrative systems to direct multi-disciplinary practice, the organisational culture, and the leadership and operational systems for the hospital (Ambrose-Miller et al 2016:102). Therefore, the findings related to organisational factors responsible for lowering the participants' job satisfaction are discussed next.

According to Bronfenbrenner's bioecological systems approach, organisational structure/factors are situated at the exo level, which Krishnan (2010:8) explains is the context in which the person has to function. Healthy organisational structures offer staff resources and opportunities that advance staff's wellbeing so that they become more productive and meet their professional obligations (Liao et al 2010:5). The organisational structure (exo level system) determines the culture of the organisation, the communication and decision-making processes, practical issues such as organisational hierarchy and the remuneration of employees. Literature indicates that hospital management in most cases decides what is expected of social workers in the hospital, prioritises allocation of funds to medical patient care rather than to social programmes and follows hospital statutory policies and guidelines in terms of formulating basic conditions of employment for social workers (Fraser 2010:27; Kirschbaum 2017:11; Dobrikova et al (2016 85:91). It is inevitable that since the balance of power in hospital settings rests with hospital management that does not include social workers, the findings would reveal factors about the organisational structure that would undermine job satisfaction of social workers in some areas. In discussing organisational factors that lower job satisfaction and contribute to high turnover of social work staff, Calitz et al (2014:153) include the organisational climate and culture; salary; job benefits; promotional opportunities and administrative load; autonomy; decision making; workload; supervision; and professional development opportunities. Whilst some scholar sources (Zychlinska 2022:449) include the lack of knowledge and appreciation of the roles held by other health professionals in this grouping of poor organisation, management and employment policies, others discussed it

under the previous grouping of lack of supervision, support and poor collaborations. The organisational factors identified by participants as contributing to their negative experiences of their job satisfaction, relate to their remuneration and opportunities for advancement in their social work careers.

Remuneration refers to the total return an employee receives from the organisation that employs him or her for the services he or she has performed (Agustiningsih et al cited by Martono, Khoiruddin & Wulansari 2018:236). Remuneration to employees is usually packaged to include money or salary, fixed allowances, variable allowances, incentives and other facilities (Martono et al 2018:236). Tambasco et al (2017:147) include opportunities for being listened to and providing the worker support in the workplace in the package. Participants in this research expressed dissatisfaction regarding their remuneration as hospital social workers. They perceived their remuneration to be lower than the remuneration of allied professional cohorts in the multidisciplinary teams in which they functioned, noted the limited opportunities social workers in hospital settings had for career progression and complained of being expected to act in senior roles such as allied professional manager, without adequate remuneration and their social work workload being reduced.

Salary is one of the factors that contributes to the job satisfaction among social workers (Calitz et al 2014:160; Schweitzer, Chianello, Kothari 2013:152). When they perceive their salaries to be poor, their job satisfaction decreases mostly because they feel they are being taken advantage of (Calitz et al 2014:160). Whilst job satisfaction drops, Fitts (cited by Calitz et al 2014:160) notes that this does not mean that social workers intend to leave their positions. Participants expressed themselves as follows in this regard:

Participant	Excerpts from interviews
RP1	*"And also the when it comes to remuneration, I believe that our remuneration is not fair…haaahh…. haah… For the amount of time that we took to train, get our qualifications and the amount of work that we do social worker you are everywhere you work in your office, you work in the wards, you also have to go outside" And when I look at the remuneration it really does not match the efforts that I put in, the effort that I…I….I…I put in when I do my work, because you can, you can put the social worker in every any field they would fit in and they will have a role that they play there but when you look at the remuneration it really does not worth the efforts, ya actually undervalued when you look at it but eerh … government and how they structure our…. eerh …. Remuneration." "There isn't much, eerh… opportunity to move up through the ranks in the hospital. It is very hard to up your grade level. Like, I'm a social worker now …grade three. For me to move up I have to become a social work supervisor which is grade four. Unfortunately, such promotions seldom occur. Only when a senior social worker resigns or retires."*
RP2	*"The thing that makes me be less satisfied working here is the salary. We are under paid as social workers. We all need money. Money is not everything that makes a person to be satisfied. But at least if you get paid for what you have done…you feel satisfied. I mean you need something to make you feel that you are being rewarded for what you have done. So, I hope the issue of salary*

	will be looked at." "Job satisfaction is poor. You cannot do half a job and feel good when you don't have the resources to do that job properly!"
RP4	*"It is unfair, we social workers work just as hard and also do the things that the other allied professionals do. They visit the homes or the clinics and schools. We also do home visits, but we don't get those allowances. They get special allowances like a rural allowance, extra payment for home visits they make, or the outreach programmes they conduct. We don't get these things."*
RP3	*"It is like you will be a social worker at the same level for your life. You don't show any growth in your career. There is no growth even if you can acquire further education. This means nothing to them. You have to do whatever they say you must do."*
RP7	"It was so *difficult. I was doing two jobs. That's what you have to do. Sometimes I even had to stand in when the Human Resource manager was not there. Filling this managerial role impeded my performance as a social worker and the service I delivered to my patients." "It was hard to fill my managerial tasks and my role as the hospital social worker at the same time. I couldn't really make an appointment with a patient. I couldn't for example say come Wednesday ten o'clock because I didn't know if at ten o'clock on that day I will have to be in a meeting. That was one of the frustrations. Or I could start off with the meeting at eight o'clock, sit there the whole day, and then when I had finished with a very long meeting go back to my office to find patients who had been waiting to see me."*
RP10	*"And the issue with our hospital is that a lot of staff get changed quite few times. Even management which causes a breakdown in communication. So it comes to a point where the people acting in managerial positions say they were not there when something was said, or they didn't hear it when it was said. So, matters never get resolved. They just continue to snowball. They roll and roll and roll, just getting bigger all the time."*

Participant **RP1** reflected as follows that the poor remuneration they received as hospital social workers was demoralising: "*For the amount of time that we took to train, get our qualifications, and the amount of work that we do as social workers! You are expected to work in your office! You work in the wards! You also have to go outside* [referring to the outreach services]. *And when I look at the remuneration it really does not match the effort that I put in. You actually feel undervalued when you look at it…. But augh… the government and how they structure our remuneration! The remuneration needs to be better than what we are getting…. At the end of the day we are paid peanuts. It demoralises me every day."*

This sentiment was echoed by **RP2** stating that - *"The thing that makes me be less satisfied working here is the salary. We are underpaid as social workers. We all need money. Money is not everything that makes a person to be satisfied. But at least if you get paid for what you have done…you feel satisfied. I mean you need something to make you feel that you are being rewarded for what you have done. So, I hope the issue of salary will be looked at.*"

These views are corroborated by the findings of a study conducted by Raniga and Kasiram (2010:270) that found that even doctors and nurses in the health care services indicated that the social workers need better salaries to uplift their delivery of services which in turn would uplift their professional standing.

Another factor associated with participants' dissatisfaction with their remuneration is the realisation that remuneration benefits of some other allied clinical team members differed from theirs. **RP4** was offended because social workers were not remunerated equally with other allied professionals in the multidisciplinary team for similar tasks performed, by stating that - *"It is unfair, we social workers work just as hard and also do the things that the other allied professionals do. They visit the homes or the clinics and schools. We also do home visits, but we don't get those allowances. They get special allowances like a rural allowance, extra payment for home visits they make, or the outreach programmes they conduct. We don't get these things."*

Adeoye and Fields (2014:345) concur that compensation is an important factor in motivating staff to do their work so that the organisation's good performance is upheld. Remuneration is a way an employer acknowledges their staff which contributes positively to their wellbeing (Aluntas 2014:89). It is a factor that is often a bone of contention within multidisciplinary teams because of the low salaries and precarious working conditions experienced by some members in multidisciplinary health teams (Tambasco 2017:146). Participants clearly felt that their remuneration failed to match their output. It is evident that hospital employment regulations and human resource structures in health care grade the positions of different disciplines differently which results in different dispensations amongst team members (Leah, Fondriest, Lucca, Storti, Balsamo et al 2018:116).

It is recognised that evidence of promotional opportunities is the best predictor of job satisfaction (Fitts as cited by Calitz et al 2014:160). The life model theory indicates that for persons to achieve a good person-in-environment fit, they must experience feelings of competence, self-direction, self-concept and self-esteem (Greene 2017:11). These states of wellbeing can only be developed in the workplace when the person's abilities are used in their job and their personal needs for growth and fulfilment are met (Greene 2017:11). This provides an explanation of why the limited opportunities for career progression of social workers in state hospitals in the Waterberg District hospitals affected participants' experiences of job satisfaction negatively.

RP1 expounded as follows on the complexities of trying to advance one's position as a social worker in the state hospital: *"There isn't much, eerh… opportunity to move up through the ranks in the hospital. It is very hard to up your grade level. Like, I'm a social worker now …grade three. For me to move up I have to become a social work supervisor which is grade four. Unfortunately, such promotions seldom occur. Only when a senior social worker resigns or retires."*

The years of service and job grades of the research participants are presented in the section describing participants' biographical information (see section 4.2 biographical information about research participants). The evidence displayed reflects the limited number of appointments in senior positions that are available to social workers in the Waterberg District state hospitals. Currently, there are nine unfilled social work managers' posts in the state hospitals which have been vacant with no chief social worker having been appointed since the introduction of social workers in state hospitals.

This concern was shared by **RP6**: *"Mhhhm…I've been waiting for ten years so that I can be a supervisor. Social work is just so...so frustrating because no matter what government department you work for. A supervisor post requires ten years' experience before you can apply. Wherever you go is ten years. We are treated is the same, and it is tiring to sit here, every day, with no opportunities for growth…Nothing."*

Participant **RP3** emphasised as follows how powerless social workers in the hospitals were to address the career progression issue that contributed to low job satisfaction: *"It is like you will be a social worker at the same level for your life. You don't show any growth in your career. There is no growth even if you can acquire further education. This means nothing to them. You have to do whatever they say you must do."*

Several psychological theories such as Maslow's Humanistic Psychology, Carl Rogers' Person-Centred Theory and Erikson's 'eight stages of man' highlight the innate desire of the person to move forward towards self-realisation, fulfilment, self-striving because these represent growth and improvement (Corey 2014:161-162). This is applicable within the workplace where employees need to grow and improve professionally. It was for instance found that the need for professional recognition and opportunities for professional growth are opportunities that affect job satisfaction of nurses in multidisciplinary teams (Tambasco et al 2017:147). In addition, it is pointed out that the acquisition of new knowledge and skills in the workplace helps to prevent burnout, stress and poor job dissatisfaction amongst social workers (Calitz et al 2014:162).

Whilst opportunities for participants to advance their social work careers in the state hospitals were scarce, one participant reported that acting in a management position came at a cost to the participant's job satisfaction. **RP7** shared the experience of having acted for three years as the allied professional manager. Acting managerial posts in DoH are rotational in nature

and at first **RP7**, a radiographer and an optometrist took turns serving in the acting allied professions management position for three months at a time. Later **RP7**and the radiographer alternated for six months at a time. The participant explained that -: *"It was so difficult. I was doing two jobs. That's what you have to do. Sometimes I even had to stand in when the Human Resource manager was not there. Filling this managerial role impeded my performance as a social worker and the service I delivered to my patients."* **RP7** went on to explain: ***"****It was hard to fill my managerial tasks and my role as the hospital social worker at the same time. I couldn't really make an appointment with a patient. I couldn't for example say come Wednesday ten o'clock because I didn't know if at ten o'clock on that day I will have to be in a meeting. That was one of the frustrations. Or I could start off with the meeting at eight o'clock, sit there the whole day, and then when I had finished with a very long meeting go back to my office to find patients who had been waiting to see me."*

Staffing of the health sector in Limpopo Province seems to be a major a problem worsened by inadequate human resource information systems that delay the appointment of staff, workforce planning and training. Research pointed out that human resource shortages, poor stewardship and leadership fail to offer continuity of support and resolve problems reported by health professionals (Rispel 2016:20).

The acting positions in the hospitals posed problems for staff. Matters concerning social workers had to be raised several times with management because those in authority did not acknowledge that they had received the complaint previously. This point was illustrated as follows by **RP10**: "*And the issue with our hospital is that a lot of staff get changed quite few times. Even management which causes a breakdown in communication. So, it comes to a point where the people acting in managerial positions say they were not there when something was said, or they didn't hear it when it was said. So, matters never get resolved. They just continue to snowball. They roll and roll and roll, just getting bigger all the time*."

Finally, **RP2** mentioned being frustrated about not being able to access the necessary resources needed to render services effectively. Mention was made about the participant's needs for a telephone, printer, internet connection, transport and training opportunities. **RP2** stated as follows that this impacted negatively on job satisfaction: "*Job satisfaction is poor. You cannot do half a job and feel good when you don't have the resources to do that job properly!"* This is confirmed by the finding that inadequate resourcing is one of the seriously undermining factors that social workers have to deal with in the workplace and that a lack of resources constrains social workers from completing their work goals (Shier & Graham 2013:100).

4.3.1.3 Conclusions of theme one: Participants experiences of job satisfaction working in multidisciplinary teams in state hospitals in the Waterberg District

For some participants there were specific factors which contributed positively to their job satisfaction. However, several participants indicated that their job satisfaction was low and that it was influenced by a lack of support from management, lack of resources, lack of acknowledgement and lack of recognition.

In addition, the issue of remuneration and its relation to job satisfaction, came through very strongly. In the literature, remuneration is described as being closely linked to job satisfaction, individual performance improvement and employee motivation (Martono et al 2018:543) which explains why the experiences of the participants had affected them so badly. It was found that better reimbursement in the workplace creates a conducive atmosphere within hospital work teams (Bartram 2019:395; Dong, Liu & Yang 2021; Granata & Hamilton 2015:17). On the other hand, it was also found that poor remuneration, being expected to perform tasks that were not aligned with their job grades; and poor opportunities for professional development and career progression undermined research participants' job satisfaction (Ambrose-Miller et al 2018:113; Schweitzer, et al 2013:152).

Theme 2 reflects the participants' experiences of hospital organisation and management in state hospitals in the Waterberg District.

4.3.2 THEME 2: PARTICIPANTS' EXPERIENCES OF HOSPITAL ORGANISATION AND MANAGEMENT IN STATE HOSPITALS IN THE WATERBERG DISTRICT

The role and responsibility of social workers in multidisciplinary teams in hospital settings (as incorporated in section 2.3.2.4) are clearly described as conducting bio-psychosocial assessment of the diverse client systems, to identify and develop culturally and contextually suitable interventions to manage physical, psychological and social health challenges by applying relevant models of intervention with client systems which are consistent with appropriate South African legislation, policies and procedures (Minister of Social Development 2020:14).

Against the above background, participants were asked: "How does the hospital organisation and management support and or compromise your ability to fulfil your social work professional obligations?" In responding to this, participants related more negative factors than positive

ones. Their responses are arranged according to the following four subthemes: feeling disrespected and unsupported in the hospital; lack of resources for social work departments; misunderstanding about the role of social work in the multidisciplinary team; and poor relationships between social workers and hospital management. Each of these subthemes are expanded upon and reflect the different perspectives of the participants' responses.

4.3.2.1 SUBTHEME 2.1: Social workers' perceptions of being disrespected and unsupported

Several participants shared that the hospital organisation did not seem to support the role of social workers as much as the social workers expected them to. Working in secondary settings such as a hospital poses certain challenges for social workers because the service social workers render in the hospital is not part of the hospital's core medical business. These challenges are amplified in developing countries where resources are seriously constrained (Malinga & Mupedziswa 2009). It is advised by Agarwal, Brooks and Greenberg (2019:57) that secondary settings that employ social workers must understand the challenges social workers experience and offer them support to fulfil their role in their secondary setting.

It appeared from the participants' statements that they did not feel that the hospital organisation understood their needs nor took their role seriously. Their main concern was that they did not feel supported and respected by the hospital organisation and management for the professional services they rendered. Participants expressed themselves as follows in this regard:

Participant	Excerpts from interviews
RP8	*"It…it is frustrating…. It is frustrating because the hospital environment is not really supportive of social workers."*
RP3	*"They don't deal with our concerns. They don't."*
RP7	***"I** don't think social workers are really acknowledged at all"*
RP5	*"Yes, it is like I'm not regarded as an employee of the department* [DoH], *because even my needs are not being heard by the department"* and *"Ae…. I don't think we are respected. So, we just must do the best that we can. Other than that, there is nothing else we can do. It's not going to change."*
RP10	***"**If they acknowledged me, and my job as a social worker was acknowledged, then why are the important things that I need for me to do my job not being addressed? If I was acknowledged then I would have an office, privacy for my clients. I would then be able to give my clients the dignity that they deserve."*
RP4	**"***Ya…I would say that this problem has been here for a long time. They know our challenges. I doubt that they take them to heart. They just listen…ke gore* [is like] *it goes into the one ear and out of the other ear."*

Participants shared that even when they raised their concerns with hospital management their concerns were seldom followed up and resolved. **RP3**'s remark "*They don't deal with our*

concerns. They don't." suggests that they felt hospital management was not interested in addressing social workers' concerns because no follow-up action materialised. **RP5** added that *"Yes, it is like I'm not regarded as an employee of the department* [DoH], *because even my needs are not being heard by the department"* and *"Ae…. I don't think we are respected. So, we just must do the best that we can. Other than that, there is nothing else we can do. It's not going to change."* Their positions were that it was as if management had closed minds and chose not to take their concerns seriously. In addition, **RP10** pointed out that if their concerns were seriously considered then social workers would have basic resources to protect the privacy and confidentiality of their service users, by stating that "*If they acknowledged me, and my job as a social worker was acknowledged, then why are the important things that I need for me to do my job not being addressed? If I was acknowledged then I would have an office, privacy for my clients. I would then be able to give my clients the dignity that they deserve."* It was clear from **RP4**'s remark that the issue of feeling disrespected and unsupported was a longstanding one. The extract from one of the interviews conducted with them was, **"***Ya…I would say that this problem has been here for a long time. They know our challenges. I doubt that they take them to heart. They just listen…ke gore* [is like] *it goes into the one ear and out of the other ear."* It is pointed out that interdisciplinary collaboration between medical associates and the medical social worker is unequal which reinforces the medical social worker's subordinate status in the health setting (Weiss 2005:5)

Two excerpts pointed to the potential sources of the problem. The responses of **RP2** and **RP5** offer some insight in this regard. The first was the remark made by **RP2** that: *"It's very stupid of my…my…. profession. Social workers themselves don't regard our profession as important. So therefore, others in the hospital don't regard it as reliant and that is why they undermine us".* This sentiment is endorsed by Weiss (2005:10) who recognises the importance of medical social workers asserting their professional status and expanding the clinical role. Similarly, Raniga and Kasiram (2010:271) urge social workers in medical health care settings to be responsible for making themselves more visible, contemplate their image and determine what corrective action they must take to improve their professional status to be taken more seriously by others in the hospital.

According to the second perspective, that of **RP5**'s, *"You see there are certain challenges where you can say ok, I talked to my boss. He tried to solve the problem. But it still happens. You can't fault him. He's taken it further. So, it's not his fault that it is not sorted out."* In this instance, **RP5** makes the point that the acting allied manager they report to does not have power to effect decisions in a workplace dominated by physicians who hold more power. A further statement made by **RP4** overlaps with **RP5**'s perspective. **RP4** explained that they

received support from the allied professional manager, but in his absence the participant's concerns were never addressed: "*But when he is on leave it is a challenge. I think, out of the whole hospital management, he is the only person that…...err…. supports us. Otherwise other management members do not."*

Social workers in the state hospitals in the Waterberg District experienced certain obstacles accessing the support they needed in the hospital. The first was that there were so few social work supervisors and only one chief social worker in the whole Waterberg District. Statistics provided by the Waterberg District Human Resource Department (4 February 2022) indicate that there are nine unfilled social work managers posts in Waterberg District hospitals because they have not been budgeted for. There is one chief social worker's post in the Waterberg District. There are nine unfilled and unbudgeted social work manager's posts. The social workers in hospitals report to managers of different professional disciplines (allied professional managers). Secondly, the chain of communication as determined by the hospital structure was experienced as being inhibiting because those who were in managerial positions did not understand social work and therefore were improperly informed to make decisions in the interest of social work practice. As pointed out, managers who are not qualified social workers fail to address the challenges of social workers in the hospital setting because they do not fully understand their professional operational needs and values (Đinđic, Jovanovic, Đinđic, Jovanovic, Pešic et al 2013:563; Fraher, Richman, Zerden & Lombardi 2010:46). The third contributing factor, as endorsed in the literature, suggests that medical team members hold proportionately more power and authority than the other allied professionals that work in the multidisciplinary teams. As a result, they fail to prioritise the matters that concern social workers (Limon 2018:24; McAuliffe 2009:6; Raniga & Kasiram 2010:206; Weiss 2005:5).

Being the only social worker at a hospital gave rise to the feeling of being unsupported by management. Apropos to this, **RP8** said: *"You know like in district hospitals…You will find that there is only one social worker in the whole hospital!"* Having no social worker to relieve one was tough, as shared by **RP9**: **"***It is tough because when I'm not around, like on leave, there are no services. So, when I come back, I have to start from the day I left* [meaning the tasks allocated in her absence accumulate]. *So I will be tired from the first week of my return…It's like I have to pay for my absence. So, ja, it is tough.*"

RP7 and **RP10** shared the same sentiments of not being acknowledged at their work place as medical social workers. **RP7** viewed their position as follows: *"I don't think social workers are really acknowledged at all."* **RP10** shared that**: "***If they acknowledged me, and my job as a*

social worker was acknowledged, then why are the important things that I need for me to do my job not being addressed? If I was acknowledged then I would have an office, privacy for my clients. I would then be able to give my clients the dignity that they deserve."

Linked to participants feeling undermined and unsupported, was a complaint that hospital management failed to ensure that social workers had access to resources they needed to complete their social work tasks. Their descriptions of lack of resources are discussed next.

4.3.2.2 SUBTHEME 2.2: Lack of resources for social work departments

Studies consistently report that having access to job resources is positively associated with high levels of employee work engagement (Calitz et al 2014:159). In addition to personal resources and social resources that mitigate against work overload and burnout, social workers need tangible resources from the employing organisation such as training to upgrade their professional knowledge, supervision, financial resources and promotional opportunities (Calitz et al 2014:159). Participants raised concerns about the limited resources they had at their disposal in the hospitals where they worked. To get their work done, they had to improvise. This often meant using their personal resources such as their personal computers, internet connection, fax machines, telephone and transport, or approaching others outside the hospital for assistance with these. The following excerpts selected describe how the participants were affected by the hospital managements' failure to provide them with what they needed to fulfil their work obligations:

Participant	Excerpts from interviews
RP2	*"In this district, we don't have resources. Resources are very…. very…. scarce. So, without resources we have to prioritise what services we will offer. This limits our job satisfaction. Sometimes you have to go to visit the patient's family. You end up not going there. Sometimes, as a social worker, you need attend to some cases urgently, but because of lack of resources, cars and everything you end up not being able to manage your cases as you planned."*
RP10	*"If I don't have the resources to do my job then how am I supposed to do my job? if I can't do my job because I am not given the things I need then is my job even respected?"* *"The hospital setup seems to lack sufficient resources to deliver the services they are expected to!"*
RP3	***"****The thing about the hospital management that affects me the most and is most stressful and challenging is the lack of resources we as social workers have to work with. You don't have the tools you need to render services properly. Say you have to print a report….you have to go to the court or somewhere else to print it."*
RP7	***"****Management does not give you the things you ask for because there never is money available. They say the budget is used for other items. We just want basic things to do our jobs like a vehicle, cell phones, aftercare services.…Social workers really are finding it hard here."*
RP6	*"One doesn't have the resources one needs to do your work. Not only me, other social workers too. Things computers, internet and staff. Also, trying to arrange a vehicle is a big issue. For us to get transport to do an outreach or home visit is not simple. We have to book transport at least*

	a day in advance. For every request we have to motivate why we need transport. Eventually they end up providing you with the transport you need. But the other things like computers and printers… I don't know. I have never been allocated a new computer. The printer I have is an old one. It hasn't worked for three years. I don't have a printer. I have to go another office to do my printing. They do not provide us with anything!"

Participants' responses clearly reflect that their poor access to resources prevented them from doing their work properly. As asserted by Shier and Graham (2013:100), failure to access resources compromised their ability to achieve their work goals.

Working in a busy setting made the lack of resources a major stumbling block for **RP2**. **RP2** explained that social workers did not even have the most basic resource, a proper space to confidentially conduct their interviews: "*We have a heavy case load. A heavy case load without resources! We don't even have offices that are conducive to proper counselling!"*

Participants' used their personal resources or sought assistance from outside sources such as the Department of Social Development's offices, or another hospital that was better resourced to ensure they could achieve their work goals. Given the participants' complaints of poor remuneration (see section 4.3.5.1) one assumes that this was an expense they could not afford. **RP1** explained as follows that they did not sit back as a result of not having been provided with the necessary resources to complete their work tasks, but used their own resources or relied on favours from others who had the resources they needed: "*I even spend my own money to get the job done. So, if I need to fax a report somewhere, like a referral and there is no fax machine, there is no email because we cannot access the internet, I just go and do that outside the hospital. I use my own money to do that. Or if there is someone in another office who can assist me, then I will use their resources. Like I often have to send my reports to another hospital that has better resources. I don't even have a fax machine here at this hospital.*" **RP2** adopted the same solution to get the necessary tasks done: "S*ometimes you use your own resources. You use your own car to do your …your own work things."*

Rather than be challenged or delayed by unfinished tasks because of resources not being available, **RP3** too, purchased the resources they to complete the work tasks: *"You don't have a printer, you don't have an email... So, so, you need to go and buy it yourself. If you don't you just sit back and watch the work pile up."* **RP10** confirmed that insufficient resources were allocated to medical social workers to render their medical social work services, such as printers, fax facilities and transport to conduct home visits. **RP10** shared, ***"****If I don't have the resources to do my job then how am I supposed to do my job? if I can't do my job because I*

am not given the things I need then is my job even respected?" "The hospital setup seems to lack sufficient resources to deliver the services they are expected to!"

Factors related to spatial designs and man-made buildings are referred to by the life model l theory, as the physical environment in which the person is situated (Gitterman 2009; Teater 2010:24; Teater 2010). Therefore, the researcher has added participants' discussions about this physical environment under the subtheme lack of resources, because essentially the physical environment is a resource. Practical issues such as having to share offices, the availability of limited private spaces for social workers to interview patients, other team members interrupting social workers' sessions and lack of confidentiality in dealing with patients are the issues linked to limited private spaces that participants complained about. The poor spatial design of the hospitals made it difficult for social workers to render what they considered to be professional services to patients and their families. It is noted that the spatial designs of state hospitals in the Waterberg District are not conducive for social work services (Martin, Nettleton, Buse, Prior & Twigg 2015: 1009).

Four participants related their concerns about not being provided with the necessary private and confidential work spaces in which to conduct interviews with patients and their family members as follows:

Participant	Excerpts from interviews
RP2	"*Because my office doesn't erhh…. doesn't allow much confidentiality and when you work as a social worker you must protect the client' confidentiality. So, the set-up of this office, and other spaces we work in, does not make it easy for us to protect our patients' confidentiality."*
RP3	"*The disturbances we have to deal with! Like if I'm having a patient and the other social worker is having another patient in the same office, you can't work properly. Also, people who pass through the office stare at my patient. You know, those things depress me."*
RP7	*"There is lot of people who enter this office where we are now. This is the clinical support office. When I'm alone in the office I can offer my patients a confidentiality service. But that doesn't happen often. The patient will be sitting there where you are sitting now, crying, or whatever, and then someone comes, knocks and enters."*
RP10	**"***No, we all share the office. Sometimes when I interview a patient the other social worker will be at outreach. If she is not busy outside, she will be present during the whole session. It is frustrating and compromises the patient's privacy. We explain to the patient say we do the same work with patients so they can express themselves freely without risk. But it is not easy and sometimes when the other social worker is doing ward rounds, she will come in and out of the office during the session."*

RP2, **RP3**, **RP7** and **RP10** raised concerns that the hospital organisation and management failed to understand the importance of providing social workers with private and confidential spaces where they could interview patients. Confidentiality is one of the basic principles in

social work (Petrova, Dewing & Camilleri 2016:443) but the social workers were unable to maintain the privacy of their patients when rendering counselling services. Some participants had to share offices and interviewing spaces with other social workers or allied professionals.

In addition to the hospital organisation and management not acknowledging the importance of creating interviewing spaces which protect the privacy and confidentiality of their patients, the spaces social workers were allocated were not free of interruptions. Interruptions are one of the factors that negatively affects work operationalisation (Tambasco et al 2017: 145). Excerpts taken from the interviews with **RP7** and **RP10** illustrate why this was problematic for participants.

RP7 was one of the participants who raised this: *"The patient will be sitting there where you are sitting now, crying, or whatever, and then someone comes, knocks and then enters…Please sign this, or do this". So that is one aspect that I do not like. It makes it difficult to focus on your patient…"* These interruptions did not only happen in **RP7**'s office but also with other social workers. **RP7** said that people within the organisation would call them away from whatever they were doing to attend to matters they considered to be urgent: "*There is always something else that happens that needs your immediate attention, such as you have to run to a meeting, or you are suddenly called to submit a report straightaway!"* These unscheduled demands interrupted their planned work schedules. The interruptions affected **RP10** too, because the participant realised it affected the therapeutic process with patients negatively **RP10 "***No, we all share the office. Sometimes when I interview a patient the other social worker will be at outreach. If she is not busy outside, she will be present during the whole session. It is frustrating and compromises the patient's privacy. We explain to the patient say we do the same work with patients so they can express themselves freely without risk. But it is not easy and sometimes when the other social worker is doing ward rounds, she will come in and out of the office during the session."*

The last factor with regards to the spatial constraint experienced by social workers within the hospital was that their work operations were negatively affected in that social workers sharing office space found it challenging to coordinate their activities. This is confirmed by Tambasco et al (2017:145). **RP6** explained it as follows: *"You have all your things organised in your office. You run around to complete some tasks. When you get back to the office, the person you share the office with is on lunch. You are stuck. You can't do anything. You must wait until they get back. It's things like that that frustrate you."*

It was confirmed by Tambasco et al (2017:146) that when participants could not access the material or resources they needed to do their work, they felt dissatisfied and their quality of life at work dipped. However, as confirmed in the literature, they adapted by making their own plans to find the resources they most needed to restore their work balance (Gitterman & Germain 1976:602; Pike et al 2010:117). The risk of doing this long term is that if unable to sustain their personal efforts to access the environmental resources, the social workers will experience stress which may develop into a crisis. Because hospital funding is directed to medical patient care, social programmes and social work departments are not prioritised when resources are budgeted for (Fraser 2010:27; Kirschbaum 2017:11; Dobríková, et al 2016 85;91). Further factors that could contribute to the lack of resources being allocated to social workers in state hospitals are issues of poor management and underfunding within the state healthcare sector as mentioned in the literature (Delobelle 2013:159; Plaks & Butler 2012:138).

Not all participants were however negatively affected by the hospital organisation and management's dismissive response to the work-based resource needs of social workers. **RP4**'s experience was that the management of the specialist hospital where this participant worked, provided the resources needed to do the job: *"Examples of some of the resources that we have that make it easier for us to do our jobs are air conditioning in both offices, telephones. As you heard, I just called **RP5** to arrange your appointment…. There is a car that I can use for home visits. The management doesn't give us a problem when we need to use the transport. Ya……for now I am satisfied. …. I'm fine."* [laughs and adds] *"But it would be nice to have a few better chairs for patients to sit on in our office."*

Participant **RP10** summarised the second subtheme nicely**:** "*No I'm not being acknowledged. My job of being a social worker is not being acknowledged. If it were, then they would address some of the important things that I need for me to be able to do my job. If I was being acknowledged I will have an office, privacy for my clients, and I will actually be able to give my clients the dignity they deserve."*

In conclusion, participants shared the frustrations that arose because they could not access the resources they needed to complete their professional responsibilities in the hospital setting. Lack of resources such as office space that provided privacy and confidentiality for patient interviews, lack of transport to conduct home visits for case follow-ups; printers, fax machines, cell phones, and computers were mentioned. The poor response from hospital management to address the requests of social work for such resources, led participants to

conclude that the hospital management was not committed to addressing the needs of social workers in the hospital setting. lack of support from hospital management.

The third subtheme of the participants' experiences of hospital organisation and management in state hospitals in the Waterberg District discussed, is the frustration participants suffered because of the poor understanding multidisciplinary team members had about the role of social workers in hospitals.

4.3.2.3 SUBTHEME 2.3: Multidisciplinary team members' poor understanding of the role of social workers

The roles that non-medical team members play in patient care and the hospital are frequently misunderstood in hospitals, particularly the role of social workers (Albrithen & Yalli 2016:132). Shier and Graham (2013:95) note that for social workers based in hospital settings, their professional and workplace expectations often collide in practice and that this impacts negatively on their personal wellbeing. When a social worker's professional expectations have to be adapted to satisfy workplace expectations, one can expect negative consequences such as self-doubt and workplace interpersonal conflict (Shier & Graham 2013:96). If professional and workplace expectations are not aligned, the social worker experiences a poor person-in-environment fit (Teater 2014). This phenomenon was explained as follows by several participants and the excerpts of their interviews illustrate the stress it caused them:

Participant	Excerpts from interviews
RP2	*"The team itself they don't know what you are expected to do. They don't even know what we should be doing, so it makes it difficult for them and for me as a social worker when I don't even know what are my roles in a….in…a multidisciplinary…..So in our hospital setting eerrh… there are no clear roles."*
RP4	***"****The main thing with hospital management is that they don't understand anything about social work, what we need is for them to have a meeting with us so that we can teach…. not to teach but to rather have a briefing session about our roles, duties and so on…...then that's where they will know what resources we need to function in providing medical social work services here."*
RP8	*"Like when you mention social work, they think of those child support maintenance and family issues. They don't want to know what hospital social work is about!"*
RP7	"*As a medical social worker, I don't deal with patients that…...for instance need taxi fare. No, I shouldn't be expected to deliver such services. I should render services like counselling. But they don't seem to want to hear this."*
RP1	"*The government regulations developed for social work are not acknowledged by the hospitals which obstructs you from assisting your patients and giving them a good or reasonable services."*

The other team members' poor understanding of the role of social workers is illustrated as follows by **RP2**: "*The way they don't understand what social work is all about …. ahhh… or*

how we operate! They don't have a clue about how social workers operate." **RP2**'s perception was supported by **RP4** who said: "*I think that that the majority of them do not understand our profession."*

Participants demonstrated how the misconceptions held by other multidisciplinary team members about the role of social workers restricted the types of cases that were referred to hospital social workers. Multidisciplinary teams' members expected social workers to deal with cases that needed transport, residential placements and financial support, and to assist them with it, rather than conducting and assisting patients with psychosocial counselling.

RP4 raised the issue of other team members having a limited understanding of the roles and functions of social workers in the hospital as follows: *"Some members of the multidisciplinary team think the main role of social workers is to help patients apply for social relief and grants or find them suitable accommodation when they are discharged."* **RP8**'s perception of how team members interpreted the social worker's role was similar. The participant's explanation suggested that people were resistant to changing their understanding of the social worker's role in the hospital setting: *"Like when you mention social work, they think of those child support maintenance and family issues. They don't want to know what hospital social work is about!"*

Having to deal with the referrals related to the allocation of practical resources for patients frustrated **RP7** because the participant expected them to know what the social worker's role was: "*As a medical social worker, I don't deal with patients that…..for instance need taxi fare. No, I shouldn't be expected to deliver such services. I should render services like counselling. But they don't seem to want to hear this."* For **RP7**, the issue was more serious. It highlighted the dichotomy between team members' expectations of social workers and the South African welfare policies expectations of social workers. The medical team expected social workers to provide practical help and social relief in place of preventive and empowerment services. Sehlabane (2014:1) recognises social relief as a way of addressing food insecurity, which on its own fails to empower clients. Empowering vulnerable groups is more self-sustaining and developmental in nature (Bassier, Budlender, Zizzamia, Leibbrandt, Ranchhod et 2021:1).

Scholarly views of the challenges faced by social workers in medical settings are presented in Table 2.1. It was noted that the purpose of social work separates social workers from medical experts. Social workers advocate for patient rights, adopt a humanistic approach, uphold cultural sensitivity, and endorse person centred communication, social inclusion and empowerment interventions (Kirschbaum 2017:335). These actions and intentions place

social workers in conflict with their medical counterparts (Carpenter & Platt 1997:337; Kirshbaum 2017:22-24; Dobrikova et al 2016:87; Ambrose-Miller & Ashcroft 2016:101-109).

The extract taken from **RP1**'s interview illustrates this well by explaining that the hospital complied with government regulations appropriate to health care but failed to take into consideration government regulations related to social work. Hence managers would overrule some social work plans worked out for client systems. **RP1** explained this point as follows: "*The government regulations developed for social work are not acknowledged by the hospitals which obstructs you from assisting your patients and giving them a good or reasonable services* [Her reference is about the White Paper for Social Welfare (1997) and the Framework for Social Welfare Services (1997)]. *Due to the restrictions imposed by the hospital management you don't assist your patients in accordance with the welfare policies."*

The transformation of welfare services as informed by the White Paper for Social Welfare and the Framework for Social Welfare Service were discussed in section *2.3.2.2.* The developmental approach advocated by current welfare policies is meant to target previously disadvantaged groups by offering them integrated services that provide a continuum of care to assist them to become socioeconomically independent and self-sufficient. The transformation of social work is meant to happen in health care services as well. Sadly, it is noted that few training opportunities have been given to social workers to facilitate this transition which confirms the research findings (Gedviliene & Didziuliene 2019:259; Beasley, Hardin, Magliocca & Smith 2021:193; Phelan & Kirwan 2020:3532). Hospitals continue to expect their social workers to deliver one on one remedial social relief rather than facilitate the empowerment of client systems at meso- and macro levels (Tshabala 2021:1).

Members of the medical professions are statutorily required to register with the Health Professions Council of South Africa (HPCSA) in terms of the Health Professions Act (Act 56 of 1974), members of the nursing profession with the South African Nursing Council (SANC) in terms of the Nursing Act, 2005 (Act No. 33 of 2005) and members of the allied health professions with the Allied Health Professions Council of South Africa (AHPCSA) in terms of the Allied Health Professions Act 63 of 1982. These professions are regulated by their councils according to their respective acts. Hospital management aligned their work regulations according to the requirements of these councils. Apparently the multidisciplinary team and hospital management overlooked the fact that the social work profession is regulated by the SACSSP) in terms of the Social Service Professions Act (Act 110 of 1978) (Lombard 2015:13) and that social workers are bound by the Code of Conduct developed by the SACSSP for their professional conduct and had failed to take cognisance of the developments in the social

welfare realm. This has severe repercussions on the social workers who are inter alia expected to fulfil mandated continuous professional development (CPD) requirements stipulated by the SACSSP (Lombard 2015:12).

RP7 expressed the following concern in this regard: "*When it comes to CPD meetings, for instance, they cater for the medical professionals and other allied professionals. They forget that we are social workers and need our own continuous professional development around developments in social work. If we tell them that we can't even get points by attending their CPD presentations, they don't understand. It is as if they forget that we do not belong to their council. We are registered with the South African Council for Social Service Professions.*

In conclusion, it is clear that the role of social workers in hospital settings is not clearly understood by both multidisciplinary team members and the hospital management

The fourth and final subtheme addresses participants' experiences of hospital organisation and management, and participants' perceptions of the relationship between social workers and hospital management.

4.3.2.4 SUBTHEME 2.4: Poor relationships between social workers and hospital management

Several participants suggested that their ability to fulfil their social work professional obligations was hampered by the power struggles between social workers and some hospital managers.

Participant	Excerpts from interviews
RP3	"It's not just about policy. It is about people who are in power."
RP6	*"He would not hear me out* [referring to the hospital's chief executive officer]. *I knew that we needed to apply for a pauper's funeral for the child, because that is what we always do in cases like this. But he insisted that I put pressure on the farmer to pay for the child's funeral. I knew what I was doing. I had already approached the farmer. I knew he would not assist and we had to arrange the child's funeral. It has now been three months and the child has still not been buried. The body is still in the hospital mortuary and the farmer doesn't want to meet with me*."
RP7	**"**My point is that politicians are appointed in high posts, not only in hospitals but in all government spheres. So, most of them don't deserve to hold the posts they have been allocated. They are not open to hearing from professionals who are in lower posts than them. They don't want to hear their views about what needs to be done. So that is the reason things are not moving."
RP8	*"I think they are threatened by us. You know that this management only cares about doctors."*

Extensive research concludes that there are many challenging factors that undermine the effective functioning of multidisciplinary teams, such as the unequal status of team members,

competitiveness, domination by those in power, competition for 'patient ownership' and differing value bases (Albrithen & Yalli 2015:131). Ambrose-Miller et al (2016:100) expand upon the power differentials in hospital settings, explaining that they may be overt and covert. Overt power differentials are detected in structural factors in hospital organisation and management such as the models of governance used to place one profession in charge of decision-making above the others and remuneration practices that reward some professions more advantageously than others (Albrithen & Yalli 2015;132). The covert power differentials are more subverted and evident in observations that reflect the degree of collaboration that occurs within the hospital structure (Ambrose-Miller et al 2016:101). Based on the comments of participants it was clear that issues were seldom resolved through collaboration and social workers were made to feel their role in the hospital was a subordinate one.

In discussing the issue of having to deal with people in power, **RP3** gave the example of management deciding that social workers in the hospital were not entitled to their own designated telephone lines in their offices, which meant they had to direct all their calls through the switchboard. This was totally impractical, given their need to make several calls related to patient care and support. Their experience was that decision-making was centralised and not collaborative. **RP3** explained: **"***For us social workers, they make decisions on our behalf. When they go to meetings, they agree on certain things that they expect social workers to do even though it is not something that we can do. We are not engaged; we are not consulted in any way. They will say social workers are expected to do one, two, three, four, and when you check whatever they say you are expected to do, it is not in your scope of practice."* **RP3** later added: *"Yes, is like I'm not regarded as an employee of the department, because even my needs are not being heard by the department, whether I'm guilty or not is none to them."*

The following excerpt from **RP6**'s interview projected an example of what **RP3** had referred to: *"He would not hear me out* [referring to the hospital's chief executive officer]. *I knew that we needed to apply for a pauper's funeral for the child, because that is what we always do in cases like this. But he insisted that I put pressure on the farmer to pay for the child's funeral. I knew what I was doing. I had already approached the farmer. I knew he would not assist and we had to arrange the child's funeral. It has now been three months and the child has still not been buried. The body is still in the hospital mortuary and the farmer doesn't want to meet with me*." In saying this, **RP6** felt professionally disrespected by a senior management official who instructed that **RP6** should act in contradiction to a hospital policy the senior official should have been familiar with.

As previously cited, **RP8**'s perspective was that those in management were not interested in social work, did not understand the mandate of social workers properly and were not willing to change things because they were invested in upholding the status of physicians. The following excerpt from **RP8**'s interview illustrates this perspective: "*The thing is that they do not care about social work. They don't have a clue about it. They don't want to ask about it. I think they are threatened by us. You know that this management only cares about doctors.*"

In mentioning an example of hospital management failing to include social workers in planning patient care, **RP5** further said that: ***"****You find that people err...eerr… refer as you say but then they don't cooperate with you, they will refer a patient. You see the patient. Before you are done with your work, they discharge the patient. You go there…where is so and so? The patient is not there. They discharge him but you are not finished with your work."*

The participants not only felt side-lined, but also felt dictated to by management and were offended that their professional knowledge and experience were disregarded. This is one of the realities of working in what Dane and Simon (1991:208) refer to as a "host organisation". Whilst the article published by the cited authors appears dated, it still aptly explains the power imbalance social workers in hospital settings experience. A 'host organisation' is defined as an arena in which social workers work that is determined and dominated by others who are not social workers. It is emphasised that for social workers committed to serving patients with integrity and who remain committed to the professional value of self-determination, the clash with host organisation leaders who prioritise accountability to their boards of directors and funders, containing costs and attaining organisational goals above client wellbeing, is inevitable (Dane & Simon 1991:208). The cited authors go on to identify the four predictable stresses social workers as resident guests within host settings encounter, namely value discrepancies between themselves and their hosts; being marginalised; social work role ambiguity; and role strain. The poor communication and working relationships result in emotional difficulties, low-self-esteem and burnout (Skjeggestad, Norvoll, Sandal & Gulbrandsen, 2017:432). For social workers to overcome the four stressors, they are urged to decide among themselves what their specific professional identity is, so that they can counteract conflicting and damaging notions about social work and its role (Scholar et al 2014:1012).

There were however also some exceptions to the power struggles mentioned above by participants. Two participants offered the following positive reflections in this regard:

RP7 had a good relationship with management: *"I think I have a good relationship with our management. This is a very small hospital, so everybody knows everybody. So, it is very easy, and we are very accessible. So, it is easy for people to ask one another for help or talk about patients or cases and share ideas. Ya."* According to **RP1**, the managers the participant reported to, were active in resolving the problems reported to them: *"But most of the things they get to sort them out."* In these two instances the positive leadership skills that participants encountered improved their satisfaction (Podolsky, Kini, Darling-Hammond & Bishop 2019:27).

4.3.2.5 Conclusion of theme two: Participants' experiences of the hospital organisation and management

This concludes the findings about participants' experiences of hospital organisation and management in state hospitals in the Waterberg District and how it affected their ability to fulfil their professional obligations. Four subthemes were identified from the interview transcriptions.

The first was that social workers felt disrespected and unsupported in the hospital. The reasons related to this were that participants perceived management as not taking the concerns of social workers seriously; social workers failed to assert their professional status in the hospital setting; social workers felt frustrated about not being managed by qualified social workers and having to report to allied professional managers; and experiences of poor working conditions and work overload that social workers in the hospital endured.

The second subtheme focused on the lack of resources that social work departments in the state hospitals were allocated. In order to adapt to the hospital environment and its dynamics and make sure that they could complete their social work tasks, the social workers improvised, they obtained external sources to assist them, or they used their own personal resources. One of the undermining factors that affected them negatively that they could not manage to resolve, was the special layout of the hospitals which affected the size and number of offices available for social workers to use. Many of the participants indicated that they had to share offices or interview clients in offices where they experienced many interruptions and could not protect the confidentiality and privacy of the patients.

The third subtheme focused on the misunderstanding of the role of social work in the multidisciplinary team. It was evident that different team members failed to grasp the nature of a professional social worker's role in the hospital and its related tasks. It became evident that

social workers were often used as 'janitors' who cleaned up issues that other members in the team did not wish to address. The dichotomy between the multidisciplinary team expectations and social welfare expectations was large and difficult for the social workers in the hospitals to bridge. Furthermore, social workers were frustrated because their professional requirements for CPD were overlooked within the hospitals where they were based.

The fourth subtheme of Theme 2 examined the poor relationships between social workers and hospital management. Some of the power struggles between social workers and management were described and participants' reflections about their exclusion from patient care planning were shared.

Theme three deals with the participants' experiences of challenges encountered while working in multidisciplinary teams in the Waterberg District's hospitals.

4.3.3 THEME 3: CHALLENGES WHILE WORKING IN MULTIDISCIPLINARY TEAMS

The concept 'challenge' as defined by the Collins English Dictionary refers to something that is new and difficult that requires effort and determination to overcome (Collins English Dictionary 2018, Sv "challenges"). The definition of the Cambridge Dictionary's (2018) is similar, it describes the noun as a situation that needs great mental or physical effort to manage, which tests the person's ability (Cambridge Dictionary 2018, Sv "challenges"). These explanations confer with the term 'life stressor' used in the life model theory, as discussed in section 2.4.1.2. Teater (2010:26) defines a life stressor as a life issue that the person perceives to be very demanding that requires more than the personal and environmental resources they have available to manage it. Much has been written about the factors that challenge social workers in working in hospitals as presented in Table 2.1 listing the challenges faced by social workers in medical settings according to different authors.

Amongst the commonly referred to challenges faced by social workers in hospital settings while working in multidisciplinary teams, as documented, are issues such as –

- power imbalances, exclusion, discrimination and exploitation (O'Leary et al 2013:135);
- boundary issues (O'Leary, et al 2013:135);
- limited medical expertise (Beytell 2014:176);
- lack of resources (Limon 2018:28; O'Reilly, Lee, O'Sullivan, Cullen, Kennedy et al 2017);
- poor communication and inter-professional conflict (Limon 2018:29);

- resistance from other team members to change (O'Reilly et al 2017);
- heavy workloads and emotional exhaustion (Limon 2018:29; O'Reilly et al 2017);
- poor leadership and financial mismanagement (Josefsson, Avby, Bäck & Kjellström 2018:411; Hasan 2018:70; Ipsen, Karanika-Murray & Nardelli 2020:2); and
- other systemic determinants (Morely & Cashell 2017:211).

Theme 3 reports on the challenges participants mentioned related to working as social workers in multidisciplinary teams in state hospitals in the Waterberg District. Three subthemes are presented using a selection of descriptions gathered from participants during their interviews, namely about their individual challenges experienced, internal hospital challenges within the multidisciplinary teams, hospital organisation and management; and external challenges encountered outside the hospital.

4.3.3.1 SUBTHEME 3.1: Individual challenges

The bioecological systems approach considers individual factors to be those situated at a micro level. They refer to the person's perceptions of organisational demands and their perceptions of how these impact on their personal sense of wellbeing (Barile et al 2016:658). Challenges affecting participants' perceptions of their self-identity, role clarity, knowledge and expertise and professional values, are some of the experiences situated at a micro level that relate to experiences of social workers in multidisciplinary teams in state hospitals in the Waterberg District, as confirmed by Kirschbaum (2017:8-10). The challenges that affected participants in this study at a micro level related predominantly to the demands of working in multidisciplinary teams in state hospitals, as described by Barile et al (2016:658) and Robinson (2012:18-19).

Some participants described working in multidisciplinary teams in state hospitals as being restrictive. Opportunities for learning new things were described as being limited, career development opportunities as poor, caseloads as heavy, and some participants inferred that they considered themselves to be taken advantage of. Each of these factors is discussed separately.

Participant	Excerpts from interviews
RP1	"*Being situated in a specialised hospital, you don't get to have a lot of different kinds of cases or a lot of different patients. Therefore, you don't gain a lot exposure to different types of cases or different types of problems. You also don't gain experience in the other social work roles that other social workers working in welfare settings get to perform in their institutions. Like you find*

	that most the cases that you have to attend, don't really challenge you. There isn't that much that you learn that you can apply in another social work setting."
RP10	***"**If I'm being acknowledged, my job of being a social worker……my job of being a social worker is being acknowledged then why are some of the important things that I need for me to be able to do my job are not actually being addressed. If I was being acknowledged I will have an office. Privacy for my clients, and actually give….be able to give my clients the dignity that they deserve."*
RP9	*"Ahhh not exactly but what I meant is that I need to know what I should do and what I should not do, but now yes it makes sense because I'm also doing other duties which are not for my grade like I'm the only social worker here, I see patients, I attend meetings and compile monthly statistics and reports which are the responsibilities of the senior grade, so ja, it means I'm not paid for other duties which I should not be performing, you see?"*

- ***Limited opportunities to advance skills and knowledge***

Social work demands professionalism which is achieved when social workers acquire theoretical and other knowledge and expertise in social work practice on an ongoing basis (Wiles 2013:858). Being situated in a secondary setting restricted the participants' obligatory CPD. The following response provided by **RP1** confirms the need for social workers in medical settings to access opportunities to continue developing their professional knowledge and intervention skills: "*Being situated in a specialised hospital, you don't get to have a lot of different kinds of cases or a lot of different patients. Therefore, you don't gain a lot exposure to different type of cases or different types of problems. You also don't gain experience in the other social work roles that other social workers working in welfare settings get to perform in their institutions. Like you find that most the cases that you have to attend, don't really challenge you. There isn't that much that you learn that you can apply in another social work setting."* To emphasise the point, **RP1** repeated this more than once and then concluded, *"You don't get the same experience and training that other social workers get out there."*

Learning opportunities and skill acquisition reduce job stress and improve the quality of a person's work life by increasing the person's cognitive and behavioural capabilities which contribute positively to social workers' attitudes and reduce their anxiety (Ajala 2013:52). As posited by Cohen and Gagin (2005:86) social workers in medical settings need opportunities to enrich their intervention skills, which increase their sense of self-efficacy, motivate them and challenge them to master something new, which is exciting. Ongoing training and development contribute positively to the person's sense of professional identity (Shier & Graham 2013:103; Wiles 2013:858). Seemingly, a strong sense of professional identity is difficult to achieve for social workers when they work in difficult and uncertain environments such as medical settings (Shier & Graham 2013:103). According to **RP1**, the hospital management failed to provide opportunities to maintain and develop the skills needed for the participant to remain viable in the job market, as is also pointed out by Ajala (2013:48).

Linked to limited opportunities for learning something new, were the limited opportunities that the state hospitals in the Waterberg District afforded social workers working in multidisciplinary teams for their career development.

- ***Poor career development***

Limited opportunities for career progression were mentioned in section 4.3.1.1 by three participants, **RP10**, **RP1** and **RP9** when they voiced their negative experiences of job satisfaction. It was concluded that their limited opportunities for career progression lowered their job satisfaction. For the sake of completeness these participants' responses are repeated below. In addition, **RP6** and **RP3** shared their frustrations that there are no opportunities for development and growth as medical social workers hence they are not promoted to senior posts and that the only promotion to the senior post can be considered if the social worker has more than ten years' experience in their current position.

Participant	Excerpts from interviews
RP3	*"For social workers as employees of this department, there is no professional or career development. It is like you will be a social worker at the same level for your life. You don't show any growth in your career. There is no growth even if you can acquire further education. This means nothing to them."*
RP1	*"There isn't much, eerh… opportunity to move up through the ranks in the hospital. It is very hard to up your grade level. Like, I'm a social worker now …grade three. For me to move up I have to become a social work supervisor which is grade four. Unfortunately, such promotions seldom occur. Only when a senior social worker resigns or retires."*
RP6	***"****Mhhhm…I've been waiting for ten years so that I can be a supervisor. Social work is just so...so frustrating because no matter what government department you work for. A supervisor post requires ten years' experience before you can apply. Wherever you go is ten years. We are treated is the same, and it is tiring to sit here, every day, with no opportunities for growth…Nothing."*

The discussion is expanded on here by giving more focus to the importance of career planning as a significant work place factor necessary for employee wellbeing. Ajala (2013:48) provides evidence of studies that conclude that poor compensation and promotional prospects are key sources of dissatisfaction in the workplace. Lack of career planning for social workers in multidisciplinary teams is therefore a negative factor that one assumes will lower job satisfaction. The reverse, career planning, is acknowledged to reassure the employee that their employer is willing to invest in them, provides employees with a chance to plan and manage other aspects of their lives to coincide with their work life, and prepares the employee for a clear promotion track which raises their optimism for their future (Ajala 2013:48). In the instance of this study, the participants clearly expressed concern about the absence of career planning and opportunities for their development and felt dejected because these were overlooked.

The heavy workload experienced by participants in the multidisciplinary teams in state hospitals was another challenge mentioned.

- ***Workload***

Two participants had the following to say about their workloads:

Participant	Excerpts from interviews
RP1	***"****The one challenge that really gets to me, is me working alone here. Neh…I work alone in this institution. So, sometimes you feel like… I don't know whether it should be referred to as workload or what? …But I feel like I carry the social work office on my shoulders "wa bona"* [you see]*."*
RP9	"*I need to know what I should do and what I should not do. But now I have been allocated other duties which are not in line with my grade. I'm the only social worker here. I see patients, I attend meetings and compile monthly statistics and reports which are meant to be the responsibilities of those with more senior grades. So, ja! I'm not paid for other duties which I should not be performing. You see?"*

This issue of emotional pressure associated with having to deal with a high workload and working in isolation were raised by participants again when asked to identify the challenges they experienced in their work setting. **RP1** referred to the realities of working in isolation, because like many others, this participant was the only social worker in the hospital concerned. This led to feelings of being burdened and the participant stated that - ***"****The one challenge that really gets to me, is me working alone here. Neh…I work alone in this institution. So, sometimes you feel like… I don't know whether it should be referred to as workload or what? …But I feel like I carry the social work office on my shoulders "wa bona"* [you see]*."*

Literature endorses **RP1**'s perception of hospital social workers being overloaded. O'Reilly et al (2017) and Limon (2018:21) mention that heavy social work workloads in hospitals stretch resources, dampen motivation and participation in the workplace. Limon (2018:21) adds that increasing paperwork, insufficient time to do their job, and the large number of cases hospital social workers are assigned, are commonly reported stressors that undermine their general wellbeing.

An excerpt from **RP9**'s interview demonstrated that this participant too felt overwhelmed. The source of their stress was multifactorial. **RP9** performed multiple roles, which were not properly clarified, and trying to balance all of these roles was demanding. To make it worse the participant felt demeaned due to being not adequately remunerated for the additional responsibilities and efforts, described as follows: "*I need to know what I should do and what I should not do. But now I have been allocated other duties which are not in line with my grade.*

I'm the only social worker here. I see patients, I attend meetings and compile monthly statistics and reports which are meant to be the responsibilities of those with more senior grades. So, ja! I'm not paid for other duties which I should not be performing. You see?" In addition, being given more senior tasks was not perceived by **RP9** as an opportunity to learn more skills and develop. Participants expected their efforts to be remunerated in some tangible way, as confirmed by Granata & Hamilton and (2015:17).

This concludes the discussion of the individual factors that challenged the research participants. There were clear individual stressors that participants articulated which were associated with their experiences of working in the hospital environment. Poor work and training opportunities meant participants were uncertain about whether their social work skills would remain viable. Career planning of social workers was not taken seriously by the hospital management. Some participants' heavy workloads and the additional responsibilities they fulfilled were not acknowledged. The stressors described made participants feel physically and emotionally drained. Working in multidisciplinary teams was demanding. According to the life model theory, these challenges were responsible for creating a poor fit between social workers and their workplace. In addition, participants mentioned environmental resources that were available to them to mitigate against these challenges, as raised by Teater (2014). Most of the participants were in middle adulthood, which Erikson describes as the life state where adults try to resolve the challenge of generativity versus stagnation (Horner et al 2020:143). It is pointed out that people in this life stage need to feel productive, that they are progressing, instead of being bored, stagnating which leads to their becoming overinvolved with themselves (Horner et al 2020:141).

The next section addresses some of the internal challenges participants faced working within the multidisciplinary team, hospital organisation and management. As explained, the internal challenges that they identified were meso- and macro level factors.

4.3.3.2 SUBTHEME 3.2: Internal challenges within the multidisciplinary team, hospital organisation and management

The internal challenges discussed by participants referred to the tensions that were situated on the meso level, namely the social workers' interactions with other members of the multidisciplinary teams and with line managers. The meso level is that level of the bioecological systems approach that refers to the bidirectional relationships a person has with others (Holosko & Feit 2013:09). The interactions in the workplace are not overly personal, but are usually proximal, occur on a frequent basis and when interactions are positive, provide

support and assistance (Holosko & Feit 2013:10). In the context of a hospital setting, the interactions at a meso level refer to the social worker's interactions with the multidisciplinary team members (Liao et al 2010:9). Robinson's (2012:18-19) interpretation of the meso level in this context includes the medical social worker's relationships with community members, too. The characteristics of positive meso level interactions amongst team members of different disciplines should include collaboration, role clarity, good communication, conflict management skills and respect towards one another (Kirschbaum 2017:20-21; Limon 2018:25; O'Reilly et al 2017). According to Morely and Cashell (2017:208) four critical elements constitute collaborative practice in multidisciplinary teams in health care, namely:

- Coordination - the team members work to meet shared goals.
- Cooperation - team members understand and appreciate the contributions of other team members.
- Shared decision making -that involves negotiation, communication, openness, trust and respectful interactions amongst the team members.
- Partnerships - respectful, open, equitable relationships that are nurtured over time between the different team members.

Many of the challenges social workers experienced at this level referred to factors discussed as part of the participants' experiences of hospital organisation and management in state hospitals in the Waterberg District (see section 4.3.2) with the focus being on the participants' perceptions of being disrespected and unsupported in the hospital; lack of resources allocated to social work departments; poor interdisciplinary relationships; and conflicting professional mandates (see section 4.3.2). The responses participants gave when asked to describe some of the challenges they faced working as social workers in multidisciplinary teams in state hospitals overlap with their responses to being asked what their experiences were of the hospital organisation and management in the state hospitals where they were based.

In focusing on the internal challenges participants experience as members of the multidisciplinary team, with the hospital organisation and with management, their descriptions of their roles as social workers not being understood and social workers not being heard or taken seriously, are presented.

- ***The role of social worker is not understood***

A recurring theme in the literature on social work in hospital settings is that the multidisciplinary teams and management do not understand the role of social work in the hospital setting

(O'Reilly et al 2017). Not having a clear idea of the roles and responsibilities that fellow team members play and have, negatively impacts on the individual team members and patient care (O'Reilly et al 2017). The excerpts taken from the participants' interviews and literature check confirming their experiences, support this statement.

Participant	Excerpts from interviews
RP2	"S*ometimes you find that the team doesn't t know what you are expected to do. They don't, really don't know what your role is! So, this makes it difficult for the team and for me, as the social worker. I don't even know what my roles are in the multidisciplinary team. So, in our hospital setting eerrh… there doesn't seem to be clear roles."*
RP6	*"Ja. They don't even understand the line of referral. Like this case is for the social worker and this one for the psychologist. Eeerrh...Maybe I understand better because I work as a social worker. I know my role and I understand psychology more than them."*
RP5	"*But then sometimes they don't give you that chance to explain your role. They just refer a person to the social worker, and you find it is a problem that does not require your services."*
RP3	"*They expect us to do miracles. You find that they expect you to do something that is beyond your professional duties and your scope of practice. For example, they refer a patient with a medical condition, like diabetes, to a social worker instead of someone who has expert knowledge of diabetes* [implying a member of the allied clinical team such as a dietician or pharmacist]."
RP4	"They refer *like anything to us. If they have a challenge, any social problem regarding a patient, they refer to social worker. And they expect you to do magic. What can I say? …errhh…. Sometimes they will send a patient for a food parcel and as you can see, I don't have food parcels in my office for patients. Department of Social Development deals with food parcels, but still they will refer to us. All the time, they still refer them here and you ask them, "Why do you still refer them here and they say….."It is because you are social worker and so you can do something for them."*
RP7	"*I think that there is a lot of administrative tasks that are not part of the social worker's role. You don't have to be a social worker with a degree to process applications for a pauper's burial. That is admin related. A social worker should not do a pauper's burial. Any admin person can do it."*
RP9	"*I mean firstly there is no clear view of my role, no job description and as a social worker there are certain things like is not my duty to deal with. Like foreign nationals who cannot speak one of our languages. So, when they are stuck with such a case they are treating, then they call me to say they can't communicate with the patient. Eehhh…They have a communication or language barrier. I'm not a translator or a communication officer. So, I just outsource someone from outside. Someone who is from that country. Then the translation happens, and they are happy. What can I do?"*

After commenting about the lack of clarity of the social work role within the multi-disciplinary team, **RP2** said as follows that this impacted negatively on patient care as well: "*Because they don't understand what social workers do or how they operate, you end up only doing half of what you should be doing. You do not get satisfaction because your job is only half done. And at the end of the day, the person suffers because you did not offer them what you could have offered them."* This is confirmed by O'Reilly et al 2017). **RP2** also mentioned that social workers in the state hospitals have jobs that are ambiguous, which prompted them to interpret their roles themselves. This is consistent with the position of Ambrose-Miller et al (2016:105)

that in hospital settings, social workers do not have a clearly stated and measurable purpose in the multidisciplinary team. They urge that social workers must become more proactive in shaping their role in the health setting because if they do not, lack of role clarity will continue and undermine the professional identity of social workers within the multi-disciplinary team (Ambrose-Miller et al 2016:104).

Poor role clarity was mentioned by **RP6**, *"Ja. They don't even understand the line of referral. Like this case is for the social worker and this one for the psychologist. Eeerrh...Maybe I understand better because I work as a social worker. I know my role and I understand psychology more than them."* who indicated that some team members could not differentiate between the role of psychologists and that of social workers. This is confirmed by Albrithen and Yalli (2005:132) who found that the medical professionals do not understand exactly what social workers do in relation to other team members. In addition, **RP7** blamed the hospital management for not understanding social work: *"The main thing with hospital management is that they don't understand anything about social work."*

Sadly, the lack of understanding results in delegating inappropriate tasks to social workers as shared by **RP5**, **RP3**, **RP4**, **RP7** and **RP9**. **RP5** who complained of having cases referred to them that were clearly situated outside the domain of social work. **RP3**, **RP4**, **RP7** and **RP9** provided examples of some of the inappropriate referrals they received from other team members. This included having to educate patients on how to manage their diabetes; arrange food parcels for disadvantaged patients; make application for pauper's funerals; or act as an interpreter during medical consultations. The fact that it is acknowledged that physicians are more inclined to refer tasks to other team members to save their own time (O'Reilly et al 2017) may play a role here. These tasks are the less glamorous tasks which Craig and Muskat (2013:10) note are allocated to social workers in hospital settings, which make them unhappy. The researchers further comment that other professionals avoid these tasks, being confident that the social worker will take care of them (Craig & Muskat 2013:10).

Clarity of team member's roles and responsibilities in multidisciplinary teams is important for developing collaboration and cooperation between team members. Lack of clarity leads to tensions within the inter-professional network (Craig & Muskat 2013:10; Kirschbaum 2017:23). Social workers are mostly affected by role ambiguity because they lack the medical background that other allied professionals in the multidisciplinary team best relate to (O'Reilly et al 2017). Some suggest that the role of social work is not only misunderstood, but also seldom acknowledged by other members of the multidisciplinary team (O'Reilly et al 2017). Limon (2018:24) suggests that this is because mental health is seldom regarded as being as

important as physical health. This becomes difficult for social workers, who contrary to the other disciplines in the team, generally demonstrate respect towards other team members, appreciate their expertise, and are happy to collaborate with them in terms of patient care (Kirschbaum 2017:20).

In conclusion, a lack of clearly delineated responsibilities of social workers working in secondary or host settings, allows other professionals to chip away at many of the traditional social work tasks (Dane & Simon 1991:212). This impacts on the professional identity of social workers within the hospital setting. The outcome of poor role clarity for social workers in host organisations about their tasks and responsibilities, makes them despondent, give up on advocating for their clients, demonstrate less empathy towards the clients and spend more time on 'paper shuffling'. This feeds into the next individual challenge, feeling that their voices are not heard or that they are not taken seriously.

- ***Not being heard or taken seriously***

Participants expressed themselves as follows about not being heard or taken seriously by the other multidisciplinary team members and management:

Participant	Excerpts from interviews
RP1	*"You have to remind people time and again that this is my role, this is not my role."*
RP6	*"It is a bit challenging. Most of the time we try to explain to them to make sure that they understand what we do. We don't fight with them. We just explain to them that we don't do something like this, or it is not our responsibility."*
RP5	"*They just expect you to do as they request. Errhhh…. we do discuss it with them. Actually, we even discuss it with our boss, but it still goes on…and on…on…The same thing will happen over and over again, until we are tired. You end up doing what they ask you to do. You will see the patient because there is no use trying to talk to them."*
RP9	"*We do talk up. I call them, I visit them, only to be told, 'I'm working on it', and then they say that I don't have the power to pressure them because their departments do things their own way."*
RP2	"*So, I can say that eerrhh… we are being undermined. Maybe it's because they don't have any interest in what we have to say."* The participant explained that even when the social workers submitted petitions about their grievances, they were not taken seriously: ***"****So, whatever the petition is that is handed to our management eerrrhhh…. Even when the petition represents the voices of all the social workers, not just me, one individual...our voices are still not heard...are not heard. If I remember correctly, there might have only been one occasion when they addressed our concern, and that was after a very, very, long time… This is unlike the way they treat the concerns of the other professionals in the team."*

Participants felt that the other multidisciplinary team members and management do not hear them, as described in some of the excerpts extracted from the transcribed interviews. The feeling of not being heard was based on two factors: having to repetitively educate other team members about the role of social workers in the hospital; and the dismissive manner in which management responded to work related matters that were raised by social workers.

Several participants shared their frustrations about having to repetitively educate other team members about their roles, without any positive effect. For example, **RP1** stated that: *"You have to remind people time and again that this is my role, this is not my role."* **RP6** explained that social workers try to be patient when team members refer patients for services that are not within the social worker's role: *"It is a bit challenging. Most of the time we try to explain to them to make sure that they understand what we do. We don't fight with them. We just explain to them that we don't do something like this, or it is not our responsibility."* Raising the issue of the misconceptions of the role of social work with the line member also proved unsuccessful. **RP5** shared the following experiences in relation to this: "*They just expect you to do as they request. Errhhh…. we do discuss it with them. Actually, we even discuss it with our boss, but it still goes on…and on…on…The same thing will happen over and over again, until we are tired. You end up doing what they ask you to do. You will see the patient because there is no use trying to talk to them."* To deal with the matter, **RP6** mentioned that the social workers had used staff meetings in trying to raise awareness of the roles of social workers in the hospital: *"Every time when we have meetings, we try to explain. Mmm…we even had a presentation to show that we are responsible with social issues; psychological issues are for the psychologists. But every time you will find that even the experienced doctors who you think will understand, still expect us to do things that do not fall within the social work role."* Scholarly sources confirm this by observing that the delineation of roles in multidisciplinary teams in hospital settings remain physician centred and are based on the medical professionals' interests (O'Reilly et al. 2017).

The second factor that made the participating social workers feel unheard and overlooked within the hospital setting was how the management and hospital organisation responded to the concerns they raised. As indicated below, even when there was evidence that organisational practices interfered in the ability of social work staff to complete their work functions, management did not take their concerns seriously.

An example given by **RP9** was the following: "*We do talk up. I call them, I visit them, only to be told, 'I'm working on it', and then they say that I don't have the power to pressure them because their departments do things their own way."* This example describes the frustration

social workers experience when communication and cooperation break down in the team (O'Reilly et al (2017).

RP2 explained as follows that they felt undermined by others in the hospital who clearly were not interested in the matters that social workers raised: "*So I can say that eerrhh… we are being undermined. Maybe it's because they don't have any interest in what we have to say."* The participant explained that even when the social workers submitted petitions about their grievances, they were not taken seriously: ***"****So, whatever the petition is that is handed to our management eerrrhhh…. Even when the petition represents the voices of all the social workers, not just me, one individual...our voices are still not heard...are not heard. If I remember correctly, there might have only been one occasion when they addressed our concern, and that was after a very, very, long time… This is unlike the way they treat the concerns of the other professionals in the team."*

Researchers confirm the secondary position and minority status of social workers in hospital settings from various angles. Dane and Simon (1991:208) aptly describe the dynamics of social workers situated in secondary social work settings. The authors use the terms "host organisation" and "resident guest" which infer the differential status that social workers experience working in a non-traditional social work setting (Dane & Simon 1991:208). Beddoe (2013:26) makes a similar reference to social workers as the "guest under the benign control of the medical and nursing professions". Being a minority subgroup in an organisation where 85% or more of the employees are linked to the medical profession, is likely to marginalise social workers and allocate them a minority status in the team (Dane & Simon 199:208). The minority status of social workers is further compounded by the discrepancy between the professional mission and values of the host organisation, that is the hospital, and other dominant individuals such as the physicians and nurses, and the values held by social workers (Dane & Simon 1991:209). Minority status is not likely to afford social workers power that allows them to design their work tasks according to their perspectives of how best they can execute the organisational tasks expected of them without compromising their professional and personal perspectives. Such power would also enable social workers to make their needs for resources and recognition more explicit (Ajala 2013:47).

Researchers point out that social workers need respect and acknowledgement, communication, shared responsibility and shared ethics and values from medical colleagues (Albrithen & Yalli 2016:132). As indicated in various excerpts of the interviews above with participants, these requirements were not forthcoming in the current research, according to the participants' responses. Listening is a key task for building resilience and support

(Simpson, Loughran, Lumsden, Mazzocco, Clark et al & Winterbottom 2017:174). Various participants' descriptions referred to already, clearly reflected that they did not feel listened to. When employees are heard and their recommendations regarding how organisational service delivery can be improved are taken seriously enough to be implemented, they thrive (Burris, Detert & Romney 2013:24). Mills, McGregor, Baroutsis, Riele and Hayes (2016:102) concur that employees need to have strong working relationships with the other members in the multidisciplinary teams. This is difficult to achieve in hospitals, given the hospital pressures and the busy nature of work in such a setting (Albrithen & Yalli 2016:132). A collaborative culture in a hospital setting is often determined by the leadership, because formal and informal leadership reinforce collaborations amongst the members (Ambrose-Miller et al 2016:104). Not being heard or listened to reinforced feelings of lower status in the multidisciplinary team which undermined the social workers' r professional identity within the multidisciplinary team. This concluded the discussion of factors related to the interactions that participants experienced at a meso level. **RP2***"So, whatever the petition is that is handed to our management eerrrhhh…. Even when the petition represents the voices of all the social workers, not just me, one individual...our voices are still not heard...are not heard. If I remember correctly, there might have only been one occasion when they addressed our concern, and that was after a very, very, long time… This is unlike the way they treat the concerns of the other professionals in the team."*

With reference to the internal challenges within the multidisciplinary team, hospital organisation and management, the descriptions by the participants portray issues of poor remuneration, heavy workloads, poor career planning, limited resources and poor spatial arrangements for social workers in the hospital. The exo level matters related to the context in which the participants operated (Krishnan 2010:8). Their interactions at this level were distal and as social workers they had limited recourse to change their working environment (Krishnan 2010:372). The participants were underrepresented at managerial level and most decisions were made by the DoH structures and DWD at provincial and national levels. This theme is discussed in the next subtheme as external challenges that constricted social workers from fulfilling their professional obligations and duties (Liao et al 2010:9). This section highlights the macro level stressors that impacted on the research participants.

4.3.3.3 SUBTHEME 3.3: External challenges

It is widely recognised that health care delivery is affected by many challenges situated outside the hospital, at a macro level which generates work stress for social workers based in hospital settings (Robinson 2012:18-20). Changes in demographics that affect health needs, persistent

health inequalities and increasing financial constraints are some examples (Robinson 2012:18). Robinson's (2012:18) position is supported by Morely and Cashell (2017: 211) who assert that there are many systemic factors that are risk factors for social workers situated in a hospital context. Some that they mention are compensation schemes, professional practice regulations, institutional policies and the larger physical context in which the health system is situated.

External factors identified by participants as challenges and described in this study, include politics, policies and centralised power that rest within the Departments of Health and Social Development at provincial and national levels; a poor network of support services needed for patient recovery and wellbeing, the influx of foreigners into the Limpopo Province; and the Coronavirus pandemic. The first topic discussed addresses participants' expressed sentiments regarding politics, policies and centralised power held by the national and provincial DoH.

- ***Politics, policies and the centralized power resting within the Departments of Health and Social Development***

One of the challenges that social workers face is that policy makers continuously modify their roles in accordance with the government's agenda (Shier & Graham 2013:101). This impacts on social workers in two ways. Firstly, they are resident guests of a host organisation that is constituted mainly of medical professionals and the setting is mostly governed by medical legislation and policies that are related to health care and the delivery of health care services. Secondly, social workers are obliged to satisfy the mandated expectations of their own professional body. In other words, social workers may find themselves trying to wear two different professional caps, designed by two different professional bodies. As indicated, social workers register with the SACSSP, whilst medical professionals register with the Health Professions Council of South Africa (HPCSA) and nurses with the South African Nursing Council (SANC). The SACSSP is a statutory body appointed and elected in terms of the Social Service Professions Act 110 of 1978 (the Act). The role of this council is an authoritative one that determines, guides and directs welfare services within the structure of social service professions in South Africa. The HPCSA is a statutory body, appointed and regulated by the Health Professions Act 56 of 1974 to protect the public and provide professional guidelines for their affiliated members (Health Professions Council of South Africa 2022). Both professional councils share the same objectives (Medical and nursing Protection 2022; SACSSP 2022), namely to:

- set minimum standards for the training and practice of the members of the professions registered with them;
- discipline those members of the professions registered with them who behave improperly and or unprofessionally;
- regulate and monitor the compulsory requirements for continuing professional development for registered members and to ensure that the training institutions meet their required standards;
- set professional and ethical standards and issue guidelines for practitioners registered with them to follow; and
- take policy resolutions and formulate them into guidelines for the professional practice of those who fall under their auspices.

The two acts provide different guidelines for the medical, nurses and social professional groups (Chung, Feldacker, LLiffe, Pintye, Michael et al 2017:3; Abdullah 2015:44). Finding themselves in a setting where medical personnel significantly outnumber social work personnel, social workers find that hospital operations and practices are mostly regulated by the medical acts, policies and guidelines and the social work professional mandate is overshadowed by them. Social workers are left to themselves to adapt the requirements of social work professional practice (Leach et al 2017:116) to create a goodness of fit with the hospital's medical requirements.

Participants expressed their views and experiences about the politics, policies and the centralised power resting within the Departments of Health and Social Development as follows:

Participant	Excerpts from interviews
RP1	"*I think sometimes when the government regulations for social workers are not in place in the hospital, you are obstructed from assisting your patients and giving them a good and better service."*
RP7	"*The highest hospital managerial posts are political posts, I'm sorry to say! So those people have political influence and make recommendations to the government before they even take out recommendations into consideration. They have no clue about the internal resources we need, but they don't make time to liaise with us. That is not done. So, it is political. When they make requests to the provincial and national management levels the government provides! We don't have the power to force them to address our needs, unfortunately."*
RP9	*"Treasury is the one that approves the budget. What should happen is that we send a request for more posts to them. With the motivation we provide they should approve the additional posts. But you hear our managers say that they sent their budgets to treasury motivating the need to hire more staff, but treasury did not approve it. So, the problem lies at a national level, not here in our hospital or district. Treasury is the one that rejects our budget."*

A participant explained how the White Paper for Social Welfare (South Africa 1997) and the Framework for Social Welfare Services (Department of Social Development 2013) were overlooked in social work practice in hospital settings. As a result **RP1** described as follows that services social workers rendered in the hospital had failed to be modified to incorporate the advocated developmental approach in service delivery which was to the detriment of patients: "*I think sometimes when the government regulations for social workers are not in place in the hospital, you are obstructed from assisting your patients and giving them a good and better service"* [referring to health policies failing to give consideration to the White Paper for Social Welfare 1997].

Being a resident 'guest' in the medical host organisation, posed a further dilemma for social workers based in the hospital. **RP1** pointed out that social workers were not considered to be part of the HPCSA.

RP1 felt social workers in hospital settings were seldom updated about policy developments within both the health sector and the welfare sector, by stating that: "*Most of the time we are not included in the communications that comes to the hospital. It's like we are not recognised as health practitioners even though we work within the health environment. So, who is supposed to recognise us? You find out that social development offers trainings for their social development social workers, but they don't include us, even though we are a government department. So, you ask yourself, 'if social development seems to forget about us and the health department also seems to forget about us, then who will address the development needs of hospital social workers? Who will try to find out what their challenges are?"* As mentioned previously (see 4.3.3), social workers need and are required to ensure their continued professional development (CPD) to remain viable and reliant within the social work profession, therefore like all professionals, social workers require ongoing capacity development (Ajala 2013:48).

In addition, some participants eluded to some of the political agendas that undermined the delivery of services in the state hospitals in the Waterberg District. Rispel (2016:17), after analysing the progress and fault lines of health sector transformation in South Africa, identified three fault lines that undermine transformation of health services in South Africa, namely tolerance of incompetence together with management and governance failures, the lack of a fully functional district health system, and the inability to deal positively with the health care crisis. The following excerpts from **RP7** and **RP9**'s interviews suggest that all three of these fault lines played a role in the frustrations of social workers in the state hospitals in the Waterberg District:

RP7 explained: "*The highest hospital managerial posts are political posts, I'm sorry to say! So those people have political influence and make recommendations to the government before they even take our recommendations into consideration. They have no clue about the internal resources we need, but they don't make time to liaise with us. That is not done. So, it is political. When they make requests to the provincial and national management levels the government provides! We don't have the power to force them to address our needs, unfortunately."* In a previous statement, **RP7** accused those in top managerial positions in the state hospitals as wielding power over those with lower status, which hampered positive transformation in the hospitals.

RP9's perspective was that the district health system was not functional because of the centralisation of power and resource allocations. This compounded the workforce crisis that social workers in state hospitals in the Waterberg District experienced, as follows: *"Treasury is the one that approves the budget. What should happen is that we send a request for more posts to them. With the motivation we provide they should approve the additional posts. But you hear our managers say that they sent their budgets to treasury motivating the need to hire more staff, but treasury did not approve it. So, the problem lies at a national level, not here in our hospital or district. Treasury is the one that rejects our budget."*

It is alleged that South African governance is decentralised and lacking stewardship, which is responsible for the disorganised health care structure and fractious political leadership responsible for poor health services (Conmy 2018:3). The examples provided by **RP9** and **RP7** suggest that their frustrations working in the hospital were that the leadership was poor, and management decisions were top down, and in some respect, determined by political allegiances within the health care departments.

In conclusion, the medical dominance of multidisciplinary teams remains, and services and programmes of social workers continue to be mediated via third parties in hospital settings (Beddoe 2011:29). In this regard, O'Reilly et al (2017) suggest that physicians are the main mediators who allocate social workers their roles and responsibilities. The low number of social workers based in multidisciplinary teams in state hospitals in the Waterberg District explain why the medical policies and practice requirements were more dominant. Being the 'resident guest' in the hospital setting offered some insight as to why the host organisation (the hospital) overlooked the allocation of manpower and training resources for social workers (Beddoe 2011:26; Dane & Simon 1991:2010). Politics, policies and the centralised power of national and provincial departments of Health and Social Development offer some explanation of why

the participants' experienced being marginalised and powerless in the workplace. Some of the professional expectations that social workers had of themselves were difficult to reconcile with the roles they were allocated by the multidisciplinary team and hospital management which added to their frustrations (Shier & Grahan 2013:99).

The next issue raised addresses the lack of community-based resources to augment patient support, recovery and rehabilitation.

- ***Lack of community-based resources for patients and their families***

Participants shared their challenge of the dwindling community resources for patients and their families in the Waterberg District.

Participant	Excerpts from interviews
RP9	*"At least in other countries there are resources. When a person is abused, you take them to a victim empowerment centre. In other countries, they have centres for different social issues. If a child is being neglected in the United Kingdom, they have centres that provide different resources and services for the child. If we had that, it would be much easier."* *"So there are no resources. Like our roles, our work roles, are not clear in whatever setting or department we work in. We all have to offer general social work services."*
RP1	"*Some of the cases you have to refer externally, and then you don't get your feedback report timeously, so that affects you and the patient."* "*You expect to receive feedback from the other social workers outside. But often they don't have resources, so they can't do their investigations or interventions. This takes time. I don't get a quick response from them."* *"When you refer to maybe Social Development it takes a long time for them to attend to your referral. If you were handling the case, you would be able to assist the patient much quicker."*
RP7	*"Mmmm I remember, a year or year or two ago, we had a lot of problems with mental health care, especially in the Lephalale area. We struggled to get help for those who suffered mental illnesses and needed support services."* "*Ahhhmmmm…...I think that the other area where we struggled to find help for patients was substance abuse, ya…. I don't even know if Seshego is functioning* [referring to the rehabilitation centre for substance abuse]. *I still don't know if they have managed to get someone in Seshego to deal with problems of substance abuse."*
RP9	*Ehhhh…. For example, we…we…we have I think only one registered old age home here in this town, and then besides that, the other resources are far from us, like a place of safety. I think we have one in this District. So, it becomes a challenge when we want to assist the client or patient. For example, if you have a mentally challenged patient whose family is rejecting them, and you have to find them a place to stay, it is a problem. The resources that are available are limited. Well, actually, it is like they are not there at all."*
RP6	"*Ja, ja, you can see she is trying by all means not to go home because there is no food at home. The patient shared that her mother doesn't buy food. When you check on the file, the only source of income the mother has, is the child support grant for the two children, which is seven hundred rand. The mother is not working, and the mother is an alcoholic."*

	"*You cannot feed and care for a family of three or four on only eight hundred rand. So, I think the government must provide food parcels to supplement the grants. The childcare grant is not enough."*

Social workers in health care settings are recognised as resource brokers or referral personnel (Shier & Graham 2013:102) due to their in-depth knowledge of community resources to augment patient support, recovery and rehabilitation when they leave the hospital (Demeco, Marotta, Barletta, Pino, Marinaro et al 2020:3; Keefe, Geron & Enguidanos 2009:582). A central role played by social workers in the hospital is to arrange patient discharge, patient long-term care planning, and identify community-based services and resources to support the patient's rehabilitation (Demeco, Marotta, Barletta, Pino, Marinaro et al 2020:3; Keefe et al 2009:586). Ideally social workers should be able to link patients and or their families with a basket of community resources that will offer the patient and family practical help and support to advance their recovery and contribute to their long-term wellness.

Kitchen and Brook (2005:11) offer details of the different kinds of community based resources hospital patients and their families may need to access, such as home-help services for example home-based carers who offer basic nursing care; community support services which offer programmes including parenting programmes, early childhood development programmes, mental health support groups, domestic violence education; transportation services; regulatory agencies who address matters such as rape, domestic violence, child abuse and endangerment; government agencies for grants, housing subsidies, workmen's compensation, unemployment benefits and sheltered employment; Home Affairs for identity documents and registrations of births, deaths and marriages; community physicians or primary health clinics for ongoing patient treatment and monitoring; social relief services for food parcels, baby formula and shelter; and sub-speciality social work services inter alia for marriage counselling and substance abuse. These community resources are sorely lacking in underdeveloped communities (Ammendola et al 2020:3). The participants' storylines reflected that many of these services were no longer accessible for patients in their communities which was problematic in terms of ensuring patients received the services they needed to support their physical recovery.

Skhosana (2020:114) notes that with the downward turn of the economy, human service organisations have struggled to survive. Funding cuts from donors, and reduced subsidies from the Department of Social Development have seen an increase in staff resignations and retrenchments, budget cuts, cut-backs on services and programmes, and some organisations, even closing. The participants' responses clearly reflected those resources in the Waterberg

District had decreased which meant that their role as resource broker was severely hampered, as described by Kitchen and (Brook 2005:11). As inter alia described below, long waiting lists for appointments for clients to see DSD social workers, slow investigation turnaround times, scarce sub-speciality social services such as family counselling or substance abuse assistance provided by rehabilitation organisations, were mentioned by participants in this regard.

When discussing the difficulty of accessing social work services for patients outside the hospital, **RP9** explained that the range of social welfare services available was poor, and that it was difficult to access social worker services because of the social work shortage. This made their role of referral broker very difficult. **RP9** compared social work services offered in South Africa with those of other countries such as the United Kingdom as follows: *"At least in other countries there are resources. When a person is abused, you take them to a victim empowerment centre. In other countries, they have centres for different social issues. If a child is being neglected in the United Kingdom, they have centres that provide different resources and services for the child. If we had that, it would be much easier."* **RP9**'s storyline infers that the adoption of the residual welfare model in South Africa has reduced the community-based support services needed by patients and their families. The participant then explains their experiences of the practicalities of the residual approach in social work by mentioning the following: *"So there are no resources. Like our roles, our work roles, are not clear in whatever setting or department we work in. We all have to offer general social work services."*

The difference between the residual and institutional models of social work is explained by Melendez (2018). According to the author, the residual model motivates that the state should prioritise attending to disadvantaged people and that they should only provide social welfare as a last measure safety net for those who do not have the means to be helped (Melendez 2018). The government intervenes and provides some income relief, but only until the beneficiaries become self-reliant again. In comparison, the institutional model holds that all people, irrespective of their means are entitled to a range of services that are needed for their wellbeing. Government assistance is considered a natural and normal occurrence in all people's lives, irrespective of socio-economic circumstances. **RP9** explained how the residual approach to welfare services had affected the scope of services that were available to patients and their families in the district where she worked: *"You just get to see social workers when there is no food, or when your house burns down. They send social workers then. You understand?"* **RP9** then described the problems of trying to access appointments for their clients to see community based social workers and used the Department of Social Development as an example: *"Even when you call Department of Social Development, they*

have the same challenge of staff shortage. If you go to their offices to refer a case they will say, 'There are only two of us here today'. Where are the others? We are told that they can only attend to our referral the next day."

Delays in receiving feedback from external service providers was a further challenge associated with the poor network of community resources that were available to patients and their families in the Waterberg District. **RP1**'s excerpt illustrates this: "S*ome of the cases you have to refer externally, and then you don't get your feedback report timeously, so that affects you and the patient."* **RP1** went on to explain that social work services in their area were often disrupted by the lack of resources that the community-based organisation suffered such as the unavailability of internet connection and transport. According to the participant's response, the lack of resources required, extended the turnaround time for the community based social work organisations to offer feedback about the cases that had been referred to them: "*You expect to receive feedback from the other social workers outside. But often they don't have resources, so they can't do their investigations or interventions. This takes time. I don't get a quick response from them."*

RP1 further complained as follows about the long turnaround time of the cases referred to the Department of Social Development which affected the patient: *"When you refer to maybe Social Development it takes a long time for them to attend to your referral. If you were handling the case, you would be able to assist the patient much quicker."* Read in conjunction with **RP9**'s experiences of the Department of Social Development, it seems as though staff shortages and lack of resources contributed to the delay in the services that DSD rendered.

Other examples given by participants reflected their frustrations associated with the lack of community-based resources for patients and their families, which were described as follows:

RP7 spoke of the long period that it took and the difficulties of accessing mental health care for their patients: *"Mmmm I remember, a year or year or two ago, we had a lot of problems with mental health care, especially in the Lephalale area. We struggled to get help for those who suffered mental illnesses and needed support services."* **RP7**also shared the problem of referring patients for specialised treatment for substance abuse as follows: "*Ahhhmmmm…...I think that the other area where we struggled to find help for patients was substance abuse, ya…. I don't even know if Seshego is functioning* [referring to the rehabilitation centre for substance abuse]. *I still don't know if they have managed to get someone in Seshego to deal with problems of substance abuse."* The excerpts that were taken from **RP7**'s interview appear to be related to the shortage of social work staff, lack of specialised services for mental health

assistance and substance abuse rehabilitation, and the challenge of trying to access services in rural areas. A report published by the United Nations (2021) indicates that access to basic services and opportunities is poor when people live in rural areas, and or on the peripheries of urban areas. Those affected the most, are disadvantaged persons, especially women.

The lack of social services available in the Waterberg District was further highlighted as follows by **RP9**: **"***Ehhhh…. For example, we…we…we have I think only one registered old age home here in this town, and then besides that, the other resources are far from us, like a place of safety. I think we have one in this District. So, it becomes a challenge when we want to assist the client or patient. For example, if you have a mentally challenged patient whose family is rejecting them, and you have to find them a place to stay, it is a problem. The resources that are available are limited. Well, actually, it is like they are not there at all."*

Whilst social services appeared to be limited, the demand for it has increased. This point was made by **RP6** who gave an example of the kinds of cases that the social workers in the hospital were being inundated with. **RP6** shared having to deal with the case of a young patient who was referred because of not having wanted to be discharged: "*Ja, ja, you can see she is trying by all means not to go home because there is no food at home. The patient shared that her mother doesn't buy food. When you check on the file, the only source of income the mother has, is the child support grant for the two children, which is seven hundred rand. The mother is not working, and the mother is an alcoholic."* **RP6** motivated that in cases such as this, food parcels should be provided by the government: "*You cannot feed and care for a family of three or four on only eight hundred rand. So, I think the government must provide food parcels to supplement the grants. The childcare grant is not enough."*

Previous statements made by other participants reported the many referrals they received from team members for food parcels and social relief. This suggests that the socioeconomic circumstances of patients receiving hospital treatment was poor. Mention was already made that there was an increase in the number of South Africans suffering food poverty (see section 2.3.4.4), with the Limpopo Province reflecting the second highest poverty levels amongst the nine South African provinces. Referrals to the Social Work Department in the Waterberg District hospitals were usually for shelter accommodation, applications for social grants, social relief and transport. The growing number of referrals placed additional demands on the social workers who did not have a network of community-based organisations who could offer the practical resources that patients required. The resources that the social workers could access for their patients are confirmed as having been a far cry from the referral resources that Kitchen and Brook (2005:11) advocate.

In conclusion, a combination of factors seemed to be responsible for the lack of social services that the participants could source for patients, including the reduction of specialised welfare services associated with the residual welfare model advocated by the White Paper for Social Welfare (South Africa 1997), shortages of social work staff, lack of funding for social services, poorly resourced welfare organisations, a growing demand for food parcels and social relief and the challenge of accessing resources for those living in rural areas were the most present.

The impact of the influx of foreign nationals in Limpopo Province is discussed next in terms of how this phenomenon challenged the social workers based in the multidisciplinary teams in state hospitals in the Waterberg District.

- ***The influx of foreign nationals into Limpopo Province***

It is asserted that the influx of foreign nationals into South Africa has created an additional burden for the health care system in South Africa, particularly within the Limpopo Province (Ramathetje & Mtapuri 2017:579; Vanyoro 2019). Many foreign nationals who settle in Limpopo Province originate from Zimbabwe, Mozambique, Malawi, Congo and Nigeria. Some are legal immigrants and others are illegal. It is difficult to estimate the number of illegal foreign nationals because they try to remain hidden to protect themselves from being deported (Ramathetje & Mtapuri 2017:575). Those classified as legal foreign nationals are entitled to governmental provisions and services such as electricity, tap water, hospital clinics and police services, but not to RDP housing (Ramathetje & Mtapuri 2017:579).

The struggle to access healthcare in South Africa affects both South African nationals and foreign nationals alike (Vanyoro 2019; Vearey, Modisenyane & Hunter-Adams 2017:89). The problem is attributed to general shortages of doctors and nurses, and a range of issues that challenge state hospitals which include high bed occupancy; high workload; low staff morale; and the drain on health care resources caused by the HIV pandemic (Vanyoro 2019). However, others argue that the challenge to access health services is much greater for foreign, particularly illegal foreign nationals. Research conducted by Vanyoro et al (2017:91) reported that the most common issues that made it difficult for foreign nationals in the Limpopo Province to access health care services, were related to their not having the correct documentation, their inability to speak one of the South African native languages and discrimination by health care providers. Vanyoro (2019) adds that healthcare providers within South Africa are bound by institutional, bureaucratic and policy regulations. Some of the existing policies and programmes for managing communicable and infectious diseases dictate that foreign nationals should not benefit from them (Vanyoro 2019), despite the increase in communicable

diseases and non-communicable disease being associated with internal and cross border migration movements of South African nationals and foreign nationals (Vanyoro et al 2017:89).

Against this backdrop of information, the following experiences of the research participants demonstrate how the influx of foreign nationals, particularly those without proper documentation contributed to the challenges social workers faced working in the state hospitals in the Waterberg District.

Participant	Excerpt from interviews
RP8	"*He is the employer. He can only pay a person at month end. It's the same for me where I work. I only get paid month end. When your cousin dies do you think the Department will give you money to bury your cousin? Naa! I wrote a report for the couple about the problems they had had with the COVID-19 restrictions and gave the reasons why they were not able to work so that they could be granted a pauper's funeral to bury their child. They didn't have the money. They were not being paid for all the time that the COVID regulations forced to stay at home."*
RP7	"*Remember, where Lephalale town is situated, there is a border to Botswana and Zimbabwe there. So, we have a lot of migrant workers. So, people come here well, but with time they get very sick or die here. They may need support or care, but they have no family members. They are not from here, but from Zimbabwe. Or maybe their baby dies here. The parents leave the body in a mortuary and run away to Zimbabwe. We get cases like that. The social worker is expected to trace them."*
RP9	"*Mmmm you know most of our patients come from other countries. Aahhh… Zimbabwe, Mozambique and Malawi mostly. Some have worked on the mines and have lost their jobs and have nothing…absolutely nothing… So, when they get too sick, they are brought here. And that's where the problem worsens. Firstly, they don't have money…...You find that their girlfriends left them after they lost their jobs. So, looking for their relatives is quite a challenge. Some of them are lucky and they manage to get a job on the farms after losing their jobs on the mines. So, working with them* (referring to the foreign nationals) *is always a challenge, unlike dealing with the people who are from around here."*

The first challenge that was raised by a participant was that discriminatory attitudes of some hospital personnel made it difficult for foreign nationals to receive the services they were entitled to receive. **RP8** provided the example of having been instructed by a hospital manager to persuade a farmer who had employed a husband and wife as day labourers' whose child had died, to advance their wages to enable them to pay for their child's body to be removed from the hospital mortuary. The child died during the first wave of COVID-19 when South Africa was at level five lock-down. Under the regulations at that time, the parents were unable to work, which meant they did not receive any wages for that period. **RP8** suspected that because the couple were Zimbabweans, the hospital manager did not want to approve their application for a pauper's funeral to bury the child. Consequently, the child's body remained in the hospital mortuary for several months. To appease the hospital manager, **RP8** visited the farmer, who would not assist in this regard: "*He is the employer. He can only pay a person at month end. It's the same for me where I work. I only get paid month end. When your cousin dies do you*

think the Department will give you money to bury your cousin? Naa! I wrote a report for the couple about the problems they had had with the COVID-19 restrictions and gave the reasons why they were not able to work so that they could be granted a pauper's funeral to bury their child. They didn't have the money. They were not being paid for all the time that the COVID regulations forced to stay at home."

The storyline suggests that **RP8** was frustrated by the manager expecting that the case be addressed in a way that conflicted with professional and personal expectations. The participant wanted to manage the couple's dilemma in a respectful manner and ensure that their dignity and rights were upheld (Carpenter & Platt 1997:344 Holosko et al 2013:11). Beddoe (2011:35) warns that for those social workers who work in a medical setting, they must prepare themselves for the times they will be challenged when they try to uphold their professional ideal of social justice.

The second issue that participants mentioned related to the challenges social workers faced when undocumented foreign nationals were referred to them, was that as social workers in the hospital setting, other team members expected them to "clean up", "deal with the unpleasant things", "the left-over problems such as finding the families of a dead person without proper identification" as described by Craig and Muskat (2013:10). Two participants provided examples of having had to "clean up" and "deal with the left-over problems".

The first was **RP7** who described the situation well: "*Remember, where Lephalale town is situated, there is a border to Botswana and Zimbabwe there. So, we have a lot of migrant workers. So, people come here well, but with time they get very sick or die here. They may need support or care, but they have no family members. They are not from here, but from Zimbabwe. Or maybe their baby dies here. The parents leave the body in a mortuary and run away to Zimbabwe. We get cases like that. The social worker is expected to trace them."* This is confirmed by Vanyoro et al (2017: 91) reporting that in many instances foreign nationals arrive healthy, having been accustomed to healthier diets and lifestyles before their migration. Unfortunately, over time, the health status of foreign national migrants joins that of South Africa's health population. In many instances their health deteriorates to such an extent that they are too sick to work and must return to their home country.

RP9's story line illustrates the issue of being left to "clean up" in one of the cases allocated to the participant: "*Mmmm you know most of our patients come from other countries. Aahhh… Zimbabwe, Mozambique and Malawi mostly. Some have worked on the mines and have lost their jobs and have nothing…absolutely nothing… So, when they get too sick, they are brought*

here. And that's where the problem worsens. Firstly, they don't have money…...You find that their girlfriends left them after they lost their jobs. So, looking for their relatives is quite a challenge. Some of them are lucky and they manage to get a job on the farms after losing their jobs on the mines. So, working with them [referring to the foreign nationals] *is always a challenge, unlike dealing with the people who are from around here."*

The language barrier experienced by health care professionals in the Waterberg District was also mentioned. Many of the foreign nationals who come for medical treatment speak only Swahili, French, Portuguese or Chewa (Vanyoro 2019). Staff and local patients try to work together to make sure that foreign nationals are understood by the medical team and achieve this by using informal interpreters, co-workers or patients who are fluent in these languages (Fatahi & Krupic 2016:61; Vanyoro 2019). In the hospitals where the research participants were based, social workers were expected to be the mediators of the informal interpretive services (Steyn 2015:18) as discussed (see 4.3.3).

It is recognised that this is a common issue that social workers in Nigerian hospitals must contend with. Social workers must carry out comprehensive social investigations to trace the families of foreign nationals who have been abandoned (Fatahi & Krupic 2016:61). Section 27 of the Bill of Rights states that all the people, not only South African nationals, are fully entitled to emergency medical care services (Crush & Tawodzera 2014:658). It appears that illegal foreign national's place additional strain when in need of social relief (SRD) on the already burdened social workers in state hospitals in the Waterberg District based on the experiences the social work participants shared. Some argue that unregulated migration in a developing country like South Africa with limited health care resources may lead to a total collapse of the health care systems (Castro-Palaganas, Spitzer, Kabamalan, Sanchez, Caricativo et al 2017:1).

- ***COVID-19 pandemic***

Some of the participants in this study shared that COVID-19 was one of the challenges that had affected their ability to carry out their professional mandate in the state hospitals in the Waterberg District as discussed here. The COVID-19 pandemic forced the Government to declare a State of Disaster in South African on 27 March 2020 that required hospital priorities and work practices to be redefined (Willan et al 2020:301). COVID-19 made it very difficult for social workers to fully exercise their social work duties (Cai et al 2020b:301; Willan et al 2020:1). Participants expressed themselves as follows in this regard:

Participant	Excerpt from interviews
RP1	"*And then we heard that our institution was now identified as an isolation facility for COVID-19. So, the wards that were used for our hospital patients were now to be used for COVID-19. Everything was happening so fast. Our institution was not ready. Initially we had been told that there will be a new block built for covid-19 patients. Then suddenly it was a different story and wards that were used to offer specialist care of our patients were now going to be used for COVID-19."*
RP7	*"Well you know, like COVID has been one of the challenges we have had to face. It has become a serious priority in our institution. So, many of our regular services were not considered to be a priority. We had to set them aside."*
RP6	*"Let me say, before Corona, we used to have Monday CPD meetings. We don't have them anymore and that is a challenge. We no longer get time to communicate with one another."*

Social workers were severely affected by the stressful situations and anxiety that the pandemic created, especially because of their close proximity to many people in the hospitals (patients and fellow colleagues) who had contracted the virus and were very sick or dying (Martínez-López, Lázaro-Pérez, & Gómez-Galán (2021:61). As one of designated groups of frontline workers, social workers were expected to deal with grief and loss related to, and unrelated to COVID-19 at a time when family and friends of the in-patients were prohibited from having contact with hospitalised loved ones (Abrams & Dettlaff 2020:302; Bienz, Jeffery, King, & Willan 2020:1). Suddenly, many of the traditional methods of conducting social work duties had to be substituted with innovative initiatives to keep social workers in touch with patients and their families without having tested the new methods. Cook and Zschomler (2020:303-305) explain that many face-to-face interviews had to be replaced by virtual communication methods and that text messaging was used to enable social workers to stay in touch with patients and family members who could not access the hospital. The COVID-19 protective measures meant that teams worked on a rotational basis, which affected the continuity of social work services.

The participant's explanations of how COVID-19 challenged their execution of their professional obligations were however, different to the themes outlined here. The issues they raised related to the sudden rearrangement of hospital care priorities, reorganisation of hospital wards to prepare for the creation of extra bed spaces to accommodate the numbers of COVID-19 patients who would require intensive care treatment and or treatment in isolation wards. In this regard, **RP1** based at a specialist hospital, described how the hospital was converted into an isolation facility for COVID-19 patients who required hospitalisation: "*And then we heard that our institution was now identified as an isolation facility for covid-19. So, the wards that were used for our hospital patients were now to be used for covid-19. Everything was happening so fast. Our institution was not ready. Initially we had been told that there will be a new block built for covid-19 patients. Then suddenly it was a different story and wards*

that were used to offer specialist care of our patients were now going to be used for COVID-19." **RP1**'s storyline infers that the communication was not clear and direct and created confusion and some anxiety for staff members.

Similarly, **RP7** described how hospital priorities suddenly changed and that some hospital services had to be suspended so that the hospital team could focus on managing the pandemic: *"Well you know, like COVID has been one of the challenges we have had to face. It has become a serious priority in our institution. So, many of our regular services were not considered to be a priority. We had to set them aside."*

According to **RP6**, COVID-19 had reduced the contact that multidisciplinary team members had with one another, which hampered interdisciplinary team communication as follows: *"Let me say, before Corona, we used to have Monday CPD meetings. We don't have them anymore and that is a challenge. We no longer get time to communicate with one another."*

In conclusion, social work operations were disrupted by COVID-19. Many of the existing hospital services were suspended to create additional spaces and increased manpower capacity to manage the COVID-19 crisis. For one participant this created stress because hospital communications about the suspension of services to create an isolation facility were unclear and contradictory. For another, it meant that a work activity of the multidisciplinary team was suspended at a time when opportunities for collegial support would have benefitted them all.

External challenges situated outside the hospital do challenge members of multidisciplinary teams, even when multidisciplinary teams apply their personal energy and creativity to the situation, and the hospital makes resources available to address the challenge. Externally imposed challenges such as those discussed in Theme 3, are very hard to overcome (Leach et al 2017:123). According to Bronfenbrenner's bioecological systems approach the challenges discussed are risk factors. The absolute opposite of risk factors are protective factors which lead to positive outcomes and compensate for the negative impact of the risk factors (Holosko et al 2013:9).

4.3.3.4 Conclusion of theme three: Challenges while working in multidisciplinary teams

It is therefore concluded that the challenges faced by social workers working in multidisciplinary teams in state hospitals in Waterberg District in Limpopo Province are inclusive of: lack of career development and opportunities for professional growth and development for social workers in the hospital setting; lack of sufficient resources for social workers to perform their daily duties and responsibilities such as conducting home visits; politics and policies in the hospital setting that are mal aligned with those of the Department of Social Development's; the impact on foreign nationals who have added strain to the already overburdened and under resourced health sector; and lastly, and the negative impact the COVID-19 pandemic has had on hospital social work services.

The focus of theme four is on the protective factors that participants used to increase their adaptations to accommodate or change the factors that undermined their person-in-environment fit.

4.3.4 THEME 4: COPING STRATEGIES

When a person experiences one or more life stressors at a particular point in his or her life, it may be viewed by the person as something overwhelming and unmanageable, or a challenge they cannot solve using the resources they have at their personal disposal (Gitterman & Germain 2008:60; Teater 2010:27). The challenges that stressed the social work participants in this research and threated their adaptation in their workplaces, the state hospitals in the Waterberg District, were discussed in theme three.

This theme addresses how participants managed their challenges and what environmental, social and individual protective factors they used to adapt to their work situations corresponding with the findings of Holosko & Feit l (2013:9). Some refer to adaptation as resilience (Holosko & Feit 2013:9), and others regard it as a process of consciously selecting coping measures to increase their person-in environment fit (Teater 2010:26) (see 2.4.1.2). The theme is subdivided into four subthemes, namely individual coping strategies (microlevel protective factor); making use of supervision and collegial support or peer supervision (meso level protective factors); training (exo level protective factor); adhering to DoH district and provincial hospital policies (macro level protective factor) (also see section 2.2.4.3) Finally, an example is provided of a participant who did not think she was coping.

The discussion begins with some of the internal coping measures participants used.

4.3.4.1 SUBTHEME 4.1: Individual coping strategies

This subtheme reflects the internal resources that the participants relied on to manage their stressors in the workplace. These internal resources are the person's inner strengths, or protective resources that enable them to manage (Holosko & Feit 2013:10). In some instances, their personality traits, such as cognitive ability enable them to manage their adverse situation to allow them to adapt (Kapoulitsas & Corcoran 2015:97).

The inner strengths participants in this research used to cope were adaptability, upholding the value of altruism - helping others; focusing on the bigger picture - one's life purpose, accepting things they could not change; and letting off steam.

- ***Adaptability***

Adaptability refers to a person's ability to modify his or her reactions when experiencing a challenging situation. Persons can adapt to it by altering their perceptions about the issue, regulating their sensory perceptual responses, and or by consciously adjusting their reactive behaviour (Teater 2010:26). Adaptability is a favourable psychological wellbeing outcome (Martin, Nejad, Colmar & Liem 2013:728; Lin, Miao, Zhang, Zhou Gu et al 2016). Participants expressed themselves as follows about their adaptability in the workplace:

Participant	Excerpt from interviews
RP2	*"You must be flexible because eeerh…. things change every now and then. Like for example… Covid-19. Now we have to work in shifts. So,…..It means you must be able to change and adapt so quickly."*
RP8	"*Like sometimes you need to print reports then and there, but there is no cartridge for the printer. You will just take your money and go and print your reports outside the hospital. Or you will drive to social development and make copies there."*
RP5	*At the end of the day, you just have to accept it and cope with it. You have to know how to handle yourself, you, yourself, internally. Because nobody else cares. I have never heard of a debriefing for social workers, I have never of it."*

RP2's storyline reflected the participant's ability to change the way of doing things, like reorganising the work life routines to be enabled to adjust to the external changes of COVID-19 which were initially experienced as stressful. **RP2***"You must be flexible because eeerh…. things change every now and then. Like for example… Covid-19. Now we have to work in shifts. So…. It means you must be able to change and adapt so quickly."* Things would have been more unsettling for **RP2** if the participant has been rigid in this situation. **RP8** emphasised

the ability of not allowing oneself to be overcome by frustrations about operational glitches in the workplace. **RP8** "*Like sometimes you need to print reports then and there, but there is no cartridge for the printer. You will just take your money and go and print your reports outside the hospital. Or you will drive to social development and make copies there."* As confirmed by the literature, they prioritized completing their work tasks over dwelling on the negativity of the situation. (Kapoulitsas & Corcoran 2014:97). In addition, as described in the literature, **RP5** accepted that they did not have power to change their situation, and their only option was to accept the boundaries of their sphere of influence and move on (Mette, Wirth, Nienhaus, Harth & Mache 2020). Acceptance therefore was the participant's effective coping measure, as confirmed by Mette et al (2020).

- ***Focusing on the bigger picture - one's life purpose***

Participant	Excerpt from interviews
RP3	*"Ahhh, I just, stop and say to myself, 'you know you are here to work for your family'. So being a mother, I will make sacrifices for my children's survival."*

One participant, **RP3**, focused on the bigger picture or purpose in his or her life, namely to offer his or her family a better future. When **RP3** became stressed and overwhelmed by the work situation, a reminder about this helped. **RP3** shared it as follows: *"Ahhh, I just, stop and say to myself, 'you know you are here to work for your family'. So being a mother, I will make sacrifices for my children's survival."*

This is confirmed by research indicating that people can achieve personal satisfaction when they devote themselves to providing their family with a better future, although Barak and Watted (2018:14) question whether doing this is sustainable, as over a long period of time it may be at the person's personal expense. However, it is acknowledged that the support and positive exchanges social workers receive from their families is a coping measure that helps to mitigate against acute work stress (Mette et al 2020).

- ***Personal value of altruism - serving others***

Participant	Excerpts from interviews
RP4	*"I think…. Well, let me say, I don't know what other career would satisfy me as much as social work. I think that is what motivates me."*
RP10	*"it is my passion to be able to assist, and to contribute something to the community. So that's one of the things that actually keeps me going."*
RP1	*"I try to focus and remain positive, and I also make a point of trying to be there for my colleagues whenever they need support or… counselling, and that definitely seems to help me feel better about my struggles."*

Altruistic behaviour is explained as an individual's willingness to help others without expecting anything in return (Chao & Gu 2021). It is described by Reamer (2017:8) as "acts of compassion and generosity that brighten people's lives." Altruism is central to social work's core values because the primary goal of social work is to help people in need and address their social problems (Reamer 2017:8). It is however warned that the values of altruism could become so integrated into social workers' selves that they may find it difficult to distinguish between their personal and professional life and their desire to help people as much as they can (Wiles 2013:858). Altruism contributes to positive social relationships, builds trust, and gives people a sense of meaning in their lives which positively impact on their subjective wellbeing (Chao & Gu 2021). It is asserted that social workers select the social work profession because of the personal satisfaction they receive when helping others and it increases their job satisfaction (Stevens, Moriarty, Manthorpe, Hussein, Sharpe et al 2012:11)

Confirmed by the above-mentioned research findings, the storylines of two participants who identified that altruism was a central part of social work which compensated for the stressors they faced in the hospital setting, entail the following: **RP4** stated that - *"I think…. Well, let me say, I don't know what other career would satisfy me as much as social work. I think that is what motivates me."* **RP10** too, spoke of the positive sense of meaning experienced by working in the community helping others: "*it is my passion to be able to assist, and to contribute something to the community. So that's one of the things that actually keeps me going."*

The feeling of always wanting to help others described by Reamer (2017:8) was carried over into the workplace where a participant's acts of kindness and generosity were directed to colleagues and uplifted their spirits. Only one example is presented here, because references made by other participants are presented under the category of collegial support. In wanting to help others, **RP1** said: *"I try to focus and remain positive, and I also make a point of trying to be there for my colleagues whenever they need support or… counselling, and that definitely seems to help me feel better about my struggles."*

The term that Rotabi, Roby and Bunkers (2016:649) use to describe the beneficial outcome of helping others as a means of helping oneself is "altruistic resilience." As expressed by the above participants, co-worker support creates a sense of belonging amongst colleagues, encourages them to help one another complete tasks, and contributes towards a friendly work environment. These positive outcomes improve individual wellbeing and foster a sense of belonging to something bigger than themselves (Gitterman & Germain cited in Teater (2014:3).

Social workers in hospitals provide support to others as a way of coping with the demanding needs of the hospital environment, also by letting off steam.

- ***Letting off steam***

Participant	Excerpts from interviews
RP5	*"So you get so frustrated. They tell you to go there, and so you say 'ok… fine… let me go there', Then you come back, and then they want you to go somewhere else. So, you go where they tell you to go. Then they don't cooperate with you. Ya. You get so angry, so very angry. You swear there and then. And then you pull yourself together."*

The storyline that follows, demonstrates how sometimes a person's emotions build and create internal pressure that needs to be released. **RP5** gave an example of letting off steam*: "So you get so frustrated. They tell you to go there, and so you say 'ok… fine… let me go there', Then you come back, and then they want you to go somewhere else. So, you go where they tell you to go. Then they don't cooperate with you. Ya. You get so angry, so very angry. You swear there and then. And then you pull yourself together."* By giving expression to the emotions the participant experienced, **RP5** was able to regain emotional control.

In summary, participants stressed the need to be resilient in an unfavourable working environment. To survive, they stressed that they had to adjust and to improvise in order to ensure that they were able to render hospital social work services with limited resources. As explained in the literature, workplace stress places participants at high psychological and emotional risk (Ben-Ezra & Hamama-Raz 2020:15). Therefore, participants found effective resources within themselves to change the way they managed their stressors. For this purpose, they used different techniques such as problem solving, cognitive restructuring, giving expression to their emotions, altruism and altruistic resilience. These control-oriented coping behaviours helped to buffer the effect the stressors had on their emotional exhaustion and job satisfaction (Mette et al 2020).

The focus on the next subtheme is the support participants received from others.

4.3.4.2 SUBTHEME 4.2: Supervision

The meso level was discussed in section 2.4.1.1, in terms of Bronfenbrenner's bioecological systems theory as encapsulating the daily interactions individuals have with significant others who are situated within their immediate work setting (Holosko & Feit 2013:10). The individual becomes interconnected with these significant others and benefits from the support and assistance received from them (Liao et al 2010:59). Participants provided insight into their

social support structures which enabled them to adapt to the challenges they experienced in the workplace. There were two main sources of coping strategies relating to supervision that participants relied upon, namely support from their social work supervisors and peer supervision in the form of professional support.

- ***Support from supervisors***

Whilst supervision was not equally available to all participants, it became clear from participants' responses that for those who could access it, it provided relief from some of their workplace stressors. The accepted benefits of supervision for social workers who receive supervision from senior and experienced social workers include: it offers supervisees administrative direction, helps them to become accountable, provides educational direction and knowledge, and increases the support that is needed to work in an emotionally draining occupation (Fraher et al 2010:46). To this, one should add that employees who experience organisational support demonstrate stronger engagement with their job and organisation, especially when that support is in the form of social work supervision. The motivation provided by Calitz and et al (2014:161), applies here. Two participants focussed on supervision being a valuable measure they used to manage work stress as confirmed by the above findings. Their supervision took place once or twice a month, in addition to *ad hoc* supervision as and when the participant was stuck and needed direction. Supervision offered them a combination of emotional support and practice knowledge. Participants described their experiences about their supervision as follows:

Participant	Excerpts from interviews
RP10	*"Once or twice a month I receive supervision. During the supervision session I receive some debriefing. If I might be in need of supervision when something is not right, I can ask for an appointment to get assistance."*
RP6	*"Ahhh…sometimes when I'm tired, or I have just seen a very touching case, I will debrief with my supervisor. We discuss the situation. She comes up with solutions and advice. 'If you feel tired, take some leave', or 'Go home and rest'. So, this helps me to cope. I usually use my supervisor for when I need debriefing. I go to her most of the time. My supervision is not scheduled. But I can say I have it maybe once in a month***."**

Participant **RP10** shared an office with the supervisor: *"Once or twice a month I receive supervision. During the supervision session I receive some debriefing. If I might be in need of supervision when something is not right, I can ask for an appointment to get assistance."* **RP10** explained the nature of debriefing that the supervisor offered as follows*: **"**Sometimes you see a client who has broken down over some of the things that have broken you down, as well. You know we are human; we go through same situations as our clients."* The participant expanded as follows on the nature of the debriefing received from the supervisor: *"When you*

are in state because of your own experience of a client's problem, you discuss it with her and then she comes up with ways for you to deal with the situation." **RP10** then explained the way the supervisor contributed to the supervisee's practice knowledge as follows: *"She tells you that you should try to use one, two, or three skills, or try to do one, two, and three. That helps me to feel empowered. It helps me to be able to do my job, to the best of my ability."* **RP10** further appreciated the supervisor being empathic and willing to advocate on their behalf, by explaining that - *"She actually is empathic towards us because she knows of the troubles that we go through. Sometimes she just stands up for us and for example will demand a car for us, so that we can do our job."*

Whilst **RP6**'s supervision was not regular, the participant was able to access it when feeling overwhelmed either by the nature of the case being handled, or when experiencing an emotional overload. **RP6** described the experience of turning to the immediate supervisor when not coping with the work situation, as follows: "*Ahhh…sometimes when I'm tired, or I have just seen a very touching case, I will debrief with my supervisor. We discuss the situation. She comes up with solutions and advice. 'If you feel tired, take some leave', or 'Go home and rest'. So, this helps me to cope. I usually use my supervisor for when I need debriefing. I go to her most of the time. My supervision is not scheduled. But I can say I have it maybe once in a month."* **RP6** explained further that when being unhappy about something in the workplace, it would be taken up with management to get their advice and that this is a helpful form of support too. The participant stated it as follows: *"If there is something that I'm not happy about, I can even talk with the management. I can say, 'I'm not happy about one, two, or three' and then after talking, I see what happens."*

Supervision was an important source of support for participants. It was typically provided on a one on one basis. This is confirmed by the findings of Mette et al (2020) that supervision offers valuable opportunities for self-reflection, knowledge exchange and new learning tools and work methods. The opportunity for self- reflection, helped to lower participants' psychological distress and increased their morale and well-being in the workplace as described in the literature (Ahmed, Majid, Al-Aali & Mozammel 2019:3; Charoensukmonkol & Phungsoonthorn 2020:7).

Another important social support structure of the participants was the collegial support exchanges they had with colleagues in the hospitals where they worked.

- ***Peer supervision (collegial consultations)***

A study undertaken by Mette et al (2020) reported that social workers repeatedly commented on the support and much needed care that they gained from colleagues when faced with their challenging work situations. Collegial support leads to a positive team spirit within the workplace (Mette et al 2020). The term that Ahmed et al (2019:3) use to describe collegial support is "co-worker support." The authors note that it plays an important role in improving the employees' performance and contributes to their positive well-being in the work place (Ahmed et al 2019:4).

The participants' perspectives about collegial support confirmed this. As indicated below, the peer support and peer supervision they received from one another took place mostly as informal exchanges in the workplace as described by Martin, Milne & Reiser (2017:3).

Participant	Excerpts from interviews
RP8	"*You know, I sort of ventilate or debrief with other colleagues in the institution, because in that way I'm sure that I will be sharing with people who are sort of in the same boat as me. I know the challenges that I'm facing are the same challenges that they are facing in their hospitals. So, sharing, motivating and encouraging each other gives us hope and strength to continue rendering services to the best of our abilities."*
RP4	"*So, we all get along in our section and after one has experienced a very difficult case, we come together to discuss it. It's a sort of debriefing for one another. The fact that we have good working relationships means that we are always there for one another. We debrief each other, informally."*
RP7	"*This is a very small hospital. So, everybody knows everybody. So, it is very easy, and we are very accessible. So, it is easy for people to just go to someone and ask for help or talk about a patient's case and so on."*

RP4 worked in a hospital where there was more than one social worker. In addition to the benefits of emotional support and peer guidance they received from their colleagues, they were reassured as follows that in their absence there would be someone else who could continue with their cases: ***"****We always fill one another in about our cases, in case, on the following day you cannot be at work. And in that way, they can always continue, so that our cases still receive attention. I think that helps me a lot."* This was a relief because other participants when discussing their challenges noted how distressed they were when the social services they offered were disrupted in their absence.

In another comment **RP8** shared, that when really demotivated and considering resigning, turning to the management would help, as they would listen, offer support and that would help to reduce the feelings of emotional distress. However, this was done less frequently, ass described: *"So, relying on management …. mmmm…. not so often…But sometimes you find yourself in a frustrating situation. You recognise it as soon as the event crops up…. It's when*

you feel so frustrated that you even consider resigning because of all the stress. So, as soon as I feel like I have this burden, and it's too much for me, I don't hesitate, I will go to a manager."

RP7, being in a smaller hospital expressed confidence in the support system available: "*I think I have a very good support system, even in the allied professions in the team. I think and hope that it is true that I have a good working relationship. I know everybody, and everybody knows me. They know how we work, what I need, I know I can go to any department to say I need this and that so I think that's the important thing to have a very good relationship with your team."*

Peer support in a working environment enhances psychological and emotional resilience and increases the social worker's social support (Agarwal, Brooks and Greenberg 2019:57). Therefore, participants in this study sometimes relied on collegial support from social workers based in other state hospitals in the Waterberg District. **RP9** offers an example: *"I was assisted by **RP8** from one of the other hospitals. "*[The colleague] *was… the first person I got hold of in the district when I needed help. And* [the colleague] *was so helpful …* [The colleague] *was there for me. Like even now,* [the colleague] *is the one I consult if I have to deal with challenges because* [the colleague] *is helpful."*

It was further mentioned that social workers interacted with social workers based outside the hospitals, as **RP2**'s storyline reflects: *"Sometimes we turn to external social workers, like social workers from DSD. That is one way we get more support. We get to learn about other departments and where we can source social services for our patients. We try to link up with social workers in the community so that our patients can get the resources that they need in the community."* **RP8**'s following storyline confirms **RP2**'s comment: **"***Lucky for me, I have been in service for a long time. I rely on other social workers… ehhh. Sometimes when I experience social developmental issues, social work matters that are more related to social development, I reach out… To survive you have to sort of have a network or consult with other social worker's that's how we survive in the health sector."*

In some of the excerpts shared, it appeared as though the collegial support from colleagues had a deeper more meaningful purpose. This is borne out by Townsend, Kim and Misquita (2013) finding that when two people going through similar stressful experiences talk to each other about it, the communication between them assists to cushion them from high levels of stress, especially when their feelings are shared. The authors continue to explain that communicating with a person who genuinely understands your emotions and responses,

because they too are experiencing it, at the same time, offers significant relief from stress (Townsend et al 2013).

As confirmed by the literature referred to above, participants' descriptions highlighted the importance their exchanges with colleagues had for them. They included other multidisciplinary team members, management and social workers based inside and outside the hospital setting and this network of collegial support strengthened their coping measures, as described by Mette et al (2020). Corresponding with research sources, some participants expressed their need to ventilate their emotions, internally or externally with others (Caza & Creary 2016:4; Kessler, Cheng & Mullan 2014:2336).

Another coping measure that participants mentioned referred to the availability and utilisation of education and training opportunities

4.3.4.3 SUBTHEME 4.3: Education and training

Participants seemed to uphold the proverb that 'knowledge is power'. The excerpts from the interviews with participants presented about education and training as a coping strategy, reflect their belief that continued education and training assisted them to better control their work situations and manage some of the challenges they faced more effectively. This is in line with the finding that ongoing social work training increases social workers' support, helps to prevent burn-out and enhances job satisfaction (Calitz et al 2014:160-161). Several forms of practical training are recognised to enable social workers to adapt to their work environment, such as training about applicable legal aspects, de-escalation techniques, counselling know-how and management skills (Mette et al 2020).

Participants had the following to say about their professional education and training as a coping measure assisting them to adapt to their work environment:

Participant	Excerpts from interviews
RP1	"*When it comes to coping it's a, as social workers professionally you are being trained to help other people to cope with adverse situations."*
RP2	*"So if there is a patient who is mentally ill then this is how we are going to …to…to .. help to rehabilitate the patient. As social workers, we involve the whole family. Involving the family is our main job. So, without this specialised knowledge we bring, the medical team cannot assess the case, because they cannot rely on what the mental health care user* [patient] *has told them."*

The professional education and training that the participants mentioned referred to their undergraduate education and training and online continued education and training offered by other organisations.

- ***Undergraduate social work education and training***

Participant	Excerpts from interviews
RP1	*"When it comes to coping… it's your professional training as social worker that enables you to cope, your professional training helps you to help other people cope with adverse situations."*
RP2	"So if there is a patient who is mentally ill then this is how we are going to …to…to … help to rehabilitate the patient. As social workers, we involve the whole family. Involving the family is our main job. So, without this specialised knowledge we bring, the medical team cannot assess the case, because they cannot rely on what the mental health care user [patient] has told them."

Two participants reflected on the value of their social work undergraduate training. Whilst not specifically trained in medical social work, **RP1** believed and stated as follows that the Bachelor of Social Work degree prepared them well for the main purpose of social work which is to help others: "W*hen it comes to coping… it's your professional training as social worker that enables you to cope, your professional training helps you to help other people cope with adverse situations."* **RP2** mentioned some specific areas of knowledge obtained in their undergraduate social work training that prepared them to cope in the workplace: *"So if there is a patient who is mentally ill then this is how we are going to …to…to … help to rehabilitate the patient. As social workers, we involve the whole family. Involving the family is our main job. So, without this specialised knowledge we bring, the medical team cannot assess the case, because they cannot rely on what the mental health care user* [patient] *has told them."*

The undergraduate education and training, understanding of the ecological approach and family systems theory, served to broaden the whole multidisciplinary team's understanding of the patient's holistic functioning. The social workers' contribution benefitted the whole team, which in turn advanced holistic patient care and better treatment outcomes. These successes allow social workers to assert themselves within the multidisciplinary team, improve their self-esteem, professional identity, and personal confidence- which strengthens their resolve to cope within their stressful work environment.

- ***Online training offered by external service providers***

In the absence of continuous professional development offerings and limited in-service training for social workers in the Waterberg District's state hospital settings, social workers had to make their own arrangements for their continued professional development (CPD). One of the participants reflected that ongoing training and development was so important that the participant gladly enrolled for online training at their own expense. **RP10** said the following in

this regard: *"At the end of the day, I don't even mind using my own data and resources to learn something that will help me professionally. I am happy to learn things online."*

The participants' quotations under this subtheme are supported by Ahmed (2019:8) who asserts that education plays a crucial role in improving the multidisciplinary team's performance in social services. Scholarly sources advise that social workers can better manage their workload effectively if properly trained to deal with multiple roles such as advocating for patients, providing counselling, doing case and group work practice and networking with other stakeholders. Training clearly enables medical social workers to assist patients in specific health care areas such as facilitating patient understanding of their diagnoses, adhering to home care instructions and committing to follow up treatment (Ahmed 2019:5; Jafree & Burhan 2020:5148).

In conclusion, as confirmed by the literature, participants rely on their undergraduate training and collegial support they receive from their peers for peer debriefing, to cope and adapt to their hospital working environment.

The last subtheme described by participants as a coping strategy in their work environment consists of participants' recognition of adherence to the policies and guidelines issued by the DoH as a coping strategy.

4.3.4.4 SUBTHEME 4.4: Adhering to district and provincial DoH policies

Participant	Excerpts from interviews
RP2	*"To follow the policies because you cannot work on your own. You have to know about the processes that govern the hospital. You have the policies and you have the rules, so it makes things simpler when you follow those procedures, when you follow the policies. These policies are the ones that guide you how to do things and when to do them and who should do those things."*
RP9	"Yes, we must follow the hospital policies…I try but it is hard. When I am stuck, I say, this is hard, but I must not give up hope. There are policies. You remind yourself that this is what procedure I must follow. …the procedure says I must do this and this. We have to follow certain procedures."

Referring to the Department of Health's policies regarding service delivery to guide social workers during their rendering of support services in hospital settings, the participants responded as follows:

RP2 said that - "*To follow the policies because you cannot work on your own. You have to know about the processes that govern the hospital. You have the policies and you have the rules, so it makes things simpler when you follow those procedures, when you follow the*

policies. These policies are the ones that guide you how to do things and when to do them and who should do those things."

RP9 added the following: "*Yes, we must follow the hospital policies…I try but it is hard. When I am stuck, I say, this is hard, but I must not give up hope. There are policies. You remind yourself that this is what procedure I must follow. …the procedure says I must do this and this. We have to follow certain procedures."*

The sentiments expressed about the Department of Health's policies regarding social work service delivery indicate that policies determine the professional standards of care one expects to see in hospital settings. In the absence of specific social welfare policies at the hospitals in the Waterberg District, the social workers followed the DoH policies. However, participants admitted that in many respects, they as social workers, were bound to practice in accordance with the social work code of ethics, corresponding with the findings of Guttmann (2013:15)

Whilst the issue of not coping with working within the state hospitals in the Waterberg District was raised by one participant, the coping measures that participants had shared had enabled the majority to achieve a good person-in-environment fit.

4.3.4.5 SUBTHEME 4.5: Not coping

One participant reported not coping with the work environment. The term 'not coping' describes the point where a situation is too overwhelming for persons and the resources at their disposal are not sufficient to enable them to adapt to the situation (Teater 2014).

This is how **RP9** experienced the inability to cope in the work situation as follows: *"Ahhh, I just try to stay positive. But I know that things won't change here, so I just have to find something else. Like a different environment to work in. That's the only choice for me now, if I want to growth."*

4.3.4.6 Conclusion of theme four: Coping strategies

Many of the storylines presented are supported by the position of Mette et al (2020) that social workers use multiple coping strategies and support resources in the workplace, to enable them to cope with their job demands and change their emotional responses to these demands.

According to Gitterman and Germain (2008:55) there are three interventions that social workers in hospital settings could use to achieve an adaptive person-environment fit. They can -

- change themselves to satisfy the hospital environment's perceived demands by taking advantage of resources and opportunities available to them;
- try to change the hospital environment so that the social and physical environment would be more responsive to their social work needs and goals; and or
- try to change the social worker-hospital environment interactions to negotiate a better fit.

The responses of the participants presented indicate that social workers were the ones to initiate change. They tried to adapt by satisfying the hospitals' perceived demands and relying on their inner resources and meagre external resources to do so. This leads to the conclusion that structured efforts are needed to change the hospital environment to be more responsive to social work needs and that goals and dialogue are needed to create a more collective understanding about the role of social workers in hospital settings so that occupational boundaries will be clarified and multidisciplinary team efforts strengthened as suggested by Wiles (2013:859). Another conclusion was that the social workers concerned needed additional measures of support, specifically in terms of systemic workplace health promotion.

The next theme addresses the recommendations that participants made to improve their levels of occupational satisfaction in the workplace.

4.3.5 THEME 5: PARTICIPANTS' RECOMMENDATIONS TO IMPROVE THE OCCUPATIONAL SATISFACTION OF SOCIAL WORKERS IN MULTIDISCIPLINARY TEAMS IN STATE HOSPITALS IN THE WATERBERG DISTRICT

Essentially, qualitative research is undertaken to develop a detailed understanding of a phenomenon and use that understanding to inform practice (Carey 2012: 9:20). The purpose of the study (outlined in section1.3.2) states that the researcher wanted to obtain an understanding of the experiences of social workers working in multi-disciplinary teams in state hospitals in the Waterberg District and use the understanding of their experiences to make recommendations to improve the occupational satisfaction of social workers working in hospitals. One of the questions participants were asked was "What recommendations do you have for improving the occupational satisfaction of social workers in state-based hospitals in

the Waterberg District?" Theme 5, addresses the findings to this question which are broken down into three subthemes, namely participant's recommendations for changes in work conditions of social workers in state-based hospitals in the Waterberg District; more training and development opportunities; and employee wellness services for social workers working in those hospitals. Each of the subthemes are supported by storylines gathered from the individual interviews, and subjected to a literature control.

The discussion commences with subtheme one, recommendations for improved work conditions for social workers in the state hospitals in the Waterberg District. Many of the recommendations made were made in relation to the challenges the participants mentioned in theme three.

4.3.5.1 SUBTHEME 5.1: Improving the work conditions of social workers in the workplace

It is generally accepted that to achieve quality of work life, specific employee needs that relate to satisfactory reward systems; a conducive work environment, a suitable physical work environment, employee involvement, recognition of employees rights and advancing the employee's esteem must be fulfilled which then improves employees' job satisfaction and productivity (Ajala 2013:47). This confirms the specific aspects relating to their work conditions raised in this regard by the participants in the study, which were remuneration, making resources available for them to fulfil their professional mandate, providing support and acknowledgement in the workplace, offering social work supervision; and clarifying the role of social work in the hospital settings. Shier and Graham (2013:105) emphasise that failure to address poor remuneration and lack of resources for social workers in hospital settings places them at risk of serious mental and physical harm.

- ***Remuneration***

An employee's motivation and job satisfaction are significantly and positively influenced by remuneration (Martono et al 2018:535). The comments made by participants demonstrated that they agreed with this. Two participants clearly stated as follows that the salaries of social workers had to be increased to improve their job satisfaction.

Participant	Excerpts from interviews
RP1	"*I think that the remuneration must be better. If there the pastures are greener on the other side, then I will go. If I am offered a higher salary somewhere else, then I will go."*

RP4	*I think the main thing is…no, there are actually two things. They must improve our remuneration and increase the number of social work posts in the hospitals."*

A third participant, **RP2** not only wanted social work salaries to be increased, but also to be structured to be fair and equitable in relation to the salaries of other professionals in the multidisciplinary teams, by stating the following: *"We must be remunerated the same as other professions. We must be recognised in the same way that the other professionals are recognised. So that is how I think that they should address the issue of our salaries."* **RP1** and **RP4** also felt a great need for their remuneration as medical social workers to be adjusted as they shared their views that their remuneration should be improved. **RP1***"I think that the remuneration must be better. If there the pastures are greener on the other side, then I will go. If I am offered a higher salary somewhere else, then I will go."* **RP4** *I think the main thing is…no, there are actually two things. They must improve our remuneration and increase the number of social work posts in the hospitals."*

Literature is consistent with **RP2, RP1 and RP4**'s perspective that social workers in state hospitals are paid less than their allied professional counterparts (Ambrose-Miller et al 2018:113; Schweitzer et al 2013:152). This indicates and confirms that reimbursement practices positively influence or constrain the role functions of team members in health care systems.

The next recommendation relates to the issue of providing social workers with the resources they need to achieve their professional mandate in the hospital setting.

- ***Resources***

Allocation of resources significantly impacts on job satisfaction of social workers in multidisciplinary teams (Limon 2018:28; O'Reilly et al 2017). Unfortunately, social workers in secondary settings, such as a hospital, encounter bureaucratic control over resources and the occupational resource needs of social workers can be easily overlooked (Dane & Simon 1991:209).

Participant **RP2** recommended that the hospital administration needed to supply social workers with the resources they needed to do their jobs properly. The first resource **RP2** requested is as follows, more suitable office space for social workers that would protect patient confidentiality: *"The authorities must provide social workers with offices conducive for interviewing so that we do not have a problem with confidentiality. We must protect our clients".* Then **RP2** went on to recommend other tools of the trade that were needed: *"The social worker*

*must have a phone and a car, so that they can reach out to the outside world on behalf of the patients." T*he need for office space was repeated once more as follows: *"… and they need an office"*, and then ended saying that the resources would improve patient satisfaction of services they received: *"The resources are important for improving the satisfaction of our patients. Remember is not all about us. It is about doing better for the patients."* Tambasco et al. (2017:149) confirm that the expansion of material resources for social workers is worthy of consideration because if not sufficient in the health sector, job satisfaction drops.

- ***Support and acknowledgement***

Participant	Excerpt from the interview
RP3	*"…they provide us with the resources we need and understand our role as social workers and the scope of social work practice that we should deliver in the hospital."*
RP10	*: "I think that what needs to happen so that our job satisfaction in the hospital is improves is that the hospital must understand that for as long as we are here and work with the doctors and other professionals such as the occupational therapists. We are just as important as the other members of the team. We all have an important role to play." RP10 further elaborated as follows that acknowledgement must be a reciprocal process in the hospital environment: "And we all must communicate with each other and be able to recognise each other's strengths…"*
RP9	*"We need to mobilise. We need to mobilise people in the hospital so that management hears us. As social workers we know what we want. We know how we must work. We have been trained how to work...We know what kind of resources we require to fulfil our job. They must hear us, and they must advocate for us at a higher level. The authorities must allow us to explain why we are unhappy and then address our concerns."*

Organisational support is evident when employees feel their efforts in the workplace are recognised and the employer cares about their wellbeing (Sinha cited by Ajala, 2013:47). The benefits of this become evident in the employee's commitment to the organisation, job satisfaction and general quality of work life (Ajala 2013:47). The reported need for greater acknowledgement or recognition of the participants in the hospital setting is unpacked.

Two participants recommended that hospital management and members of multidisciplinary teams had to be more appreciative of the social workers' role in the hospital and recognise social workers' worth in the team as equal to that of the other disciplines. **RP3**'s recommendation was that the role of social workers within the hospital should be better clarified amongst multidisciplinary team members: *"I urge that they start to understand our role. Like we are as important as the other professionals in the hospital."* **RP3** also mentioned that one would be able to tell when social workers are properly supported and acknowledged within the hospital system when: *"…they provide us with the resources we need and*

understand our role as social workers and the scope of social work practice that we should deliver in the hospital."

Similarly, **RP10**'s response was the following: "*I think that what needs to happen so that our job satisfaction in the hospital is improves is that the hospital must understand that for as long as we are here and work with the doctors and other professionals such as the occupational therapists. We are just as important as the other members of the team. We all have an important role to play."* **RP10** further elaborated as follows that acknowledgement must be a reciprocal process in the hospital environment: ***"****And we all must communicate with each other and be able to recognise each other's strengths…"*

For **RP9** organisational support was an important indicator of work satisfaction that needs the attention of the hospital administrators and said that social workers should organise themselves to lobby for it: *"We need to mobilise. We need to mobilise people in the hospital so that management hears us. As social workers we know what we want. We know how we must work. We have been trained how to work...We know what kind of resources we require to fulfil our job. They must hear us, and they must advocate for us at a higher level. The authorities must allow us to explain why we are unhappy and then address our concerns."* **RP9**'s excerpt stresses that social workers need to act themselves, to promote their professional status as confirmed by Beddoe (2013:169).

With reference to employee support and acknowledgement, as reflected in what the participants said, the following findings by researchers, should be taken into consideration:

- A good person-environment fit is evident when human-relatedness within the workplace is high (Carpenter & Platt 1997:347).
- A person must have a sense of connectedness with others to feel accepted and acknowledged for playing a positive role in the organisation. Social workers need respect and acknowledgement, positive communication, shared responsibility and common ethics and values, from medical colleagues (Albrithen & Yalli 2016:132).
- However, for social workers in hospital settings to be taken seriously and be acknowledged, the process should begin with themselves (Beddoe 2013:169; Raniga & Kasiram 2010:271; Weiss 2005:10).

- ***Social work supervisors as line managers***

Participant	Excerpt from the interview
RP3	*"Maybe if we can have social work managers, proper social work managers [referring to a qualified social work supervisor]. We do not only want to be managed by other professionals."*
RP8	*"There…should be a designated social work supervisor for each hospital and area. Every social worker delivering social work services in the hospitals should have someone who is suitably qualified and experienced to supervise them. That way we will ensure that social workers grow and their job satisfaction working in the hospital will improve."*

Calitz et al (2014:159) purport that supervision in social work offers social workers organisational support. When the supervision a person receives is good, it assists them to function better in the workplace and achieve a better work life fit (Ajala 2013:49). As pointed out, relating to participants' negative experiences of job satisfaction, lack of social work supervision in the state hospitals in the Waterberg District was a factor that lowered the research participants' job satisfaction (see section 4.3.1.1). Supervision of social workers in South Africa is regulated by the Social Service Professions (Act 110 of 1978); the Code of Ethics of the Social Work Profession; the Children's Act 38 of 2005 and the Supervision Framework for the Social Work Profession in South Africa (Lombard 2015:18; Bhuda et al 2019:51).

Organisational structures within the state Waterberg District hospitals failed to take the supervision of social workers seriously. Social workers reported to line managers in many instances who were not social workers and therefore had limited understanding of social work operations and the professional functions of social workers. Participants felt strongly about this problem and two recommended as follows that this problem be corrected and that supervision should be given by social workers as line managers. Therefore, **RP3** asserted as follows that social workers should only be supervised in the hospital setting by other social workers**:** "*Maybe if we can have social work managers, proper social work managers* [referring to a qualified social work supervisor]. *We do not only want to be managed by other professionals."*

In a similar vein, **RP8** pointed out the need to create an organisational plan for social work supervision: ***"****There…should be a designated social work supervisor for each hospital and area. Every social worker delivering social work services in the hospitals should have someone who is suitably qualified and experienced to supervise them. That way we will ensure that social workers grow and their job satisfaction working in the hospital will improve."*

The last recommendation related to the subtheme of work conditions concerned the lack of clarity amongst multidisciplinary team members and hospital management regarding t the professional scope of practice of social workers in the state hospitals in the Waterberg District.

- ***Clearly defined job descriptions***

The problem of poor clarification of social work roles in hospital settings is also discussed under the challenges experienced by social workers based in multidisciplinary teams in hospital settings (see section 2.2.2.2). Research participants' experiences of the deleterious effect that poor role clarity of social work in multidisciplinary teams had on their job satisfaction and professional identity were combined with a literature check and presented in themes one to three in this chapter. Researchers pointed out that multiple variables are associated with this problem within hospital teams, such as different interests, goals, expectations, personal styles and experiences amongst team members (Shier & Graham 2013:203; Morely & Cashell 2017:211). In addition, it was found that different professional perspectives stemming from different professional backgrounds, made social workers and medical personnel weight the importance of physical and mental health differently (Limon 2018:24), as well as the power differentiation between the "host setting" and the "resident guests" (Kirschbaum 2017:25: Dane & Simon 1991:208). This is reflected as follows by the participants in this research:

Participant	Excerpt from the interview
RP9	"*…they should sort this out at a national, provincial and district level. They need to develop a common understanding about what social work in hospital setting is all about and then give us a uniformed job description…There has be a standard job description to guide us. Thereafter, you can adapt it to suit your setting. It is the government's duty to formulate, oversee and monitor the process of developing the job description."*
RP2	**"***The hospital administrators should familiarise themselves with the role of the social worker in the hospital. They can develop a … what do we call it …. a directive to say that social workers can do this and cannot do this. At the moment everything is haphazard because no one knows what is expected of us."*
RP6	**"***For now, actually I don't know… I don't know whether they, the hospital managers and other members involved with treating patients, need, maybe a…...a workshop to say social work does this and psychology does that."*

Several recommendations were forthcoming from participants about the clarification of social work roles in hospital settings. The first was that the government had a duty to develop a job description for social workers in district and provincial hospitals. **RP9** proposed that the government be allocated the responsibility for resolving the problem "…*they should sort this out at a national, provincial and district level. They need to develop a common understanding about what social work in hospital setting is all about and then give us a uniformed job description…There has be a standard job description to guide us. Thereafter, you can adapt*

it to suit your setting. It is the government's duty to formulate, oversee and monitor the process of developing the job description."

The second recommendation was that the hospital administrators should issue a directive to be shared with all the multidisciplinary team members involved in patient care about the role and duties of social workers and indicate who will be tasked to carry out the directive. This was proposed as follows by **RP2**: ***"****The hospital administrators should familiarise themselves with the role of the social worker in the hospital. They can develop a … what do we call it …. a directive to say that social workers can do this and cannot do this. At the moment everything is haphazard because no one knows what is expected of us."*

The third recommendation was to arrange a workshop for hospital managers and other team members suggested as follows by **RP6**: **"***For now, actually I don't know… I don't know whether they, the hospital managers and other members involved with treating patients, need, maybe a…...a workshop to say social work does this and psychology does that."*

The fourth recommendation was made by **RP7** along similar lines as **RP6's** suggestion, a proposal for a more informal, face to face encounter between hospital managers and multidisciplinary team members to clarify the roles and duties of social workers in the hospital, formulated as follows: *"What we need is for management to have a meeting with us so that we can teach…. No, not teach… but rather have a briefing session with them about our roles, duties and so on…...Then that's where they will know what resources we need to provide medical social work services here and function properly in the multidisciplinary team."* **RP7**'s recommendation was a positive one in that the participant believed that when hospital managers and other team members were familiar with the role and duties of social workers in the hospital setting, they would be more cooperative about providing them with the resources they needed in the hospital.

Two participants pointed out that social workers in their individual capacities should be responsible for educating other colleagues about their roles as well. **RP9** suggested this could be done by: *"taking personal responsibility to correct team members who do not understand our role on an ongoing basis".* **RP2**'s suggestion was to lead by example: "*I can recommend that social workers in these hospitals make a point of working with the team."*

The recommendations of having ongoing dialogues between social workers, the other disciplines and hospital administrators addressing the role of social workers in hospitals are supported by Wiles (2013:859) who explains that such collective narratives maintain and

reinforce professional boundaries. The recommendation of hospital administrators issuing a directive would also instil and reinforce increasing awareness, understanding and acknowledgement of the role of medical social workers in the hospital team (Weiss 2005), as would workshops and briefing sessions. It is pointed out that by social workers actively challenging or rejecting some of the inappropriate referrals directed to them, some of the stereotypical impressions held by team members could be reduced (Weiss 2005). In addition, if social workers become more active in multidisciplinary teams and make their presence felt, medical social workers would come to be recognised as dynamic and proactive clinical leaders (Weiss 2005). The recommendation that the DoH should be responsible for developing a uniformed job description for social workers at a national level, is opposed by Shier & Graham (2013:107) who suggest that professional associations for social workers should avail themselves in this regard to advocate for the professional status of social workers in health care settings.

To summarise, participants' recommendations for improving the working conditions of social workers in multidisciplinary teams in state hospitals in the Waterberg District included improving their remuneration, securing additional resources for social workers, increasing support and acknowledgement for the contribution social workers make in the hospital, providing social work supervision and supporting social workers by clarifying their role within the hospital team. This is confirmed by the fact that working conditions impact on the professional identity of social workers, as they shape their perceptions of their position in the organisation and the value that it adds to the organisation as a whole (Caza & Creary (2016:4). Therefore, policies are needed in the workplace to govern and achieve a good quality of work life for employees (Ajala 2013:53).

The focus now falls on the need for ongoing training and development of personnel that is a responsibility of the employer as another factor linked to working conditions.

4.3.5.2 SUBTHEME 5.2: Training and professional development

Ajala (2013:48) builds a strong case for employers to offer training to employees so that they are equipped with new skills and eventually can become leaders in their field. Employers need to develop a career support system for personnel to encourage workplace learning. Organisations increase the pull factor for social workers when they create ongoing education and professional development opportunities for them because it increases their job satisfaction. Participants' recommendations in this regard confirmed that providing ongoing training and development opportunities for social workers in hospital settings were something

that they needed. Three factors comprising this subtheme are presented, namely in service training, continuous professional development and career planning.

- ***In-service training for social workers***

Participants' perceptions about in-0servise training of social workers are as follows:

Participant	Excerpt from the interview
RP1	*"Ya, so I think for now if the Department of Health can just look into organising training for social workers. Get people who are knowledgeable, and then we as social workers can pass this information on to other team members. Social work involves working with other governmental departments, too who can help us. This will really make our jobs easier. So, for example if you could have… regular training sessions facilitated by different government departments such as Department of Justice, DSD, SASSA, and so on …This information is needed by the people we service. …. Sometimes things change. There is so much information that we need to know about. Working here in the hospital we discover we don't know anything about these developments."*

In service training is broadly defined as "training that is given to employees during the course of employment" (Collins English Dictionary 2018, Sv "in-service training"). Its application in the context of this study is to describe training arranged for social workers in the hospital to educate them about different aspects of social work in hospital settings. Such training would be separate from the continuous professional development mandated (CPD) by the SACSSP, because neither the content of in-house training, nor the trainer would have the accreditation needed to and meet the SACSSP's approval.

The first recommendation by the participants was that information sessions needed to be arranged on a regular basis for social workers in the hospital. The information gained could be used in the interest of patients who would benefit from it. The trainings would assist social workers to increase patients' access to additional resources, opportunities and information.

RP1's recommendation in this regard was as follows**:** "*Ya, so I think for now if the Department of Health can just look into organising training for social workers. Get people who are knowledgeable, and then we as social workers can pass this information on to other team members. Social work involves working with other governmental departments, too who can help us. This will really make our jobs easier. So, for example if you could have… regular training sessions facilitated by different government departments such as Department of Justice, DSD, SASSA, and so on …This information is needed by the people we service. …. Sometimes things change. There is so much information that we need to know about. Working here in the hospital we discover we don't know anything about these developments."*

This is confirmed by Qalinga (2022:76) who asserts that social workers need to educate their clients about existing support structures available to them that can assist them to strengthen their families and communities and increase their capacity, which is part of empowerment. This recommendation is apt for social workers in hospital settings to prevent them losing touch with developments in the social work profession.

The next level of training and development recommended by participants was for continuous professional development training (CPD) opportunities mandated by the SACSSP for all registered social workers in South Africa.

- ***Continuous professional development for social workers (CPD training)***

The term 'continuing professional development' (CPD) in the context of this study refers to "A statutorily determined process that requires persons registered with the SACSSP to obtain a specified number of points annually in order to maintain ethical and high-quality service by attending or participating in activities of a professional nature in order to remain registered with the SACSSP" (Cited by Green 2010:89). The purpose of CPD training is intended to safeguard the social work profession and promote the career development of individual social workers (Green 2010:314). In large organisations, such as the DoH the Human Resource Departments should arrange such employee training activities. The benefits of CPD training for individual social workers are that they improve the social workers' levels of job satisfaction (Calitz et al 2014:160); and improve service delivery to clients (Gao, Yu, Wang, Wang, Wang et al 2014:3). Social work CPD training has according to Green (2010:314) been criticised by social workers because the programmes are not adequately structured, are not accessible to all, and have not been quality assured.

Participants' perceptions about continuous professional development (CPD) are as follows:

Participant	Excerpt from the interview
RP7	**"***The department of health should at least take note that social workers like me, fall under the South African Council for Social Services Professions. Most other professionals based in the hospital are registered under the Health Practitioners Council South Africa which is for health care professionals…...So the trainings in the hospital are based on the HPCSA 's requirements for accredited CPD training activities. This means that social workers are excluded and without proper CPD training their registration with the Council is threatened. I think they should look at this carefully so that social workers don't lose out…. But I also must mention that my recommendation is not only about CPD points. I think that the hospital must arrange slots for each section to present to other sections about the services they render in the hospital."*
RP9	"*Whilst social workers have a responsibility to improve their professional capacity by furthering their training, it is also the responsibility of management to understand the duties of social workers in hospital settings and create incentives for them to advance their knowledge and skills."*

The dilemma that social workers in the Waterberg District state hospitals face is that the Human Resource Departments do not make arrangements for social workers to have specialised and SACSSP accredited CPD trainings. The training they include social workers in does not enable them to achieve the annual prescribed number of CPD training points that social workers need, as stipulated by the SACSSP. **RP7** aptly motivates as follows for the DoH to address this issue: **"***The Department of Health should at least take note that social workers like me, fall under the South African Council for Social Services Professions. Most other professionals based in the hospital are registered under the Health Practitioners Council South Africa which is for health care professionals…...So the trainings in the hospital are based on the HPCSA 's requirements for accredited CPD training activities. This means that social workers are excluded and without proper CPD training their registration with the Council is threatened. I think they should look at this carefully so that social workers don't lose out…. But I also must mention that my recommendation is not only about CPD points. I think that the hospital must arrange slots for each section to present to other sections about the services they render in the hospital."*

The following recommendation by **RP9** supports **RP7**'s: "*Whilst social workers have a responsibility to improve their professional capacity by furthering their training, it is also the responsibility of management to understand the duties of social workers in hospital settings and create incentives for them to advance their knowledge and skills."*

The attendance of annual accredited professional training for social workers is now compulsory. Deregistration of a social worker who does not achieve the prescribed number of CPD points because of not having been exposed to suitable training, could reflect poorly on the employer and even be regarded as an unfair labour practice in the future (Manthorpe & Moriarty 2014:399). It is unfair to expect social workers who are poorly paid to pay for their statutorily required training when the medical staff do not have to pay for theirs. The need for continued professional education and training apart from the required professional CPD accredited training, is confirmed by Ahmed (2019:8) who explains that high quality training is necessary for all health care workers because the skills and knowledge gained by those who attend training usually cascade down to other health care workers they work with.

- ***Career planning and professional development plans***

Career progression was explained under the limited opportunities for career progression for the participants (section 4.3.3.1). It was noted as one of the challenges that participants felt negatively affected their general happiness and job satisfaction. Providing social workers with

suitable promotional opportunities is a positive predictor of job satisfaction (Calitz et al 2014:160). The organogram developed by the DoH allocates few social work posts and even fewer senior social work posts for the state hospitals in the Waterberg District. Therefore, there are limited opportunities for social workers working there in terms of career progression. The possibility exists that social workers may apply to act and possibly be appointed as allied professional managers; however, this cannot be considered as a promotion in social work.

RP9 referred to the number of senior posts 'available' for social workers that had been allocated by the DoH that remain vacant. Against the backdrop of comments made by participants about poor career progression for social workers in the state hospitals presented in theme three (see 4.3.3.1), **RP9** said the following: "*The social workers need to be given opportunities to better themselves. But here, in terms of promotions, ehhh! When I say they that social workers should be given opportunities to be promoted to more senior posts…. Ehhh…what I can say, the posts are already there. They are empty spaces.* [the references is to the vacant positions reflected on the organogram]. *They must do something about them."*

RP2 discussed the annual professional management development assessment of individual professional staff and his or her line manager and proposed that it should be combined with a professional development plan for the employees for the next year. Together the line manager and social worker can identify specific training needs for the social worker to address during the year. **RP2**'s storyline went like this: *"Professional enhancement… net, professional enhancement in such a way that the management team can be errrhhh…... when doing a social worker's professional management development assessment each year, they must identify what training he or she needs and in this way support them to do some social work CPD training in line with the SACSSP's requirements."*

Whilst **RP2**'s recommendation does not equate to a promotional opportunity, it can in the long run contribute to a social worker's career progression in social work. The theoretical and other knowledge and expertise gained, would upgrade the individual's skills and knowledge annually (Wiles 2013:858). Having a continued professional development plan would reassure the social workers that the employer is committed to investing in them and has a promotional plan in mind to keep them hopeful about their future prospects (Ajala 2013:48).

In conclusion, the recommendations suggest that within the state hospitals in the Waterberg District, there is scope for a career progression plan for each social worker making provision for different types of learning opportunities for social workers within and outside of the health sector by means of in-service training; accredited CPD training for social workers; and an

individualised career progression plan. Ajala (2013:53) concludes that if the implying organisation commits itself to a formalised training system as above it will contribute significantly to the employees' health and wellbeing and improve productivity and work performance in the workplace.

The last subtheme under theme five, participants' recommendations to improve the occupational satisfaction of social workers in multidisciplinary teams in state hospitals in the Waterberg District, is the recommendation that social work staff should be able to have adequate access to support and wellness services within the hospital setting.

4.3.5.3 SUBTHEME 5.3: Employee wellness programmes and debriefing sessions

Social workers working in multidisciplinary teams in hospital settings are exposed to multiple stressors that if unaddressed can lead to disastrous personal outcomes and negatively affect their productivity and impact on others in the workplace (Limon 2018:29-30; O'Reilly et al 2017). Heavy workloads, scarce resources, feeling socially excluded in the organisation, power struggles with management, working in isolation, poorly defined job descriptions, poor acknowledgement from hospital administrators and multidisciplinary team members are amongst the factors identified that threaten the general wellbeing of social workers in the Waterberg District state hospitals, as confirmed by Ajala (2012:49). In addition, in their line of duty in hospital settings, social workers deal with cases involving violence, abuse and serious illness that often drain their energy and emotional capacity, (Carlitz et al 2014:105). Hence, it is advised that services must be in place to assist them to manage the physical and psychological aspects of their harsh work environment (Ajala 2012:49). This could be done by establishing an employee wellness programme and instituting debriefing sessions provided by the employer.

Two recommendations were made by participants that social workers in the hospitals needed employee wellness services and debriefing sessions to mitigate against the outlined workplace stresses to protect them from suffering long term physical and psychological effects. This is confirmed by Shier and Graham (2013:104-105).

Participant	Excerpts from interviews
RP3	"*The other thing that I can say is that they treat just like ordinary employees.* [The participant suggests that hospital administrators do not consider the work of social workers to be potentially harmful]. *In general, we are not well cared for. Like we don't have any employee wellness services. That is what we should have."*

RP5	*"I really think that for social workers there should be debriefing. And there should be some kind of get together for social workers. We must meet once a year where we can talk to one another and share ways to cope. The social workers can say 'This is what you should do' or 'This is not how it should be done.' We should do this for ourselves. Why should we attend a conference that is arranged by someone else once a year at some place? We can do something by ourselves. We can say this is our event. We can come together to do this. There is nothing like that for us social workers, you see…"* *"…They used to have a HAART ARV (High Active Antiretroviral Therapy), event on a yearly basis. They would take the staff…the ARV staff to a lodge or something, where they would invite an external psychologist to do debriefing…"*

With reference to employee wellness services, **RP3** felt that it was an oversight on the hospital's part not to offer social workers support or resources when they were expected to manage draining client situations daily, as confirmed by Shier & Graham (2013:104): "*The other thing that I can say is that they treat just like ordinary employees.* [She suggests that hospital administrators do not consider the work of social workers to be potentially harmful]. *In general, we are not well cared for. Like we don't have any employee wellness services. That is what we should have."*

Debriefing is an intervention to help those who have been exposed to traumatic events so that they can manage early psychological and emotional distress and prevent it from becoming a post-traumatic stress disorder. Debriefing, that provides emotional and psychological care to those exposed to traumatic situations, should be available to all members of the multidisciplinary team, social workers, nurses and medical officers. Researchers found that such services enhance both employee wellness and patient care (Nocera & Merritt 2014:209; Mullan, Staple, O'Connell & Patel 2014:1; Tuckey & Scott 2013:3).

However, the hospital where **RP5** was based used to offer an annual High Active Antiretroviral Therapy (HAART) retreat for the antiretroviral therapy staff, but this was suspended because of COVID-19. **RP5** responded as follows: *"They used to have a HAART ARV (High Active Antiretroviral Therapy), event on a yearly basis. They would take the staff…the ARV staff to a lodge or something, where they would invite an external psychologist to do debriefing."* The participant proposed that social workers needed something on an ongoing basis given their risk of "burnout" or continuous stress disorder. **RP5** said**:** *"I really think that for social workers there should be debriefing. And there should be some kind of get together for social workers. We must meet once a year where we can talk to one another and share ways to cope. The social workers can say 'This is what you should do' or 'This is not how it should be done'. We should do this for ourselves. Why should we attend a conference that is arranged by someone else once a year at some place? We can do something by ourselves. We can say this is our*

event. We can come together to do this. There is nothing like that for us social workers, you see."

This need is confirmed in a study conducted by Ahmed et (2019:9) that found that employees who received support and recognition in the work place performed better and reported less psychosocial distress compared to those who did not receive any in the workplace. It is therefore crucial that social workers in hospital settings should receive support and debriefing sessions as recommended by participants to maintain their wellness and job satisfaction.

4.3.5.4 Conclusion of theme five: Participants' recommendations to improve the occupational satisfaction of social workers in multidisciplinary teams in state hospitals in the Waterberg District

This concludes the presentation of the recommendations made by participants to improve the job satisfaction of the social workers working in multidisciplinary teams in state hospitals in the Waterberg District. The recommendations are largely related to improving the working conditions of social workers based in the state hospitals by increasing their remuneration, securing additional occupational resources for social workers, increasing support and acknowledging them for the contribution their professional service offers the hospital and multidisciplinary teams, providing social work supervision, and clarifying their role within the hospital team. Participants proposed that the hospital develop a structured training system for social workers. The structured training should be comprised of in-service training opportunities, CPD accredited training for social workers, and a career progression plan for individual social workers. Participants also proposed that an employee wellness programme and debriefing sessions be instituted by the employer.

4.4 CHAPTER SUMMARY AND CONCLUSION

In this chapter the research findings of the study, commenced with the biographical data of ten social workers from eight state hospitals in the Waterberg District, Limpopo Province, who participated in the research, are presented. The subsequent findings are arranged into five themes, namely social workers' experiences and job satisfaction, social workers' perceptions of how the hospital organisation and management impacted on their ability to execute their professional mandate as hospital social workers, the challenges that they faced working in multidisciplinary teams, their coping strategies, and their recommendations for improving social workers' job satisfaction in the state hospitals in the Waterberg District.

The theme that dealt with the social workers' levels of job satisfaction indicated that hospital social workers should be acknowledged by both the hospital management and their fellow multidisciplinary team members. They should be remunerated similarly to their fellow multidisciplinary team members and be given the same respect. Their roles and tasks should be clearly defined and they should receive support from their supervisors.

The impact that the hospital organisation and management had affected their ability to carry out their professional mandate, impacted on their interdisciplinary relationships with their fellow team and negatively affected their job satisfaction.

The challenges that the social workers identified in doing their work, included a lack of necessary resources to perform their social work duties, lack of support from hospital management, lack of career development opportunities in the hospital sector and government hospital policies which are not in line with the social work profession.

The coping strategies that the social workers used to manage their work stressors were self-management, supporting one another as hospital social work colleagues and providing one another with collegial consultations.

The recommendations to improve the job satisfaction of social workers in state hospitals in the Waterberg District were to: improved the remuneration of social workers; provide social workers with appropriate occupational resources to perform their social work duties; intensify recognition and support of social workers by management, structure training opportunities and continuous professional development for social workers, and implement employee wellness and debriefings within the workplace..

One may therefore conclude that the social workers in state hospitals in the Waterberg District, Limpopo Province, were frustrated by numerous factors in the workplace. They felt that their professional roles as social workers were generally poorly understood and the professional services that they offered were not properly utilised by other professionals in the multidisciplinary teams. Medical team members often tasked the social workers to manage situations that others did not want to deal with. In many respects social workers felt marginalized and isolated in the hospitals where they worked, more like 'resident guests' hosted in a medically focused system that underplayed the importance of patients' psychosocial health care. Their needs for equitable working conditions, adequate resources, respect and support from other team members and hospital administrators, professional

supervision, employee wellness, training, and career progression were not being satisfied. Their ability to execute their professional mandate in the hospital was further affected by systemic factors based outside of the state hospitals, these were the impact of COVID-19 pandemic and the influx of illegal migrant workers who put pressure on the already exhausted resources.

However, social workers had adjusted in many respects to their harsh work environment by relying upon their personal coping mechanisms. Peer debriefing and adherence to hospital policies worked in their favour. The recommendations they made for improving the job satisfaction of social workers should be used to address their concerns at a district, provincial and national level.

The conclusions and recommendations that were reached for these findings are presented in the next chapter

CHAPTER 5

SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Chapter 1 offered a general orientation to the study and outlined the proposed research plan that developed at the outset of the research process to achieve the research goal and research objectives. It introduced the reader to the theoretical framework that was selected for the study before the detail and motivations were given about the research methodology and methods that were chosen for the research. Chapter 2 presented a review of literature related to social workers working in multidisciplinary teams in health care settings. This was followed by a detailed explanation of the theoretical framework chosen for the study: systems theory, more specifically bioecological systems approach and the life model theory. Chapter 3 described how the research methodology, the qualitative approach, and phenomenological research design, that had integrated the exploratory, descriptive and contextual research designs were applied once the research process was operationalised. The population, research sample and sampling strategies were discussed and the data collection processes that were followed were described. The process that was used to analyse the data was outlined. Detail was given about research measures that were taken to uphold the trustworthiness of the study and ethical principles that were adhered to for the protection of the research participants and the scientific integrity of this research. Chapter 4 provided full descriptions of the findings that were based on the research participants' verbatim descriptions the literature control. The biographical profile of the research participants and the findings of the five themes were presented sequentially. The findings were used to answered the overarching research question developed for this study: "**What are the experiences and challenges of social workers working in multidisciplinary teams in state-based hospitals in the Waterberg District, Limpopo Province?"**

Chapter 5 is the final chapter It is arranged in three main sections. The first section comprises a summary and conclusions of the research, followed by an explanation of the limitations inherent in the study, the researcher's recommendations made in the light of the research findings, and then ends with the summary of the chapter.

5.2 SUMMARY AND CONCLUSIONS OF THE RESEARCH FINDINGS

This section consists of a summary and conclusion of each of the four chapters. The discussion of the chapters is presented in the order as represented in Figure 5.1.

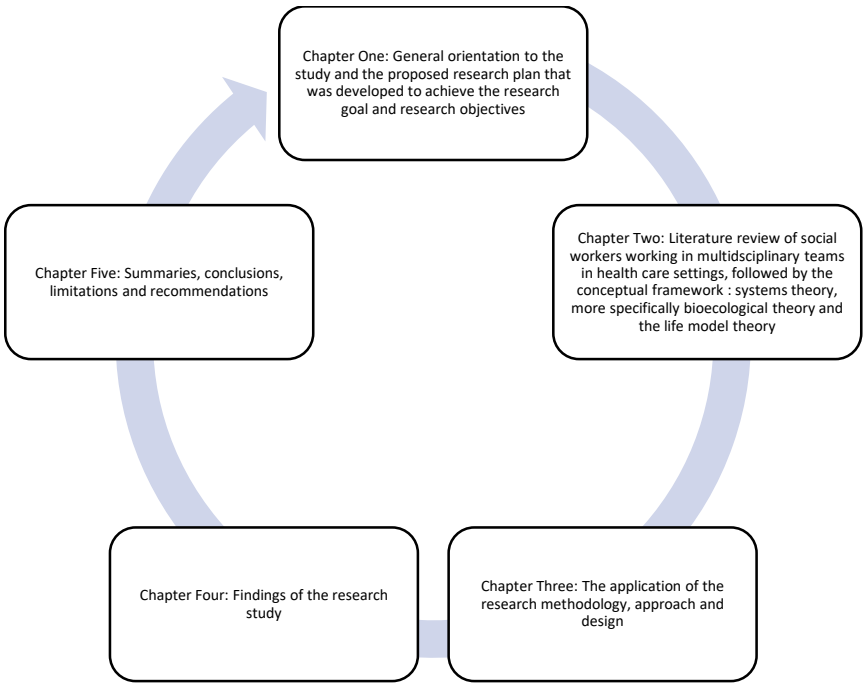

Figure 5.1: Research process and structure of the research report

As depicted in Figure 5.1, the summary of the research process and the research findings, are presented in the form of an overview of the first four chapters of this research report. Chapter 1 is a general introduction, problem formulation and orientation to the study; Chapter 2 a literature review; Chapter 3 deals with the application of the research methodology, approach and design; and Chapter 4 presents the findings of the research study.

5.2.1 General introduction, problem formulation and orientation to the study

In Chapter 1 the background motivations are provided for conducting a study that would contribute to an in-depth understanding of the experiences and challenges of social workers working in multidisciplinary teams in state-based hospitals in the Waterberg District, Limpopo Province (section 1.2). The value of including social workers in multidisciplinary teams in hospital settings is confirmed (section 2.1.1).

Scholarly definitions about multi-disciplinary teams in hospital settings are presented (Albrithen & Yalli 2016:131, Ambrose-Miller et al 2016:100; Briggs et al 2017:126; Ndoro 2013:724) (section 1.2.1.2). The definitions endorsed the value of combining the professional expertise of multiple professionals in hospitals to enhance the role of the physician by combining specialised information and interventions of different professionals who work collaboratively to offer patients holistic care. The important insight reached relevant to this study is that multi-disciplinary team members need to enjoy equal status within the team because each professional plays a specific role in patient care (Dale, Cited by McAuliffe 2009:126, Ndoro 2013:724). The benefits of adopting a multidisciplinary team approach in

healthcare for patients as reported in literature are presented and included improved intra professional communication; higher patient survival rates; shorter in-patient hospital stays; increased patient access to resources and expanded treatment options; innovations in healthcare; improved health care decisions and patient monitoring; inclusion of patients and their families in discussions about treatment options (Albrithen & Yalli 2016:129; Bowden et al 2016:56; Dobrikova et al 2016:83; Eaton 2018:853; Kirschbaum 2017:7; Ndoro 2013:726). The benefits for the multidisciplinary team members were mentioned too such as supportive relationships amongst team members; higher research outputs; improved inter-professional communication; greater work satisfaction; greater opportunities for career progression; inter professional learning; comprehensive and collaborative diagnoses (Albrithen & Yalli 2016:129; Bowden et al 2016:56; Dobrikova et al 2016:83; Eaton 2018:853 Kirschbaum 2017:7; Ndoro 2013:726). The advantages of having multidisciplinary teams in health care were noted too, namely higher quality care; contained hospital spending; increased organisational efficiency and effectiveness; and greater adherence of staff to clinical guidelines (Albrithen & Yalli 2016:129; Bowden et al 2016: 56; Dobrikova et al 2016:83; Eaton 2018:853 Kirschbaum 2017:7; Ndoro 2014:726; Dobrikova et al 2016:83)

Empirical evidence about the challenges of working in multidisciplinary teams were outlined (Beddoe 2011:35; Bowden et al 2016:83 Craig & Muskat 2013:8; Dobrikova et al 2016:83) (section 1.2.1.3). It became evident that working in multidisciplinary teams was not without challenges such as conflict between individuals and professional groups; miscommunications within the team; lack of trust; obscurity about roles and responsibilities; clashing of goals and objectives fuelled by value differences amongst the diverse disciplines within the teams; poor leadership; inequality in decision making; and power amongst team members that were issues that generated stress that were commonly cited.

Some changes in social work and health care as experienced by social workers in hospital settings were briefly mentioned, namely funding shortages; rising costs of life-saving approaches for chronic care recipients; expanded use of costly medications; expanded treatment options and services made available to patients, especially those suffering complex health conditions; and increasing hospitalisations (Craig & Muscat 2013:7) (see section 1.2.2). Additionally, new realities in welfare services as outlined by Delobelle 2013:160 & Drucker (2017:46) seemingly had affected social work services in hospital settings in the form of the industrialisation of social work services in the 1990's; remodelling of the health care sector in the post-apartheid and colonial eras in South Africa; widened access for previously disadvantaged people to state hospital care; the imminent recognition of hospital social work as a specialised clinical service in South Africa; and the global pandemics of HIV and COVID-19. This background spurred the researcher's curiosity to discover how social workers based

in multidisciplinary teams in hospital settings had adapted to these “new realities” (Nwanchukhu 2015:139) particularly in state hospitals in the Waterberg District. The researcher discovered that historically little focus had been given on the adaptations social workers had made in response to changes in social work practice in hospital settings (Weiss 2005:3). The researcher therefore concluded that a broader systemic perspective of the experiences of social workers working in multidisciplinary teams in the Waterberg District state hospitals, Limpopo Province, was needed to track their experiences, challenges and coping measures.

The dearth of publications located about contextual realities of social workers working in multidisciplinary teams in the Waterberg District state hospitals in Limpopo Province became obvious. The decision to focus on developing a locally specific understanding of these social workers’ experiences was therefore warranted. It was concluded that an exploratory, descriptive and contextual understanding would highlight the intersectionality and interrelatedness of challenges social workers faced working in multidisciplinary teams in state hospitals in the Waterberg District. Such a study would inform role players about the coping measures social workers used to adapt to and deal with the challenges or changes that had affected their roles, occupational satisfaction and professional identity.

There were several studies that focussed on the risk and protective factors of working in multidisciplinary teams in hospital settings, but their focus was more on intra organisational factors and overlooked external factors. Also, insufficient information was available about social workers working in multidisciplinary teams in hospital settings and how their work experiences impacted on their occupational satisfaction and professional identity in the hospital settings. In addition, there were no locally specific publications about social workers, working in multidisciplinary teams in state hospitals in the Waterberg District and their meanings about how they were treated by hospital management and other multidisciplinary team members. It was concluded that the interactions social workers had with hospital management and multidisciplinary team members could contribute positively or negatively to their occupational satisfaction and professional identity as social workers in hospital settings. This assumption confirmed the importance of conducting this study.

The setting of the study was contextualised by offering an overview of health care in Limpopo Province, focussing more specifically on the Waterberg District state hospitals (section 1.2.3). The high influx of illegal migrants from neighbouring countries into Limpopo Province had added additional strain on the already overburdened Waterberg District Hospitals (Misago 2017:40). The combination of the high rate of social problems in the province and financial problems of the Limpopo Provincial Government had undermined the quality of health care in

the state hospitals (Delobelle 2013:162; Phasha 2015:39). Several factors such as a shortage of medical personnel, poor working conditions, low staff morale and poor career opportunities were reported as contributing factors to the poor management of the state hospitals (Bezuidenhout 2017:193; Phasha 2015:22,39) It was further mentioned that the health care system in Limpopo Province was overburdened by the high rate of HIV/AIDS (Phasa 2015:39) and then later, by COVID-19 in 2020.

The nine hospitals in the Waterberg District, each employed between one and three permanent fulltime social workers. There was a total of thirteen social workers who worked in multidisciplinary teams in the Waterberg District state hospitals. The social workers either reported to the matron in charge of the wards they were assigned to, or if they worked alone in one of the state hospitals, they reported to the allied manager responsible for the hospital support services. Newly qualified social workers received supervisory support from an experienced social worker based within the hospital where he or she worked, and in the absence of a qualified social worker at the hospital, he or she reported to an experienced social worker based at the Waterberg District state hospital closest to him or her.

Therefore, it was concluded that a locally specific study was needed to understand what intra organisational factors within the Waterberg state hospitals and inter-organisational factors outside the Waterberg state hospitals impacted on social workers in the multidisciplinary teams. The dynamics of this locally specific cohort had to be explored separately to understand the unique contextual realities that social workers had to deal with.

The combined issues as presented, shaped the problem statement (see section 1.2.4) and the rationale for undertaking this study (see section 1.2.5). Based on the lack of locally specific literature about the perceptions and experiences of social workers working in state hospitals in Waterberg District, a qualitative study was needed. An understanding of protective and prohibiting factors responsible for social workers' occupational satisfaction, professional identity and their ability to fulfil their professional mandate as social workers within the state hospitals where they worked, was necessary. The recommendations emanating from the study would be used to inform interventions to improve the occupational satisfaction and the professional identity of social workers working in multidisciplinary teams in state hospitals in Waterberg state hospitals.

The rationale presented was that the researcher, a senior social worker based in one of the state hospitals in the Waterberg District, had mediated conflicts between social workers and other professionals in the multidisciplinary teams they were assigned to in that area. Issues he had to mediate included social workers' complaints that they were often excluded from rendering psychosocial services to patients and their families and instead performed practical

tasks other team members evaded such as discharge planning, organising transport and social relief for indigent patients. The occupational satisfaction of the social workers was low and they perceived others in the hospital setting as undermining their professional identity. Social workers objected to reporting to allied clinical managers in the hospitals who were not qualified social workers, which was the norm. The social workers' need for specialised CPD training opportunities for social workers was discounted. Social workers found it difficult to interject the medical ethical principles and values because their social work values were so different. The researcher resolved there was a need to empirically validate the social workers' complaints so that the emergent findings could be used to generate solutions to increase the occupational satisfaction and improve the professional identity of social workers working in multidisciplinary teams in the state hospitals in the Waterberg District.

The conclusion reached confirmed that an exploratory, descriptive and contextual study of the experiences of social workers working in multidisciplinary teams in state hospitals in the Waterberg District, Limpopo Province, was needed. As evident further on in the chapter, the information that was gathered has informed recommendations of what needs to be done to increase the occupational satisfaction of social workers working in multidisciplinary teams and uphold their professional identity within these locally specific hospital settings.

The theoretical framework applied in the study was outlined in section 1.3. The researcher opted for systems theory, a combination of Bronfenbrenner's bioecological systems approach and Gitterman and Germain's life model to frame the study. Systems theory was chosen to achieve a holistic account of positive and negative factors that influenced the experiences of social workers working in multidisciplinary teams in state hospitals in the Waterberg District. A dynamic perspective of the organisational functioning of the Waterberg District hospitals and the multidisciplinary teams that operated there, was needed (Barile et al 2016:654; Teater 2010:18). The findings revealed that there were several systems within the Waterberg District hospitals and externally, that were responsible for hampering the ability of the hospital social workers to meet their professional mandate. Systems theory provided both an epistemological and methodological research approach which contributed to the scientific integrity of this study (Barile et al 2016:654).The bioecological systems approach and Gitterman and Germain's life model theory were combined to achieve a deeper more holistic understanding of how leadership was structured in the state hospitals in the Waterberg District, and what the strengths and challenges of individual social workers, the multidisciplinary teams and the hospitals where they worked were (Alexander & Hearld 2012:3). The combined theories highlighted operational and human factors such as trust, leadership and cohesion that needed to be addressed to improve the occupational satisfaction and professional identity of social

workers working in multidisciplinary teams in the state hospitals in the Waterberg District (Alexander & Hearl 2012:3).

It was concluded that applying the combined theories of Bronfenbrenner's bioecological theory and Gitterman and Gremain's life model theory was valuable for this study. They helped the researcher to develop a structure that assisted him to report the study's findings in a logical, organised way (see section 4.3.4 in Chapter 4). The two theories deepened the researcher's understanding of proximal relationships the social workers experienced within the multidisciplinary teams (micro and meso system levels) as well as the distal transactions they encountered in the Waterberg District state hospitals (exo system level) and broader state departments such as the DoH, DSD, and the SACSSP (macro system levels) over which they had little control. A summary of the findings appears in section 5.2 which confirms that both theories were successful in deepening understanding of the meanings the research participants ascribed to their experiences within the multidisciplinary teams, the challenges they faced and the coping strategies they used to adapt to their working conditions. The internal and external factors that impacted on the occupational satisfaction and professional identity of the social workers in the multidisciplinary teams in the Waterberg District state hospitals were detailed in Chapter 4.

5.2.1.1 Research question and sub questions

The research question, goal and objectives of the study were outlined in section 1.4. One central, broad question about the overarching issue of interest was developed for this study (Creswell 2014:139) (see section 1.4.1). The overarching research question was:

What are the experiences and challenges of social workers working in multidisciplinary teams in state-based hospitals in the Waterberg District, Limpopo Province?

The overarching research question was broken down into five sub-questions. The sub-questions and summarised versions of the participants' answers entail the following (with more detailed answers to the sub-questions presented in sections 5.2.1 to 5.2.5):

- **Outcomes to the first sub-question**

The first sub-question was: ***What are the social workers' experiences of job satisfaction working in multidisciplinary teams in state hospitals in the Waterberg District?***

Some participants indicated that there were several positive factors of working as social workers in multidisciplinary teams in state hospitals in the Waterberg District, namely that they-

- benefitted from the personal satisfaction of doing social work and helping their patients;

- were stimulated by the specialized training and orientations that the hospitals had exposed them to;
- felt that their role in the hospitals were acknowledged by the hospital management and other multidisciplinary team members; and
- appreciated the multidisciplinary team collaborations and their benefits.

These perspectives were consistent with the factors outlined as the benefits of multi-disciplinary teams in hospital settings in section 2.2.2.1.

However, participants were more expressive about their negative experiences of working in multidisciplinary teams in state hospitals in the Waterberg District than their positive experiences. Their responses pointed to individual factors such as

- The nature of their work was taxing; their workload was too heavy; and they were frustrated by receiving instructions from line managers who were not well informed about social work issues.
- They complained of the lack of social work supervision, poor support, and inadequate collaborations in the hospitals where they worked.
- Another factor that compromised their job satisfaction was a combination of poor hospital organization, management and employment policies that negatively affected social workers, such as poor remuneration, poor opportunities for career progression, lack of resources to do their work properly, and inadequate acknowledgement and recognition from other team members and hospital management.
- For some, the level of job satisfaction was so low that they were contemplating leaving their jobs.

- **Outcomes to the second sub-question**

The second sub-question was: ***What are the social worker's experiences of the hospital organization and management of state hospitals in the Waterberg District?***

The participants' experiences of the hospital organization and management of state hospitals in the Waterberg District indicated that they –

- felt disrespected and unsupported;
- had to contend with poor resource allocations for social work departments;
- struggled with the lack of clarity that other multidisciplinary team members had about the role of social workers in hospital settings; and

- mention was made of the poor relationships that existed between social workers and the hospital management of the state hospitals in the Waterberg District where they worked.

- **Outcomes to the third sub-question**

The third sub-question that was posed was: ***What challenges do social workers experience working in multidisciplinary teams in state hospitals in the Waterberg District?***

The outcomes to this sub-question pointed to the following challenges individuals faced:

- Limited opportunities to advance their skills and knowledge; poor career development opportunities; and the heavy work load they as social workers had to contend with in the state hospitals in the Waterberg District.
- Participants struggled with internal challenges within the multidisciplinary teams and the hospital organization and management. The challenges social workers faced at this level, included a poor understanding of social work in a hospital setting; and their feeling of being unheard and not taken seriously when they raised their dissatisfactions with management.
- They were also challenged by having had to contend with several external challenges that undermined the functioning of social workers in the state hospitals in the Waterberg District. These external challenges mentioned included politics, policies and centralized power within the Department of Health and the Department of Social Development; the lack of community-based resources for patients and their families in the Waterberg District; the influx of foreign nationals into the Limpopo Province; and the COVID-19 pandemic.

- **Outcomes to the fourth sub-question**

The fourth sub-question was: ***What coping strategies do social workers use to adapt to working in multidisciplinary teams in state hospitals in the Waterberg District?***

The coping strategies the participants mentioned were subdivided into several subthemes, namely individual coping strategies; supervision; using their education and training; and adhering to district and provincial DoH policies.

- The individual coping strategies included the flexibility of individuals to adapt to their work circumstances; choosing to focus on the bigger picture - their life purpose; adopting the inner value of altruism - serving others; and letting off steam.

- The categories associated with supervision as mentioned by participants included the support offered by the supervisors and peers (collegial consultations) they interacted with in the workplace (the multidisciplinary team members, social workers based in other state hospitals in the Waterberg District, and social workers employed in social work services in the community (NGO's).
- Participants' responses associated with education and training included utilizing their social work undergraduate education and training; and independently pursuing online training offered by external service providers.
- The point made by participants about the benefits of adhering to district and provincial DoH policies was that these policies set the professional standards of care for all health professionals, and that social workers had no choice but to follow them.

- **Outcomes to the fifth sub-question**

The fifth sub-question was: ***What recommendations do social workers have for improving the occupational satisfaction of social workers in multidisciplinary teams in state hospitals in the Waterberg District?***

Several recommendations were received from participants about what needed to happen in state hospitals in the Waterberg District to improve the occupational satisfaction and professional identity of social workers working there. The recommendations were presented under three subthemes, that is improving the working conditions of social workers in the workplace; ensuring social workers received adequate training and professional development opportunities in the state hospitals in the Waterberg District; and providing social workers with employee wellness and debriefing services in the workplace:

- The participants' recommendations for improving the working conditions of social workers included improving the remuneration of social workers in state hospitals; facilitating their access to occupational resources they needed to execute their professional mandate in the state hospitals where they were based; increasing the support and acknowledgement they received from other multidisciplinary team members and hospital management; procuring qualified social work supervisors to supervise the hospital social workers in place of non-social work allied clinical line managers; and developing clearly defined job descriptions for social workers employed in multidisciplinary teams in state hospitals in the Waterberg District.
- The recommendations which related to the training and professional development of social workers included providing suitable in-service training for social workers; extending the access of social workers to SACSSP accredited CPD training

opportunities; introducing career planning and professional development plans for hospital social workers.

- Recommendations were made for providing employee wellness programmes and debriefing sessions for social workers in the hospitals.

The summarised findings were based on the data gathered directly from the research participants. The findings verify that the research question and sub questions were adequately answered.

The research goal expressed at the outset of the study (in section 1.4.2) was to develop an in depth understanding of the experiences and challenges of social workers working in multidisciplinary teams in state hospitals in the Waterberg District. The detailed subjective experiences of the research participants were reported in-depth in Chapter 4. The findings confirm that an explorative, descriptive and contextualised understanding of social workers' experiences of working in multidisciplinary teams in state hospitals in the Waterberg District was achieved.

The conclusion regarding the conducting of the research process was that the researcher kept the research process focussed and did what was necessary to satisfy the research goal (Lee et al 2015:299). The findings outlined in Chapter 4 confirm that a detailed exploration and understanding of social workers working in multidisciplinary teams in state hospitals in Waterberg District, Limpopo Province was achieved (Hesse-Biber & Leavy 2011:38).

5.2.1.2 Research objectives

The research objectives developed for the study are outlined in section 1.4.3. As this was a qualitative study it was necessary to discover and make sense of the lived experiences of the social work participants and their contextual realities directly after a lengthy engagement with them (Ritchie et al 2013:4). The specific research objectives that were developed to achieve the research goal (Ritchie et al 2013:4) are presented next, with an indication of the extent to which they were achieved.

- Objective one: **To explore the experiences and challenges of social workers based in multi-disciplinary teams in state hospitals in the Waterberg District, Limpopo Province.**

This study was a qualitative study that relied on the meanings the participants ascribed to being social workers in multidisciplinary teams in state hospitals in the Waterberg District. The researcher conducted face-to-face semi-structured interviews with ten participants who were purposively selected for the study. An interview guide that consisted of twelve open-ended questions was developed to ensure that the researcher would ask relevant questions in a

flexible way (see Addendum I. The questions encouraged participants to discuss their experiences and challenges of working in multidisciplinary teams in state hospitals in the Waterberg District and share the coping strategies they relied on to adapt to their work situation. Pre-interview sessions were arranged with all participants before the interviews commenced to inform participants of what would be expected of them and what their rights as research participants were. As a result, participants were relaxed and comfortable about sharing their personal experiences. The participants' detailed and informative responses are discussed in Chapter 4 and confirm that the data collected could be used to answer the research question and sub-questions.

Conclusion: the researcher confirms that this research objective was achieved.

- Objective two: **To describe the experiences and challenges of social workers based in multi-disciplinary teams in state hospitals in the Waterberg District, Limpopo Province.**

The aim of the study was to develop a rich description of the experiences and challenges of social workers based in multi-disciplinary teams in state hospitals in the Waterberg District. The qualitative approach integrated exploratory, descriptive and contextual designs which contributed significantly to the rich data that were gathered. Information was collected from each participant and the data were verified using an online focus group discussion. The data were analysed, and the detailed findings are presented in Chapter 4 and section 5.2. The research participants' verbatim descriptions were used throughout, to illustrate the participants' responses to the research questions as arranged according to the five themes confirmed as follows during data analysis:

  - **Social workers' experiences of job satisfaction working in multidisciplinary teams in state hospitals in the Waterberg District:** The detailed descriptions of participants' experiences of job satisfaction are presented (see section 4.3.1). The participants' perspectives of their positive and negative experiences of job satisfaction in state hospitals in the Waterberg District confirm that this objective was attained.
  - **Social workers' experiences of hospital organisation and management in state hospitals in the Waterberg District:** Detailed descriptions of participants' experiences of hospital organisation and the management in state hospitals in the Waterberg District are presented (se section 4.3.2). The descriptions address several aspects of participants' perceptions about management and hospital organisation and how they, as social workers, were affected by them. The detailed descriptions confirm that this research objective was fulfilled.

- **Challenges social workers face in multidisciplinary teams in state hospitals in the Waterberg District:** The description of the challenges social workers faced in the multidisciplinary teams in the state hospitals in the Waterberg District were discussed in section 4.3.3. The researcher is satisfied that the depth of information presented in that section verifies that this research objective was attained.
- **The coping strategies social workers use to adapt to working in multidisciplinary teams in state hospitals in the Waterberg District:** Participants provided a range of coping strategies they used to cope with their work situations as were outlined in depth (see section 4.3.4). Some participants' shared their experience of not coping in the multidisciplinary teams in state hospitals in the Waterberg. The range of coping strategies as well as the different levels of coping amongst participants discussed provide evidence that this objective was adequately achieved.
- **Social workers' recommendations to improve the occupational satisfaction of social workers working in multidisciplinary teams in state hospitals in the Waterberg District:** Participants shared their suggestions about how the occupational satisfaction of social workers working in multidisciplinary teams in state hospitals could be improved and these were presented (see section 4.3.5). It can therefore be concluded that this objective was adequately met.

Conclusion: the verbatim extracts taken from the individual interviews were used to answer each research question, were juxtaposed against the literature control, confirm that this research objective was achieved.

- Objective three: **To contextualize the experiences and challenges of social workers based in multi-disciplinary teams in state hospitals in the Waterberg District, Limpopo.**

To achieve this objective, the guidelines offered by Creswell and Creswell (2018:193) were followed. Six steps outlined by the authors were followed when the data were analysed (Creswell & Creswell 2018:193-194).

- The raw data were organised and prepared;
- the transcripts were carefully scrutinised;
- different words were used to code the data;
- the codes were used to label the themes that emerged; narrative passages that described the themes were extracted from the transcriptions; and
- the extracted descriptions using participants' own words were used to build a contextual understanding of the phenomenon.

Electronic databases enabled the researcher to conduct a literature control by identifying scholarly sources to validate, substantiate or offer different perspectives to those of the research participants. The literature review was presented in Chapter 2. Applying the bioecological systems theory and the life model theory enabled the researcher to deepen the meanings participants gave. Protective and risk factors as mentioned by participants were arranged according to the different bioecological system levels, namely the micro; meso; exo and macro system levels. Additional information was needed to contextualise certain aspects of the findings when Chapter 4 was collated.

Conclusion: the objective to contextualize the experiences and challenges of social workers working in multi-disciplinary teams in state hospitals in the Waterberg District, Limpopo Province was achieved.

- Objective four: **To draw conclusions about the findings regarding the experiences and challenges of social workers based in multi-disciplinary teams in state hospitals in the Waterberg District, Limpopo Province.**

The detailed summaries and conclusions of the five themes presented in Chapter 4 and the themes are summarised again in the summary (see section 2.4). The conclusions about the general introduction and orientation to the study, the research question and sub-questions, research goal and objectives were successfully stated. The conclusions about Chapters 2 to 4 are still to be presented (see section 5.2.4.3).

Conclusion: At the end of this final chapter, it will be evident that this outcome was achieved.

- Objective five: **To make recommendations that can be used to improve the occupational satisfaction and professional identity of social workers working in multi-disciplinary teams in state hospitals in the Waterberg District, Limpopo and share these with relevant audiences to encourage the development of responsive interventions.**

The recommendations that emerged from the findings were presented in two parts.

  - Firstly, as recommendations made by research participants themselves about the changes they thought were needed to improve the occupational satisfaction and professional identify of social workers working in multidisciplinary teams in state hospitals. These were discussed at the end of Chapter 4 and are mentioned again in summary form at the end of this final chapter.
  - Secondly, the final recommendations that conclude this chapter (see section 5.4) are presented in three categories: recommendations related to improving social work

practice, training and education; recommendations for further policy and programme development; and recommendations for further research on this topic.

In short, applying the combined recommendations of the participants and the researcher can be used to promote and strengthen the improve the job satisfaction and professional identity of social workers based in multidisciplinary teams in state hospital settings in the Waterberg District.

Conclusion: the recommendations mentioned in sections 5.4.1 and 5.4.2 confirm that that this objective was achieved.

The researcher is satisfied that the summary of Chapter 1 provided an adequate overview of the background of the study, the research question and sub questions, the research goal, and objectives. The outlined research plan developed for the study was appropriate as will be confirmed in the summary and conclusions of Chapter 3 (application of research methodology, approach and design). The next section offers the summary and conclusions of Chapter 2 (the literature review)

5.2.2 Literature review

Chapter 2, the literature review, was presented in three parts: social workers in hospital settings; ‘new realities’ affecting social workers in health care settings; and the theoretical framework developed for this study, as listed in Table 5.1.

Table 5.1 Literature review

PART 1	PART 2	PART 3
Social workers in hospital settings	'New realities' affecting social workers in hospital settings	Theoretical framework for the study
•The role of social workers in a hospital settings •Multidisciplinary teams in hospital settings •The benefits of multidisciplinary teams in hospital settings •Challenges faced by social workers in multidisciplinary teams in hospital settings	•Changes in the South African Health Care system •Industrialisation of social work in the early 1990's •South African 'new realities' impacting of social work practice in hospital settings: changes in the South African health care system; changes n the South African welfare system ; specialisation of social work in health care in South Africa; HIV/AIDS and COVID-19 pandemics; .	•Systems theory •Bronfenbrenner's bioecological systems approach •'Person-in-enviroment' theory

- **Part 1 of the literature review** as listed in Table 5.1: Social workers in hospital settings.

The discussion commenced with several scholarly perspectives about the introduction of social workers into hospitals.

- Reference was made to Richard Cabot, who was the first physician to integrate the services of social workers into hospital care in the United States of America in and around 1905 (Kirschbaum 2017:6; Pugh 2011:32).
- Note was taken of the broadened contributions that social workers have made since then to patient care, patient rights' and communication between the medical team, patients and the family of patients, have been of value, and have sensitised other members in the multidisciplinary teams to the contextual and relational factors that impact on patient wellbeing (Kirschbaum 2017:6; Kitchen & Brook 2005:6; McAuliffe 2009:130-131).
- The extension of roles social workers is currently allocated in hospital settings was mentioned. They were advocating for services for patients within health care being instrumental in changing the traditional medical model approach in health care to a more person centred one (Kitchen & Brook 2005:6; Limon 2018:1), defending patients' wishes and promoting human and social justice rights of those receiving medical treatment (Limon 2018:1).
- Apropos to the strong commitment that social workers demonstrate in terms of upholding social justice and human rights, it was concluded that social workers now play a leading role in supporting patients and their families who are faced with difficult value-based treatment decisions in specialised fields of care such as organ transplants, oncology, genetics, mental health treatment, intensive care (Brown et al 2016:1; Estelle 2017:31; Steyn & Green 2010:3).
- The social work ethics and anti-oppressive values of social workers attest to how valuable social workers have been in hospital settings in South Africa during the transformation of state hospitals after the post-apartheid era.

Next, the positive contributions multidisciplinary teams in hospital settings have made in improving hospital functioning became the focus.

- The points mentioned included: improving hospital efficiency, improving service delivery, containing hospital expenditure; reducing hospital stays and premature hospital admissions (Albrithen & Yalli 2016:129; Dobrikova et al 2016:83).
- The benefits of multidisciplinary team members were presented as increased support; extended expertise about patients' health care; increased access to the patient's

significant others; and shared decision making about patient management and support when dealing with difficult patients (Albrithen & Yallis 2016:131; Kirschbaum 2017:7).

- The benefits of multidisciplinary teams for patients included increased access to health care; promotion of patient self-care; more treatment options; increased access to a wider range of services offered by different external service providers (Agnew et al 2018:118: Dobriková et al 2016:83).

These advantages, collectively, contributed to the greater work satisfaction amongst multidisciplinary team members.

Scholarly perspectives of improving the positive outcomes of multidisciplinary teams were listed as -

- designating physical spaces for team members to converge and build a shared sense of purpose; arranging regular revisioning of multidisciplinary team goals; and
- nurturing effective communication; and developing an effective leadership structure (Leach et al 2018:116).

Four key factors of effective teamwork in multidisciplinary teams in hospital settings were noted, namely

- shared values amongst team members;
- clearly defined inter-professional roles and responsibilities;
- good inter-professional communication;
- and constant promotion of ongoing collaboration within the teams (Ambrose-Miller et al 2016:100; Dobriková et al 2016:83; Kirschbaum 2017:8; Mc Auliffe 2009:126).

The actions that contributed to good communication in hospital settings discussed, included -

- regular communication meetings;
- regular CPD training sessions;
- coordinated interdisciplinary patient review meetings;
- improved access of all team members to patient files;
- regular face-to-face team meetings;
- and the application of up-to-date electronic telecommunication methods (Giles 2016:28).

Specific challenges faced by social workers in multidisciplinary teams in hospital settings as addressed in the literature provided valuable insight. Challenges that were highlighted included –

- professional rivalry and mistrust (Ambrose-Miller et al 2016:101-107; Beytell 2014: 176; Hannson et al 2008:6; Kirschbaum 2017:29);
- domination by and lack of support from medical practitioners (Albrithen & Yalli 2016:129-130; Ambrose-Miller et al 2016:101-105; Beytell 2014:176; Dobriková et al 2016:83; Fraser 2010:27);
- different philosophical orientations to health adopted by different disciplines represented in multidisciplinary teams because of their training (Kirschbaum 2017:29; Fraser 2010:9), the social work worldview that advocating for human rights and social justice is central to all social work action (Dobriková et al 2016:87; Wayne & Rachelle 2016:101-109);
- lack of clarity about professional roles and role boundaries for social workers in hospital settings (Albrithen & Yali 2016:132; Frost et al 2005:188; Kirschbaum 2017:10; Raniga & Kasiram 2010:263; Ambrose-Miller & Ashcroft. 2016:101-109);
- role blurring within multidisciplinary teams (Albrithen & Yalli 2016:132; Ambrose-Miller et al 2016:101-105; Frost et al 2005:188; Kirschbaum 2017:10; Raniga & Kasiram 2010:263);
- oppressive management structures that are over represented by medical personnel (Dobriková et al 2016:85-91; Fraser & Saskatchewan 2010:27; Kirschbaum 2017:11);
- insufficient medical knowledge held by social workers (Beytell 2014:176); and
- inequitable remuneration and work conditions amongst multidisciplinary team members with social workers earning considerably less than the other team members and enjoying fewer work privileges (Leach et al 2018:116)

- **Part 2 of the literature review** as listed in Table 5.1: 'New realities' affecting social workers in hospital settings.

Having discussed the different ways social workers were integrated into hospital settings, the different roles they played in hospital settings, the nature of social work services delivered in hospitals, the coping strategies social workers used to survive in hospitals, the attention shifted to several factors that had impacted on hospital social work since the 1990's. These factors were labelled "new realities" and included the post-apartheid transformation of the South African health care system; the industrialisation of social work services in the early 1990's; changes in the South African welfare system; the specialisation of health care in social work, and the HIV/AIDS and COVID-19 pandemics.

Starting with the **changes in the South African health care system**, mention was made of the South African government's commitment to creating parity in all services that government departments delivered to South Africans, especially in health care. The two major challenges

of trying to achieve the desired parity were **finding ways to narrow the inequity of health services available in urban and rural areas**, (Coovadia et al 2009: 817; Plaks & Butler 2012:138; Omotoso & Koch 2018:1) and **replacing the old institutional health system that focussed on acute health care with a primary health system that would reach more people** (Coovadia et al 2009: 817).

These major changes placed strain on the South African healthcare services and resulted in the quality of health services steadily declining (Coovadia et al 2009:817; Delobelle 2013:159; Plaks & Butler 2012:138).

- The conclusion reached was that fragmentation, segregation and social injustice were still evident in the South African health system (Bhengu & Maphumulo 2019:1).
- The majority of South Africans were dependent upon a public health system that could not meet the demand (Plaks & Butler 2012:138; Mbecke 2016:3201).
- Those with a background of extreme disadvantages were susceptible to high levels of disease which included HIV/AIDS, TB, pre-transitional diseases and non-communicable diseases (Bezuidenhout 2017:190; Delobelle 2013:159).
- Those living in disadvantaged communities were predisposed to many forms of community violence, which explained why the health care system is unable to cope (Delobelle 2013:159).

The next “new reality” mentioned was the **change within the South African welfare system when the White Paper for Social Development (1997) was introduced**. Up till 1997, social work practice was remedial in nature and based on an institutional care model. The institutional care model was replaced with a developmental approach. Community work, preventive and developmental services were prioritised to address the high rate of social issues such as people living in poverty, fragmented families, abandoned children, substance abuse, gender-based violence and offer those in need a continuum of care ranging from prevention to statutory care (Qalinge 2022:76).

- Suddenly there was an expectation of social workers to promote both social and economic development in practice (Lombard 2008a 231). Social workers in hospital settings struggled to integrate socio economic interventions with their client systems for several reasons.
- The hospital teams failed to understand the relevance of developmental services in a hospital setting and social workers were not properly trained in the developmental approach and clung onto the psychosocial approaches they were accustomed to using with patients (Beddoe 2011:24).

- The socio structural forces responsible for preventing those living in poverty were difficult to dismantle and oppression, inequality, and poverty continued to exist (Mbecke 2016:3201).
- It was concluded that little empirical evidence was available about the goodness-of-fit between the revised social work services expected of social workers and the expectations of hospital management and other multidisciplinary team member's expectations of the social workers who operated in the state hospitals.

Another "new reality" mentioned was the process initiated by the **SACSSP to recognise social work in health settings as a specialised area of social work practice**. The intended scope of practice for social workers in the speciality of social work in health care as outlined in the Requirements for the Conditions for Registration of a Speciality in Social Work in Health Care (2020) were presented.

- Apart from the bio-psycho social services the social workers were accustomed to rendering, it was evident that they would be expected to play a more active role in health education and prevention of illnesses; empowering patients; rendering community-based education; interfacing with other interested parties to develop sustainable resources for patients; advocating for policies, practices and legislation to promote the interests and wellbeing of patients; establishing collaborations between patients and other health service providers; and advocating for the needs of their client systems.
- It was concluded that specialist social workers in health settings would have to align themselves more closely with the kinds of social work practice mandated by the White Paper for Social Development (1997) rather than the medical model they were accustomed to using in the hospitals.
- The published minimum regulations for registering as a specialist social worker in health care appeared to be demanding. The minimum requirement was a bachelor's degree in social work with five years' relevant evidence based practical knowledge and experience within the scope of social work in health care (Regulations relating to the registration of a speciality in social work in health care 2020).

These factors suggested it could be difficult for hospital social workers to qualify to register as a specialist in medical social work (Olckers 2013:12).

The last "new realities" mentioned were **the HIV/AIDS and COVID-19 pandemics**.

HIV/AIDS had an intense social impact in South Africa.

- Programmes to prevent mother to child HIV transmission and expand the roll out of ARVs were very costly for the health care system (Bezuidenhout 2017:193) and added its financial drain (Schmid 2016:148).
- The financial strain became worse when foreign funding for HIV/AIDS was withdrawn. Massive budget cuts in the DoH were introduced to contain health care spending.
- The burden of care for HIV/AIDS patients remained with the families and the social workers who offered them intense social work support (Bezuidenhout 2017:193).
- The coexistence of HIV/AIDS and TB morphed into a multi-drug resistant TB which was expensive for the government to manage (Bezuidenhout 2017:190).

The COVID-19 pandemic forced further health care spending despite the DoH's coffers being close to empty. Urgent measures were implemented to flatten the curve of the pandemic and increase the health care system's capacity to manage serious COVID-19 cases (Cai et al 2020b:1; Chughtai & Malik 2020:2). The South African Government declared a national state of disaster on 27 March 2020. Several lockdowns were imposed as the first four COVID-19 waves were experienced in South Africa (Bhoumily 2022). COVID-19 prevention strategies discouraged face to face contacts, imposed strict health and safety protocols, restricted public gatherings and people's access to public spaces, restricted hospital visits, and imposed restrictions on the sale of alcohol and tobacco.

It was inevitable that social workers had to adapt their services. They were prohibited from conducting normal family visits and family counselling sessions, and forced to suspend many of their support services (Cai et al 2020a:301; Willan et al 2020:1);

- Hospitalised COVID-19 positive patients were quarantined and many died without their families being able to take leave of them.
- Families struggled to access information about hospital inpatients (Barber et al 2015:3).
- The combined effects of self-isolation; social distancing; shortages of personal protective equipment were additional factors that caused emotional and mental frustration for social workers who found themselves being front-line workers at that time (de Quervain et al 2020:3; Willan et al 2020:2; Greenstone & Nigam 2020:4).
- It was concluded that social work functions in hospitals were negatively affected by several external factors. These external factors were anticipated to have had an impact on the roles and responsibilities of social workers in multi-disciplinary teams in South African hospitals. Additional external threats were identified when the data were analysed.

The information about the “new realities” deepened the researcher’s understanding of the kinds of frustrations social workers encountered in the settings where they were employed when they had to deal with external realities over which they had not control. The external factors demanded “adaptedness” from them, a concept coined by Gitterman and Germain (cited by Teater 2010:19) to enable a good ‘person-in-environment’ fit (Gitterman & Heller 2010:204).

- **Part 3 of the literature review** as listed in Table 5.1: The theoretical framework developed for the study

The theoretical framework developed for the study consists of the systems theory, more specifically a combination of Bronfenbrenner’s bioecological systems approach and Gitterman and Germain’s life model theory.

Concepts associated with **systems theory** include such terms as “systems”, “units”, “functioning as a whole” and the notion of different units of a system working together in “a synchronised and systematic manner to achieve a system’s purpose or goal” (Lindsay 2013:123; Teater 2010:18). These terms were valuable for explaining the functioning of multidisciplinary teams in state hospitals in the Waterberg District.

- The Waterberg District state hospitals consisted of different units separated by “invisible boundaries” that differentiated the units from one another (Teater 2010:19).
- The notion of a system trying to maintain its “state of equilibrium” in pursuit of its goals was used to understand the adaptation reaction social workers used when faced with unexpected challenges and change in the Waterberg district hospitals (Teater 2010:19).
- Systems theory enabled the researcher to focus specifically on the dynamics within the hospital system and explore the quality of interactions between social workers and the multidisciplinary teams, hospital management, and the broader external systems such as DoH, DSD and the SACSSP. The advantages of using the systems approach for this study were made explicit in section 1.2.2.

It was concluded that this approach enabled the researcher to deepen the meanings research participants provided, organise the information during data analysis and present the findings logically in an orderly fashion. However, systems theory on its own was too general. Greater specificity was required to uncover deeper meanings of the experiences, challenges and coping strategies of the research participants. Therefore, a combination of Bronfenbrenner’s bioecological systems approach and Gitterman and Germain’s life model theory was used to create the theoretical framework for the study.

Bronfenbrenner's bioecological systems approach helped the researcher to subdivide the contexts in which social workers operated into the five classic systems levels that are characteristic of the approach, namely the micro, meso, exo, macro and chrono systems (Rosa & Tudge 2013:26-247).

- The researcher examined the microsystem of individual social workers to understand the unique perceptions and experiences they associated with working in multidisciplinary teams in state hospitals in the Waterberg District (Holosko & Feit 2013:10); the sense of wellness they experienced working in multidisciplinary teams (Barile et al 2016 206:658); their perceptions of job satisfaction and professional identity; their personal reflections of the challenges they faced and coping mechanisms they used to overcome the challenges; their ability to collaborate with others (Ambrose-Miller et al 2016:107); and their commitment to acquiring medically related information (Kirschbaum 2017:21) were therefore all relevant to the study.
- The researcher studied the mesosystem level by assessing the relationships the social workers established with those in their immediate work setting that they interacted regularly with regularly (Holosko & Feit 2013:10). This was important because relationships at this level are known to provide individuals much needed support (Liao et al 2010:59). The researcher fulfilled one of the research goals of the study, namely to describe the interactions social workers had with their colleagues; supervisors/managers in their department; and with other members within the multidisciplinary teams to which they belonged.
- Studying the exo system-level enabled the researcher to understand the resources and opportunities that were available to social workers in the state hospitals in the Waterberg District and how they contributed to fulfilment of the social workers' professional mandate, and ultimately affected their well-being (Liao et al 2010:59). Information was gathered about how hospital culture and relationships accelerated or inhibited the creativity and development of the social workers.
- By exploring the macro level system, the researcher identified broader external influences that were situated beyond the hospitals and he scrutinised the distil impact that the external influences had had on the role and functioning of hospital social workers. For example, legislations and policies developed by DoH, DSD and SACSSP determined the role that social workers played in health care, their remuneration, the supervision they received, the leadership structures and the disciplines that were represented on the management teams, and the hierarchical hospital culture that favoured medical personnel (Kirschbaum. 2017:20).

- Finally, it was concluded that several factors which had occurred over time had impacted on social workers in hospital settings too (chronosystem-level) such as the apartheid and post-apartheid eras, outbreak of pandemics such as HIV/AIDS and COVID-19.

In summary, the bioecological systems approach provided four markers for the researcher to use to understand the experiences and the meanings the social workers ascribed to working in multidisciplinary teams in state hospitals in the Waterberg district, namely process; person; context; and time (Evans & Wachs 2010:80; Rosa & Tudge 2013:251-254).

- The concept "process" made the researcher aware of the interactions the social workers had with their surroundings, some were proximal and others distil (Petty & Mabetoa 2021:59).
- The concept "person" encouraged the researcher to focus on the individual characteristics of social workers such as their ability to adapt to their contextual realities, and their resilience to work in a challenging secondary setting.
- The concept "context" was outlined when Bronfenbrenner's bioecological systems approach was introduced. The application of the concept of "context" magnified the researcher's understanding of the experiences and challenges social workers faced working in state hospitals. He identified both protective and risk factors situated within each of the contextual layers of the bioecological systems approach (Rosa & Tudge 213:246).
- The concept of "time" prepared the researcher to acknowledge the events and developmental changes that had influenced the experiences of social workers working in multidisciplinary teams in the state hospitals in the Waterberg District over time.

It was concluded that many of the anticipated advantages and disadvantages of using a bioecological systems approach as discussed in section 2.4.4, were accurate.

- The bioecological systems approach contributed to the scientific vigour of this study. It was well suited to the exploratory, descriptive and contextual research designs that had been chosen for the study.
- The bioecological systems approach provided the researcher a lens through which he could see events and social workers' experiences more clearly so that he could make sense of what it was like to work in the state hospitals in the Waterberg District (Maxwell 2013:49).
- The bioecological systems approach deepened the contextual understanding as anticipated. It successfully highlighted specific risk factors that need to be addressed

to improve the occupational satisfaction and professional identity of social work in hospital settings in each of the bioecological layers.

- As indicated in the discussion of the disadvantages, effecting the changes that were needed to improve the occupational satisfaction and professional identity of social workers would be difficult if on receiving the research report the leadership refuted the recommendations or lacked the strength or capacity to drive and implement them (Coovadia et al 2009:832). Additionally, it was evident that the bioecological systems approach was not in itself action orientated (Coovadia et al 2009:832).

The life model theory (Gitterman & Germain 1976:605; Teater 2010:26) provided valuable concepts to help the researcher explore and describe the challenges social workers working in multidisciplinary teams in state hospitals faced and the coping strategies they used to overcome them or adapt. The meaningful concepts included "person-in-environment-fit", adaptations, stressors, coping measures, relatedness, self-esteem, autonomy, and coercive power.

- The concept "person-in-environment fit" enabled the researcher to focus on the social workers' perceptions of their physical, emotional, intellectual, and motivational strengths and limitations, and environmental resources they had at their disposal to manage their work tasks and challenges (Gitterman & Heller 2010:205; Teater 2010:26). As a result, the reasons why social workers experienced stress in the multidisciplinary teams in state hospitals in the Waterberg District were elucidated (Gitterman & Heller 2010:205).
- The concept "adaptedness" was used to note how social workers were able to change their perceptions and or initiate specific behavioural responses they needed to survive during times of change or stress in the workplace (Gitterman & Germain 1976:605).
- The concept "stressor" explained social workers' experiences of not having enough personal or environmental resources to cope in the workplace and made them feel "off balance" (Teater 2010:26).
- The concept "coping measures" was used to refer to the efforts the social workers used to manage or deal with the stressors in the workplace (Barile et al 2016:653; Gitterman & Heller 2010:205).
- The concept "relatedness" alerted the researcher to the connections, social ties, social workers needed to develop a sense of belonging in the multidisciplinary teams where they were based (Teater 2010:26).
- The concept "self-esteem" helped the researcher to find out what was needed for social workers to feel respected, competent and worthy members of the multidisciplinary teams and the hospital to which they were connected (Shin & Steger 2017:20).

- The researcher became mindful of how much control the social workers in the hospitals felt they had over their lives (autonomy), and what ability they had to make personal and professional decisions on their own within the state hospitals in the Waterberg District (Teater 2010:26). It was important to discover the extent to which social workers were included in hospital deliberations and could contribute their ideas and suggestions about the cases they were involved in, their job descriptions and training needs Deurden & Will 2010:115) because these are known to promote a sense of relatedness and self-esteem.

The advantages and disadvantages of using the "person-in-environment" theory for this study were presented in section 2.4.5.

- The "person-in-environment" theory kept the researcher focused on "what was happening to social workers working in multidisciplinary teams in state hospitals in the Waterberg District?" (Gitterman & Germain 2008:54).
- The combination of the findings and "person-in-environment" theory revealed what needed to happen to improve the occupational status and professional identity of social workers in state hospitals in the Waterberg District.
- The concepts outlined in section 2.4.3 augmented the bioecological systems approach and deepened the understandings of the challenges, opportunities, interactions the social workers encountered in the workplace (Gitterman & Heller 2011:205).
- The "person-in-environment' theory provided a map or guide for change (Gitterman & Heller 2010:205-206). Firstly, it directed the researcher to consider how social workers could be assisted to develop new behaviours to increase their adaptiveness to work in the hospital setting. Secondly, it identified which significant role-players should be responsible for addressing the occupational satisfaction and professional identity of social workers in the state hospitals in the Waterberg district.
- The person-in-environment theory created a schema of interconnected empirically validated concepts that enabled the researcher to sharpen his observations, apply meaningful terms to describe the researcher's observations, and make more accurate inferences about what was going on (Gitterman 1996:472-473).

In conclusion, the literature review provided significant information that was helpful to compare the research participants' experiences with.

- The discussion of the "new realities" confirmed that professionals, including social workers in hospital settings, had to be able to adapt to remain relevant in the constantly changing world they found themselves in.

- The theoretical framework developed for the study was comprehensive enough to use to structure the information gathered and deepen the meanings the social workers ascribed to their work experiences in multidisciplinary teams in state hospitals in the Waterberg District.
- The combined concepts from systems theory, the bioecological systems approach, and life model theory were invaluable when trying to frame the participants' experiences.

The researcher was satisfied that the literature reviews adequately fulfilled its purpose in this study.

5.2.3 Application of research methodology, approach and design

In Chapter 3 the researcher reported how the research methodology and methods were applied during the study to achieve the study's aim and the research objectives. The purpose of this discussion firstly was to evaluate whether the research methodology and methods applied were relevant for finding the answers to the research questions. Secondly, it was to establish if the research plan that was operationalised resulted in the findings being trustworthy and ensure research ethics had been adequately prioritised so that the integrity of the study was safeguarded.

Interpretivism was the research paradigm that the researcher favoured and chose because the research interest was to explore the subjective meanings social workers held about job satisfaction and professional identity within the hospital settings where they were based (Creswell & Creswell 2018:8). The three motivating factors for adopting this paradigm were achieved. Firstly, the findings were based on the social workers' perspectives of their engagement and interactions in the workplace as members of multidisciplinary teams in state hospitals in the Waterberg District. Secondly, rich detail of historical and social perspectives was collected directly from the social workers which contributed a comprehensive contextual understanding of this research topic. Thirdly, the prolonged time that the researcher spent in direct contact with the social work community enabled him to feel and describe what it was like to be a social worker in a multidisciplinary team in a state hospital in the Waterberg District and he could describe it accurately so that others could experience it too (Crotty cited in Creswell & Creswell 2018:8).

In conclusion, the interpretivist paradigm was appropriate for this study and positively shaped the research decisions taken to during the study as evident in the discussions that follow.

The researcher applied the **qualitative research method** to build a comprehensive interpretation of the experiences of social workers working in multidisciplinary teams in the

Waterberg district in Limpopo Province. The qualitative approach demanded intensive, direct, one-on-one communication between the researcher and research participants (Creswell & Creswell 2018:181). The data were gathered directly from research participants personally by the researcher which enabled him to bury himself in the information collected and be key in interpreting it (Creswell & Creswell 2018:181). The interviews were conducted face-to-face with research participants at their workplaces in the state hospitals, which provided opportunities for the researcher to observe them up-close in their natural settings (Creswell & Creswell 2018:181). Being interpretive in nature, incorporating the political, social and cultural context, participants found themselves in was imperative (Creswell & Creswell 2018:181). The researcher worked back and forth between the emergent themes and the data base to establish a complete set of themes, then returned to the data base to locate as much evidence as he could to support each theme (Creswell & Creswell 2018:181). The researcher and participants collaborated closely to confirm that their meanings had been clearly understood. Several verbatim extracts were taken from each participant's interviews to make sure that when the findings were presented participants' personal meanings came across strongly (Creswell & Creswell 2018:182). The researcher practised reflexivity throughout the study to keep his experiences as a Black, middle-aged, senior social worker working in a multidisciplinary team in a state hospital in check and separate them from those of the research participants so that the findings nor the research decisions he had to make were not contaminated (Creswell & Creswell 2018:182). Multiple sources of information were used as follows: interviews of multiple participants, situated in different state hospitals in the Waterberg District, literature, a virtual online discussion forum, and policy documents retrieved from the Waterberg District state hospitals (Creswell & Creswell 2018:181). The research plan had to be flexible so that the researcher remained responsive to the participants' research needs and when it was operationalised in real life, research methods could be adjusted to accommodate unanticipated field related factors (Creswell & Creswell 2018:182).

The application of the qualitative approach meant that at the end of the study, the researcher was able to present a complex account of the experiences of social workers working in multidisciplinary teams in state hospitals in the Waterberg District. This research report confirms that the findings offered an accurate, holistic account of the life of a social worker working in a multidisciplinary team in the state hospitals in the Waterberg District (Creswell & Creswell 2018:182).

In conclusion, the qualitative approach was appropriate for this study. There was a dearth of locally specific information about social workers working in multidisciplinary teams in state hospitals in the Waterberg District (Craig & Muscat 2013:7-8). Little was known about the experiences, challenges and coping strategies of this cohort and what influenced their job

satisfaction and professional identity in the hospitals where they were based. The theoretical framework used for the study, systems theory, more specifically the bioecological systems approach (Bronfenbrenner) and life model theory (Gitterman & Germain 2008:54) were consistent with the qualitative approach. Subsequently, a holistic account of the research phenomenon was achieved.

The **phenomenological research design** was appropriate for the study. It enabled the researcher to explore a single concept, the social workers' lived experiences of working in multidisciplinary teams in state hospitals in the Waterberg District, by relying on their personal accounts of the phenomenon (Creswell & Creswell 2018:13; Creswell & Poth 2018: 76-77). A heterogenous group of participants were identified, ten social workers of different ages, who had worked in the state hospitals for different durations, and their levels of seniority differed. The participants worked in eight different state hospitals in the Waterberg District (Creswell & Poth 2018:76). The relationship between the researcher and participants was a collaborative one throughout the study (Creswell 2014:186) and participants' suggestions in relation to the research process were constantly incorporated into the research plan. Individual interviews facilitated by an interview guide consisting of a few open-ended questions were used. Participants could choose to answer the questions in any sequence they wanted (Creswell & Poth 2018:105). Once the data were gathered an inductive and deductive data analysis process was followed (Creswell & Creswell 2018:181). The in-depth report of how participants had experienced the phenomenon under investigation was possible because verbatim extractions from interviews were used to share the meanings the participants associated with their experiences (Creswell & Poth 2018:106). Additional sources of information such as the literature review and literature control complimented the participants' meanings to strengthen the trustworthiness of the findings (Creswell 2014:186).

The integration of **exploratory, descriptive and contextual research** designs augmented the phenomenological research design and was instrumental in arriving at an even broader understanding of the phenomenon (Terrell 2016:162).

The exploratory research design yielded information about social workers' experiences of working in multidisciplinary teams in state hospitals in the Waterberg District. This was important because little had been documented about their challenges, and the coping measures they used to adapt to their work context (Hesse-Biber & Leavy 2011:10; Creswell 2014:29; Thomas & Pierson 2010:440).

The descriptive research contributed to the in-depth understanding of different elements of the research problem (Hesse-Biber & Leavy 2011:10) such as the stressors that affected the social workers; their "adaptedness"; the experiences of "person-in-environment" fit, the quality

of their relationships with other multidisciplinary team members and hospital management, experiences of social worker's autonomy and coercive power within the hospitals, and their self- esteem and professional identity. This detailed description was needed to reveal who and what were responsible for the occupational tension social workers suffered in the state hospitals and identify what moderating factors enabled them to cope.

The contextual research design assisted the researcher to achieve a layered understanding of the different contextual realities participants experienced and how these realities were connected to the research phenomenon (Creswell 2014:47). The contextual research design, therefore, supported the phenomenological design. The contextual research design situated the events as described by participants in the context in which they occurred, and explained why some participants were affected by those events more than others (Babbie & Benaquisto 2010:82).

In conclusion, the phenomenological research design, augmented by the exploratory, descriptive and contextual research designs remained true to the tenets of qualitative research, and were consistent with the theoretical framework of the study. In-depth information was generated so that the research aim could be achieved and the research question and sub-questions could be answered. The researcher was satisfied with the choice of the research design for this study.

The population studied was small and comprised of 13 social workers who worked in multidisciplinary teams in the state hospitals in the Waterberg District. The sample consisted of ten of the 13 social workers. The researcher, being a senior social worker in the state hospitals in the Waterberg District, did not participate because he was the researcher and interviewer. The two social workers who were based at the same hospital where the researcher worked, were also excluded to uphold their confidentiality and privacy, and protect them from the in balance of power that could be experienced when discussing their experiences of job satisfaction with their line manager. These two social workers volunteered to participate in the pilot test of the interview guide and interview protocol so that they could have a part to play in the study. The ten participants constituted a non probability sample that used typical case and criterion sampling strategies. The participants were purposively selected for their personal experiences of the phenomenon and the information they had that could answer the research questions (Hesse-Biber & Leavy 2011:45; Bouma et al 2014:149; Carey 2012:39: Creswell & Creswell 2018: 249). The participants were interested in participating, had the capacity needed to do so (Flick 2014:176). The participants satisfied the selection criteria determined at the outset of the study, as outlined in section 3.5.2 (Creswell & Poth 2018:157). The sample chosen presented a significant category of experience for the study

(Mason 2018:128). The sample was heterogenous because there was some diversity amongst the participants such as their ages, levels of seniority, number of years of service in the hospitals where they were based, and the different hospital settings where they worked.

In conclusion, the population and sample for the study were adequate. The smaller sample enabled the researcher to gather in-depth information above quantity of information (Hesse-Biber & Leavy 2011:45; Bouma et al 2012:149) as is consistent with phenomenological studies (Bouma et al 2012:140). Because of the heterogeneity amongst the participants, responses to the research questions offered a range of different experiences.

As detailed in Section 3.6.4, two **data collection methods** were used, namely conducting semi-structured interviews guided by an interview guide and a focus group discussion. The interview guide was first reviewed by the University's Department of Social Work's Scientific Review Committee and then piloted on the two social workers who were excluded from the research sample. The questions for the focus group discussion were also reviewed by the Department of Social Work's Scientific Review Committee, the supervisor and an independent social worker who was asked to facilitate the focus group discussion.

The **semi-structured interviews** with participants were conducted face-to-face (Richie et al 2013:56; Terrell 2016:76). The interviews were slightly structured, so the interview stayed focussed and the participants were all exposed to the same questions (Govender & Sivakumar 2019:45). However, they were flexible enough to create a relaxed, conversational atmosphere where participants could determine the pace of the interview themselves. At times, at the request of a participant, the questions were reworded to clarify what was being asked and at other times the sequence in which the questions were asked were changed so that the researcher stayed in-step with the participant's train of thought (Carey 2012:110; Chan et al 2013:5; Edwards & Holland 2013:29). Qualitative interviewing skills such as discussing open-ended questions, probing, paraphrasing, clarifying, summarising, active listening, and attending were used during the semi- structured interviews and the focus group discussion (Dikko 2016:523; Edwards & Holland 2013:29; Polit & Beck 2010:341). After all the interviews had been transcribed, the researcher identified places where he had missed opportunities to explore topics raised by the participants more deeply. A second interview was then arranged to address this. During the second interview an individual member check was conducted to verify that the researcher had transcribed the interview accurately. After that the researcher reopened those areas of discussion that needed more probing, to confirm whether the participant wanted to add more information or explanation.

The **focus group discussion** did not proceed in the way as planned. The lock down regulations that were imposed to flatten the second COVID-19 peak, meant the face to face

focus group discussion could not proceed. After consulting participants, a decision was taken to convene the focus-group discussion in the form of a virtual online forum discussion (Carrol 2021; Iyiola & Keen 2021; Kamarudin 2015) using Microsoft Teams. The virtual online forum discussion was more problematic than anticipated. Three members and the independent facilitator could not log on the day because of problems with their internet connection. For others, the unstable internet connection interrupted the flow of the group discussion (Iyiola & Keen 2021; Kamarudin 2015) and they had to log on and log out several times. The researcher facilitated the group discussion and managed participants' technical challenges at the same time, which was not ideal. Lack of experience of online discussion forums amongst participants meant that some participants did not know how activate or deactivate their microphones or video cameras. Some struggled with logging out and logging back in. Some complained at times that it was difficult to hear the presenter (Iyiola & Keen 2021). At the end of the session, it was nevertheless clear that the preliminary findings of the study the researcher presented were accurate, according to those who had participated.

In conclusion: Once the interviews were transcribed and the data analysed, the researcher was satisfied that the open-ended questions had generated the exploratory, descriptive and contextual data needed for the study. Rich and complex details about the social workers' experiences of working in multidisciplinary teams in state hospitals in the Waterberg District were successfully gathered (Carey 2012:109; Creswell & Creswell 2018:187; Khan 2014:306). Whilst the virtual online forum discussion did not achieve all its objectives, it allowed those who could connect to confirm as a group that the findings presented were accurate and consistent (Flick 2014:253).

The **analysis of data** was outlined in section 3.6.6. The analysis of the data was done manually. The eight coding steps presented in Creswell and Creswell (2018:196) were applied. It was to the researcher's benefit that he could immerse himself in the data and use inductive and deductive reasoning throughout this process (Creswell & Creswell 2018:181). At the end of the analysis the essence of the research phenomenon could be explained and described (Creswell & Poth 2018:199). Thereafter an independent coder analysed the data and the researcher and independent coder conferred about the themes that had emerged. The following five themes and their subthemes were agreed upon as presented in Chapter 4: participants' experiences of job satisfaction; participants' experiences of hospital organisation and management in the state hospitals in the Waterberg District; the challenges participants faced working in multidisciplinary teams in state hospitals in the Waterberg District; the coping strategies participants used; and lastly, participants' recommendations for improving the occupational satisfaction of social workers in multidisciplinary teams in state hospitals in the Waterberg District. Member checks confirmed the five themes as did the online forum meeting

(Bouma et al 2012:142; Carey 2012:127, 246). A literature control was carried out once the data analysis phase had been completed and ensured the researcher was confident that the themes were authentic.

In conclusion, the researcher is satisfied that the analysis of the raw data was suitably conducted and the themes identified were true to the meanings the participants shared during their interviews (Creswell & Creswell 2018:182). The findings presented in Chapter 4 confirm that a thick description of social workers' experiences of working in multidisciplinary teams in state hospitals was achieved.

Protective measures were in place to confirm the study's **trustworthiness and soundness** (Hesse-Biber & Leavy 2011:58). The notion of trustworthiness as discussed in Lietz and Zayas (2010:443) was adopted for the study and attention was given to four elements, namely credibility; transferability, dependability and confirmability.

- The steps taken to uphold the credibility of the findings were discussed in section 3.6.7.1. The researcher's prolonged engagement with the research participants (two interviews and a virtual online forum discussion); accurate recoding of the data, engagement of an independent coder, participation in peer debriefing and supervision, and the member checks and virtual online discussion forum as conducted, contributed to the honest and accurate presentation of the findings (Creswell & Poth 2018:259; Hooimeijer & Nieuwenhuis 2016:321).
- Detailed descriptions were provided about the research participants and the context of the study (Koonin 2014:258: Padgett 2017:210). This enabled transferability by enabling those interested in the study to decide if the findings were applicable to their contexts and the people they were interested in (Anney 2014:277; Creswell & Poth 2018:495-496).
- The dependability of the study was upheld by regularly checking and crosschecking transcripts for accuracy; referring back to raw data that were securely stored, conducting member checks and the virtual online forum discussion with participants to verify the accuracy of the findings (Creswell & Creswell 2018:201; Daymon & Holloway 2010:86; Korstjens & Mostert 2017:435).
- Measures were in place to increase the reliability and objectivity of the research process and findings (confirmability) (Connelly 2016:435; Gunawan 2015:4). Supervision, peer debriefing, bracketing, journaling, using verbatim extracts from the interview transcriptions to confirm and describe themes, and detailed explanations of the research methods used were used jointly to strengthen the confirmability of the research findings (Chan et al 2013:2; Mason 2018:240). The engagement of an

independent coder confirmed that the researcher had been objective when analysing the data.

In conclusion: The researcher was satisfied that adequate measures were taken to uphold the trustworthiness of the study. The data verification plan was executed as planned which definitely strengthened the trustworthiness of the findings.

In maintaining the necessary **ethical principles**, the importance of protecting participants from being harmed in any way through their participation in the study was contemplated at the outset of the study. The plan to uphold ethical principles throughout the study was carried out during the study to protect the participants and the scientific integrity of the study. The application of these measures was reported in section 3.7.

The four ethical principles that were upheld throughout the study were: informed consent; confidentiality and anonymity; beneficence; and careful management of the research information.

The following measures were in place to make sure that each participant's **consent** to participate in the study was fully intentional (Creswell & Poth 2018:55; Polit & Beck 2010:127):

- When setting up the pre-interview sessions with members, information about the study was sent to them so that they had time to think about it and ask questions before they were interviewed (Addendum A).
- A pre-interview was held so that the contents of the information sheet were discussed and participants could ask questions about the study, how the findings would be used, and deliberate about the meaning of voluntary participation (Hesse-Biber & Leavy 2011:64; Creswell & Poth 2018:55; Ritchie et al 2013:66).
- An informed consent form was presented and discussed when the participants confirmed their intention to participate (see Addendum B).
- Finally, the participant was asked to sign the consent form (Addendum C) and Consent Form Requesting Permission to Publish the findings (Addendum D).

The privacy of participants was protected in two ways, by upholding their **confidentiality** and safeguarding their **anonymity** (Creswell & Creswell 2018:95; Ritchie et al 2013:67). Confidentiality was extremely important because it involved employees' (social workers') experiences of working in a specific setting (multidisciplinary teams in state hospitals in the Waterberg District). The number of social workers employed in multidisciplinary teams in the state hospitals in the Waterberg District was small. Several measures kept participants' identities and responses confidential. The places where the interviews were held were carefully selected to protect participants' privacy, a coding system was developed before the

interviews commenced so that all raw data related to each participant was labelled with the code (the field notes and labels of the audio digital recordings) and their personal details were removed from the transcriptions and findings. The independent coder, language editor and facilitator of the planned focus group discussion were expected to sign a letter of confidentiality (Addendum S). The researcher spelled out the measures he would undertake to protect participants' identities in Addenda B and C. Hard copies related to data, such as field notes and transcriptions were stored in a lockable cabinet in the researcher's home. These safety measures enabled the researcher to gain the trust of participants (Creswell & Poth 2018:55). Maintaining the anonymity of participants was equally considered. The researcher, supervisor and language editor read and reread the research report to find any information that could identify any of the participants. Any personal or professional information or place that placed a participant at risk of being identified by others outside of the study was removed (Grinyer 2009:50).

With reference to the principle of **beneficence**, the researcher had to commit to take measures that would protect the research participants from being exploited or abused because of their participation in the study. To do this, the researcher had to make sure that they would not be harmed, uphold their respect and dignity throughout the research process and see to it that the research would benefit them in the long term (Coovadia et al 2009:11; Creswell & Creswell 2018:93). Therefore, ethical clearance was obtained from UNISA's College of Human Sciences Research Ethical Review Council (Addendum R). Additionally, participants were reassured that the DOH had authorised the study and no one would suffer any form of harm from their involvement in the study (Addendum Q). An independent social worker was identified to be on standby to offer debriefing sessions to any participant who was negatively affected, emotionally or psychologically because of their participation in the study (Dey, Thorpe, Tilley & Williams 2011:35-36). (Eventually, none of the participants needed this service). The research materials were carefully managed.

In **carefully managing the research information**, the researcher believed that he has stayed true to the research participants by making sure that their voices and concerns were accurately captured and would be amplified after the study has been examined (Sutton & Austin 2015: 229). As reflected under the trustworthiness of data, digital recordings were carefully transcribed so that participants' perspectives were captured verbatim. Additionally, in accordance with both the SACSSP (2015:11) and UNISA's (2016:17) research policies hard copies of the research data will be stored in the lockable cabinet at the researcher's home and then destroyed after the obligatory five- year period has lapsed. Computerised material was secured in a password encrypted file

In conclusion: The researcher was satisfied that adequate measures were taken to uphold ethical principles throughout the research process.

Conclusions of Chapter 3**.** This chapter fulfilled its purpose. The summaries and conclusions reached about each step of the research process were shared. The summary offers a clear indication of the research methodology and methods used to gather the information that was needed to find meaning in the information that the research participants had shared. The researcher confirms that the research approach, design, and research methods were relevant for this study and produced the outcomes that were needed to answer the overarching research question without harming participants, the research site, or the institutions to which the researcher was associated. The researcher is satisfied that the research methodology and methods were instrumental in enabling him to achieve the purpose and objectives of the study.

5.2.4 Findings of the research study

Chapter 4 focuses on the findings of the research study, as shown and listed in Figure 5.2. The overarching research question developed for this study was: **What are the experiences and challenges of social workers working in multidisciplinary teams in state-based hospitals in Waterberg District, Limpopo Province?** This section offers the summary and conclusions of Chapter 4, the biographical profile of the research participants and their responses to the five sub questions as developed for the study.

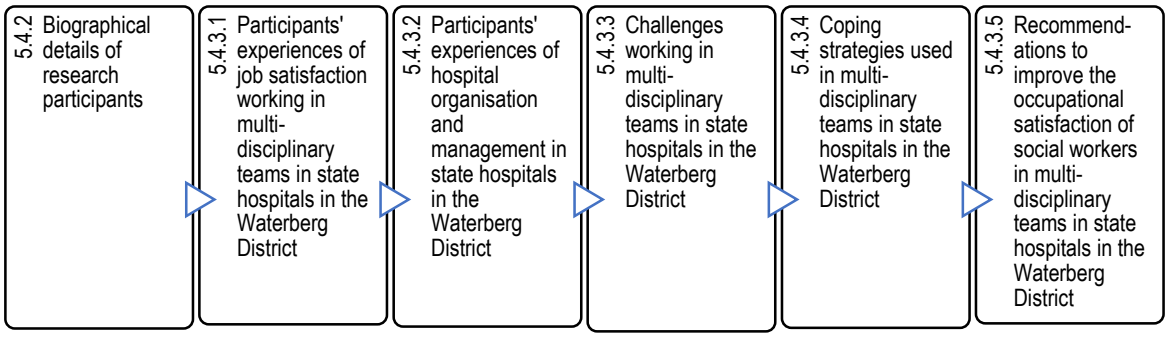

Figure 5.2. Findings of the research study

The discussion commences with the summary and conclusions about the biographical profile of the research participants.

5.2.4.1 Biographical details of research participants

The biographical profile of participants is presented in section 4.2. In summary, ten social workers participated in the study. Their ages ranged between the 31 to 51years. Most were in middle adulthood between 41 and 51 years (eight). Two were in early adulthood (31 and 32 years of age). Nine were females and one was a male. The over representation of females in social worker and health care worker studies is common because gender role classification continues to assign helping and caring tasks to women (Tambasco et al 2017:143). All participants had a Bachelor of Social Work degree and had not pursued further post graduate studies. It is noted that few social workers extend their studies beyond their bachelor's degree studies in Limpopo Province (Sithole & Mmadi 2019a). The participants had been employed in the Waterberg District state hospitals between five and 30 years. Most had more than 11 years' service as social workers in the state district hospitals (seven) which confirms that staff turn-over was low. The grade levels of the participants ranged from grade one to ten, with only three participants occupying senior positions (senior social worker or chief social worker) which validated that opportunities for career progression for social workers in state hospitals in the Waterberg District were limited. This is a significant issue considering that most participants were in middle adulthood, where one of the characteristics of this life-phase is that by this stage a person's career should have been developed (Horner et al 2020:44). There are limited opportunities for social workers to progress in hospital settings because usually senior positions are reserved for medical professionals (Cai et al 2020:88). It was concluded that lack of career progression opportunities was a leading factor in the high dissatisfaction of social workers working in the hospital settings (Chai et al 2020:88).

In conclusion, the researcher is satisfied that the sample of participants in the study had adequate knowledge and experience to answer the research questions. The diversity within the sample was sufficient to ensure that the participants adequately represented social workers who worked in multidisciplinary teams in state hospitals in the Waterberg District when the study was undertaken. The turnover of staff in the state hospitals in the Waterberg District was low, the social workers stayed in their positions as social workers, but few advanced their careers, or pursued advanced studies.

The above discussion is followed by presenting the summary and conclusions of the themes and subthemes that arose from the data after analysis.

5.2.4.2 Themes and Subthemes

This section summarises the findings and describes the conclusions based on the five themes and subthemes that emerged from the raw data after analysis, as presented in section 4.3. The themes that emerged were the following:

- Participants' experiences of job satisfaction working in multidisciplinary teams in state hospitals in the Waterberg district
- Participants' experiences of hospital organisation and management in state hospitals in the Waterberg district
- Participants' Challenges
- Participants' Coping strategies
- Participants' recommendations for improving the occupational satisfaction of social workers in multidisciplinary teams in state hospitals in the Waterberg district

(1) Theme 1: Participants' experiences of job satisfaction working in multidisciplinary teams in state hospitals in the Waterberg District

- ***Summary:***

There were two subthemes in relation to participants' responses about job satisfaction as social workers in state hospitals in the Waterberg District. Some indicated there were several appealing aspects of being social workers in multidisciplinary teams; and others indicated that they did not experience any job satisfaction working as social workers in multidisciplinary teams in state hospitals in the Waterberg District.

Factors that contributed positively to participants' levels of job satisfaction were identified by some participants, in the form of the satisfaction of practising social work; the benefits of the specialised training and orientation they had received working in multidisciplinary teams, being acknowledged by hospital management and other multidisciplinary team members for their contribution to patient care; and the benefits of working in a multidisciplinary team.

The **participants' positive experiences of practising social work** included: being able to assist people in need; being recognised by others for performing their social work tasks; and having an opportunity to use their under-graduate social work training. However, they worried that the demand for their services exceeded their ability to provide the services needed because social work was a unique profession that others in the hospital team could not perform. The job satisfaction that some experienced was connected to an altruistic need to

assist people as confirmed in the literature (Alegre et al 2016:1392; Wiles 2013:858). Participants were satisfied when they could fulfil their roles as social workers (Zhu 2012:294) and were acknowledged for doing so (Jacobsen 2020:465). The combination of these factors produced positive emotions amongst participants which contributed favourably to feelings of job satisfaction.

Those participants fortunate enough to receive specialised training and adequate orientation when they started working in the hospitals indicated that these had contributed positively to their job satisfaction. The types of training and orientation differed in terms of their nature and those who facilitated it. The training and orientation included being inducted by a social worker when they first entered the hospital, internal orientation trainings for new allied professionals to familiarise them of the range of services that were available in the hospital and the types of cases they could expect to treat, and lastly, the incidental learning participants received from working alongside other multidisciplinary team members in the hospital. Several scholarly sources validate these findings. For instance, job satisfaction of social workers in hospital settings improves when they are exposed to specialised knowledge that they need to function adequately in specialised settings. In-service training where multidisciplinary teams' members explain their professional roles, and the scope of the interventions they offer are valuable (Wamsley et al 2018:267; Cwikel & Friedman 2019:1; Hartgerink et al 2013:211).

Being positively acknowledged by others in the hospital setting, such as hospital managers and multidisciplinary team members, was a further positive contributor to job satisfaction. There were two forms of being acknowledged, namely members of staff communicating that the efforts of social workers in the hospital were valued; and management and other team members communicating their willingness to offer their assistance and support to social workers when needed. Acknowledgement from leaders and multidisciplinary team members are important to social workers in hospital settings (Devine et al 2021:81). When management and multidisciplinary team members respond timeously, frequently, and attend to problems swiftly, the teams function strongly (Bakker & Demerouti 2013:111). However, several authors assert that if social workers choose to survive in multidisciplinary teams in hospital settings, they must become assertive and self-assured (Abraham, Barbara, Baumlin, Hamilton, & Hwang 2015:852; Beder 2009:11; Mancini et al 2019).

Multidisciplinary team collaboration was another positive factor mentioned in relation to participants' positive feelings of job satisfaction. For some these collaborations made them feel needed and trusted. For others the collaborations meant that the responsibility of patient management was shared and did not rely solely on the social worker. It also meant their patients benefitted from the holistic treatment they received from the multidisciplinary team.

For some, working in multidisciplinary teams made them more accountable because they did not want to let the other team members down. Strong commitment to team tasks led to better patient outcomes for patients which added to participants' job satisfaction (Imayavan 2021:1424).

There were more participants who mentioned low job satisfaction than those who discussed high levels of job satisfaction. Multiple reasons were offered as to why this was so. The reasons were discussed in three separate subthemes (see section 4.3.1.2): individual factors; lack of supervision, support and collaboration; and finally, poor hospital organisation, management and the DoH employment policies.

The individual factors that impacted on employees' job satisfaction at a micro level, were factors such as participants' perceptions and experiences of the hospital's demands and how these impacted on their personal well-being (Barile et al 2016:658). Participants shared the negative emotions they experienced. Mention was made of social workers being very depressed. RP5 stated: *"We all feel depressed", RP2 explained: "We all feel stuck" and later, "…it is like you are working in …a cage, if not in a prison. You are a prisoner."* RP7 was so disillusioned that resigning appeared to be the best solution: *"Personally, there are times when I considered packing and just leaving, and I don't see myself working until my year or retirement."* As stated by Gitterman and Germain (1976:605) when people experience environmental resources to be inadequate, or they lack personal strength to adapt, they experience stress. One participant described this stress as: *"You feel like you are going crazy on a busy day."*

Several factors were identified by participants which contributed to their stress. The work they were allocated was emotionally taxing, and in some instances, it was difficult for them to detach themselves from patients' problems. Several frustrations were shared: having to manage chronic cases that were chronic and hopeless; insufficient time to complete professional processes expected of social workers, such as conducting consultations with the patient's family before patient discharge; and the challenge of communicating with patients in their home language (referring to work with foreigners). Shier & Graham (2013:99) refer to social workers experiencing despair when their clients' problems do not appear to have solutions. Barak et al (2016:1079) mention the experience of emotional overload that is common amongst social workers who over-identify with their clients.

The heavy workload was difficult for participants to manage because for most, they were the only social workers in the hospitals where they were based no one could relieve them when they were sick or went on leave. This left participants "emotionally drained". Participants described how challenging it was to go from one hospital department to another, trying to meet

the requests of multidisciplinary team members, without commensurate acknowledgement for their efforts.

According to Bronfenbrenner's bioecological approach (Holosko & Feit 2013:10) supervisory and support factors are situated at the meso level. Lack of support, insufficient guidance, especially for inexperienced social workers were common complaints of the social work participants. Most reported to an allied clinical manager who could not offer the clinical insight that was needed to supervise social workers. The responsibility for securing social work supervision and guidance rested with individual social workers, even those who were newly appointed. Lack of supervision and support contribute to high turnover of social workers (Calitz et al 2014:159). Participants needing supervisory support or guidance turned to other social workers based in the other district hospitals for help. This was a major professional dilemma for the social work participants. Supervision of social workers in South Africa must be offered by qualified and experienced social workers as mandated by several regulating documents such as the Social Service Professions Act 110 of 1978; the Code of Ethics of the Social Work Profession; the Children's Act 28 of 2005 (Engelbrecht 2014:125); and the Supervision Framework for the Social Work Profession in South Africa (Bhuda et al 2019:51; Lombard 2015:18). Without professional supervision from a qualified social worker, maintaining a professional identity becomes a major challenge (Lévesque et al 2019:2526; Manthorpe et al 2014:271). The failure of the state hospitals in the Waterberg District to establish a suitable supervision system for the social workers in their y employ was therefore one of the contributing factors to the low level of job satisfaction among the participants.

Another complaint was, that there were limited opportunities for social workers who were based in the state hospital in the Waterberg District to meet with other social workers in the hospital settings to offer one another support and exchange professional ideas. The only times the social workers in the state hospitals in the Waterberg District came together was for the quarterly district meetings. Some added that they felt lonely. Support from colleagues and supervisors is known to positively affect the job satisfaction amongst social workers (Leiter & Bakker 2010:185).

An additional factor that lowered the job satisfaction of some of the participants was the lack of appreciation they received from other team members in the hospital setting. The sentiment was that social workers in the state were taken for granted by the other multidisciplinary team members. Those participants who adopted a self-sacrificing attitude in terms of their work felt demoralised by the lack of recognition they received for their efforts. One participant described social workers in hospitals as being "invisible" to others in the hospital, unless they had to

perform as political puppets of some political leaders who expected them to drive their political agendas.

Several participants discussed the poor comprehension that other team members had of the role of social workers in hospital settings. As a result, participants complained that social workers in the hospital context became the “dumping ground” for the tasks that others did not want to deal with. These descriptions have been discussed by several authors (Albrithen & Yalli 2016:132; Ambrose-Miller & Ashcroft 2016:101; Kirschbaum 2017:10; Raniga & Kasiram 2010:263) (see section 1.2.1.1). Other professionals in hospital settings tend to consider the roles of social workers as less important than their own and assign them a lesser status which is demoralising (Ambrose-Miller & Ashcroft 2016:101). At the other extreme, social workers were allocated duties that were intended for those on a higher job grade which was unfair because they were expected to perform the additional responsibilities without compensation.

In some instances, participants reported that teamwork had fallen away in some of the hospitals because of the lack of coordination of patient treatment among the multidisciplinary team members. One of the ways suggested to obviate this problem was to regularise multidisciplinary meetings which according to Housely (2017:126) is a positive way of ensuring that multidisciplinary teams remain effective and sustainable.

Multiple complaints were received from the participants about poor hospital organisation, management, and employment policies. As in the case of most hospital settings, the hospital management of the state hospitals in the Waterberg District adopted and implemented the job descriptions and working conditions of social workers as stipulated in statutory hospital policies and guidelines (Dobriková et al 2016:85, 91; Fraser 2010:27; Kirschbaum 2017:11), which were not regularly revised. The low salaries of social workers were a pressing contributor to the poor levels of job satisfaction amongst the hospital social workers as their remuneration was lower than the other allied clinical multidisciplinary team members. They described this as demoralising. The word “unfair” was used by more than one participant to describe their sentiments about their remuneration. As explained by a participant, the salary they received was not commensurate with the training they had undergone to qualify as social workers, nor the level of responsibility they were allocated in the hospital setting. When the salaries of employees are low, they end up feeling they are being taken advantage of (Calitz et al 2014:160). Raniga and Kasiram (2010:270) confirms that doctors and nurses in health care services recognise that social workers merit better salaries. The participants felt strongly that their remuneration failed to match their outputs.

Limited opportunities for the progression of social workers in state hospitals in the Waterberg District negatively affected the participants’ level of job satisfaction because they wanted more

opportunities to grow and develop in the workplace (Greene 2017:12). Usually, the provision of promotional opportunities is a good predictor of job satisfaction (Fitts cited by Calitz et al 2014:160). For social workers in the state hospitals in the Waterberg District, promotional opportunities as hospital social workers were rare. One participant had waited for ten years for a promotional post as a supervisor. RP3 illustrated how disheartening this was for the hospital social workers by stating that: "*It's like you will be a social worker at the same level for your life. You don't show any growth in your career. There is no growth, even if you can acquire further education."* For those who accepted acting allied clinical managerial positions in the state hospitals in the Waterberg District, these came at a price. The social workers who accepted the acting managerial positions were expected to fulfil their social work roles alongside their acting managerial roles which lowered their job satisfaction. The work load of the two jobs was too much for them to manage.

The acting allied clinical managerial positions in the state hospitals in the Waterberg District posed another problem for participants. The inadequate human resource information systems in the DoH created a serious backlog in the appointment and promotions of staff (Rispel 2016:20). Existing staff were appointed to act in managerial positions on a rotational basis till the recruitment processes had been finalised. The acting managers were rotated every three-months and often did more than one rotation before the vacant managerial position was filled. Lack of managerial continuity aggravated breakdown in communications and delayed the finalisation of issues that had been reported to acting line managers, particularly requests for resources. Many matters that had been forwarded to management remained unresolved. RP10 explained: *"So, matters never get resolved. They just continue to snowball. They roll, and roll, and roll, just getting bigger all the time."*

The limited budgeting of occupational resource allocations for social work departments in the state hospitals in the Waterberg District was another contributing factor to low job satisfaction amongst participants. Tools of the trade such as telephones, printers, internet connectivity, transport and money allocations for training and development opportunities were in short supply. RP 2 summed up the frustration social workers experienced: *"Job satisfaction is poor. You cannot do half a job and feel good when you don't have the resources to do that job properly!"* Inadequate resourcing of social workers in the workplace is commonly experienced which contributes to their stress and constrains them from accomplishing their goals (Shier & Graham 2013:100)

- ***Conclusions:***

On the one side, there were specific factors that contributed positively to the job satisfaction of some participants. These were protective factors situated at different levels of the bioecological system at an individual level (micro); multidisciplinary team level (meso); management level (exo) and the broader social arena (macro), entailing the following:

  - The protective factors situated at the micro level were the altruistic values of social workers which meant they felt good about helping vulnerable people; they felt satisfied knowing they were recognized and appreciated for their contribution to patient care, and in the hospitals where they were based; the satisfaction of attaining a life ambition, to practise as a qualified social worker; and several individual qualities participants identified within themselves such as self- assurance and assertiveness.
  - The protective factors of working in multidisciplinary teams (the meso level), included being positively acknowledged by other team members for the role social workers played in the hospital; the non-formal learnings they accrued from working with other disciplines in the multidisciplinary team; and being able to share responsibilities with the other team members, enjoying the support and positive collaborations they experienced working in some of the state hospitals.
  - The protective factors situated at the hospital management level (exo level) included being acknowledged by hospital management, being exposed to knowledge and interventions that the allied clinical practitioners exposed them to; and the formalised induction that they received when they commenced their career as a hospital social worker in the Waterberg District; and the incidental learnings they gathered from working alongside other professional disciplines that very few social workers were exposed to; being supervised by a qualified social worker.
  - The only protective factor mentioned in terms of the macro level was the generic undergraduate training that they, as social workers, had undergone. Some participants shared that the Bachelor's degree in Social Work had prepared them well for generalist social work practice.

However, on the other side, a substantial number of participants indicated that their job satisfaction was low. The risk factors that participants mentioned in their interviews outnumbered the protective factors. Risk factors were situated at three levels, namely the micro, meso and exo-levels which entailed the following:

  - Poor job satisfaction at a micro or individual level is usually a combination of emotional and personal dynamics as indicated by Gitterman and Germain (2008:55). Participants

shared several negative sentiments. This included depression, despondency, feeling they were being taken advantage of by others in the hospital settings, feeling anxious and overworked were the main negative emotions that lowered their levels of job satisfaction. The nature of their work was emotionally draining, and negatively impacted on their outlook in the workplace (Shier & Graham 2013:99). The heavy workload and lack of adequate supervision added to their stress.

- At a meso level, the structure of hospital social work supervision left the social workers floundering because most reported to non-social work line managers who could not offer them professional social work guidance and placed them at risk of contravening the professional regulations for social workers as stipulated by the professional body, the SACSSP. The SACSSP regulates that social workers must only receive supervision from other registered social workers (SACSSP 2015:11). Other factors situated at the meso level that were raised, were the lack of clarity about the role of social work in the hospital setting and the breakdown of teamwork and collaboration within the multi-disciplinary teams. Leach et al (2017:120) recognise these as important factors that contribute to social workers' feelings of being supported and secure within the multidisciplinary teams.
- Many of the stressors that undermined the participants' job satisfaction were situated at the exo level, such as the clinical and administrative systems responsible for directing multi-disciplinary practice, organisational culture and operational systems in the state hospitals in the Waterberg District (Ambrose-Miller & Ashcroft 2016:102). Poor remuneration of social workers, lack of opportunities for career progression, being expected to perform tasks misaligned with their job grades, inadequate resources, dysfunctional human resource information systems that were responsible for the breakdown of management structures (Rispel 2016:20).

These stressors fuelled participants' despair, anxiety, depression and panic. While there were some participants whose level of job satisfaction was reasonable, generally the level of job satisfaction amongst the social workers was low. It was therefore concluded that the first sub-question, "***What are the social workers' experiences of job satisfaction working in multidisciplinary teams in state hospitals in the Waterberg District?"*** could be answered.

The summary and conclusions of Theme 2, participants' experiences of hospital organisation and management in state hospitals in the Waterberg District, follow.

(2) Theme 2: Participants' experiences of hospital organisation and management in state hospitals in the Waterberg District.

- ***Summary:***

The second theme focussed on whether the social workers' experiences and perceptions of hospital infrastructure and management in the state hospitals in the Waterberg District supported or compromised their ability to fulfil their professional obligations. Four subthemes emerged under this theme, namely social worker's perceptions of being disrespected and unsupported by management; poor allocation of resources for social work departments in the state hospitals; poor role clarity about social work in the multidisciplinary hospital teams; and the poor relationship between social workers and hospital management.

With reference to **social worker's perceptions of being disrespected**, the consensus was that the hospital did not understand the needs of social workers, nor take the role of social work in the hospital setting seriously. Participants did not feel supported because when they reported their concerns to management they were seldom addressed. It made participant RP4 feel that their needs were taken seriously which had been a longstanding problem. RP4 summed up this situation: *"Ya…I would say that this problem has been here for a long time. They know our challenges. I doubt they take them to heart. They just listen…it is like it goes in one ear and out the other ear."* The participants interpreted the lack of follow-ups to their requests as a lack of interest and a lack of respect of social workers from hospital management.

There were two potential sources of the problem according to the participants. The first source was the failure of social workers to assert their professional status and social work role in the hospital setting, a point made by Weiss (2005:10) more than seventeen years ago. The second was the hospital managerial structure placed social workers under the management of allied clinical managers. The allied clinical managers managed the clinical services of non-medical disciplines such as audiologists, psychologists, physio therapists, pharmacists, occupational therapists in the multidisciplinary teams. The hospital's core business was medical, and the resources available were severely constrained (Malinga & Mupedziswa 2009) so the requests of social workers were seldom granted even when supported by allied clinical managers. The reality was that social work was not the core business of the hospital setting. Managers who are not qualified social workers are unlikely to address the challenges of social workers in hospital settings because they do not fully understand their operational needs and values (Limon 2018:24; McAuliffe 2009:6; Raniga & Kasiram 2010:206). Furthermore, medical

team members (doctors and nurses) hold proportionately more power and authority than the allied professionals in multidisciplinary teams in hospital settings (Limon 2018:24; McAuliffe 2009:6; Raniga & Kasiram 2010:206). It was clear that participants felt that working in a secondary setting was a challenge (Agarwal, Brooks, & Greenberg 2019:57).

The **allocation of occupational resources** for social work departments was an issue of concern raised by participants. Lack of occupational resources needed to perform r social work duties resulted in social workers having to prioritise the services they offered. Equipment such as cell phones, computers and printers were lacking. Poor access to transport meant social workers struggled to do home visits or offer outreach services. Lack of social work staff added to their stress and impacted on the quality of supervision and training they received. Service delivery was curtailed because several social work posts in the state hospitals in the Waterberg District were frozen and the existing staff compliment could not meet the demand for social work services. Social workers adapted to the lack of resources where they could by supplying their own. They turned to better resourced hospitals in the Waterberg District or other social service providers such as the DSD for assistance. These "adaptations" helped to restore their work balance (Gitterman & Germain 1976:602; Tambasco et al 2017:146).

There was one exception to the complaint of poor occupational resource allocation for social work departments in the state hospitals in the Waterberg District. One participant stated they were fortunate enough to have most the resources they needed, including air-conditioned offices, telephones and transport. The participant however acknowledged that more suitable seating for patients was something that they needed for their social work offices.

The allocation of office space for hospital social workers in the state hospitals, was described by most participants as a major challenge. Office spaces for social workers must offer adequate privacy for their patients, a factor that was ignored in the state hospitals in the Waterberg District. Social workers interviewed patients and their families in the offices they shared with other team members that were not even partitioned to provide a little privacy. The participants considered this a serious issue because they were forced to violate their patients' rights to confidentiality and anonymity, a core social work value (Christensen, Lamont-Mills & Moses 2018:2). Preserving client confidentiality and privacy is included in the SACSSP's code of ethics for social workers (SACSSP 2005:14-15). The social workers tried to plan their appointments around the times their cohorts were out, but that was not always possible as illustrated by RP4's storyline: *"There is a lot of people who enter this office where we are now. This is the clinical support office. When I am alone in the office, I can offer my patients a confidential service. But that doesn't often happen. The patient will be sitting here where you*

are sitting now, crying, or whatever, and then someone comes, knocks, and enters." It was disruptive trying to synchronise their activities with the others who shared their office, and in many instances prevented the social workers from getting their administrative duties done because they would leave the office when a colleague needed to meet with a patient (Tambasco et al 2017:145).

The failure of hospital management to attend to the occupational resource requirements of social workers was interpreted as management being dismissive of social workers. RP10 emphasised this point: "No, *I'm not being acknowledged. My job as a social worker is not being acknowledged. If it were, then they would address some of the important things I need for me to do my job. If I was being acknowledged I will have an office, privacy for my clients, and I will actually be able to give my clients the dignity they deserve."*

The third subtheme, **poor role clarity** of social work, once again related to the poor understanding the other multidisciplinary members had of the role of social work in hospital settings. Generally, participants shared that their cohorts in the multidisciplinary teams did not understand the profession of social work nor the scope of services that social workers were able to offer. An example of their comments is that of RP4: *"Some members of the multidisciplinary teams think that the main role of social workers is to help patient apply for social relief and grants or find them suitable accommodation when they are discharged."* A clear dichotomy existed in terms of the expectations from the medical team (practical help and social relief for patients) on the one hand and the professional social work bodies (who advocate a developmental approach using preventive and empowerment interventions) on the other (Bassier et al 2021:1). Participants who had held positions for a long time regarded their role as offering patients and their families psychosocial services, and failed to integrate developmental practices in their work. The personal, professional, and workplace expectations of social workers were in conflict which resulted in a poor "person-in-environment fit" for the social workers (Teater 2014). A poor person-in-environment fit usually leads to self-doubt and workplace conflict (Shier & Graham 2013:96). One participant was concerned that hospital management complied with government regulations in relation to healthcare but were oblivious of the regulations and welfare policies that social workers had to uphold. RP1 noted: *"The government regulations for social work are not acknowledged by the hospital which obstructs you from assisting your patients and giving them good or reasonable services. Due to the restrictions imposed by the hospital management, you don't assist your patient in accordance with welfare policies."* The role of social workers in state hospitals in the Waterberg District had not been aligned with the White Paper for Social Welfare (1997) and the Framework for Social Welfare Services (1997). Social workers, not just hospital social workers

have been exposed to limited training on the development approach to help e them to successfully transform the social work services they provide to be more developmental and empowering (Beasley et al 2021:193; Gedviliene & Didziuliene 2019:259; Phelan & Kirwan 2020:3532). Hospital management's omission to keep abreast with national welfare developments and the regulations developed by the statutory social work professional body for social workers, meant that the social workers in the state hospitals would not meet the minimum requirements for CPD training as regulated by the SACSSP, because their professional training and development needs were overlooked. The social workers were expected to attend the hospital CPD trainings which did not assist them to attain the required minimum number of CPD points to be a registered social worker in South Africa. Participant RP7 explained: *"When it comes to CPD meetings, for instance, they cater for the medical professionals and other related allied professionals. They forget that we are social workers and need our own continuous professional development around developments in social work."*

The final subtheme in Theme 2, the **poor relationship** between social workers and hospital management related to participants' experiences of hospital organisation and management in state hospitals in the Waterberg District. Most participants described the relationship between social workers and hospital management as poor. Almost half of the participants shared that the relationships between hospital management and social workers in the state hospitals in the Waterberg District were tenuous. References were made about the exploitive power of people who occupied managerial positions, poorly informed managers who issued directives to social workers about cases they were not well versed about, nor were they familiar with the procedures that had to be followed in those cases, lack of training and experience of those who had been appointed in the most senior positions in health care who had secured those positions based on their political affiliations; and management favouring the interests of doctors above those of the other allied clinical professions. These issues were aggravated by the exclusion of social workers in deliberations about matters that affected social workers directly. RP3 offered an example*: "For us social workers, they make decisions on our behalf. When they go to meetings, they agree on certain things that they expect social workers to do, even though it is not something that we can do. We are not engaged. We are not consulted in any way."* It was concluded that social workers felt as though they were side-lined by management, and despite their professional knowledge and experience, their suggestions were often over-ruled (Liao et al 2010:5). This confirms that little had changed with regards to the status of social workers in multidisciplinary teams in hospital settings over the last 31 years.

There was one exception to the complaints. RP7 shared what it was like to have a good relationship with hospital management: *"I think I have a good relationship with our*

management. This is a small hospital, so everybody knows everybody. So, it is very easy, and we are very accessible. So, it is easy for people to ask one another for help, or talk about patients or cases and share ideas."

Skjeggestad et al (2017:2) caution that poor working relationships and communication undermined the self-esteem of the "resident guests" in "host organisations" which makes social workers more susceptible to burnout.

- ***Conclusions***

It was concluded that hospital infrastructure and management in state hospitals in the Waterberg District, compromised the ability of social workers to fulfil their professional mandate in several different ways. As a result of feeling disrespected by hospital management the social workers suffered high levels of frustration and low morale. The inadequate occupational resource allocations for the social work departments not only affected their ability to execute their professional mandate but weakened their ethical conduct in such as upholding the privacy of their patients too. The spaces reserved for social workers to conduct confidential interviews with patients and their families were mostly unsuitable. The shared offices made it difficult for social workers to safeguard the privacy of their patients and disrupted their administrative tasks too. When the person they shared their office with had to meet with a patient, they would have to leave their desk and only return when their colleague had finished their interviews. Poor role clarity within the multidisciplinary teams and more specifically poor understanding of the role social workers in hospital settings were responsible for, prompted their multidisciplinary team cohorts to offload tasks they did not want to perform onto the social workers. The relationships between social workers and hospital management were mostly poor.

Dane and Simon (1991:208) coined the classic terms of being "a resident guest" in a "host organisation" in the early 1990s by describing the demerits "resident guests" encounter whilst working within "host organisations" that confirmed the issues the participants had mentioned. Skjeggestad et al (2017:432) identify similar demerits which include value discrepancies between the "resident guests" and their "hosts"; feeling marginalised; struggling with the poor understanding multidisciplinary team members have about the role of social workers in hospital settings; role strain; poor communication; and conflictual relationships.

Four areas were identified where social workers could be more proactive in terms of improving the "person-in-environment fit" in state hospitals in the Waterberg District, namely that social workers -

- needed to be more assertive about their professional status in the hospital setting, and willing to expand their clinical role (Weiss 2005:10);
- had to be creative and resourceful and find their own way to get things done so that they could fulfil their professional mandate instead of sitting back and waiting for things to happen;
- had to educate the hospital authorities about the SACSSP's regulations about professional matters such as social work supervision, continuous professional development and ethical conduct of social workers;
- and had to be open to taking measures to improve their communication and relationships with hospital management so that they would be included in discussions around matters that would affect them.

It was concluded that the second sub-question "***What are the social worker's experiences of the hospital organization and management of state hospitals in the Waterberg District?"*** was answered.

The summary and conclusions related to Theme 3 are presented next

(3) Theme 3: Participant's challenges while working in multidisciplinary teams.

- ***Summary:***

The challenges participants faced working in multidisciplinary teams in state hospitals in the Waterberg District were broken down into three subthemes, namely challenges that affected individual social workers personally; internal challenges within the multidisciplinary teams, hospital organisation and management; and external challenges, situated outside the hospital setting.

The **challenges that affected individual social workers** which participants faced at a micro level, were predominantly related to the stressors associated with working in multidisciplinary teams in state hospitals in the Waterberg.

- For some participants, working in a multidisciplinary hospital environment restricted their advancement in terms of social work skills and knowledge, and overtime, working there became unstimulating. Those in specialist hospitals had relatively few opportunities to experience new cases and problems. The cases they dealt with

became routine and predictable. It concerned RP1 who pointed out that: *"You also don't gain experience in the other social work roles that other social workers working in welfare settings get to perform in their institutions."* This could become a threat for social workers because unless they upskilled themselves, they could find that they were no longer viable in the job market (Ajala 2013:48). Others mentioned that they had been forced to narrow the scope of services they rendered in the state hospital because of the limited resources they could access.

- Additionally, poor career development and progression as discussed in section 4.3.1.1 created frustration for the participants. Senior posts appointments for social workers were scarce and allocated according to a candidate's years of service, rather than professional qualification or merit. Many of the participants had worked in the hospital for longer than ten years on the same job grade. The dire financial status of the DoH in Limpopo Province, had aggravated this situation because several vacant senior posts for social workers had been frozen.
- The workload of some of the participants was stressful. In most instances participants interviewed were the only social workers in the hospital where they were based. Servicing multiple wards and departments was stressful, as described by RP1: *"The one challenge that really gets to me is working alone here. I work alone in this institution. So, sometimes you feel like…I don't know whether it should be referred to as workload or what? …But I feel like I carry the social work office on my shoulders."* Other participants described the challenges of being expected to perform multiple roles, usually allocated to senior social workers or social work managers for which they received no additional reward. Some suggested that this was one of the ways in which the hospital management took advantage of them.

The **internal challenges** within the multidisciplinary team, hospital organisation and management formed the second subtheme that was discussed. Participants felt strongly that the role of social work in the state hospitals in the Waterberg District had not been clearly understood, and social work issues remained understated in the hospitals.

- Participants complained that the multidisciplinary teams and management did not know what the role of the social worker was in the hospital, nor were they interested when social workers tried to explain it to them. Most team members were uninformed about the correct line of referrals, confused about the differences between social workers and psychologists, and were unrealistic about what social workers could do to help patients. The example provided by RP4 was: *"They refer like anything to us. If they have a challenge, any social problem regarding a patient, they refer to the social*

worker. They expect you to do magic. What can I say? Sometimes they will send a patient for a food parcel, and as you can see, I don't have food parcels in my office for patients. DSD deals with food parcels, but still, they refer to us. All the time, they still refer them here and you ask them, 'Why do you still refer them here?' and they say, 'it is because you are a social worker, and you can do something for them'."

- Participants shared that many of the tasks expected of them were not social work-related tasks such as processing paupers' burials, finding interpreters for team members who could not communicate with foreign national patients, educating patients about how to manage medical conditions, such as diabetes. Attending to these tasks meant they had less time to dedicate to their core business and left them feeling dissatisfied with the standard of care they rendered to the other patients who needed their professional services. These frustrations led to a few participants mentioning that they felt "used" by other team members. As mentioned by O'Reilly et al (2017), it is not uncommon for multidisciplinary team members to refer cases to social workers to save their own time or pass the less glamorous tasks onto social workers knowing they will not object (Craig & Muskat 2013:10).
- The storylines participants shared, described their frustration of being "unheard" and not taken seriously by team members and hospital management. They complained of having to repeatedly remind hospital staff, and their managers of the roles of social workers in the hospital setting. RP5 shared, "*They just expect you to do as they request. We do discuss it with them. Actually, we even discuss it with our boss, but it still goes on…on…on. The same thing will happen, over and over again, until we are tired. You end up doing what they ask you to do. You will see the patient because there is no use trying to talk to them."* The matters participants reported to their line managers were seldom addressed. Even submitting petitions endorsed by all the social workers in the district had failed to get the attention of the hospital management. Participants felt despondent. RP2 concluded: *"So, I can say that … we are being undermined. Maybe it's because they don't have any interest in what we have to say."*

There is a distinct disadvantage of being what Beddoe (2013:26) describes as "the guest under the benign control of the medical and nursing professions." The participants indicated that the minority status that some in the state hospitals in the Waterberg District conferred upon social workers, meant that their perspectives of how best to execute organisational tasks and what they needed to fulfil their purpose in the hospitals were irrelevant to them.

The third subtheme referred to the **external challenges** that had affected social workers working in the state hospitals in the Waterberg District hospitals. The challenges as mentioned

by participants included politics, policies and centralised power of both DoH and DSD; inadequate network of community-based services to promote and support patient recovery and wellbeing when patients were discharged; the influx of foreign nationals into the Limpopo Province that had burdened the state hospitals; and the COVID-19 pandemic. These, as asserted by several authors, are systemic risk factors (Morely & Cashell 2017:211; Robinson 2012:18).

Participants reflected that the activities and employment conditions of South African social workers based in state hospitals were regulated by two different national departments and the national statutory professional body for social workers (DoH, DSD and the SACSSP). They were seldom updated about policy developments in both the health and welfare sectors. RP1 pointed out: *"Most of the time we are not included in the communications that comes to the hospital. It's like we are not recognised as health practitioners even though we work within the health environment. So, who is supposed to recognise us? You find that social development offers trainings for their social development workers, but they don't include us, even though we are a government department. So, you ask yourself, 'if, social development seems to forget about us and the health department seems to forget about us, then who will address the development needs of hospital social workers?' Who will try to find out what their challenges area?"*

As indicated by participants, the hospital settings overlooked governmental regulations for social work practice. Social workers in the state hospitals felt they had not transitioned from an institutional approach to welfare to a residual one and were not adopting a developmental approach in their practice, thereby not contributing towards the socio and economic upliftment of patients.

It was felt that most appointments of senior managers in the state hospitals in Limpopo Province were politically motivated and political allegiances determined what matters were elevated from a district level to provincial or national level. Recommendations or requests of the state hospitals in the Waterberg District seldom reached the attention of senior management, particularly at national level. **RP7** explained: *"When they [meaning politically connected senior managers] make requests to the provincial or national management levels, the government provides. We don't have the power to force them to address our needs."*

Dissatisfaction was expressed about the centralised decision-making process that the DoH adopted, particularly with regards to appointing more social workers in the state hospitals in the Waterberg District. National Treasury rejected the social workers' motivations to fill the

frozen posts for social workers. One participant found it incomprehensible that there was no one at the National Treasury level to support the needs and requests of social workers in state hospitals.

The downward turn in the economy had contributed to a breakdown of services in government departments and non-governmental welfare organisations in the Waterberg District e which had impacted negatively on social workers in the state hospitals too. Community based human service organisations were struggling to survive (Skhosana 2020:114). The hospital social workers were challenged to find community-based human services agencies to support and service patients on their discharge from the hospitals. A role of a resource broker is an important one for hospital social workers (Shier & Graham 2013:120). The social work service of being able to link patients with community-based services benefits hospitals in many ways. It strengthens inpatient discharge planning, long-term planning for patients; and patient rehabilitation (Demeco, Marotta, Barletta, Pino, Marinaro et al 2020:3; Keefe et al 2009:586). As a result of the shrinking community-based services, there were long waiting lists for DSD social workers to follow-up on patients that had been referred to them, slow investigation turn-around times, and scarce subspecialist social services such as family counselling, victim empowerment and substance abuse rehabilitation.

The delayed feedback from social workers who attended to the hospital social worker's referrals was problematic because treatment decisions were in many instances based on the feedback of community based social workers. The community based human service organisations struggled financially as reflected in the lack of resources they had at their disposal such as internet connection and transport, tools of the trade needed to conduct their investigations.

The limited community-based social services hospital patients could access were highlighted by RP9: *"You just get to see social worker when there is no food, or when your house burns down. They send social workers then."* Another participant, RP7 shared: *"For example, we…we have one thing only, one registered old age home here in this town, and then beside that, the other resources are far from us, like a place of safety. I think we have on in this District. So, it becomes a challenge when we want to assist the client or patient. For example, if you have a mentally challenged patient whose family is rejecting them, and you have to find a place for them to stay, it is a problem. The resources that are available are limited. Well, actually, it is like they are not there at all."* Because of the lack of specialised services available in the Waterberg District, hospital social workers rendered general social work services over

and above their medical social work services. This was a disadvantage of the residual approach to welfare services in South Africa (Melendez 2018).

The high level of food poverty experienced in the Waterberg District resulted in patients lingering in the hospital knowing that when they were discharged they would not be able to access food. Those patients were referred to the hospital social workers for grocery parcels even though the social work departments had no resources to offer social relief. Participants felt strongly that DSD should be responsible for providing indigent persons with grocery parcels and attending to these cases.

The challenges of the **influx of foreign nationals** into Limpopo Province had further burdened the state hospitals in the Waterberg District (Ramathetje & Mtapuri 2017:579, Vanyoro 2019) The increased uptake of health care services by foreign nationals had added to the workload of all hospital staff, including social workers. When foreign national patients died in the hospital and their families could not afford to bury them, the hospital mortuaries had to keep their bodies, which they did not have adequate capacity to do. Social workers were pressurized by hospital administrators to trace the families of deceased patients to arrange for the removal of the bodies from the mortuaries. If that was unsuccessful, the hospital social workers made applications for paupers' funerals. Participants objected to being delegated these tasks because they were not their core social work business. The tasks were clerical in nature and could have been attended to by clerical staff. The hospitalisation of foreign nationals placed additional responsibilities on hospital staff. In many instances by the time foreign nationals were hospitalised, they presented advanced chronic illnesses, were indigent and without networks of support. Social workers complained that these cases were hopeless and very difficult to manage. Most health care professionals in the Waterberg hospitals could not speak the national languages of the foreign nationals and needed interpreters to assist them. Social workers were expected to be the mediators of the informal interpretive services (Steyn 2015:18).

The last external stressor mentioned by participants was COVID-19. Some of the state hospitals were nominated as COVID isolation facilities for the Waterberg District. Specialised services, normally offered at these hospitals were suspended and, in some instances, inpatients were relocated to different hospitals. The rearrangement of hospital priorities, reorganisation of hospital wards to create more bed spaces, the panic of anticipating high numbers of COVID-19 patients needing intensive care treatment and hospitalisation in isolation wards, were the factors the participants mentioned that stressed them. The social workers were amongst the frontline workers and were engaged to facilitate processes to

execute the new hospital priorities. The hospital communications about the suspension of services and the creation of the isolation facilities were vague and at times, contradictory. The intensity of the COVID-19 pandemic fragmented the multidisciplinary teams. Staff worked on a rotational basis, and regular hospital meetings and CPD trainings were cancelled. The suspension of meetings at a time when multidisciplinary team members needed collegial support was a stressor for some.

- ***Conclusions***

Theme 3 focused on the contextual realities that challenged participants' "adaptedness" to their work situations in the multidisciplinary teams in state hospitals in the Waterberg District. Some of the challenges related to their proximal interactions at micro and meso levels and other to their interactions at exo and macro levels (Rosa & Tudge 2013:251). The challenging proximal interactions involved power imbalances between social workers and the medical staff, social workers being excluded from discussions about matters that affected them in the hospital settings, and other team members overloading them with inappropriate referrals, particularly tasks they did not want to perform themselves (O'Leary, Tsui, M. & Rush 2013:135; Limon 2018:28). This intensified the social workers' discontent because they suffered lack of support, poor role clarity and feeling disrespected. The challenges entailed the following:

- The challenging distil processes at an exo level related to poor representation of social work interests at a management level, inadequate occupational resource allocations to social work departments (Limon 2018:28; O'Reilly et al 2017), inadequate staffing, insufficient provision of supervision and training for social workers, limited opportunities for career progression, and poor spatial allocations for social workers in the hospitals; and, the minority status of social workers in the hospital setting.
- Distil processes that impacted on the social workers at a macro-level were the politics, policies and centralised power resting with the DoH and DSD. In particular, that DoH policies and frameworks took precedence over DSD policies and frameworks, and overlooked the SACSSP's regulations for social workers, lack of community based resources for patients and their families in the Waterberg District, the influx of foreign nationals that increased the numbers of hopeless chronic cases social workers were allocated as well as extra administrative tasks, and the COVID-19 pandemic.

The third sub-question that was developed for this study was ***What challenges do social workers experience working in multidisciplinary teams in state hospitals in the Waterberg District?*** It is concluded that the meanings the participants shared about the challenges they faced, were well described, and deepened the understanding of what their

stressors were and where they were situated. This insight can be used to develop suitable interventions to mediate against the stressors in time to come. As noted by Gitterman and Germain (2008:54) the finding highlighted the possibilities of what can be changed. The researcher is satisfied that the third sub-question developed for the study was answered.

(4) Theme 4: Participant's coping strategies.

- ***Summary:***

Theme 4, participants' coping strategies consisted of four subthemes: participants' individual coping strategies; supervision; educational and training opportunities; and following the district and provincial DoH policies.

The first subtheme was participants' reliance on **individual coping strategies** to manage the stressors that they could not control (Ben-Ezra & Hamama-Raz et al 2020:15). Participants' responses were arranged in the following four t categories: adaptability; focusing on the bigger picture (their life purpose); altruistic values; and letting off steam, and entailed the following:

- Adaptability was presented as a valuable individual characteristic in the workplace because there were many external factors that impacted on the hospital setting. For example, **RP2** shared: *"You must be flexible because eeerh…. things change every now and then, like we are affected by something like Covid-19, now we are working eeerrr…. on shifts ok….it means you must be able to change and adapt so quickly."*
- Adjustments such as reorganising their work routines, being more accepting of operational malfunctions, and developing contingency plans were characteristics that enabled them to complete their work tasks (Kapoulitsas & Corocran 2015:97). When negative workplace thoughts were replaced with reminders of their life purpose, giving their families a better future, they felt more positive to carry on (Barak & Watted 2018:14).
- Taking stock of the pleasure they experienced from being able to serve people in need made them discover meaning in their work which made their work stresses bearable (Chao & Gu 2021:3195). Rotabi et al (2017:648) refer to this coping strategy as "altruistic resilience".
- Lastly, participants acknowledged that over time, the stressful experiences built up, and had to be released. **RP5** shared*, "Ya, you get so angry, so very angry. You swear there and then. And then you pull yourself together."*

In other words, these strategies were control-oriented coping mechanism: problem solving, cognitive restructuring, emotional expression and altruistic resilience (Mette et al 2020:5)

Subtheme two focussed on **supervision** and the support that the hospital social workers received from qualified social work supervisors and collegial support, professional support from team members and hospital social workers. Only two participants received regular supervision from a senior, experienced supervisor, once or twice a month and ad hoc supervision on the spot guidance as needed. Participants responded as follows in this regard:

- They described the supervision as empowering. By example, **RP10** illustrated the value of guidance from the supervisor: *"…she tells you that you should try to use one, two, or three skills, or try to do one, two or three… That helps me to feel empowered".*
- The participants added that supervision provided them with much needed support. **RP6** and **RP10** described this support as "debriefing," an intervention to assist when they had been traumatised after dealing with patients who experienced similar traumas they had suffered.
- Additionally, the supervisors had offered practical interventions to support the participants such as allocating them "time out", to rest and replenish their energy.
- Finally, supervisees used the supervisors to represent their workplace issues to the hospital management.
- Social work supervision created opportunities participants needed for self-reflection, knowledge exchange, as mentioned by scholarly sources (Mette et al 2020:10). The third component meant they had someone in the hospital system who was willing to convey their opinions to hospital management, something that was considered an important benefit.
- Lastly, the support they received from the social work supervisors during difficult times boosted their psychological well-being in the workplace (Ahmed et al 2019:229).

Unfortunately, other participants did not receive social work supervision. They relied mostly on other colleagues for collegial support and debriefing. **RP7** pointed out that collegial support, or co-worker support as referred to by Ahmed (2019:232) was available to those who worked in small hospitals: "… *so, everybody knows everybody, so, it is very easy, and we are very accessible. So, it is easy for people to just go to someone and ask for help or talk about patients or cases or, ya."* The contacts were mostly informal exchanges as noted by Martin and et al (2017). Where the teamwork was good, the team members had one another for support, particularly when they felt hospital management was disinterested in their concerns. **RP8** spoke of the emotional relief they experienced from colleagues**:** "*You know we sort of ventilate or debrief with other colleagues within the institution because in that way we are*

sharing with people who are sort of in the same boat as us…. Management…hhhh…not so often." The social workers also turned to social workers in other state hospitals in the Waterberg District for support, as explained by **RP9**: *"I was assisted by* [the colleague] *from one of the other hospitals.* [The colleague] *was the first person I got hold of in the district when I needed help. And* [the colleague] *was so helpful.* [The colleague] *was there for me. Like, even now*, [the colleague] *is the one I consult If I have to deal with challenges because* [the colleague] *is helpful.*" Lastly, some of the social workers turned to external social workers who were based in service organisations such as DSD. **RP2** highlighted the value of and established professional network that had developed over time: "*Lucky for me, I have been in service for a long time. I rely on other social workers…To survive you have to sort or have a network of other social workers to consult with. That's how we survive in the health sector."* Support from multidisciplinary team members, social workers within and outside the hospitals where they worked, formed a meaningful network of collegial support that strengthened the coping measures of the social work participants (Mette et al 2020:5).

The penultimate subtheme was about professional social work **education and training** being a coping strategy, and external education and training opportunities revitalising some participants. Two participants stated that their undergraduate Bachelor of Social Work education and training had prepared them well for helping client systems to cope with general difficult life situations. The ecological systems approach, family systems theory, and holistic theory knowledge base benefitted them and the multidisciplinary teams in which they functioned. This knowledge base increased their self-esteem, professional identity and personal confidence, all of which strengthened their resolve to cope when their work situation was stressful. In the absence of a continuous professional development training programme for social workers in the Waterberg District for hospital, the onus fell on them to find their own CPD training opportunities. This point was demonstrated by **RP10**: *"At the end of the day, I don't even mind using my own data and resources to learn something that will help me professionally. I am happy to learn things online."* It was therefore concluded that education, undergraduate and ongoing education were appropriate coping strategies for the social workers in state hospitals in the Waterberg District. The benefits of ongoing education and training of hospital social workers is acknowledged in the literature, but usually in terms of specialised training in specific health care areas (Ahmed et al 2019:234; Jafree & Burhan 2020). Scholarly sources acknowledge the importance of ongoing training for all social workers as it increases job satisfaction, enables social workers to adapt to their work environment, improves counselling know how and builds management skills (Calitz et al 2014:160; Mette et al 2020:5).

The final subtheme pertaining to **coping strategies** used by the social workers in the multidisciplinary teams in the state hospitals in the Waterberg District was to adhere strictly to district and provincial DoH policies. Whilst the policies the social workers strictly followed were not social work policies, as "resident guests in a host organisation" (Liao et al 2010:05) they followed the health setting policies and practice procedures. Expressions by **RP2** and **RP9** endorsed the policies and rules at their disposal, which gave social workers direction and clarity about what they had to do, when they had done certain tasks, and who they needed to involve because these were indicators of the standards of care expected of all multidisciplinary team members.

One participant was stressed and could not identify any coping strategies that were effective. The participant's work situation continued to overwhelm the participant, because the resources available were severely lacking (Teater 2014). Given the unlikelihood that the stressors would change, the participant considered leaving the hospital's service.

- ***Conclusion*:**

With reference to **participants' coping strategies**, Gitterman and Germain (2008:55) identified three interventions recommended for "adapting" and achieving a better person-in environment fit, namely changing themselves, changing the hospital environment, and altering the social worker-hospital interactions to negotiate a better adaptive person-in-environment fit.

- The most popular form of adaptation referred to by the participants, was for the social workers to change themselves. Participants used a combination of control-oriented techniques such as problem solving, cognitive restructuring, emotional expression and altruistic resilience (Mette et al 2020:5). When these failed, they turned to others in the hospital setting for support, such as their supervisors and collegial connections. This included other multidisciplinary team members within hospitals where they were based, or social workers situated in other state hospitals in the Waterberg District, or social workers based in other social work service offices. It was strongly stated that to cope, social workers needed to establish a network of support for themselves. The network of support provided them with emotional support and guidance, and to a lesser extent helped to alerted the hospital administrators about the stressors that social workers had to contend with. The social work supervisors and multidisciplinary team members were the proactive groups who raised the concerns of the social workers with management teams.
- There was no evidence of changing the hospital environment interactions to negotiate a better fit between the social workers and the hospitals that employed them. It was

concluded that systemic workplace change in the state hospitals in the Waterberg District was needed to resolve the stressors experienced by social workers in relation to occupational boundaries, resource allocation and work conditions that impact on social workers (Wiles 2013:859). However, it was also acknowledged that the involvement of the DSD and SACSSP in addressing the issues was needed.

The fourth sub-question developed for this study was ***What coping strategies do social workers working in multidisciplinary teams in state hospitals in the Waterberg District use?*** The researcher concluded that this research objective was adequately fulfilled.

(5) Theme 5: Participants' recommendations to improve the occupational satisfaction of social workers in multidisciplinary teams in state hospitals in the Waterberg District.

- ***Summary:***

Under this theme participant shared their recommendations of what had to be done to improve the occupational satisfaction of social workers in multidisciplinary teams in state hospitals in the Waterberg District. Their recommendations were presented in three subthemes, namely improving the work conditions of social workers in the workplace; offering training and professional development; and providing hospital social workers employee wellness programmes and debriefing sessions.

The suggestions for **improving the work conditions** of social workers in the workplace included: reviewing the remuneration of social workers in the state hospitals in the Waterberg District, ensuring that occupational resources that social work departments needed were budgeted for, increasing the support and acknowledgement the social workers received in the hospitals; appointing more social work supervisors; and creating clearly defined job descriptions for the social workers in the state hospitals in the Waterberg District.

The remuneration of social workers was a contentious issue given the high patient-to-social worker ratio, and the disparity of salaries amongst social workers and other professionals in the multidisciplinary teams. **RP2** recommended: *"We must be remunerated the same as other professions. We must be recognised in the same way that other professionals are recognised."* The issue of unfair remuneration of social workers is a long-standing one and not specific to the state hospitals in the Waterberg District (Ashcroft, McMillan, Ambrose-Miller, McKee, & Brown. 2018:113; Schweitzer et al 2013:152). When this happens, employee's motivation and job satisfaction are affected (Martono et al 2018: 535).

The bureaucratic control over resource allocations resulted in social workers having to do without the "tools of their trade" which as confirmed by academic sources reduced the job satisfaction of social workers in multidisciplinary teams (Limon 2018:28; O'Reilly et al 2017). The occupational resources such as access to private office spaces, telephones, and transport to do home visits were meant to enhance patient treatment outcomes and patient satisfaction, rather than benefit the social workers personally. **RP2's** storyline demonstrated this: "*The resources are important for improving the satisfaction of our patients. Remember, it is not all about us. It is about doing better for the patients."* Tambasco et al (2017:149) explain that the expansion of material resources for social workers must be addressed to improve their job satisfaction in hospital settings.

Participants then recommended hospital management should offer more support to social workers. Ensuring that social workers received the occupational resources that were mentioned such as suitable interviewing spaces, internet connection, printers, telephones and transport was one suggestion of how hospital management could demonstrate support of social workers in the hospital. The second recommendation was for hospital management to be clear about what was expected of social workers in hospital settings and understand the scope of social work services that social workers were meant to deliver and communicate this to other team members. The last recommendation was for management to treat social workers and other multidisciplinary team members equitably. Ajala (2013:47) reminds us that when organisation support is experienced by employees, their commitment to the organisation, and job satisfaction improves. Building organisational support was regarded by **RP10** as a two-way process, where social workers needed to demonstrate greater appreciation of other multidisciplinary team members, and acknowledge them for the roles they fulfilled, and work towards open and clear communication between themselves and other team members. Participant **RP9** urged as follows that social workers should be willing to lobby for change for the status of social workers within hospital settings, themselves: "*We need to mobilise, we need to mobilise people in the hospital so that management hears us…They must hear us and they must advocate for us at a higher level. The authorities must allow us to explain why we are unhappy and then address our concerns."* Several scholarly sources indicate that if social workers want to be taken seriously, the process should begin with themselves (Beddoe 2013:169; Raniga & Kasiram 2010:271; Weiss 2005:10). These findings are consistent with other scholarly works. Firstly, a good person-in-environment fit relies on greater human-relatedness within the workplace (Carpenter & Platt 1997:347). Secondly, social workers should experience more respect and acknowledgement, positive communication, and fair distribution of responsibilities within the multidisciplinary teams (Albrithen & Yalli 2016:132). The perspective held by participants was that the state hospitals in the Waterberg District failed

to take the importance of regular supervision from qualified social workers seriously, as discussed on section 4.3.1.1 which motivate the recommendation that all the hospital social workers should be supervised by qualified social workers, and not allied clinical line managers. Recommendation was as follows: *"Maybe, if we can have social workers as our managers, proper social work managers* [referring to qualified social work supervision] *We do not only want to be managed by other professionals."* It was suggested that there be a designated social work supervisor for each hospital and area so that every social worker would be supervised by someone who was qualified to supervise them. The frozen posts for social work supervisors, therefore, should be opened so that hospital social workers in the state hospitals in the Waterberg District would receive quality supervision as regulated by the Social Service Professions Act 110 of 1978; the Code of Ethics of the Social Work Profession and the Supervision Framework for the Social Work Profession in South Africa (2012).

The last category as discussed in section 4.3.5.1, was to develop clearly defined job descriptions for social workers in the multidisciplinary teams in the state hospitals in the Waterberg District. The recommendation was that the government should initiate a collaborative process involving DoH stakeholders at provincial and national levels to develop a common understanding of what social work in their context should include, so that a standard job description for social workers could be compiled and accepted. The different hospital settings that employed social workers could adapt the general job description to align it to the specialist services required in their hospitals. This position is opposed by Shier and Graham (2013:107) who recommend that the professional associations for social workers should avail themselves in this regard. In the South African context, it would be necessary to include DSD. Another suggestion was for hospital administrators to issue a directive to all hospital staff about what should and should not be expected of social workers in the state hospitals in terms of their professional mandate. The last recommendation was for social workers to arrange a workshop to educate hospital managers, allied clinical managers and multidisciplinary team members about their role in the hospital setting. **RP7** was convinced that management and staff would be sensitised about how they could support social workers and motivated to provide the resources they required to fulfil their professional tasks within the hospital setting once their understanding of social work in the hospital setting improved. A few participants commented that in addition to these recommendations, individual social workers had an ongoing responsibility to educate those who overstepped their boundaries or made inappropriate referrals to social workers in the hospital setting. It seemed obvious that ongoing dialogues between social workers, members from other disciplines, and hospital administrators were necessary (Wiles 2013:859).

The recommendations for improving the working conditions of social workers were feasible. If operationalised, they could improve the job satisfaction of the social workers. Policies were needed in the workplace to regulate the working conditions of social workers based in state hospitals in the Waterberg District. The policies needed to address the remuneration of social workers, the allocation of occupational resources, ensure that measures would be in place to increase the support and acknowledgement social workers received from other disciplines and management, provide social work supervision for social workers, and develop a clear job description for social workers. The achievement of these would strengthen the professional identity of social workers in the state hospitals (Caza & Creary 2016:4).

The next subtheme highlighted participants' recommendations for ongoing **training and professional development** for social workers based in state hospitals in the Waterberg District. These recommendations were discussed in terms of the following three categories: in service training for social workers, continuous professional development for social workers, and career planning and professional development plans for social workers in state hospitals in the Waterberg District.

The in-service trainings as recommended, would be in the form of regular information sessions offered by different government departments. They would address trending social realities and inform social workers about resources and opportunities available to patients. By empowering social workers to educate patients about existing support structures, they would be enabling patients to strengthen themselves, their families and communities (Qalinga 2022:76).

The second recommendation was to ensure that opportunities were created for social workers to participate in accredited CPD training which would safeguard the social work profession and promote career development of social workers (Calitz et al 2014:160; Green 2010:314). The need for CPD training for social workers in the hospitals were important to **RP7**, because the CPD training social workers were offered in the hospitals were not accredited by the SACSSP: "*So the trainings in the hospital are based on the HPCSA's requirements for accredited CPD training activities. This means that social workers are excluded, and without proper CPD training their registration with the Council is threatened. I think that they* [referring to management] *should look at this carefully so that social workers don't lose out."* Participants indicated that it should be the responsibility of hospital management to create opportunities for social workers to advance their knowledge and skills. Failure to do so could in future lead to the deregistration of social workers who did not to earn the required CPD points each year. Employers are cautioned that in times to come, those who fail to expose their staff to ongoing

training and development may be liable for unfair labour practice (Manthorpe & Moriarty 2014:399).

Career planning and the development of professional development plans for social workers in state hospitals in the Waterberg District was the final recommendation. This recommendation was in response to the limited promotional opportunities available to social workers working in state hospitals in the Waterberg District. **RP9** recommended: "*Social workers need to be given opportunities to better themselves. But here, in terms of promotions, ehhh! When I say that social workers should be given opportunities to be promoted to more senior posts…ehhh…What I can say, the posts are already there. They are empty spaces.* [The participant refers here to the vacant positions reflected on the organogram] *They must do something about them*." **RP2** proposed the introduction of professional career development plans for social workers with the annual professional management development assessments that social workers completed annually. The social worker and management teams could identify training opportunities together that would benefit the social worker and the hospital and enable them to achieve the annual professional CPD targets set by the SACSSP. Professional development plans are known to reassure employees that the employer is committed to investing in them and interested in their career progression. Career development plans were recognised **RP2** as one way of keeping social worker's hopeful about their prospects in the state hospitals in the Waterberg District (Ajala 2013:48).

The last subtheme in Theme 5 was a recommendation for the introduction of **employee wellness programmes and debriefing sessions** for social workers in the state hospitals in the Waterberg District. Participant **RP3** noted as follows that the hospitals had overlooked the importance of offering social workers support and resources to assist them to deal with the stressors they encountered whilst attending to the draining circumstances of their patients: "*The other things I can say is that they treat us like ordinary employees.* [The participant suggested that hospital administrators failed to consider the work of social workers to be potentially harmful]. *In general, we are not well cared for. Like we don't have any employee wellness services. That is what we should have."*

The second recommendation mentioned was that of **RP5**, for providing social workers with debriefing services. **RP5's** recommendation was different to the formal interpretation of debriefing: "*I really think that for social workers there should be debriefing. And there should be some kind of get together for social workers. We must meet once a year where we can talk to one another and share ways to cope. The social worker can say, 'This is what you should do' or 'This is not how it should be done'."* Mostly debriefing offers participants formal

emotional and psychological care to those who have been exposed to traumatic situations. The benefits of such an intervention for employees are that both employees' wellness and patient care benefit favourably from providing such interventions for employees (Ajala 2012:49).

- ***Conclusions:***

In conclusion, regarding participants' recommendations for improving the occupational satisfaction of social workers in state hospitals in the Waterberg District, several recommendations were made by participants about how the job satisfaction of the social workers working in multidisciplinary teams in state hospitals in the Waterberg District could be improved.

- The recommendations were largely related to improving the working conditions of the social workers in the state hospitals. This could be done by increasing their remuneration, securing additional resources for social workers, increasing the support they received from other disciplines and hospital management and acknowledging the contribution social workers make in the hospital settings, ensuring that all social workers are supervised by professional social workers based in the state hospital settings, and clarifying their role within the hospital team.
- A more structured training system needed to be established to address the training and development need of the hospital social workers. The structured training proposed would consist of special in-service training opportunities for the social workers, involving presentations by DSD and other government departments and social service organisations, access to accredited CPD for the hospital social workers, and career development plans alongside the annual professional management development assessments for individual social workers.

The fifth sub-question developed for this study was ***What recommendations do participants have for improving the occupational satisfaction of social workers working in multidisciplinary teams in state hospitals in the Waterberg District use?*** The researcher concluded that this research objective was adequately fulfilled. The participants' proposals of how the occupational satisfaction of social workers in state hospitals the Waterberg District can be improved were used to inform the recommendations that are presented after the reflection of the limitations of this study.

5.2.4.3 Conclusions of Chapter 4

Figure 5.3, in the form of a schematic representation, offers a synopsis of the holistic process of change needed for improving the occupational satisfaction of social workers in multidisciplinary teams in state hospitals in the Waterberg District, based on the answers to the five research questions as presented.

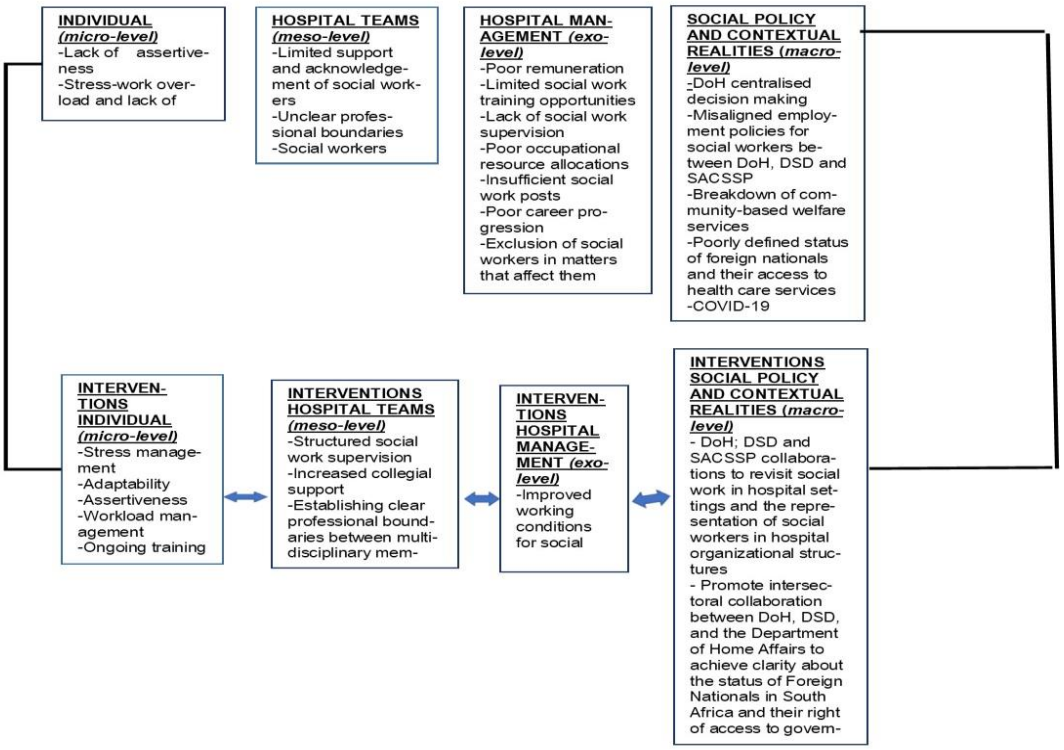

Figure 5.3. Process of change for improving the occupational satisfaction of social workers in multi-disciplinary teams

The findings of the study are schematically represented in Figure 5.3. reflecting the challenges experienced by the participants across four ecological levels, the micro to macro-system levels. The participants' descriptions of the transactions hospital social workers had with multidisciplinary team members, hospital management and policy makers were largely one-directional and distant. Without social workers being able to represent their interests at each level, the stressors they experienced in the workplace were difficult to resolve. The participants' recommendations for improving the occupational satisfaction and professional identity of social workers in multidisciplinary teams are reflected in the second line, as proposed interventions. Whilst interventions were proposed for each system level, it should be noted that the transactions between social workers and the different system levels need to be

stronger, more inclusive and bidirectional. Direct, open communication, and inclusion are protective factors that drive positive change that over time will improve the occupational satisfaction and professional identity of social workers, even amidst the external challenges over which they have little control. Strengthening interactions between the health professionals, management and policy makers is therefore strongly indicated.

In accordance with Gitterman and Germain's (2008:55) recommendation for promoting the adaptability of hospital social workers to the health care system, the following three sets of recommendations were received from participants:

- Change within themselves to enable facilitate their "adaptedness" to the demands of health care systems. In this regard the recommendations made by participants included stress management, adaptability, assertiveness, workload management and participating in ongoing professional training and skills development.
- Efforts to change the hospital environment to be more responsive to the needs of social workers and their aspirations. The recommendations made target the meso and the exo-system levels. The proposed interventions for increasing support for the hospital social workers include ensuring that social workers receive structured social work supervision, building collegial support within the social work department and multidisciplinary teams and establishing clear professional boundaries amongst multidisciplinary team members. The interventions recommended for hospital management focus on two broad areas, namely revisiting the working conditions of social workers in state hospitals in the Waterberg District and including social workers in making decisions that affect them. In terms of the latter intervention, it was recognized that there is an urgent need for social workers to have a designated person to represent their social work-related interests and concerns within the organizational structures.
- Change the social work hospital environment interactions to negotiate a better fit. The findings suggested that many of these interactions have systemic causes and therefore those involved in policy development need to be involved in facilitating change. The primary intervention recommended was to facilitate national collaboration between DoH, DSD and SACSSP so that the role of social work in hospital settings can be revisited, the organizational structures of hospitals amended to increase the participation of social workers in hospital matters that affect them, and DoH service conditions of social workers to be better aligned with those of DSD and the regulations for social workers developed by the statutory professional body, the SACSSP. Secondly, the status of foreign nationals in South Africa and their right of access to health care requires much more clarity and inter sectoral collaboration between DHA,

DoH and DSD. Such collaborations will not only uphold the human rights of foreign nationals, but also resolve practical issues hospital social workers are burdened with outside their professional tasks. Amongst such issues are arranging interpreters for the multidisciplinary teams to be able to converse with foreign nationals, processing paupers' funeral applications and tracing the families of foreign nationals. Finally, there was an urgent call for policy makers to identify measures that will strengthen the capacity and sustainability of NGOs given that the resources to support communities are rapidly shrinking.

The researcher concluded that the purpose of the research study was achieved according to the findings of the interviews. Each research objective was achieved. The recommendations as developed from these discussions are presented after reflecting on the important limitations inherent in the study.

5.3 LIMITATIONS INHERENT IN THE STUDY

The focus now falls on the inherent limitations in this research. The limitations include the non-generalisation of the findings; limitations in terms of the demographic profile of participants; limitations of conducting research in the workplace; and limitations of the virtual online discussion forum.

5.3.1 Non-generalisation of the findings

The strength of the study lies in the detailed information gathered about the experiences of social workers working in multidisciplinary teams in state hospitals in the Waterberg District, and the coping strategies they used to adapt to challenges they faced in the workplace. The depth of information was possible because only a limited number of participants were included which was practical and resulted in a personalised research process. There were ten participants recruited from a locally-specific area, the Waterberg District. The non-purposive sample, small group size and specific geographical location of the study suggest that the results cannot be generalised to a wider population. This is consistent with the nature of qualitative studies.

5.3.2 Limitation in relation to the demographic profile of participants

There were two main limitations related to the demographic profile of participants. The first was that only one African male participant took part in the study and the second, only one white female participated in the study while the rest of particpiants were African femsles. The sample represented the demographics of the social workers working in multidisciplinary teams in state hospitals in the Waterberg District, Limpopo Province. There were only two male social workers working in multidisciplinary teams, one of the participants, and the researcher. Female

social workers significantly outnumber male social workers in health care (Tambasco et al 2017). Similarly, the demographics of Limpopo Province reflect that 96.7 per cent of the province's population are Black Africans (Day, Budgell & Gray 2011:4; Wikipedia 2022) which explains why only Black African social workers are employed to work in the multidisciplinary teams in state hospitals in the Waterberg District.

5.3.3 Limitations of conducting research in the workplace

Serious consideration was given to the ethical implications of conducting this study at the researcher's workplace, particularly because of the power imbalance between himself and the participants because he was their senior in the state hospitals in the Waterberg District (Creswell & Poth 2018:154). The researcher knew that it would be difficult for participants to trust him to uphold their confidentiality and or they were likely to worry that they may offend him by speaking openly and honestly about their experiences (Carey 2012:133; Creswell & Poth 2018:154), and some would be afraid of a possible backlash after the findings are released. Several measures were in place to mitigate against the anticipated risks. Time was spent individually with each participant in a pre-interview session to discuss the threats as mentioned, reassure them that the DoH had sanctioned the study, clarify his role as one of researcher rather than senior social worker and assure them that an independent debriefer was available to process any negative experiences related to their participation in the study. Secondly, the researcher practised reflexivity throughout the study to keep his personal and professional experiences separate from those of research participants (Creswell & Poth 2018:261). Supervision, peer debriefing and the engagement of an independent coder held the researcher accountable for his research choices and applications of research methods and the interpretations of the findings. Keeping a research diary meant the researcher stayed mindful of his personal reactions and experiences throughout the research process (Creswell & Poth 2018:261). The researcher was satisfied that the research methods used helped to mitigate against the anticipated risks and resulted in meaningful insights about the research topic.

5.3.4 The limitations of the virtual online discussion forum

One cannot compare online face to face meetings with real life face to face meetings. The problems that were experienced during the virtual online discussion affected the outcome. Technical aspects such as the internet not being stable, the programme automatically logging some participants out and back in were problematic. It affected the attendance and the researcher had to replace the independent focus group facilitator. As a result, it was difficult to keep the discussion flowing, participants struggled to hear and follow one another and the multiple interruptions wasted time so that not all research questions could be answered in the

online group format. However, the session created a meaningful opportunity for participants to verify the findings as a group.

As a result of the findings and the researcher's thoughts about the study, several recommendations related to social work practice in multidisciplinary teams in state hospitals in the Waterberg District manifested. These are presented next.

5.4 RECOMMENDATIONS OF THE STUDY

This section is presented in sections comprising of the recommendations for social workers in hospital settings; recommendations for multidisciplinary teams, recommendations for hospital management in the state hospitals in the Waterberg District; commendations for policy development, and recommendations for further research.

5.4.1 Recommendations for social workers in hospital settings

The following recommendations were made for social workers in hospital settings:

- Ongoing training and capacity building are a responsibility of all social workers. It enables them to stay abreast of developments in social work practice and health care settings. Unless social workers develop themselves further, through training sessions, their professional skills suffer, they do not stay viable in the job situation, their self-efficacy suffers, and they become bored and unstimulated. Consistently mastering new skills and knowledge contributes positively to job satisfaction and professional identity. It is mandatory for social workers in South Africa to attend a CPD training sessions accredited with the SACSSP and obtain a certain number of points each year as prescribed by the SACSSP (2015:11). It is therefore important that social workers continue to participate in ongoing professional training and capacity building, especially those in hospital settings, because professional training is a positive contributor to job satisfaction and professional identity.
- Hospital social workers must prepare themselves for the specialist knowledge and expectations required of them to function in hospital settings. New hospital social work employees need to be properly inducted. Their induction training should increase their understanding of multidisciplinary teams in hospital settings, the roles and responsibilities of different multidisciplinary members, and DoH work policies related to patient management and standards of practice. Additional health information is required in several broad areas, such as medical knowledge, advanced professional skills needed to work with diverse patients, bio-psycho assessment skills, health education and prevention of illnesses, discharge planning, making referrals to inter-sectoral partners, advocating for policies, procedures and legislation that positively

contribute to the functioning and wellbeing of patients. Additionally, as proposed in the Regulations relating to the Registration of the Specialty in Social Work in Health Care (SACSSP 2020) social workers must be able to apply relevant models of interventions highlighted in South African legislation, policies and procedures such as the social development approach, the continuum of care, and inter-sectoral collaborations that to achieve sustainable social service solutions. Soon it will be necessary for those who wish to be registered as a clinical specialist social worker in health care, to augment their social work qualification, knowledge and experience with postgraduate learnings such as a master's degree in health care, post-graduate certificate, diploma, or accredited short courses in social work in health care.

- Social workers in hospital settings must be clear about the professional roles and responsibilities of social workers in multidisciplinary teams in state hospital settings. When they are uncertain about these, they struggle to set their professional boundaries and win the respect of other multidisciplinary team members. Social workers need to be more assertive to break the pattern of accepting tasks or referrals from other team members that do not fall within their professional mandate.
- Hospital social workers must decide how they will apply the basic tenets of the social development approach in the hospital setting. It is expected of all social workers in South Africa to apply models of intervention that are consistent with South African legislation, policies and regulations. It is important that hospital social workers reposition themselves and their hospital social work services to remain viable and true to their profession.
- It should be the responsibility of all hospital social workers to lobby to change the perceptions that other multidisciplinary team members have about social workers and their status in hospital settings. Such lobbying must be continuous and involve all hospital social worker's so that this change gains momentum. The lobbying should consist of both formal and informal change initiatives. Formal efforts should involve every social work department in every state hospital in the Waterberg District to offer regular information sessions for every new intake of staff in the hospitals to introduce them to social work and the scope of services social workers offer in state hospitals. These workshops should debunk commonly held misconceptions that hospital personnel have about social work. In addition, a well- designed media campaign is needed to design and circulate brochures about hospital social work amongst hospital staff and disseminate factual updates about hospital social work on social media platforms to target hospital staff. Informal lobbying is the responsibility of hospital social workers during their day-to-day interactions with other multidisciplinary team members. During the social workers' daily interactions with other team members, they must

correct commonly held misconceptions about social work roles and responsibilities and be more assertive in declining tasks or referrals directed to them that fall outside their professional mandate.

5.4.2 Recommendations for the multidisciplinary hospital teams

The recommendations made for the multidisciplinary hospital teams entailed the following:

- Multidisciplinary team members need ongoing support and guidance in the workplace. The hospitals need an organizational plan to ensure that every member of the multidisciplinary team is supervised by a designated person who has the same professional qualification as them. This person must also have the required experience and knowledge to teach the person new skills and work methods, offer guidance and support with difficult cases, quality control their work and encourage self-reflection. Allied clinical managers who serve as line managers should not offer team members "professional" or clinical guidance unless they are from the same profession. Regular supervision from a qualified social worker with work experience is prescribed for South African social workers by the SACSSP (2015:11). An organizational structure for supervision in Waterberg District state hospitals must be created so that social workers receive regular bi-monthly supervision from a qualified social worker, even if the social worker is based at another state hospital in the Waterberg District. Because of the geographical distance between the Waterberg District hospitals online supervision can be attempted to ensure supervisees and supervisors connect regularly.
- Every district hospital must delineate the responsibilities for the different professional disciplines represented in the multidisciplinary teams. Access to such information will contribute positively to transparency and openness within the teams and help to ease existing tensions caused by role ambiguity amongst team members.
- Collegial supervision and support should be encouraged. Collegial support is a positive team builder and cushions employees from occupational stress. For hospital teams to be supportive towards their members, the teams must have a designated space where they can meet, their meetings must be scheduled weekly, and they should all be involved in patient review meetings that are coordinated at times when all team members can be present. These measures will positively contribute to a culture of coordination, cooperation, shared decision-making and partnerships within the state hospital multidisciplinary teams.
- Hospital social workers in the Waterberg District need to form a support structure within the Waterberg District to increase the support they receive from one another and

narrow the geographical separation they suffer. The quarterly district meetings should be increased, and additional time should be allocated during the scheduled meetings to include two additional purposes. The first purpose is to offer social workers a space to exchange practice ideas and information. The second purpose is for group debriefing sessions facilitated by suitably qualified persons employed in the Waterberg District state hospitals. Finally, in keeping with the participants' recommendations, the hospital social work departments in the Waterberg District should be tasked to organize an annual self-care workshop for the hospital social workers to strengthen their coping measures to manage their workplace challenges.

It would be remiss at his point not to make recommendations for hospital management in state hospital in the Waterberg District.

5.4.3 Recommendations for hospital management in the state hospitals in the Waterberg District

The following recommendations were made for hospital management in state hospitals in the Waterberg District:

- It is strongly recommended that hospital management in the Waterberg District revisit the working conditions of social workers in the state hospitals there. Amongst the issues that need to be addressed by management, are the existing patient social work ratio; the allocation of occupational resources for social work departments; the lack of recognition and support social workers receive from hospital management; the shortage of qualified social workers to supervise social workers on a regular basis; the absence of an employee wellness programme and debriefing for social workers, inadequate and inappropriate training and development opportunities for social workers, particularly accredited CPD training; and the non-existence of career development planning for hospital social workers.
- It is further recommended that social workers be better represented at DoH at district and provincial levels to elevate their voices and concerns directly. Up till now, the line of communication that social workers in state hospitals in the Waterberg District have used to represent the interests of social workers are their line managers who are clinical allied managers. This communication chain has failed and it is recommended that a more participatory process be followed to include social work issues in management meetings. Social workers should be able to nominate one of the district

social workers to represent their interests and concerns as a spokesperson in hospital management meetings.

5.4.4 Recommendations for Policy Development

The set of recommendations to address suggestions for policy development relevant to this research topic entailed the following:

- The conflict of interests experienced by social workers working in state hospitals in the Waterberg District requires intervention at the highest level. Intersectoral collaborations between DSD, DoH and SACSSP are recommended to deliberate on and develop an effective staffing structure for social workers in state hospitals, an updated job description and scheduled training and supervision in the workplace as aligned to the national regulations for South African social workers. It is recommended that the SACSSP and the labour unions should advocate on behalf of the hospital social workers to resolve the conflict of expectations between DoH and the professional body of social workers and DSD in terms of what hospital social work should involve.
- Accredited training sessions required of specialist social workers in health care must be driven by the SACSSP. The SACSSP can enlist the support of institutions of Higher Learning to develop training offerings such as post graduate degrees, higher diploma and certificate courses, and short accredited training courses to address the shortages of such trainings. This will ensure that the current cohort of social workers in hospital settings can upgrade their qualifications to enable them to register as specialists in health care.
- Policies related to foreign nationals and their access to South African government services must be urgently revisited to protect the foreign nationals' human rights and dignity and ensure that foreign national recipients of South African governmental health care services are treated with dignity. The state hospitals need additional resources to treat the foreign nationals such as professional interpreters and additional administrators to trace relatives of foreign national patients and process applications for paupers' funerals for the deceased indigent foreign nationals. Intersectoral collaborations between the DHA the DoH state hospitals are needed.

5.4.5 Recommendations for further research

The study was an exploratory locally specific study and there is ample scope for further research in relation to this research topic. Hence, the following set of recommendations focuses on further research initiatives in relation to this research topic:

- It is recommended that further research be conducted to develop a model for enhancing the occupational satisfaction and professional identity of hospital social workers in state hospitals in the Waterberg District.
- It is recommended that a larger more rigorous study of the experiences of social workers in multidisciplinary teams in state hospitals be conducted with all hospital social workers in the Limpopo Province to confirm the challenges and coping strategies experienced by social workers working in multidisciplinary teams in state hospitals to build a more robust set of findings. Such a study should adopt a quantitative research approach.
- Further research is indicated to explore the experiences, benefits and challenges of hospital social work from the perspectives of hospital management in state hospitals in the Waterberg District.
- There is scope to research the perspectives of those currently employed as hospital social workers in terms of the introduction of the specialisation in health care and the advantages and disadvantages of the specialist registration for social workers who are already employed in state hospitals.
- It is recommended that additional research be conducted to develop a supervision framework for social workers in hospital settings.
- A further research topic is suggested to explore the perceptions of hospital social workers in terms of the feasibility of adopting a social development approach in hospital social work.

This concludes the final discussion in this chapter.

5.5 SUMMARY OF THE CHAPTER

The purpose of this chapter was to provide a summary of the whole study which was presented chapter by chapter. At the end of each section, the researcher offered his conclusions about how that section had contributed to the attainment of the research goal and objectives. Revisiting each section of the research process has enabled the researcher to conclude that the information gathered resulted in clear answers to the research question and sub questions.

The evidence presented supports the position that the study was successful in terms of achieving its purpose, to offer an in-depth understanding of the experiences, challenges and coping strategies of social workers working in state hospitals in the Waterberg District, Limpopo Province. It was, however, acknowledged that there were several limitations inherent in the study. The findings of the study provided robust information that the researcher used to develop his recommendations for hospital social workers, multidisciplinary teams, hospital management, policy development and future research.

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ADDENDA

ADDENDUM A: PARTICIPANT INFORMATION SHEET

Ethics approval reference number: 2020 SWREC-37323008
Research permission reference number:

Date:

Dear Prospective Participant

My name is Legodi Tsemeng Jack and I am doing research towards an MA (Social Work) degree at the University of South Africa under the supervision and guidance of Dr. Ann Petty. We are inviting you to participate in a study entitled:

Experiences of social workers in multidisciplinary teams in state hospitals in Waterberg District, Limpopo Province.

WHAT IS THE PURPOSE OF THE STUDY?

To investigate the experiences social workers in state hospitals in Waterberg District encounters and to develop recommendations/measures on how to manage such experiences and challenges.

WHY ARE YOU BEING INVITED TO PARTICIPATE?

As a social worker working in a state-based hospital in Waterberg District you have insights and experiences relevant to the research project. These can highlight the challenges and coping strategies that social workers experience as they address their daily tasks as social workers in a hospital. As a researcher I need to obtain this information first-hand from social workers based in these hospitals.

WHAT WILL THE NATURE OF YOUR PARTICIPATION BE IN THIS STUDY?

As a participant you will provide information about your experiences as a social worker working in a multidisciplinary team in a state hospital in the Waterberg District during an individual face-to-face interview(s) and a focus group discussion. Participation is voluntary and as a willing participant in the study, you have the right to withdraw your participation at any given time.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

There are no financial benefits for taking part in the study, however the recommendations from the study may assist to reduce the challenges encountered by social workers employed in the state-based hospitals in the Waterberg District because the social workers' insights will generate valuable recommendations of ways to improve the occupational satisfaction of social workers and enhance their professional identity in the hospital setting.

ARE THERE ANY NEGATIVE CONSEQUENCES FOR YOU IF YOU PARTICIPATING IN THE RESEARCH PROJECT?

There are no anticipated negative consequences for taking part in the study, however it is acknowledged that in telling one's experiences one may experience some emotional or psychological discomfort. Debriefing sessions with a social worker who is not involved in the DoH will be available for any participant who experiences this.

WILL THE INFORMATION CONVEYED TO THE RESEARCHER AND YOUR IDENTITY BE KEPT CONFIDENTIAL?

Yes**.** All those who play a direct role in the collection and analysis of data, or offer debriefing services are ethically bound to protect the identities of every participant. They are expected to reiterate this commitment by signing a confidentiality agreement. Any lapse on their part to do so can lead to their prosecution by the South African Council of Social Service Professions.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

All data will be stored in a safe place in a locked cabinet at the researcher's home. Pseudonyms will be used when the presenting the research findings. Any identifying details will be excluded from the research report. Field notes and digital recordings will be coded, and will not contain any participants' names

WILL YOU RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

No. Participants should obtain intrinsic benefits from participating in the study. They will be giving a voice to the issues that affect social workers working in state-based hospitals in the Limpopo Province. This will be used to develop recommendations about what needs to be done to maximize the role of social workers in state-based hospitals in the region, increase their occupational satisfaction and enhance their professional identity in the workplace.

HAS THE STUDY RECEIVED ETHICS APPROVAL?

Yes**.** Participants may request to see the ethical clearance certificate and the documents confirming that the required ethical approval was granted for the research to be undertaken.

HOW WILL YOU BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you would like to be informed of the final research findings, please contact Legodi Tsemeng Jack on 083 717 6919 (telephone number) or at email address tsemenglegodi@gmail.com

Should you have any concern about the way in which the research has been conducted, you may contact my research supervisor Dr. Ann Petty on her landline (031) 335 1742. Should you require any further information or want to contact the researcher about any aspect of this study, contact the Chairperson of the Research Ethics Committee of the Department of Social work at Unisa, Dr KJ Malesa (Acting chairperson). The chairperson can be contacted on this landline, (012) 429 4780. Should you feel that the information provided by the above research team is not sufficient for you to give consent to the study, you may direct queries to the Chairperson, Ethics Committee, College of Human Sciences, PO Box 392, Unisa, 0003. Should you agree to participate in this research study upon reading and understanding the contents provided, you are requested to give your written consent by signing and dating the information and attached consent form and to initial each section to show that you understand and agree with the conditions.

Thank you for taking time to read this information sheet and for participating in this study.

Yours sincerely

Signature: 

Name: Legodi TJ

ADDENDUM B: LETTER REQUESTING A SOCIAL WORKER'S PARTICIPATION IN THE RESEARCH PROJECT (CONSENT FORM)

INFORMED CONSENT FORM

TITLE OF THE RESEARCH PROJECT:

The experiences of social workers working in multi-disciplinary teams in state hospitals in the Waterberg District in the Limpopo Province

REFERENCE NUMBER: _____

PRINCIPAL INVESTIGATOR/RESEARCHER: Legodi Tsemeng Jack
ADDRESS: P O Box 705
Ga- Maraba
0705

CONTACT TELEPHONE NUMBER: (083) 717 6919)

DECLARATION BY THE PARTICIPANT: I, THE UNDERSIGNED, _____ (name), [ID No: _____] of _____ _____ _____(address) **A. HEREBY CONFIRM AS FOLLOWS:** 1. I was invited to participate in the above research project which is being undertaken by Legodi Tsemeng Jack of the Department of Social Work in the School of Social Science and Humanities at the University of South Africa, Pretoria, South Africa.	Initials
2. The following aspects have been explained to me : 2.1. Aim: The researcher is studying:	Initials

--- --- --- The information will be used to/for --- --- --- 2.2.I understand that --- --- --- 2.3. Risks: --- --- --- Possible benefits: As a result of my participation in this study --- --- --- Confidentiality: My identity will not be revealed in any discussion, description or scientific publications by the investigator/researcher. Access to findings: Any new information/benefit that develops during the course of the study will be shared with me. Voluntary participation/refusal/discontinuation: My participation is voluntary. My decision as to whether or not to participate will in no way affect me now or in the future. 3. The information above was explained to me by _____ (name of relevant person) in Afrikaans/English/Sotho/Xhosa/Zulu/other _____ (indicate other language) and I am in command of	Initials Initials Initials Initials Initials Initials

this language/it was translated to me satisfactorily by _____ (name of the translator). I was given the opportunity to ask questions and all these questions were answered satisfactorily.	
4. No pressure was exerted on me to consent to participate and I understand that I may withdraw at any stage from the study without any penalty.	Initials
5. Participation in this study will not result in any additional cost to me.	
B. I HEREBY CONSENT VOLUNTARILY TO PARTICIPATE IN THE ABOVE PROJECT. Signed/confirmed at _____ on _____20__ Signature of participant: ---------- Signature of witness: ----------	

ADDENDUM C: CONSENT FORM TO PARTICIPATE IN A RESEARCH STUDY

CONSENT FORM

I, _____, agree out of my free will that to participate in this research topic, which focuses on **the experiences of social workers working in multi-disciplinary teams in state hospitals in the Waterberg District in the Limpopo Province**

I understand that the information that I will share will be used for research purposes only and that my identity will be in nowhere made known in any research report or publication. I am also aware of the fact that I can withdraw at any time during the study without incurring any penalty.

_____

Signature of research participant

_____

Date

ADDENDUM D: CONSENT FORM REQUESTING PERMISSION TO PUBLISH

Name of researcher: LEGODI TSEMENG JACK

Title of research study: THE EXPERIENCES OF SOCIAL WORKERS WORKING IN MULTI-DISCIPLINARY TEAMS IN STATE HOSPITALS IN THE WATERBERG DISTRICT IN THE LIMPOPO PROVINCE

- I agree to participate in this research project.
- The researcher has explained the consent form and the purpose of the study, and I had the opportunity to ask questions about them.
- I understand that I was selected to participate in this study due to my current situation as a social worker working in multi-disciplinary teams in a state hospital in the Waterberg District in the Limpopo Province.
- I agree to my responses being used for educational and research purposes as long as my privacy is respected.
- I understand that I am under no obligation to take part in this research project.
- I understand that this research might be published in a research journal or book. In the case of dissertation or thesis research, the document will be available to readers in the University library in printed form, and possibly in electronic form as well.

Name of participant _____

Date _____

ADDENDUM E: DECLARATION BY THE PARTICIPANT

Title of the research: THE EXPERIENCES OF SOCIAL WORKERS WORKING IN MULTI-DISCIPLINARY TEAMS IN STATE HOSPITALS IN THE WATERBERG DISTRICT IN THE LIMPOPO PROVINCE

Reference:

Researcher: LEGODI TSEMENG JACK

Contact cell-phone number: 083 717 6919/ 076 799 0590

DECLARATION BY THE PARTICIPANT:	Initial
I, THE UNDERSIGNED, _____ (name), [ID No: _____] the participant of _____ _____ _____(address) A. HEREBY CONFIRM AS FOLLOWS: I was invited to participate in the above research project which is being undertaken by …….of the Department of Social Work in the School of Social Science and Humanities at the University of South Africa, Pretoria, South Africa.	
1. The following aspects have been explained to me: 1.1 The researcher is studying on the …… 1.2 The information will be used to …… ……	Initial
2. I understand that: Information about the goals and purpose of the research study has been explained to me. The reason for being selected to this project and that my participation is voluntary. I will not be pressured to participate in the research project. I will participate in …… The information that I will share will be audio- and paper recorded and later transcribed The information that I will share will be made available to the public through a research report and might be used in subsequent scholarly presentations, printed publications or further research. I have the right to ask for clarification or more information throughout the study.	

I have the right to withdraw from the study at any point.	
3. Risk and benefits: I do not see any risks associated with this study	Initial
4. Possible benefits: As a result of my participation in this study, suggestions and recommendations for……... …… ……	Initial
5. Confidentiality and anonymity: Every effort will be made by the researcher to ensure that my identity will not be revealed in any discussion, description or scientific publications by the researcher.	Initial
6. Access to findings: Any new information benefit that emerges during the course of the study will be shared with me. All information gathered from the participants will only be used for the purpose of this study and I will be able to access the findings from the researcher.	Initial
7. Voluntary participation, refusal and discontinuation: My participation is voluntary. I am free to withdraw or discontinue participating from the research study at any time with no negative consequences.	Initial
8. The information above was explained to me by …….. in ……. (language used) and I am in command of this language. I was given an opportunity to ask the questions and all the questions were answered well.	Initial
9. No pressure was exerted on me to consent to this study and I am aware that I can withdraw from the study at any time without penalty.	Initial
10. There are no financial costs directed to me for participating in this study.	Initial
I hereby consent voluntarily to participate in the above project Signed at _____on _____ 0f 20 _____ _____ Signature of participant Signature of witness	

ADDENDUM F: RESEARCHER ACKNOWLEDGEMENT

THE COLLEGE OF HUMAN SCIENCES

RESEARCHER ACKNOWLEDGEMENT

Hereby, I LEGODI TSEMENG JACK, ID number 8701185882086, in my personal capacity as a researcher, acknowledge that I am aware of and familiar with the stipulations and contents of the

- Unisa Research Policy
- Unisa Ethics Policy
- Unisa IP Policy

And that I shall conform to and abide by these policy requirements

SIGNED:

Date: 2020/02/20

ADDENDUM G: STATEMENT AND DECLARATION

STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S) I, LEGODI TSEMENG JACK, declare that • I have explained the information given in this document to_____ (name of participant); • he/she was encouraged and given ample time to ask me any questions; • this conversation was conducted in English and no translator was used. Signed at _____ on _____20___ (place) (date) _____ _____ Signature of investigator/representative Signature of witness	

IMPORTANT MESSAGE TO PARTICIPANT	
Dear Participant Thank you for your participation in this study. Should at any time during the study • an emergency arises as a result of the research, or • you require any further information with regard to the study, or • you need to refer someone who is a potential participant for this study, kindly contact me (LEGODI, TSEMENG JACK) at cell phone number, 083 717 6919/ 076 799 0590	

ADDENDUM H: RISK ASSESSMENT TOOL

RESEARCH ETHICS - RISK ASSESSMENT TOOL			
5.1	Does your research include the direct involvement of any of the following groups of participants? *(refer to section 4 in the SOP)*	YES	NO
Place an 'x' in the tick box [if yes, provide details in the space allocated for comments]			
a)	Children or young people under the age of 18		X
b)	Persons living with disabilities (physical, mental and/or sensory)		X
c)	Persons that might find it difficult to make independent and informed decisions for socio, economic, cultural, political and/or medical reasons		X
d)	Communities that might be considered vulnerable, thus finding it difficult to make independent and informed decisions for socio, economic, cultural, political and/or medical reasons		X
e)	People who might be vulnerable for age related reasons e.g. the elderly		X
f)	Unisa staff, students or alumni		X
g)	Persons whose native language differs from the language used for the research		X
h)	Women considered to be vulnerable (pregnancy, victimisation, etc.)		X
i)	Plants		X
j)	Molecular or cell research		X
k)	Animals		X
l)	Environmentally related research		X
m)	Other. Please describe.		X
Comments:			

5.2	Does your research involve any of the following types of activity?	YES	NO
Place an 'x' in the tick box [if yes, provide details in the space allocated for comments]			
a)	Collection, use or disclosure of information WITHOUT the consent/assent of the individual or institution that is in possession of the required information, i.e. will be conducted without the knowledge of the participants (with the exception of aggregated data or data from official databases in the public domain)		X

b) Causing discomfiture to participants beyond normal levels of inconvenience		X
c) Deception of participants, concealment or covert observation		X
d) Examining potentially sensitive or contentious issues that could cause harm to the participants	x	
e) Research which may be prejudicial to participants or may intrude on the rights of third parties or people not directly involved		X
f) Using intrusive techniques e.g. audio-visual recordings without informed consent		X
g) Study of or participation in illegal activities by participants that could place individuals and/or groups at risk of criminal or civil liability or be damaging to their financial standing, employability, professional or personal relationships.		X
h) Innovative therapy or intervention		X
i) Personal information collected directly from participants	X	
j) Personal (identifiable) information to be collected about individuals or groups from available records (e.g. staff records, student records, medical records, etc.) and/or archives		X
k) *Psychological inventories / scales / tests		X
l) Activities which may place the researcher(s) at risk		X
m) Collecting physical data from the participants such as body measurements, blood samples, etc.		X
n) Collecting physical samples from animals such as blood, etc.		X
o) Harvesting indigenous vegetation		X
p) Harvesting vegetation or soil from privately owned land		X
q) Other. Please describe.		X
Comments:		

**Please add details on copyright issues related to standardised psychometric tests and registration at the HPSCA of test administrator if test administration is in South Africa or of an equivalent board if administration is non-South African.*

5.3	DOES ANY OF THE FOLLOWING APPLY TO YOUR RESEARCH PROJECT?	YES	NO
Place an ' x' in the tick box [if yes, provide details in the space allocated for comments]			
a)	Reimbursement or incentives to any participants.		X

b) Financial obligations for the participants as a result of their participation in the research.		X
c) Financial gains to be anticipated by any of the involved researchers.		X
d) Any other potential conflict of interest for any of the researchers (real or perceived personal considerations that may compromise a researcher's professional judgement in carrying out or reporting research, such as conducting research with colleagues, peers or students).	x	
e) Research will make use of Unisa laboratories.		X
f) Research will be funded by Unisa or by an external funding body.	X	
Comments:		

5.4	Guided by the information above, classify your research project based on the anticipated degree of risk. *[The researcher completes this section. The ERC critically evaluates this benefit-risk analysis to protect participants and other entities.]* *Place an 'x' in the tick box*						
Category 1 Negligible		Category 2 Low risk		Category 3 Medium risk	*x*	Category 4 High risk	

(a) Briefly justify your choice/classification

The might be a minor emotional and psychological risk depending on both the emotional and psychological intelligence of the prospective participant, however debriefing services are put in place if the will be a need

(b) In medium and high-risk research, indicate the potential benefits of the study for the research participants and/or other entities.

The purpose of the study is to use the findings to create a positive working environment for social workers who are based in state-based hospitals in the Waterberg region. The researcher plans to use the social workers' recommendations of what is needed to enable social workers to perform their professional social work duties within the hospital setting, so that ultimately their occupational satisfaction and professional identity in the workplace will improve. The researcher believes that the intended outcome will outweigh the risks, provided he takes precautionary measures to reduce the risks.

(c) In medium and high-risk research, indicate how the potential risks of harm will be mitigated by explaining the steps that will be taken to minimise the likelihood of the event occurring (e.g. referral for counselling, debriefing, etc.)

A qualified social worker has been identified to render debriefing services for participants who may be psychologically or emotionally affected by their involvement in this study.

The qualified social worker will assist any affected participant to reduce the emotional discomfort by arranging a time and a safe place for them to process their emotional experiences

Information that may link any participant with a hospital or multi-disciplinary team will be edited to safeguard his/her identity. The way the researcher presents the findings will be carefully worded to protect participants.

Pseudonyms will be used to refer to participants in the research report.

Codes will be assigned to every field note and transcription to protect participants' confidentiality

All participants will be obligated to sign confidentiality forms, including the researcher, debriefer, independent coder, participants of the consultation workshop.

The chosen debriefer has knowledge and experience of the mandate of social workers and insight to recognise if participants require legal protection or intervention to deal with workplace conflict.

The researcher will exclude the two social workers based at the hospital where he works from the interviews but will use them for the pilot study if they are willing.

He plans to use multiple strategies to validate the findings- triangulation and will mention any negative cases in his analysis and will report on any disconfirming findings. Participant checks are planned throughout, and the researcher will collaborate with research participants constantly during the study (Creswell & Poth 2018:261)

Reflexivity will be used to keep any researcher bias in check (Creswell & Poth 2018:261). Supervision and peer debriefing will create opportunities to challenge the researcher about his choice and application of research methods, meanings and interpretations so that he endures that participants will remain protected from any harm.

An independent coder will be used during the data analysis phase to ensure that the researcher's perspectives do not contaminate the findings.

The consent given by the DoH to conduct the study will be made explicit to each participant to reassure them that their right to participate is protected.

ADDENDUM I: INTERVIEW GUIDE

Interview guide:

THE EXPERIENCES OF SOCIAL WORKERS WORKING IN MULTI-DISCIPLINARY TEAMS IN STATE HOSPITALS IN THE WATERBERG DISTRICT IN THE LIMPOPO PROVINCE

Biographical details

- Age
- Level of qualification
- Work grade
- Length of service
- Position held

Topical questions

1. What are your experiences of practising social work in the state hospital where you are employed?
2. What internal or external factors or circumstances positively or negatively influence your performance as a hospital social worker in your work setting presently?
3. What coping strategies enable you to fulfil your professional social work responsibilities as a hospital social worker given the current situational and contextual realities of working in a state hospital now?
4. What activities are you expected to perform as a social worker by other multi-disciplinary team members in the hospital where you work?
5. What are your thoughts regarding authority and decision-making processes within the multi-disciplinary team that you are part of in your hospital?
6. How does the hospital management facilitate or compromise your ability to fulfil your social work professional obligations to patients?
7. Please explain whether your voice as a social worker is heard or not in your work context.
8. What are the challenges that you are faced with as a social worker in the hospital where you are based?
9. What recommendations do you have for improving the occupational satisfaction of social workers in state-based hospitals in the Waterberg region?
10. How does the hospital where you work respect your professional identity as a social worker?
11. How do you rate your occupational satisfaction working as a social worker in a state-based hospital presently? Please explain your answer.

ADDENDUM J: LETTER ASKING PERMISSION FROM THE AUTHORITY

Attention : Head of Department
Department of Health
Limpopo Province

Enquiries : Legodi, TJ

Contact no : 083 717 6919

Email address : tsemenglegodi@gmail.com

Re : Request to do a research study with social workers in Waterberg hospitals

Date: 2020/02/20

Dear Sir/ Madam

My name is Legodi Tsemeng Jack. I am a Master's student in Social Work at UNISA, my student number is 37323008 and my ID number is 8701185882086. I am employed as a social worker at FH Odendaal hospital and planning to do a study within Waterberg District hospitals under the titled topic: **The experiences of social workers working in multi- disciplinary teams in state hospitals in the Waterberg District, Limpopo Province.**

I am hereby requesting permission to conduct this study with social workers employed in Waterberg District state hospitals. The study will be for educational purposes and a copy of the results (dissertation) will be forwarded to you at the end of the study.

Please forward your response via the email address included above to me and feel free to contact me at any given time for any queries that you may have.

Looking forward to hearing from you soon.

Yours sincerely

Legodi TJ
Researcher

Date: 2020/02/20

ADDENDUM K: EDITOR'S LETTER

DR J LOMBARD

RESEARCH REPORT CRITICAL READING, LANGUAGE & TECHNICAL EDITING

136 Erich Mayer St
Cel: 078 116 8018 PRETORIA NORTH
e-mail: berto@woodcarving.co.za 0182

EDITOR'S LETTER

EDITING OF MSW DISERTATION: TSEMENG JACK LEGODI (37323008)

This is to certify that I have critically read and edited Mr Tsemeng Jack Legodi's dissertation for the degree Master of Social Work (MSW) entitled:

The experiences of social workers working in multi-disciplinary teams in state hospitals in the Waterberg District, Limpopo Province

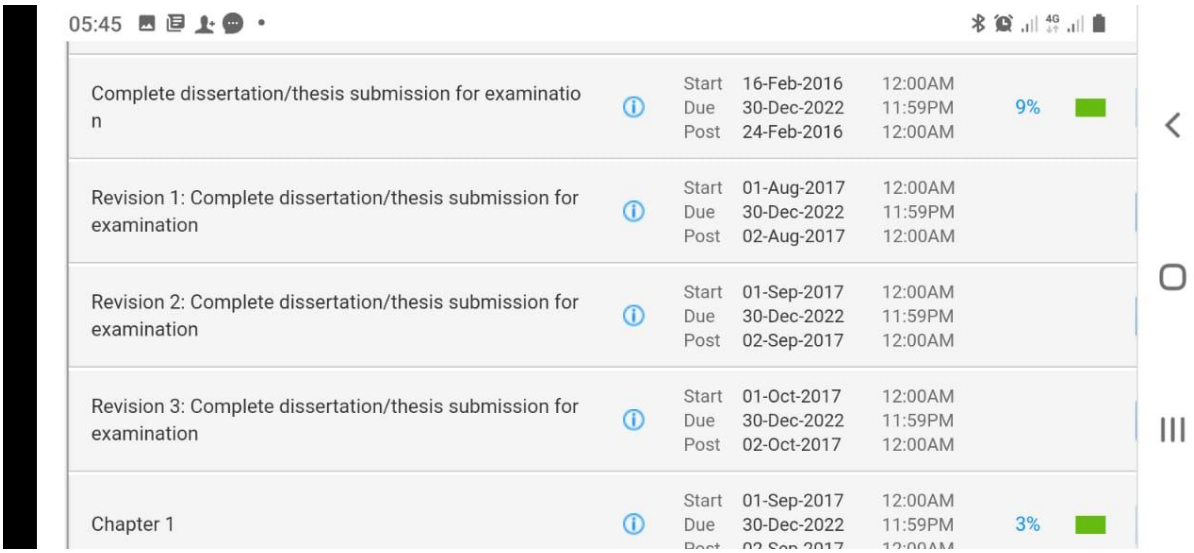
The following aspects of the dissertation were edited:

- Spelling
- Grammar
- Sentence structure
- Logical sequencing
- Consistency of references and reference method used
- Consistency of layout

The responsibility to do the corrections and implement my comments and suggestions correctly, remains that of the student.

DR J LOMBARD
1 November 2022

ADDENDUM L:TURNITIN REPORT



ADDENDUM M: REQUEST FOR DEBRIEFING SERVICES

Att : Manhange M.R

Enq : Legodi T.J

Contacts : 083 717 6919

E-mail address: tsemenglegodi@gmail.com

Date : 26 August 2019

Re : Invitation to participate as research participants' debriefer

Greetings to you Madam

You are cordially invited to participate as research group participants debriefer for my research project, the research project will focus on social workers in Waterberg district hospitals where I request you to assist by debriefing those participants who might need debriefing sessions as a result of taking part in the research study. The research study is for my educational purposes.

Your positive response in this regard will be highly appreciated

Yours faithfully

Legodi T.J
Researcher

ADDENDUM N: ACCEPTANCE LETTER FROM DEBRIEFER

Date: 30 September 2019

Enquiries: Mahange M.R

(014)718 – 7224

Re: Permission for Legodi T.J. to refer clients for research purposes

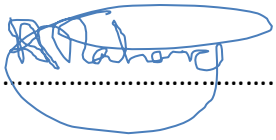
This letter serves to inform you and your institution (UNISA) request to refer clients (research participants) to our office during for the duration of the data collection phase or when the need arise, including debriefing and counseling needs of participants during your study has been approved. My office will be ready for sessions Monday to Friday from 07:30 to 16:30.

I am a practicing social worker registered with the South African Social Services Professions (SACSSP), my registration number is 103-5530. My Curriculum Vitae has been attached to the letter for more information.

Kind wishes

M.R Mahange

Medical Social Worker



……..

ADDENDUM O: CURRICULUM VITAE OF DEBRIEFER

Personal Data

Names	Rosemary Maseipei
Surname	Mahange
Maiden name	Mabunda
Contact Details	Cell phone: 072 676 7720 Work: (014) 718 -7224 E-mail: rmabund@yahoo.com
Residential Address	48 Koot van der Walt Street Bela-bela 0480
Identity Number	781110 0484 08 1
Drivers Licence	Code B
Own Transport	Yes

Education and Training

Qualification	Institution	Year	Majors
Current Studies B A Psychology	UNISA	2016 to currently	Health and Community Psychology
Certificate in Short Course Employee Assistance Programme	Enterprises University of Pretoria	2- 5 October 2018	Therapeutic Components of EAP Contextualization of EAP EAP and Wellness
B A Social Work	UNISA	2014	Social Work I – IV Psychology I – III
Certificate of Attendance	UNISA Chance to Advance Workshops	2014	Understanding the Role of Local and National Government, Management of sexual offences: Family Violence, Child abuse and Sexual Violence.
Certificate in HIV & Aids Counseling	UNISA	2011	HIV and Aids Care and Counseling

Leadership roles

- Team leader for the research team at UNISA Bright Site Project – Department of Social Work (2014)
- Team leader for Ministry of helps, Ministry of Couples Fellowship & Children's Ministry.

Employment Details

Current Details	Organization	Duration
Medical Social Worker	Limpopo Department of Health	09 September 2015 to currently

Responsibilities

- Intake psychosocial assessment, counselling and implementation of various interventions of in and out patients and their families;
- Provide psychosocial support and other social work services to all patients;
- Conduct home visits to assess home circumstances of patients and provide health education to affected communities, families and groups;
- Conduct outreach and support services to communities, clinics and hospitals promoting Department of Health and Social Work services;
- Recommending or referring individual clients to an appropriate external resource for further intervention where clinically appropriate;

ADDENDUM (P): INVITATION LETTER TO THE FOCUSSED GROUP FACILITATOR

Att : Ledwaba B.V

Enq : Legodi T.J

Contacts : 083 717 6919

E-mail address: tsemenglegodi@gmail.com

Date : 26 August 2019

Re : Invitation of participation as focused group facilitator

Greetings to you Madam

You are cordially invited to participate as the focus group facilitator for my research project, the research project will focus on social workers in Waterberg district hospitals where I request you to assist by facilitating the focussed group discussions. The research study is for my educational purposes.

Your positive response in this regard will be highly appreciated

Yours faithfully

Legodi T.J

(Researcher)

Addendum Q; Permission letter by the DoH to conduct the study in Waterberg District hospitals

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Ref .. LP-2020-07-01 1
Enquires .. K. Letseparela
Tel .. 015-293 6028
Email .. Kurhula.Hlomane@dhsd.limpopo.gov.za
TJ Legodi

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES

Your Study Topic as indicated below;

Experiences of social workers in multidisciplinary teams in state hospitals in Waterberg District, Limpopo province

1. Permission to conduct research study as per your research proposal is hereby Granted.
2- Kindly note the following:
   a. Present this letter of permission to the institution supervisor/s a week before the study is conducted.
   b. In the course of your study, there should be no action that disrupts the routine services, or incur any cost on the Department.
   c. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
   d. The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   e. The approval is only valid for a 1 -year period.
   f. If the proposal has been amended, a new approval should be sought from the Department of Health
   g. Kindly note that, the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated

Head of Department

31/08/2020

Date

Private Bag X9302 Polokwane
Fidel Castro Ruz House, 18 College Street. Polokwane 0700. Tel: 015 293 6000/12. Fax: 015 293 6211.
Website: http/www.limpopo.gov.za

Addendum R: Ethical clearance certificate

SOCIAL WORK RESEARCH ETHICS COMMITTEE (SWREC)

Date: 6 July 2020

Dear Mr TJ Legodi

DECISION:
Ethics approval from 6 July 2020 to 31 January 2021

SWREC Reference #: 2020-SWREC-37323008
Name: Mr TJ Legodi
Student #: 37323008
Staff #: N/A

Researcher(s): Name: Mr TJ Legodi
Contact details: 37323008@mylife.unisa.ac.za; 083 717 6919

Supervisor(s): Name: Dr A Petty
Contact details: pettya@unisa.ac.za, 031 5722326

Title of research:
Experiences of social workers in multidisciplinary teams in state hospitals in Waterberg District, Limpopo Province

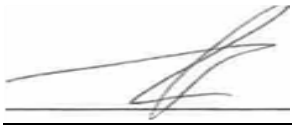
Qualification: Master of Social Work (MSW)

Thank you for the application for research ethics clearance by the Social Work Research Ethics Committee

(SWREC) for the above mentioned research. Ethics approval has been granted effective from **6 July 2020.**

The following are standards requirements attached to all approval of all studies:

1. Approval will be for a period of **six months** from of the date of issue of the certificate. At the end of this period, if the study has been completed, abandoned, discontinued or not completed for any reason you are required to submit a report on the project. If you complete the work earlier that you had planned, you must submit a report as soon as the work is completed. Reporting template can be requested from the SWREC administrator on radebn1@unisa.ac.za
2. However, at the **end of six months' period** if the study is still current, you should instead submit an application for renewal of the approval.
3. Please remember that you must notify the committee in writing regarding any amendments to the study.
4. You must notify the committee immediately in the event of any adverse effects on participants or any unforeseen event that might affect continued ethical acceptability of the study.
5. At all times you are responsible for the ethical conduct of your research in accordance with the SWREC standard operating procedures, terms of references, National Health Research Council (NHREC) and university guidelines.
6. During data collection, ensure that you adhere to the UNISA COVIC-19 regulations. Yours sincerely



……

Dr KJ Malesa: Chairperson of SWREC

Email: maleskj@unisa.ac.za

Tel No.: (012) 429 4780

Addendum S: Letter of confidentiality

Letter of confidentiality

I (title Prof/ Dr/Mr/Mrs/Ms)……..(full names and surname)ID number……..contact details and E-mail address…….declare that I understand the content of the research protocols and terms of confidentiality, I therefore agree that assisted Mr Legodi Tsemeng Jack ID 8701185882086, contacts 0837176919, email address tsemenglegodi@gmail.com with participation in the research study/ the English grammar editing/or coding of his transcripts for his data collection process under his study ***"The experiences of social workers in multidisciplinary teams in state hospitals in Waterberg District, Limpopo Province".*** I therefore state under oath that I will keep the content of the transcripts confidential.

Signature: ……..

Date: 2021/

ADDENDUM (T): ACCEPTANCE LETTER BY FOCUS GROUP FACILITATOR

Att: Legodi TJ

Contacts: 083 717 6919

Enq: Ledwaba BV

Contacts: 071 832 4036

E-mail address: ledwababuwa@gmail.com

Date: 2019/10/01

Re: Participation as focused group facilitator

Greetings to you Mr Legodi

Please note that your letter requesting me to participate in your research study as a focussed group facilitator was received and approved. I'm available to help you with the focussed group facilitations. Please inform me in advance with the dates which you will need me to assist you with the facilitation so that I may plan in advance from my side.

Yours sincerely

Ledwaba BV

……